PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

MADA INSURANCE TRUST

TRADITIONAL 60/40

EFFECTIVE: JANUARY 1, 2012

RESTATED: JANUARY 1, 2017

NOTICE

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

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INTRODUCTION

This document is a description of MADA Insurance Trust (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

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

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

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

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

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

EBMS (the Claims Administrator) utilizes Aetna's Clinical Policy Bulletins (CPBs) to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The CPBs are based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals and guidelines from nationally recognized health care organizations. These CPBs are reviewed on a regular basis based upon a review of currently available clinical information.

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

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

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

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

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Claim Review and Audit Program. Program of claim review and auditing to identify charges billed in error, excessive or unreasonable fees, and charges for services which are not Medically Necessary.

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

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

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

Plan Exclusions. Shows what charges are **not** covered.

How To Submit A Claim. Explains the rules for filing claims and the claim appeal process.

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

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

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

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are reasonable and customary (as defined as an Allowable Charge); that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Pre-certification of certain services is required by the Plan. Pre-certification provides information regarding coverage before the Covered Person receives treatment, services or supplies. ***A pre-certification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan at the time services are provided.***

FACILITY SERVICES:

Northern Rockies Healthcare Alliance (NRHA) Facility:

This Plan has entered into an agreement with the Northern Rockies Healthcare Alliance (NRHA). The NRHA is an Accountable Care Organization (ACO) which contracts with certain facilities within the state of Montana. For more information regarding a list of NRHA facilities and their locations, please refer to the following website, www.mtada.com, or contact the Claims Administrator toll-free at (866) 312-6723.

When a Covered Person uses an NRHA facility, a lower deductible amount and maximum out-of-pocket amount will apply than when a non-NRHA facility or an Out-of-Network facility is used, except in the event a non-NRHA facility or Out-of-Network facility is used in connection with Mental Disorder or Substance Abuse treatment. The NRHA facility deductible and maximum out-of-pocket amount will apply for facility charges in connection with Mental Disorder or Substance Abuse treatment.

Refer to the Schedule of Benefits section regarding the applicable deductible and maximum out-of-pocket amount.

Please note it is the Covered Person's choice as to which facility to use.

Non-NRHA Facility:

A Non-NRHA facility is a facility that is not contracted with the Northern Rockies Healthcare Alliance (NRHA). The Non-NRHA Facilities Deductible and Maximum Out-of-Pocket Amount will apply when using a Non-NRHA facility.

Refer to the Schedule of Benefits section regarding the applicable deductible and maximum out-of-pocket amount.

Please note it is the Covered Person's choice as to which facility to use.

Out-of-Network Facility:

The Out-of-Network Facility Deductible and Maximum Out-of-Pocket Amount will apply when utilizing an Out-of-Network Facility.

Refer to the Schedule of Benefits section regarding the applicable deductible and maximum out-of-pocket amount.

Please note it is the Covered Person's choice as to which facility to use.

PREFERRED PROVIDER INFORMATION - PHYSICIAN SERVICES

The Preferred Provider Network (PPO) for this Plan no longer includes services and supplies provided by Hospital facilities, ambulatory health care facilities and by dialysis clinics and other facilities. For these types of providers, the Plan will identify the covered cost for the services and supplies through its Claim Review and Audit Program as Allowable Claim Limits. Covered Persons may choose to use any appropriate Medical Care Facility and Covered Charges will be reimbursed as stated in the Medical Benefits Schedule. Please refer to the section that fully describes the Claim Review and Audit Program. ***The PPO network still includes Physicians and other types of professional providers as explained below.*** Covered Persons may also contact the Claims Administrator, EBMS, or the Plan Administrator with any questions regarding which facilities may be included under the Claim Review and Audit Program, and which may be included under the PPO network agreement.

For Physicians and all other providers of service, this Plan contains provisions under which a Covered Person may receive more benefits by using certain providers ("Preferred Providers" or "PPO Providers"). The Schedule of Benefits describes the benefits for PPO and non-PPO Providers. PPO Providers are individuals and entities that have contracted with the Plan to provide services to Covered Persons at pre-negotiated rates. In addition, a Covered Person may request a Preferred Provider list by contacting the Plan Administrator. The Preferred Provider list changes frequently; therefore, it is important that a Covered Person verify with the provider that the provider is still a Preferred Provider before receiving services. The Covered Person is fully responsible for determining a provider's participation in the PPO network.

This Plan has entered into an agreement with certain Physicians and other health care providers, which are called Preferred Providers. Because these Preferred Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Preferred Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Preferred Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher Preferred Provider payment will be made for certain Non-Preferred Provider services. Any charges in excess of the Allowable Charge will not be considered eligible for payment (Balance billing may apply)

- Ancillary services, including radiology, pathology and anesthesiology when referred by a Preferred Provider to a Non-Preferred Provider and provider selection for ancillary services is beyond the Covered Person's control.
- Covered Persons residing outside the PPO service area.
- Covered Persons traveling outside of the PPO service area, and the sole purpose of travel is not for seeking medical treatment, and requires emergency or immediate care.
- If a Covered Person has no choice of Preferred Provider in the specialty that the Covered Person is seeking within the PPO service area, benefits will be payable at the Preferred Provider benefit level.

To access a list of Preferred Providers, please refer to the Preferred Provider website and/or toll free number listed on the **MADA Insurance Trust** identification card. Prior to receiving medical care services, the Covered Person should confirm with the provider and the Preferred Provider Organization (PPO) that the provider is a participant in this organization.

Deductibles/Copayments/Coinsurance payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

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

Deductibles will apply to the maximum out-of-pocket amount.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

*Copayments, **excluding** Prescription Drug copayments, will accrue toward the maximum out-of-pocket amount.*

Prescription Drug copayments will apply to the separate Prescription Drug maximum out-of-pocket amount.

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Schedule of Benefits and is the Covered Person's responsibility. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

Coinsurance is payable by the Covered Person until the maximum out-of-pocket amount, as shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the remainder of the Calendar Year.

MEDICAL BENEFITS SCHEDULE

IMPORTANT NOTE: Benefits for Hospitals, outpatient health care centers (such as Outpatient Surgery Centers and dialysis clinics) and other covered Medical Care Facilities will be based upon Allowable Claim Limits which are determined under the Claim Review and Audit Program. The PPO Provider network still applies to Physicians and other non-facility professional providers. Please refer to the Plan section describing the *Claim Review and Audit Program* for additional information regarding the program for Medical Care Facilities.

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
LIFETIME MAXIMUM AMOUNT	Unlimited	
PHYSICIAN AND NON-FACILITY CHARGES DEDUCTIBLE PER CALENDAR YEAR		
Per Covered Person	$2,500	
Per Family Unit	$5,000	
PHYSICIAN AND NON-FACILITY CHARGES MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR		
Per Covered Person	$3,500	
Per Family Unit	$7,000	
NOTE: The Physician and Non-Facility Charges, Deductibles and Maximum Out-of-Pocket Amounts will accrue to the NRHA facility, Non-NRHA facility and Out-of-Network Facility Charges, Deductible and Maximum Out-of-Pocket Amounts.		

	NRHA FACILITIES	NON-NRHA FACILITIES	OUT-OF-NETWORK FACILITIES
Refer to the Medical Benefits under the Schedule of Benefits section for more information regarding NRHA, Non-NRHA and Out-of-Network facilities.			
FACILITY CHARGES DEDUCTIBLE PER CALENDAR YEAR			
Per Covered Person	$2,250	$2,500	$3,375
Per Family Unit	$4,500	$5,000	$6,750
Note: *The NRHA Facilities, Non-NRHA Facilities and Preferred Providers, Out-of-Network Facilities and Non-Preferred Providers Deductibles will apply to each other.*			
FACILITY CHARGES MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR			
Per Covered Person	$3,250	$3,500	$4,875
Per Family Unit	$6,500	$7,000	$9,750
Note: *The NRHA Facilities, Non-NRHA Facilities and Preferred Providers, Out-of-Network Facilities and Non-Preferred Providers Maximum Out-of-Pocket Amounts will apply to each other.*			
The Plan will pay the designated percentage of Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.			

The following charges do not apply toward the maximum out-of-pocket amounts and are never paid at 100%:

- Cost containment penalties
- Amounts over the Allowable Charge
- Prescription Drug copayments and Prescription Drug maximum out-of-pocket amount

Note: The maximums listed below are the total for Preferred Provider and Non-Preferrred Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Preferred Providers and Non-Preferrred Providers.

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
COVERED CHARGES		
Non-Preferred Provider Services: Services rendered by a Non-Preferred Provider will be reimbursed subject to the **90th percentile** of the Allowable Charge. *The Covered Person will be responsible for any difference between the Non-Preferred Provider's billed amount (i.e., the cost of the service) and the amount exceeding the Allowable Charge (i.e., the allowable amount).*		
	PREFERRED PROVIDERS	**NON-PREFERRED PROVIDERS**
Hospital Services		
Room and Board	60% after deductible* The facility's semiprivate room rate *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Intensive Care Unit	60% after deductible* The Hospital's ICU Charge *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Outpatient Services and Ambulatory Surgical Center	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Emergency Room Services Facility and Physician		
Facility services	60% after NRHA deductible	
Physician services	60% after deductible	
Urgent Care Services		
Facility services	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible	50% after deductible
Office Visit	100% after $35 copayment No deductible applies	50% after deductible
Skilled Nursing Facility		
Facility services	60% after deductible* The facility's semiprivate room rate 60 days Calendar Year maximum *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible	50% after deductible
Physician Services		
Inpatient visits	60% after deductible	50% after deductible
Office visits	100% after $35 copayment No deductible applies	50% after deductible
Note: The office visit copayment includes laboratory and x-ray services rendered and billed during the office visit only.		

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Surgery	60% after deductible	50% after deductible
Allergy testing and injections	60% after deductible	50% after deductible
Alternative Medical Centers To Save Money (includes: transportation, travel, meals, lodging and travel benefit)		
Facility services	100% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	100% after deductible	
Transportation, travel, meals, lodging and travel benefit	100% after deductible	
Per diem – meals	$51 per day per person (applies to the Covered Person and one companion)	
Per diem – travel benefit	$100 per full day of travel	
Note: *For more information regarding this benefit, refer to the Alternative Medical Centers To Save Money benefit listed in the Covered Charges section.*		
Ambulance Service	60% after deductible	
Applied Behavioral Analysis Benefit (for covered Dependent children from birth through age 18 years)		
Facility services	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible	50% after deductible
Benefit maximum per Calendar Year:		
Birth through age 8 years	$50,000	
9 years through age 18 years	$20,000	
Chemotherapy and Radiation Treatment		
Facility services	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible	50% after deductible

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Diagnostic Testing (X-ray & Lab) and Imaging Services (MRIs, CT Scans and PET Scans)		
Facility services	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Independent Lab services	60% after deductible	50% after deductible
Physician services	60% after deductible	50% after deductible
Note: *Charges in connection with 3-D mammography will be a Covered Charge.*		
Down Syndrome Therapies *(for covered Dependent children from birth through age 17 only)*		
Facility services	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible	50% after deductible
Benefit maximum (applies to Facility and Physician services combined):	Occupational therapy - 52 visits maximum per Calendar Year; Physical therapy – 52 visits maximum per Calendar Year; Speech therapy – 104 visits maximum per Calendar Year.	
Durable Medical Equipment, Orthotics and Prosthetics	60% after deductible	50% after deductible
Home Health Care	60%, No deductible applies 180 visits Calendar Year maximum	
Home Infusion Therapy	60% after deductible	50% after deductible
Hospice Care Inpatient and Outpatient Services		
Facility services	100%, No deductible applies	
Physician services	100%, No deductible applies	100%, No deductible applies

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Rehabilitation Therapy **Inpatient Services** Facility services	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible	50% after deductible
Outpatient Services (includes cardiac therapy, occupational, physical and speech therapy) Facility services	60% after deductible* 20 combined outpatient visits per Calendar Year Additional 10 combined outpatient visits in increments of 5, allowed with pre-authorization. Additional 3-to-1 swap of Skilled Nursing for pre-approved treatment Plan. *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible 20 combined visits per Calendar Year Additional 10 combined visits in increments of 5, allowed with pre-authorization. Additional 3-to-1 swap of Skilled Nursing for pre-approved treatment Plan.	50% after deductible 20 combined visits per Calendar Year Additional 10 combined visits in increments of 5, allowed with pre-authorization. Additional 3-to-1 swap of Skilled Nursing for pre-approved treatment Plan.

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Mental Disorders and Substance Abuse Treatment		
Inpatient Services Facility services	60% after NRHA deductible	
Physician services	60% after deductible	50% after deductible
Outpatient Services Facility services	60% after NRHA deductible	
Physician services	60% after deductible	50% after deductible
Office Visits	100% after $35 copayment No deductible applies	50% after deductible
Organ Transplants Facility services	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible	50% after deductible
Transportation and Lodging – *Limited to coverage for Patient only*	$10,000 maximum per Transplant $200 maximum per day	Not Covered

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Preventive Care		
Routine Well Care (birth through adult)	100%, no deductible applies	50% after deductible
Routine Well Care services and Women's Preventive Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Schedule of Benefits*, and which can be located using the following website(s): http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/; and https://www.hrsa.gov/womensguidelines/ **Routine Well Care services will include, but will not be limited to, the following routine services:** Routine physical exams, prostate screening, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations. **Women's Preventive Services, will include, but will not be limited to, the following routine services:** Well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity (this does not include birthing classes), preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth. ***Note:*** *Charges in connection with 3-D mammography will be a Covered Charge.*		
Diabetic Education Benefit	100%, no deductible applies 3 visits per Calendar Year	50% after deductible 3 visits per Calendar Year
Nutritional Education Counseling Benefit Obesity Interventions for Covered Persons age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher	100%, no deductible applies 3 visits per Calendar Year 100%, no deductible applies Limited to 26 visits maximum per Calendar Year	50% after deductible 3 visits per Calendar Year 50% after deductible Limited to 26 visits maximum per Calendar Year
Tobacco Cessation Counseling Benefit	100%, no deductible applies 3 visits per Calendar Year	50% after deductible 3 visits per Calendar Year

	PREFERRED PROVIDERS	NON-PREFERRED PROVIDERS
Pregnancy		
Routine Prenatal Office Visits	40% of Covered Charges of the global maternity fee will be payable at 100%, deductible waived; thereafter, 60% after deductible, **OR,** if billed separately, 100% of the routine prenatal office visits will be payable at 100%, deductible waived	50% after deductible
Other Prenatal Care	60% after deductible	50% after deductible
	Refer to the Coverage of Pregnancy benefit listed in the Covered Charges section for more information regarding routine prenatal office visits.	
Inpatient Services		
Facility services	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible	50% after deductible
Routine Well Newborn Nursery Care (while Hospital confined at birth)		
Facility services*	60% after deductible* *Refer to the Schedule above to determine the applicable Deductible and Maximum Out-of-Pocket Amount for facility charges	
Physician services	60% after deductible	50% after deductible
Spinal Manipulation / Chiropractic services	100% after $35 copayment, No deductible applies 15 visits maximum per Calendar Year	50% after deductible 15 visits maximum per Calendar Year
Chiropractic x-rays	Limited to one (1) set per Calendar Year	Limited to one (1) set per Calendar Year
All Other Covered Charges	60% after deductible	50% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE

Prescription Drug Maximum Out-of-Pocket Amount

per Covered Person.....	$1,450 per Calendar Year
per Family Unit.....	$2,900 per Calendar Year

Note: The Prescription Drug copayment amounts for the Retail, Specialty and Mail Order Pharmacies listed below **will apply** to the separate Prescription Drug maximum out-of-pocket amount until this amount shown above has been met; thereafter, covered Prescription Drugs will continue to be payable subject to 100% (not including ineligible charges, such as Prescription Drug dispense as written (DAW) penalties) for the remainder of the Calendar Year. **The Prescription Drug maximum out-of-pocket amount will not apply to the medical maximum out-of-pocket amount as shown in the Schedule of Benefits.**

Retail Pharmacy – Limited to a 30-day supply - Administered through Navitus Health Solutions Participating Pharmacies:

Tier 1 (All covered generics and some lower cost brand products)

Copayment per prescription	$15

Tier 2 (Preferred brand products)

Copayment per prescription.....	$40

Tier 3 (Non-Preferred brand products)

Copayment per prescription.....	50%

Retail Pharmacy - Limited to a 30-day supply **–** ***When utilizing a Non-Participating Pharmacy***:

Tier 1 (All covered generics and some lower cost brand products)

Copayment per prescription	50%

Tier 2 (Preferred brand products)

Copayment per prescription.....	50%

Tier 3 (Non-Preferred brand products)

Copayment per prescription.....	50%

Note: If a drug is purchased from a **Non-Participating Pharmacy**, the Covered Person will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Covered Person will be required to submit the prescription receipt to **Navitus Health Solutions** for reimbursement (less applicable copayments as shown above).

Mandatory Specialty Pharmacy Program - limited to a 30-day supply - Administered through Navitus Health Solutions

First fill only (through retail pharamacy)

Copayment (per prescription)..... $100

Subsequent fills (through Specialty Pharmacy)

Copayment (per prescription)..... $100

For more information regarding the Specialty Pharmacy Program, please contact **Navitus Health Solutions** toll-free at 1 (866) 333-2757 or visit www.ebms.com

Mail Order Pharmacy - Limited up to a 90-day supply - Administered through Navitus Health Solutions **(Mail Order is only available through Navitus Health Solutions).**

Tier 1 (All covered generics and some lower cost brand products)

Copayment per prescription $30

Tier 2 (Preferred brand products)

Copayment per prescription..... $80

Tier 3 (Non-Preferred brand products)

Copayment per prescription..... 50%

Dispense As Written (DAW) penalty:

Note: If a Covered Person requests a Preferred or Non-Preferred brand name drug instead of a Generic drug (and a Generic drug is available), then the Covered Person will be responsible for the difference in cost between a Generic drug and applicable brand name drug in addition to the applicable copayment amount as stated above. The difference in cost **will not** apply to the Prescription Drug maximum out-of-pocket amount shown in the Prescription Drug Benefit Schedule shown above.

Additional information regarding the Prescription Drug Benefit may be found in the separate Prescription Drug Benefits section of this document.

ELIGIBILITY, FUNDING, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees.

- All Active Employees of the Employer.
- All Active Owners of the Employer

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

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

For Employees of a Large Employer:

A Large Employer is a participating Employer with 50 full-time equivalents or more (combination of full-time and part-time employees) in the prior calendar year.

If the Employee is not designated as a Full-Time Active Employee by the Large Employer, the Large Employer may use a look-back measurement period to determine the Full-Time, Active status as defined under the Plan. The Employee must average or be expected to average the required minimum hours of service established by the Employer in the Employee's initial measurement period to be eligible for coverage.

An Employee's initial measurement period begins the first day of the month following the date of hire, with an initial stability period commencing the first day of the second full calendar month following the initial measurement period. The Large Employer utilizes a standard measurement period and a standard stability period for all Full-Time, Active Employees. Coverage is effective the first day of the stability period following the applicable measurement period. To remain eligible for coverage, the Employee must average the required minimum hours of service during each subsequent standard measurement period.

If an Employee changes from a part-time position to a Full-Time, Active Employee position as defined under this Plan or transfers to the Large Employer from another participating Employer, the Employee will be credited with time worked for the employment Waiting Period.

For more information on the measurement and stability period lengths elected by the Large Employer, contact the Large Employer's human resources staff.

(2) Is a Full-Time, Active Owner of the Employer. An Owner is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work and owns at least 30% of the dealership; or

(3) Is in a class eligible for coverage; and

(4) Completes the employment Waiting Period of one (1) calendar month as an Active Employee or Active Owner.

Coverage will begin the first day of the calendar month following or coinciding with the completion of all Eligibility Requirements, Active Employee Requirement and Enrollment Requirements as stated under this Plan.

A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

Note: In the event the covered Employee transfers from one participating Employer to another participating Employer under this Plan, the employment Waiting Period will be waived to the extent the employment Waiting Period was met prior to the covered Employee's transfer. This provision will only be applicable if the transfer occurs within 30 days of either the transfer date or the terminated Employee's rehire date.

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

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

The term **"Spouse"** shall mean a person recognized as the covered Employee's husband or wife by the laws of the State in which the marriage was formalized, including common-law marriage. *This definition does not include domestic partners.* The Plan Administrator may require documentation proving a legal marital relationship.

The term **"children"** shall include natural children, adopted children, children placed with a covered Employee in anticipation of adoption and step-children.

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

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

Any child of a Plan Participant 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 participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

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

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

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

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

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

- If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

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

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

FUNDING

Cost of the Plan. The Employer may share the cost of Employee coverage under this Plan with the covered Employees.

The covered Employees may be required to pay the entire cost for coverage for their Dependents.

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

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. If Dependent coverage is desired, the covered Employee will be required to enroll for Dependent coverage as well.

Enrollment Requirements for Newborn Children.
A newborn child of a covered Employee who is currently enrolled with Dependent coverage will be automatically enrolled from the date of birth.

A newborn child of a covered Employee who is not currently enrolled with Dependent coverage will not automatically be enrolled. The Employee will be required to enroll the newborn child on a timely basis, as defined in the section "Timely Enrollment" following this section, or there will be no further payment from the Plan and the parents will be responsible for all costs.

TIMELY, LATE OR OPEN ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, or 60 days in the case of birth, adoption or placement for adoption, either initially or under a Special Enrollment Period.

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

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

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

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

(i) **Open Enrollment -** Each year there is an annual open enrollment period designated by the Plan Administrator during which Covered Employees may change their benefit elections under the Plan, and Employees and their Dependents, who are Late Enrollees, will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective **January 1st.** *Plan Participants will receive detailed information regarding open enrollment from the covered Employee's Employer.*

Benefit choices available to covered Employees and Late Enrollees may be different for each participating Employer under this Plan. Benefit choices made during the open enrollment period will remain in effect until the next open enrollment period unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from the covered Employee's Employer.

(3) **Enrollment Following Benefit Measurement Period** (applies only to Employees of a Large Employer) Employees determined by a Large Employer to be Full-Time Active Employees during the applicable measurement period (and their eligible Dependents) may enroll in the Plan the first day of the second full calendar month of the following stability period. Employees will be credited for time previously satisfied toward the employment Waiting Period.

SPECIAL ENROLLMENT RIGHTS

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

In addition, in the case of a birth, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days of the date of birth, adoption or placement for adoption or within 31 days of the date of marriage.

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

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date of loss.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date of loss.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

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

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

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

(2) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

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

The Dependent Special Enrollment Period is a period of 60 days and begins on the date of birth, adoption or placement for adoption, or 31 days and begins on the date of the marriage. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this time period as stated above.

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

(a) in the case of marriage, as of the date of marriage;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

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

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

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

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

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

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

EFFECTIVE DATE

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

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

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

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) If the Employee was employed by a Large Employer, the last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes, or if applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Large Employer. This includes death, termination of Active Employment of the covered Employee, or a reduction in hours or leave of absence, unless the Plan or an applicable law specifically provides for continuation during these periods.

(4) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

(5) As otherwise specified in the Eligibility section under this Plan.

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

Continuation During Periods of Employer-Certified Disability or Medical Leave of Absence. A person may remain eligible for a limited time if Active, full-time work ceases due to disability or a medical leave of absence and will be subject to pre-approval by the participating Employer.

This continuance will end as follows:

For disability leave only: the end of 90 days following the date on which the person last worked as an Active Employee.

For medical leave of absence: the end of 90 days following the date on which the person last worked as an Active Employee.

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

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations.

This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired within 30 days from the date of termination will be credited for time towards the satisfaction of any applicable employment Waiting Period prior to the initial date of termination.

Coverage will begin the first day of the calendar month following the date of rehire or the first day of the calendar month following the satisfaction of any applicable employment Waiting Period, whichever comes first.

A terminated Employee who is rehired after 30 days from the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Rehiring a Terminated Employee by Large Employer. A terminated Employee who is rehired by a Large Employer within 13 consecutive weeks from the date of termination will be credited for time towards the satisfaction of any applicable employment Waiting Period prior to the initial date of termination.

Coverage will begin the first day of the calendar month following the date of rehire or the first day of the calendar

month following the satisfaction of any applicable employment Waiting Period, whichever comes first.

A terminated Employee who is rehired by the Large Employer after 13 weeks from the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

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

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage may pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

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

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

(1) The period of coverage of a person under such an election shall be the period of time beginning on the date on which the person’s absence for State active duty begins, and ending:

(a) The next regularly scheduled day of employment following travel time plus 8 hours, if State active duty is 30 days or less; or

(b) The next regularly scheduled day of employment following 14 days after termination of State active duty, if State active duty is not more than 180 days; or

(c) The next regularly scheduled day of employment following 90 days after termination of State active duty, if State active duty is more than 180 days.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except that a person on State active duty for less than 180 days may not be required to pay more than the regular Participant’s share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage

upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State active duty.

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

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.)

(3) The last day of the calendar month in which a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.)

(4) The last day of the calendar month in which the Dependent ceases to meet the applicable eligibility requirements. (See the section entitled COBRA Continuation Coverage.)

(5) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

(6) As otherwise specified in the Eligibility section under this Plan.

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

MEDICAL BENEFITS

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

DEDUCTIBLE

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

The deductible will apply to the maximum out-of-pocket amount.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT AND COINSURANCE

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person after the Covered Person has met his or her Calendar Year deductible and any applicable copayment(s).

Benefit payment made by the Plan will be at the percentage rate shown in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

Once the Plan has made the applicable benefit payment, the remaining percentage owed is the Covered Person's "Coinsurance" responsibility. For example, if the Plan's reimbursement rate is 60%, the Covered Person's responsibility (or coinsurance) is 40%.

Coinsurance *does not* include any deductible or copayment amounts. Coinsurance will apply to the maximum out-of-pocket amount.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable by the Plan at the percentages shown each Calendar Year until the maximum out-of-pocket amount shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

LIFETIME MAXIMUM BENEFIT AMOUNT

The Lifetime Maximum Benefit Amount is shown in the Schedule of Benefits.

COVERED CHARGES

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

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

Room charges made by a Hospital having only private rooms will be payable at the average private room rate of that facility.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness and will be payable as stated in the Schedule of Benefits.

Note: Routine prenatal office visits will be payable as stated under the Pregnancy benefit as shown in the Schedule of Benefits section. The following services will continue to be payable per normal Plan provisions:

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of Pregnancy (as defined under this Plan), delivery, and post-partum care.

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

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is Medically Necessary; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

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

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Charge for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Allowable Charge.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Outpatient private duty nursing care is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

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

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

The following *will not* be a Covered Charge under this Plan: Maintenance or custodial care visits; domestic or housekeeping services; "Meals-on-Wheels" or similar food arrangements; visits, services, medical equipment or supplies not approved or included as part of the Covered Person's treatment plan; services for mental or nervous conditions; or services provided in a nursing home or Skilled Nursing Facility.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six (6) months and placed the person under a Hospice Care Plan.

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

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Allergy testing and injections.** Covered Charges will include testing, injections, serum and syringes.

(b) **Alternative Medical Centers To Save Money.** The Plan encourages Plan Participants to consider all options available when planning for upcoming medical treatment, services and/or procedures. ***Accessing alternative medical centers, in or out of state, is available when mutually beneficial to the Plan Participant and the Plan.*** When scheduling medical treatment, services, and/or procedures, a Covered Person should determine what options are available and then compare cost and quality.

Plan Participants are permitted to travel within Montana and seek treatment from providers and facilities when mutually beneficial to the Plan Participant and the Plan.

Plan Participants also have access to independent Ambulatory Surgery Centers in the United States that offer transparent pricing and a considerable savings to the Plan Participant and the Plan. Plan Participants are not required to access these independent Ambulatory Surgery Centers. However, the Plan encourages Plan Participants to consider all options available when planning for upcoming medical treatment, services and/or procedures. *For assistance in locating*

a U.S. Alternative Medical Center with Transparency Pricing / Quality, please contact EBMS at 1-866-677-8745, option 4.

Remember, accessing alternative medical centers, in or out of state, is available when mutually beneficial to the Plan Participant and the Plan. *It is important to contact EBMS to verify benefits prior to seeking treatment, to verify that it is mutually beneficial and to verify that a specific treatment, service and/or procedure is available at the facility you have chosen.*

In many instances, seeking treatment, services, and/or procedures at alternative medical centers can result in significant savings. Covered Charges include all medical costs incurred while receiving treatment, services and/or procedures, and at the Plan Administrator's discretion may include the following as well:

1. Round trip coach transportation for the Covered Person and one designated companion from the Plan Participant's state of residency and hotel accommodations near the facility when traveling 100 miles or more from the Covered Person's primary residence. All transportation and lodging must be reserved and scheduled in advance by calling EBMS at 1-866-677-8745, option 4.

2. Travel within the state will be reimbursed at the applicable standard medical mileage rate as set forth by the Internal Revenue Services as well as hotel accommodations if required. For more information, refer to the following hyperlink:

   https://www.irs.gov/publications/p502/ar02.html#en_US_2014_publink1000179021.

   If lodging is required, hotel accommodations must be scheduled in advance by calling EBMS at 1-866-677-8745, option 4.

3. Per diem meals for the Covered Person and one companion at the rate of $51 per day per person. The Covered Person's per diem will not be paid during any required inpatient stay.

4. A travel benefit to the Covered Person in the amount of $100 per full day of travel.

Certain examinations, tests, treatment or other medical services may be required prior to or following travel. Any Covered Charges performed for pre and post care shall be subject to the coverage limits and other terms of the Plan.

Payments for lodging (in excess of $50 per night per person, up to $100 per night), meals, and incentive payments are classified as taxable income to the Covered Person. The Covered Person should consult his or her tax advisor for additional information.

The Plan may agree to allow this benefit for Covered Charges performed at any facility. *Contact EBMS at* 1-866-677-8745, option 4, *to discuss the availability of this benefit prior to receiving the treatment, services and/or procedures.*

This benefit is an alternate benefit and will be available when mutually beneficial to the Plan Participant and the Plan, or when otherwise approved by the Plan Administrator. The Plan's decision to allow this alternate benefit shall be determined on a case-by-case basis. The Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar benefits in any other instance or waive the right of the Plan Administrator to strictly enforce the provisions of the Plan.

(c) **Ambulance.** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(d) **Anesthesia services.** Anesthesia services provided by a Physician (other than the attending Physician) or nurse anesthetist including the administration of spinal anesthesia, the injection or inhalation of a drug or other anesthetic agent.

The following will not be a Covered Charge under this Plan:

- Hypnosis;
- Local anesthesia or intravenous (IV) sedation that is considered to be an inclusive service or procedure;
- Anesthesia consultations before surgery that are considered to be inclusive services or procedures of the surgical procedure;
- Anesthesia for dental extractions or extraction of teeth, except as specifically stated as a benefit under this Plan.

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

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

(f) **Blood transfusions.** Covered Charges include the cost of blood, blood plasma, blood plasma expanders and packed cells, including the administration. Storage charges for blood will be covered when a Covered Person has blood drawn and stored for the Covered Person's own use for a planned surgery.

(g) **Breast pump, breast pump supplies, lactation support and counseling**.

Breast pump, breast pump supplies

A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.

- For female Covered Persons using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.

- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered every (3) three Calendar Years following a subsequent Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Schedule of Benefits section.

Note: *Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable at the Preferred Provider benefit level only for the purposes of this benefit.*

The Claims Administrator will require the following documentation: claim form with proof of

purchase to include purchase price and item description.

Lactation support and counseling
Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Covered Persons for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

Note: *Payment will be made for Covered Charges for lactation support and counseling under the Preventive Care benefits in the Schedule of Benefits section at the higher Preferred Provider payment for Non-Preferred Provider services for the purposes of this benefit.*

(h) **Cardiac rehabilitation** as deemed Medically Necessary, and payable up to the limits as stated in the Schedule of Benefits, provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery, or other cardiac condition; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(i) **Chemotherapy or radiation and treatment with radioactive substances.** The materials and services of technicians are included.

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

For pre-notification of services, call CareLink at the following numbers:

Toll Free in the United States:	(866) 894-1505
Local Call in Billings, Montana:	(406) 245-3575

A pre-notification of services by CareLink is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.

(j) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained web site www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial for cancer treatment.
- The Covered Person meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
- The Covered Person has signed an informed consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent;
- The trial is approved by the Institutional Review Board of the institution administering the treatment.
- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual

costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Covered Person would receive whether or not he or she were participating in a clinical trial.

Routine patient services do not include, and reimbursement will not be provided for:

- The investigational service, supply, or drug itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Covered Person; or
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g. device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

(k) Initial **contact lenses** or glasses required following cataract surgery.

(l) **Contraceptive methods.** All Food and Drug Administration approved contraceptive methods when prescribed by a Physician, including but not limited to, intrauterine devices (IUDs), implants, and injections, and any related Physician and facility charges, including complications, and will be payable under the Preventive Care benefits as shown in the Schedule of Benefits section.

Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Covered Persons.

(m) **Diabetic Education benefit.** Inpatient and outpatient self-management training and education services for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, up to the limits as stated in the Schedule of Benefits.

(n) **Down Syndrome Therapies**, including Habilitative and Rehabilitative Care, professional, counseling, and guidance services and treatment programs, and therapy services that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered Dependent child(ren).

Note: *Benefits are limited to treatment that is prescribed by a Physician and documented by a written Plan of Care and provided by the treating Physician. The Plan may require an updated treatment plan and documentation of continued medical necessity updated every 6 (six) months.*

The Plan Administrator may request periodic documentation of continued progress to goals identified in the Plan of Care.

Benefits will be payable only for covered Dependent child(ren) from birth through age 17 years and will be payable up to the limits as stated in the Schedule of Benefits.

(o) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;

- Is NOT primarily for the comfort and convenience of the Covered Person;
- Does NOT have significant non-medical uses (i.e. air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Covered Person's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Covered Person.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Covered Person if the Covered Person were to purchase the item directly. The acquisition cost of the item may be prorated over a 6 month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every 4 Calendar Years.

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Covered Person's medical condition occurs sooner than the 4 Calendar Year period.

- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Covered Person's medical condition occurs sooner than the 4 Calendar Year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the 4 Calendar Year limit.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

(p) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and are required for the administration of a home infusion therapy regimen when ordered by and are part of a formal written plan prescribed by a Physician. The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, Prescription Drugs, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor a response to therapy.

(q) **Inborn Errors of Metabolism.** Treatment under the supervision of a Physician for inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standards methods of diagnosis, treatment, and monitoring exist.

Benefits include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, Prescription Drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and nutritional supplements in any form that are used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

(r) **Intravenous injections and solutions,** including administration.

(s) **Laboratory studies.** Covered Charges for diagnostic lab testing and services.

(t) **Medical supplies.** The following supplies for use outside of a Hospital when prescribed by a Physician and deemed Medically Necessary to treat an Illness or Injury covered under this Plan:

- Syringes and related supplies for conditions such as diabetes.
- Injection aids, visual reading and urine test strips, glucagon emergency kits for treatment of diabetes. **Note:** Insulin pump and supplies will be payable under the separate Durable Medical Equipment benefit under this Plan.
- Sterile or surgical dressings.
- Catheters.
- Splints, casts and other devices used in the reduction of fractures and dislocations.
- Colostomy bags and related supplies.
- Supplies for renal dialysis equipment or machines.

(u) **Mental Disorders and Substance Abuse treatment.** Covered Charges will be payable for care, supplies and treatment of Mental Disorders and Substance Abuse. Services provided by a staff member of a school or halfway house will not be a Covered Charge.

(v) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth. Damage as a result of biting and chewing will not be a Covered Charge.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.

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

Services and supplies provided by a Hospital in conjunction with dental treatment will be covered only when a non-dental physical Illness or Injury exists which makes Hospital care Medically Necessary to safeguard the Covered Person's health. Dental treatment provided in a Hospital unrelated to a non-dental physical Illness or Injury will not be a Covered Charge regardless of the complexity of dental treatment and length of anesthesia.

(w) **Naturopathy.** Services by a licensed naturopathic provider. *No coverage will be provided for nutritional supplements or vitamins, whether or not prescribed.*

(x) **Nutritional Education Counseling benefit.** Care, treatment, and services when provided by either a registered dietician or licensed nutritionist, and will payable up to the limits as stated in the Schedule of Benefits.

Obesity Interventions. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Covered Persons age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher.

Intensive, multicomponent behavioral interventions for weight management will include group and individual sessions of high intensity (limited up to 26 visits per Calendar Year) encompassing the following:

- Behavioral management activities such as setting weight loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes

Non-surgical care and treatment and Physician prescribed weight loss medications **will not** be a covered benefit except as may be specifically described as a benefit by this Plan.

This Plan **will not** cover nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

(y) **Occupational therapy** by a licensed occupational therapist, payable up to the limits as stated in the Schedule of Benefits. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(z) **Organ transplant** benefits. Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant, which are not considered Experimental or Investigational, are subject to the following criteria:

- The transplant must be performed to replace an organ or tissue.

- **Organ transplant benefit period:** A period of 365 continuous days beginning five (5) days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.

- **Organ procurement limits**. Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. Charges incurred by the organ donor for a covered transplant will be eligible under this Plan if the charges are not covered by any other medical expense coverage.

The donor benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

(i) Evaluating the organ or tissue;

(ii) Removing the organ or tissue from the donor; and

(iii) Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed.

Note: Expenses related to the purchase of any organ, transportation, lodging and meals will not be a Covered Charge under this Plan.

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his or her Physician must contact CareLink at (866) 894-1505.

- In the event an NRHA transplant facility is utilized, benefits will be payable at the NRHA facility benefit level.

- In the event an NRHA transplant facility is unavailable and the providing transplant facility is a Center of Excellence facility, benefits will be payable at the NRHA facility benefit level.

- In the event a Non-NRHA transplant facility is utilized and the providing transplant facility is not a Center of Excellence facility, benefits will be payable at the Non-NRHA facility benefit level.

There is no obligation to the Covered Person to use either an NRHA transplant facility or a Center of Excellence facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by an NRHA transplant facility, a Non-NRHA transplant facility or whether or not a Center of Excellence facility is utilized.

A **Center of Excellence** is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Covered Person may contact CareLink to determine whether or not a facility is considered a Center of Excellence.

Travel and Lodging Expenses

If a transplant is performed at an NRHA transplant facility or a Center of Excellence facility and the Plan Participant resides 50 miles or more from the transplant facility, the Plan will pay for the following services incurred during the transplant benefit period (subject to the maximum benefit as specifically stated in the Schedule of Benefits):

- Transportation expenses to and from the NRHA transplant facility or Center of Excellence facility for the following individuals:

  - The Plan Participant

  Transportation expenses include commercial transportation (coach class only).

- Reasonable lodging and meal expenses incurred for the Plan Participant only while the Plan Participant is receiving transplant-related services at an NRHA transplant facility or Center of Excellence facility. ***Lodging, for purposes of this Plan, will not include private residences.***

Special Transplant Benefits

Under certain circumstances, there may be special transplant benefits available when the group health plan and/or a Covered Person participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact CareLink at (866) 894-1505 as soon as reasonably possible so that the Plan can advise the Covered Person or his or her Physician of the transplant benefits that may be available.

Transplant Exclusions

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

- Cornea transplantation
- Skin grafts
- Artery
- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

(a1) **Orthotic appliances**. The initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

Orthopedic devices, a rigid or semi rigid supportive device which restricts or eliminates motion of a weak or diseased body part, will be limited to braces, corsets and trusses.

Foot orthotics, including impression casting for orthotic appliances, padding, strapping and fabrication *will not* be a Covered Charge.

(b1) **Oxygen** including equipment for its administration.

(c1) **Physical therapy** by a licensed physical therapist, payable up to the limits as stated in the Schedule of Benefits. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(d1) **Prescription** Drugs (as defined). Outpatient Prescription Drugs will be payable under the separate Prescription Drug Benefit section of this Plan.

(e1) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Care. Routine well care is care by a Physician that is not for an Injury or Sickness.

(f1) **Prosthetic devices.** The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts.

Note: The prosthesis will not be considered a replacement if the prosthesis no longer meets the medical needs of the Covered Person due to physical changes or a deteriorating medical condition.

(g1) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.
This mammoplasty coverage will include reimbursement for:

- reconstruction of the breast on which a mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

(h1) Charges for **Rehabilitation therapy**. Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

Inpatient Care. Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Covered Person received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

(i1) **Speech therapy** by a licensed speech therapist, payable up to the limits as stated in the Schedule of Benefits. Therapy must be ordered by a Physician and follow either:

(i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person;
(ii) an Injury; or
(iii) a Sickness.

(j1) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. and will be subject to Medical Necessity and non-maintenance care and will be payable up to the limits as stated in the Schedule of Benefits.

(k1) **Sterilization** procedures. Sterilization procedures for female Covered Persons will be payable as shown under the Preventive Care benefit as shown in the Schedule of Benefits section.

The following charges will be payable per normal Plan provisions:
- Hysterectomies; and
- Sterilization procedures for male Covered Persons.

(l1) **Tobacco Cessation Counseling Benefit.** Covered Charges include tobacco cessation counseling visits when rendered by a Physician to aid nicotine withdrawal and will be payable up to the limits as stated in the Schedule of Benefits. Refer to the separate Prescription Drug Benefit section for coverage of prescription tobacco cessation medications.

(m1) Coverage of **Well Newborn Nursery/Physician Care.**

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child, who is neither injured nor ill, is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in

accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to the Allowable Charges for nursery care for the newborn child while Hospital confined, including circumcision, as a result of the child's birth.

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

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

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

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

(n1) **X-rays.** Covered Charges for diagnostic x-rays and imaging services.

PROVIDER SELF-AUDIT PROGRAM

Covered Persons may receive a refund if they discover an overcharge on their medical bill that:

(1) was not detected by the provider of services; and

(2) was not detected by the Plan; and

(3) was part of the charges for services which are covered under this Plan.

The Covered Person should request a copy of his/her itemized bill for services, and review it for services not received such as tests, x-rays, etc., that were not performed. If an overcharge is discovered by the Covered Person, he/she should ask the provider to correct the overcharge and send the Covered Person a revised itemized bill. The Covered Person should clearly mark both itemized bills “Provider Self-Audit Program” and send them to the Claims Administrator at:

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

The Plan may refund 50% of the total amount of the overcharge, up to a maximum $1,000 refund based on an overcharge of $2,000. The minimum overcharge eligible to qualify under the Provider Self-Audit Program is a $50 overcharge with a minimum refund of $25.

CLAIM REVIEW AND AUDIT PROGRAM – MEDICAL BENEFITS

The Plan has arranged with the "Designated Decision Maker" ("DDM") for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a usual and reasonable fee determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination which are the same rights and privileges accorded to Covered Persons; and, in return, the provider must agree not to bill the Covered Person for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the Covered Person to file an appeal under the Plan. Please refer to the section, "Internal and External Claims Review Procedures" for additional information regarding Covered Person and provider appeals.

Any Covered Person who receives a balance-due billing from a medical care provider for these charges should contact the DDM or the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Information section of the Summary Plan Description. The DDM may be contacted at:

ELAP Services, LLC
1550 Liberty Ridge Drive, Suite 330
Wayne, PA 19087
Phone: 800-977-7381
Fax: 888-560-2447

The Covered Person must pay for any normal cost-sharing features of the Plan, such as deductibles, coinsurance and copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Charges that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Covered Person as described in the *Internal and External Claims Review Procedures* section. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under the Plan, it will be necessary to deny the claim. Should such a denial be necessary, the Covered Person and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the section, *Internal and External Claims Review Procedures.*

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean the "Designated Decision Maker" ("DDM"):

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

(1) Hospital. The Allowable Claim Limit for charges by a Hospital facility and for charges by facilities which are owned and operated by a Hospital may be based upon 112% of the Hospital's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or may be based upon the Medicare allowed amount for the services in the geographic region plus an additional 20%.

(2) Pharmaceuticals. The Allowable Claim Limit for pharmacy charges by a provider may be determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK at the rate of 112% of AWP.

(3) Medical and Surgical Supplies, Implants, Devices. The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

(4) Physician Medical and Surgical Care, Laboratory, X-ray, and Therapy. The Allowable Claim Limit for these services may be determined based upon the fees for comparable services in the geographic region at the 90th percentile of the Physician Fee Reference ("PFR"), which is the highest percentile reflected in the PFR.

(5) Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including Outpatient Surgery Centers, which are independent facilities may be based upon the Medicare allowed amount for the services in the geographic region, and/or the Medicare Outpatient Prospective Payment System (OPPS), plus an additional 20%.

(6) General Medical and/or Surgical Services. The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, CMS Cost Ratios, Medicare allowed fees (by geographic region), Medicare OPPS allowed fees, published and publicly available fee and cost lists and comparisons, any resources listed in the categories above, or any combination of such resources that results in the determination of a reasonable expense under the Plan, in the opinion of the Plan Administrator. The Allowable Claim Limit for these services will be calculated using one or more of the industry-standard resources, plus an additional 12%.

(7) Unbundling. The Allowable Claim Limit will not include charges for any items billed separately that are customarily included in a global billing procedure code in accordance with American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

(8) Errors. The Allowable Claim Limits will not include any identifiable billing mistakes including, but not limited to, upcoding, duplicate charges, and charges for services not performed.

(9) Medical Record Review. In the event that the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Allowable Claim Limit according to the medical record review and audit results.

(10) Not Able to Identify or Understand. The Allowable Claim Limits will not include any charges for which the Plan Administrator cannot identify or understand the item(s) being billed.

(11) Directly Contracted Providers. The Allowable Claim Limits for providers of service who are directly contracted with the DDM will be the negotiated rate as agreed under the contract.

In the event that the Plan Administrator determines that insufficient information is available to identify the Allowable Claim Limit for a specific service or supply using the listed guidelines above, the Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

Notwithstanding any conflicting contracts or agreements, the Plan may consider the Allowable Claim Limits as the maximum amount of Covered Charges that may be considered for reimbursement under the Plan, and may apply this determination in lieu of any PPO network provider hospitals' per diem, DRG rates or PPO discounted rates as the amount considered for reimbursement under the Plan. Additionally, in the event that a determination of an Allowable Claim Limit exceeds the actual charge billed for the service or supply, the Plan will consider the lesser of the actual billed charge or the Allowable Claim Limit determination.

CARE MANAGEMENT SERVICES

The MADA Insurance Trust has contracted with EBMS CareLink (CareLink) in order to assist the Covered Person in determining whether or not proposed services are appropriate for reimbursement under the Plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

CareLink Program Phone Number:

CareLink (406) 245-3575 or (866) 894-1505
Monday through Friday, 6:00 a.m. to 7:00 p.m. (Mountain Time)

A CareLink nurse will assist/contact the Covered Person to provide:

- Health education
- Individualized support to the patient
- Contacting the family to offer assistance for coordination of medical care needs
- Assisting in obtaining any necessary equipment and services
- Monitoring the response to treatment
- Pre-surgical counseling
- Inpatient care coordination
- Evaluating outcomes

A. Utilization Review

Utilization Review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses. The program consists of:

Pre-certification of the *medical necessity* for the following listed non-emergency services before medical and/or surgical services are provided:

- Hospitalizations, except maternity;
- Inpatient admission to free-standing chemical dependency, mental health, and rehabilitation facilities;
- Skilled nursing facility stays;
- Hospice care;
- Transplants;
- Cancer treatment programs, administered on an inpatient or outpatient basis; and
- Inpatient or outpatient surgeries relating to, but not limited to, hysterectomies, back surgery, or any service deemed investigational or part of a clinical trial.

The purpose of the program is to determine medical necessity, appropriateness, health care setting, and level of care.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified as Medically Necessary before the Covered Person receives the care or treatment, it means that the charges for the care or treatment may be subject to a penalty. The Covered Person is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

How the Utilization Review Program Works.

Pre-certification. Before a Covered Person enters a Hospital on a non-emergency basis or receives other listed medical services, CareLink will, in conjunction with the attending Physician, certify the care as Medically Necessary. A non-emergency stay in a Hospital is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person or the treating provider. Contact CareLink at the numbers listed above with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Hospital, the patient, patient's family member, Hospital or attending Physician must contact CareLink **within 48 hours** of the first business day after the admission.

CareLink will review and make a determination on the medical necessity of the care, treatment or service.

Note: *Pre-certification does not guarantee payment of the Claim(s) incurred during the period of certification. Whether an individual is a Covered Person, whether a charge is eligible for payment, and how much of a charge is paid are determined after the Claim for the care, treatment or service is received by the Claims Administrator. All Claims are subject to all Plan terms and conditions, limitations, and exclusions at the time the charges are incurred. Providers and Covered Persons are informed at the time the Hospital stay is certified that certification by CareLink does not guarantee payment of Claims for the same.*

Penalty For Failure to Pre-Certify

If a Covered Person does not pre-certify the care, treatment, or service before receiving treatment, **the Plan's benefit level may be reduced to 50%.** Penalties for failure to pre-certify care, treatment or a service do not accrue to the Covered Person's Out-of-Pocket Maximum Amount.

Concurrent Review and Discharge Planning

Concurrent review of a course of treatment and discharge planning from a Hospital are parts of the Utilization Review. CareLink will monitor the Covered Person's Hospital stay or use of other medical services and coordinate with the attending Physician, Hospital and Covered Person either the scheduled discharge or extension of the Hospital stay or extension or cessation of other medical services.

If the attending Physician believes it Medically Necessary for a Covered Person to receive additional services or to stay in the Hospital for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

B. Case Management and Alternative Benefit

If a Covered Person has an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor this Covered Person, and to coordinate with the attending Physician and Covered Person to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Covered Person, the family, and the attending Physician to assist in coordinating a plan of care approved by the Covered Person's attending Physician and the Covered Person.

Case Management is a voluntary program of the Plan. If the Covered Person chooses not to participate in the Case Management program, there will be no reductions of benefits or penalties.

Each treatment plan is individualized to a specific Covered Person and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Covered Person and the attending Physician.

Alternative Benefit. The Plan may elect, in its sole discretion, to allow for alternative benefits that are otherwise excluded under the Plan. The Plan's decision to allow alternative benefits shall be determined on a case-by-case basis in conjunction with the treating provider and the Covered Person. The Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan Administrator to strictly enforce the provisions of the Plan.

The Alternative Benefit must be beneficial to both the Covered Person and the Plan.

Alternative benefits, if approved by the Plan Administrator, are subject to all applicable Plan terms and conditions, limitations and exclusions at the time the charges are incurred. Once agreement has been reached, the Plan Administrator or its delegate will direct the Claims Administrator to reimburse for Medically Necessary expenses as stated in the alternative treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connections with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

C. Focused Case Management, Disease Management, and Health Coaching

In addition to the Case Management program described above, the Plan offers additional health management programs to Covered Persons. These programs include:

- Focused Case Management;
- Disease Management: and
- Health Coaching:

The Plan offers these services through contracted vendors, including ISWM, Take Control or other consultants called "care professionals". These professionals work with covered persons who can benefit from these services, as well as family members and treating providers to identify and arrange the most appropriate, effective, and cost-efficient treatment possible.

Services are focused on those Covered Persons who have been identified as having:

- Significant medical risks; or
- Chronic health care needs, which can be reduced through prevention or disease management; or
- A need for wellness promotion and/or health coaching.

Analysis of medical/pharmaceutical claims data, wellness screening results, health risk assessments and/or vision exams will be utilized to identify Covered Persons who are most likely to benefit from these services. The Covered Person does not have to contact any of the vendors or care professionals. Covered Persons will be contacted by the vendor or care professional if they would benefit from any of these programs.

Focused Case Management, Disease Management and Health Coaching are voluntary programs of the Plan and are offered at no cost to the Covered Person. If the Covered Person chooses not to participate in these voluntary programs, there will be no reduction of benefits or penalties.

Program provisions require that the care professional who provides these services keep all claims data and other medical information strictly confidential.

DEFINED TERMS

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

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowable Charge means the charge for a treatment, service, or supply that is the lesser of: 1) for claims under the Claim Review and Audit Program, the Allowable Claim Limit; 2) the charge made by the provider that furnished the care, service, or supply; 3) the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement; 4) the reasonable and customary charge for the same treatment, service, or supply furnished in the same geographic area by a provider of like service as further described below; or 5) for specialty drug claims not subject to the Claim Review and Audit Programs, 130% of the average sales price.

The reasonable and customary charge may mean an amount equivalent to the **90th percentile** of a commercially available database, or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan. If there are insufficient charges submitted for a given procedure, the Plan will determine an Allowable Charge based upon charges made or fees accepted for similar services. Determination of the reasonable and customary charge will consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that provider..

For Covered Charges rendered by a Physician or other professional Provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charge.

The Plan Administrator or its designee has the ***ultimate discretionary authority*** to determine an Allowable Charge, including establishing the negotiated terms of a provider arrangement (including a PPO agreement if applicable) as the Allowable Charge even if such negotiated terms do not satisfy the lesser of test described above.

Allowable Claim Limits means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. The determination of Allowable Claim Limits under this Plan will supersede any other Plan provisions related to application of a usual and reasonable fee determination. Please refer to the section, "Claim Review and Audit Program" for an explanation of the determination of Allowable Claim Limits.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

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

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

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

Brand Name means a trade name medication.

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

Claims Administrator means Employee Benefit Management Services, Inc. (EBMS).

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

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Cosmetic and Reconstructive Services shall mean services which improve appearance or corrects a deformity. If a functional impairment is present and will be corrected through a Cosmetic and Reconstructive Service, then the Cosmetic and Reconstructive Service is considered Medically Necessary. If no functional impairment is present and services are provided solely to restore normal bodily appearance, the service will be considered Medically Necessary only when the defect was caused by a congenital anomaly, accidental Injury or reconstructive mammoplasty as stated as a benefit under this Plan.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Owner or Dependent who is covered under this Plan.

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

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

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is each participating employer in the MADA Insurance Trust.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) 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; or

(2) 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; or

(3) e*xcept as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Charges section,* if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) 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, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

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

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

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

Habilitative and Rehabilitative Care shall include Medically Necessary interactive therapies derived from evidence-based research, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

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

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

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

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

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

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

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

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

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

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it has received accreditation from the Commission of Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) or if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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

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

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

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

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

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

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

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

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

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Naturopathic Doctor (N.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means MADA Insurance Trust, which is a benefits plan for certain Employees of MADA Insurance Trust and is described in this document.

Plan Administrator or Plan Sponsor means the MADA Insurance Trust.

Plan of Care. A description of the goals, outcomes, prognosis, and proposed interventions for a Covered Person, including criteria for discharge and the optimal duration and frequency of therapeutic interventions.

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

Plan Year is the 12-month period beginning on January 1st and ending December 31st.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

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

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

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

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

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

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

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

PLAN EXCLUSIONS

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

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

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

(2) **Acupuncture.** Care, services and supplies in connection with acupuncture or acupressure.

(3) **Adoption expenses**. Charges in connection with adoption, including surrogate Pregnancy expenses (whether or not the mother is a Covered Person under this Plan), will not be a Covered Charge.

(4) **Athletics.** Care, services and supplies in connection with the Injury or Illness arising out of employment as an athlete by or on a team or sports club engaged in any contact sport which includes significant physical contact between the athletes involved including, but not limited to, boxing, football, hockey, wrestling, rugby, where the Covered Person's employer is not required by law to obtain coverage for Illness or Injury under state or federal worker's compensation, occupational disease or similar laws.

(5) **Biofeedback.** Care, services, supplies and treatment in connection with biofeedback.

(6) **Coding Guidelines.** Charges for inappropriate coding in accordance to the industry standard guidelines in effect at the time services were received.

(7) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(8) **Computerized items.** Charges for computerized items including, but not limited to, Durable Medical Equipment, prosthetic limbs and communication devices. Payable for deluxe prosthetics and computerized limbs will be payable based on the Allowable Charge for a standard prosthesis.

(9) **Cosmetic Surgery.** Services, supplies, drugs and devices related to non-covered Cosmetic and Reconstructive Services or treatment.

(10) **Counseling.** Care and treatment for marital, pre-marital or religious counseling, including bereavement counseling.

(11) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as specifically stated as a benefit under this Plan.

(12) **Dental services.** Services, supplies, care and treatment for dental services directly related to the care, filling, removal or replacement of teeth, including extractions; to the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth; ridge augmentation and vestibuloplasty, whether performed by a Physician, dentist, oral surgeon or any other provider; except as specifically stated as a benefit under this Plan.

(13) **Educational or vocational testing.** Services for educational or vocational testing or training, self-help programs, or stress management, except as specifically stated as a benefit under this Plan.

(14) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.

(15) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(16) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/ Investigational, is not Medically Necessary or is a clinical trial.

(17) **Eye care.** Radial keratotomy, Lasik surgery, or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(18) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease), or as otherwise deemed Medically Necessary.

Foot orthotics, including impression casting for orthotic appliances, padding, strapping and fabrication *will not* be a Covered Charge.

(19) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(20) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(21) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(22) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.

(23) **Homeopathy and holistic medicine.** Care, services and supplies in connection with homeopathy or holistic medicine.

(24) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(25) **Hypnosis.** Charges for hypnosis or hypnotherapy.

(26) **Illegal acts.** Any loss for which a contributing cause was commission by the Covered Person of a felony or attempt to commit a felony. This exclusion does not apply if the loss resulted from an act of domestic violence or a medical (including both physical and mental health) condition or if the commission of the felony is related to a pre-existing medical condition.

(27) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence or sexual dysfunction.

(28) **Infertility.** Care, supplies, services and treatment for infertility including, but not limited to, medications, artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) or zygote intrafallopian transfer (ZIFT).

(29) **Jaw joint problems.** All diagnostic and treatment services related to the treatment of jaw joint problems including, but not limited to, nonsurgical treatment for malocclusion of the jaw, temporomandibular joint (TMJ) syndrome, orthodontics or related appliances, derangements and myofascial pain syndrome.

(30) **Mailing or Sales Tax.** Charges for mailing, shipping, handling, conveyance and sales tax.

(31) **Massage therapy.** Care, services and supplies in connection with massage therapy.

(32) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(33) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(34) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(35) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(36) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(37) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except as specifically stated under the Nutritional Educational Counseling and Obesity Interventions benefits under this Plan. Health clubs, fitness centers, weight loss clinics or clubs *will not* be a Covered Charge under this Plan.

(38) **Occupational Injury**. Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies even though the Plan Participant:

(a) Has waived his/her rights to Workers' Compensation benefits;

(b) Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits;

(c) The Plan Participant is permitted to elect not to be covered under Workers' Compensation but has failed to properly file for such election.

(39) **Personal comfort items.** Personal comfort items, patient convenience items, or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(40) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(41) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(42) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(43) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(44) **Rolfing.** Care, services and supplies in connection with rolfing.

(45) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably

suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(46) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(47) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(48) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(49) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(50) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(51) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit under this Plan.

(52) **Vitamins and supplements.** Charges for vitamins, except when deemed Medically Necessary for the treatment of an Illness. Food supplements will not be covered except for treatment of Inborn Errors of Metabolism or Enteral Nutrition services.

(53) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

The Coordination of Benefits provision will not apply to prescriptions purchased at a Participating Pharmacy.

Participating Pharmacy

Participating Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. **Navitus Health Solutions** is the administrator of the pharmacy drug plan.

For prescription claims questions or to obtain a claim form please call:

Navitus Health Solutions - toll-free 1 (866) 333-2757
Or on the web by logging in to miBenefits at www.ebms.com

Prescription Drug Copayments

A Prescription Drug copayment is applied to each covered pharmacy drug, specialty medication or mail order drug charge as shown in the Schedule of Benefits section.

- *Any one retail pharmacy prescription is limited up to a 30-day supply.*

If a drug is purchased from a **Participating Pharmacy when the Covered Person's ID card is not used**, the Covered Person will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Covered Person will be required to submit the prescription receipt to **Navitus Health Solutions** for reimbursement (less any applicable copayments as shown in the Schedule of Benefits section).

If a drug is purchased from a **Non-Participating Pharmacy**, the Covered Person will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Covered Person will be required to submit the prescription receipt to **Navitus Health Solutions** for reimbursement (less any applicable copayments as shown in the Schedule of Benefits section).

Mandatory Specialty Pharmacy Program

The Specialty Pharmacy Program is a program that has been determined by the administrator of the pharmacy drug plan to **require reimbursement only through an approved specialty pharmacy vendor(s)** for medications determined to be part of the Specialty Pharmacy Program. The pharmacy benefit administrator will review and modify the list of products included in the Specialty Pharmacy Program periodically as new information becomes available.

With some exceptions, the first prescription will be allowed through the regular Pharmacy Option under this Plan; any subsequent refill for specialty medications **must** be filled through the Special Pharmacy Program.

Prescriptions under the Specialty Pharmacy Program will be limited to a 30-day fill and will be payable at the Specialty Pharmacy Program copayment level (after satisfaction of the medical deductible) and will be payable up to the maximum as shown in the Schedule of Benefits.

Note: Some specialty medications may be subject to split-fills at 15 days for up to the first three (3) months. Contact Navitus Health Solutions for more information regarding split-fills.

For more information regarding the Specialty Pharmacy Program, please contact **Navitus Health Solutions** toll-free at 1 (866) 333-2757 or visit www.ebms.com.

Mail Order Pharmacy

The Mail Order Pharmacy benefit is available for maintenance medications (those that are taken for long periods of

time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). For more information regarding the mail order drug benefit option contact **Navitus Health Solutions** toll-free at 1 (866) 333-2757.

Any one mail order prescription is limited up to a 90 day supply.

Tablet Splitting

The Tablet Splitting program saves the Covered Person money by breaking a higher-strength tablet in half to provide the needed dose. The Covered Person will receive the same medication and dosage while purchasing fewer tablets and saving on his/her copayment.

For more information regarding the Tablet Splitting program, please contact **Navitus Health Solutions** toll-free at 1 (866) 333-2757.

Step Therapy Program

Step Therapy is a process that requires the use of one or more first line agents before a medication which is part of a step therapy protocol can be utilized.

The goal of step therapy is to ensure that safe and cost effective medications are used, based on recognized treatment guidelines and well documented clinical studies. This means that in some instances the Covered Person will need to try one or more medications which are considered first line before he/she is able to receive a "second step" medication through his/her pharmacy benefit plan.

For a complete list of medications that are subject to Step Therapy protocols, contact **Navitus Health Solutions** toll-free at 1 (866) 333-2757.

Covered Prescription Drugs

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

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law, excluding any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. *A prior authorization is required for compounds costing $200 or greater.*

(3) Insulin and other injectable diabetic medications and the following diabetic supplies, when prescribed by a Physician: lancets, lancet devices, alcohol swabs, blood glucose meters, blood glucose and test strips, blood test strips, and insulin syringes and needles.

(4) Contraceptives. All Food and Drug Administration (FDA) approved contraceptive methods when prescribed by a Physician, including oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, vaginal contraceptives and injectables. Coverage **will not** include intra-uterine devices (IUDs) or implantables.

(5) Topical acne medications, when prescribed by a Physician. A prior authorization is required for Covered Persons ages 35 years and over.

(6) Injectables.

(7) Certain over-the-counter (OTC) medications are available when prescribed by a Physician and only when purchased through a Participating Pharmacy. Contact Navitus Health Solutions for more information regarding a list of medications.

The following will be covered at 100 %, no copayment required for Generic or Formulary drugs.

Benefits may be subject to prescription Generic or Formulary and/or quantity limitations. Non-Formulary prescriptions may be payable subject to the applicable prescription copayment as shown in the Schedule of Benefits. Contact **Navitus Health Solutions** toll-free at 1 (866) 333-2757 *to request coverage of the medication as a non-Formulary medical exception.*

(1) Physician-prescribed tobacco cessation products. Physician-prescribed nicotine replacement products (nicotine patch, gum, lozenges) and Physician-prescribed medications (Zyban, Chantix).

(2) Physician-prescribed contraceptives methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Covered Persons with reproductive capacity.

Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.

(3) Certain vaccinations/immunizations as recommended by applicable federal law will be covered only when rendered through a Participating Pharmacy. Please note: Not all Participating Pharmacies may be providing vaccinations/immunizations or may vary in what they offer. It is important to check with the Participating Pharmacy to determine availability, age restrictions, any prescription requirements or hours of service. *Please contact* **Navitus Health Solutions** toll-free at 1 (866) 333-2757 *for more information regarding this benefit.*

(4) Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance or deductible will be required, and will only be available when utilizing a Participating Pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one (1) year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or *contact* ***Navitus Health Solutions*** *toll-free at 1 (866) 333-2757 for more information regarding which medications are available. Note: Age and/or quantity limitations may apply*:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

Limits To This Benefit

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

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants or dietary supplements for weight loss or dietary control.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Contraceptives.** Charges for contraceptives, except as specifically stated as a benefit under this Plan.

(5) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, insulin pumps and pump supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*

(6) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.

(7) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)

(8) **FDA.** Any drug not approved by the Food and Drug Administration.

(9) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless deemed Medically Necessary.

(10) **Immunization.** Immunization agents, biological sera, blood or blood plasma, except as specifically stated as a benefit under the Prescription Drug Benefits section.

(11) **Impotence.** A charge for impotence and sexual dysfunction medication.

(12) **Infertility.** A charge for fertility or infertility medication.

(13) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(15) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(16) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs, including worker's compensation.

(17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(19) **Vitamin supplements.** Vitamin supplements even when prescribed by a Physician, except as otherwise specifically stated as a benefit under this Plan,

HOW TO SUBMIT PHARMACY CLAIMS

When obtaining a prescription, a Plan Participant should show his or her **EBMS / MADA Insurance Trust identification card** to the pharmacist. Participating Pharmacies may submit claims on a Plan Participant's behalf.

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

For more information regarding the Prescription Drug benefit section or to submit manual prescription receipts for reimbursement, please contact the Pharmacy Benefit Administrator at the following:

Navitus Health Solutions - toll-free 1 (866) 333-2757
Or on the web by logging in to miBenefits at www.ebms.com

Please submit prescription claim forms to:

Navitus Health Solutions
Operations Division – Claims
P.O. Box 999
Appleton, WI 54912-0999
Or fax ALL information to 1 (920) 735-5315 or toll free 1 (855) 668-8550

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show his or her **EBMS / MADA Insurance Trust Identification card** to the provider. Participating Providers may submit claims on a Plan Participant's behalf.

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

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number **(MADA Insurance Trust, Group #0000700)**
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at http://www.ebms.com.

WHERE TO SUBMIT CLAIMS

Employee Benefit Management Services, Inc., is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within **365 days** from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims).

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits; however, a healthcare provider can represent the Claimant in claims involving Urgent Care. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are four types of Claims:

Pre-Service Claim

A **Pre-Service Claim** is a reduction in benefits for certain Covered Services because the Plan Participant did not obtain the required Plan approval before receiving the care or treatment. This Plan does require prior approval for certain covered services or treatments as a condition to receiving benefits under the Plan. The review program is known as pre-certification. See the Schedule of Benefits and the Care Management Services section for more information.

Urgent Care Claim

An **Urgent Care Claim** is any Pre-Service Claim where the application of the time periods for review and determination of the Pre-Service Claim could seriously jeopardize the life or health of the Plan Participant or the Plan Participant's ability to regain maximum function, or – in the opinion of the Plan Participant's treating physician, would subject the Plan Participant to severe pain that cannot be managed without the proposed care or treatment

Concurrent Care Determination

A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services Section.*

Post-Service Claim

A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

Initial Benefit Determination

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. 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 involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

The initial benefit determination will be made as follows:

Pre-Service Claims for Urgent Care

If your Pre-Service Claim is determined by the Claims Administrator to be a claim involving Urgent Care, notice of the Plan's decision will be provided to the Plan Participant as soon as possible but no later than 72 hours after receipt of the Pre-Service Claim by the Claims Administrator.

The exception is if the Plan Participant does not provide sufficient information to decide the Pre-Service Claim. In that case, notice requesting specific additional information will be provided to the Plan Participant within 24 hours of receipt of the Pre-Service Claim.

The Plan's decision regarding the Pre-Service Claim will be made as soon as possible but no later than 48 hours after the earlier of:

- The Plan's receipt of the requested information or
- The expiration of the time period set by the Plan for you to provide the requested information (at least 48 hours).

Pre-Service Claims for non-Urgent Care

If your Pre-Service Claim is not an Urgent Care claim, written notice of the Plan's decision will generally be provided to the Plan Participant within a reasonable period of time, but no later than 15 days after receipt of the Pre-Service Claim by the Claims Administrator.

If matters beyond the control of the Claims Administrator so require, one 15-day extension of time for processing the Pre-Service Claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to the Plan Participant before the end of the initial 15-day period. If an extension is required because the Plan Participant did not provide the information necessary to decide your claim, the notice of extension will specifically describe the required information.

The time-period for processing your Pre-Service Claim will be deferred beginning on the date this extension notice is sent to you and ending on the earlier of:

- The date the Plan receives your response to the request for additional information, or
- The date set by the Plan for your response (which will be at least 45 days).

Concurrent Care Determination

The initial benefit determination on a Concurrent Care Determination will be made within 15 days of the Claim Administrator's notice of a Concurrent Care Claim. If additional information is necessary to process the Concurrent Care Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant or the healthcare provider must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits**.

If additional information is requested, the Plan's time period for making a determination on a Concurrent Care Claim is suspended until the earlier of:

- The date the Plan receives the Claimant's or healthcare provider's response for additional information, or
- The date set by the Plan for the Claimant or healthcare provider to respond (which will be at least 45 days).

A benefit determination on the Concurrent Care Claim will be made within 15 days of the Plan's receipt of the additional information.

Post-Service Claim

The initial benefit determination on a Post-Service Claim will be made within 30 days of the Claim Administrator's receipt of the Claim. If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits**.

If additional information is requested, the Plan's time period for making a determination on a Post-Service Claim is suspended until the earlier of:

- The date the Plan receives the Claimant's additional information, or
- The date set by the Plan for the Claimant to respond (which will be at least 45 days).

A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Determination

(1) The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant. If a Claim is denied in whole or in part, notice will include the following:

(2) Specific reason(s) for the denial.

(3) Reference to the specific Plan provisions on which the denial was based.

(4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

(5) Description of the Plan's Claims review procedures and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following a notice of the determination on final review.

(6) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

(7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the notice of the determination and that a copy will be provided free of charge to the Claimant upon request).

(8) If the notice of the determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim, or a statement that such explanation will be provided free of charge, upon request.

(9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An adverse benefit determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan participant’s failure to timely pay required premiums.

Claims Review Procedure - General

A Claimant may appeal an adverse benefit determination as follows:

- The Plan offers a one-level internal review process for Pre-Service Claims for Urgent Care;
- The Plan offers a two-level internal review procedure for a Pre-Service Claim (non-Urgent Care), Concurrent Care Claim, and Post Service Claim.

The Plan will provide for a review that does not give deference to the previous benefit determination and that is conducted by either an appropriate Plan fiduciary or the Claims Administrator on the Plan’s behalf who is neither the individual who made the initial benefit determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final notice of the determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's benefit determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Internal Appeal Procedure

First Level of Internal Review

To appeal a denial of a Claim, the Claimant must submit in writing, a request for a review of the Claim. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the denial. The Claimant may include any additional supporting information, even if not initially submitted with the Claim.

The written request for review must be submitted within:

- 15 days of the Claimant's receipt of a denial on a Concurrent Care Claim;
- 30 days of the Claimant's receipt of a denial on a Pre-Service Claim or Urgent Care Claim;
- 180 days of the Claimant's receipt of a denial on a Post-Service Claim.

The written request for review should be addressed to:

Plan Administrator
℅ Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the initial denial within the prescribed time period will render that determination final. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within:

- 72 hours of the receipt of the appeal for an Urgent Care Claim;
- 15 days of the receipt of the appeal for a Pre-Service Claim or a Concurrent Care Claim; or
- 30 days of the receipt of the appeal for a Post Service Claim.

Second Level of Internal Review

If the Claimant does not agree with the Claims Administrator's determination from the first level of Internal Review, the Claimant may submit a second level appeal in writing. The Claimant may request a second level appeal on Pre-service Claims (non-Urgent Care) and Post-Service only along with any additional supporting information.

The written request for review of the first level of internal review must be submitted within:

- 15 days of the Claimant's receipt of the first level of internal review on a Pre-Service Claim (non-Urgent Care);
- 15 days of the Claimant's receipt of the first level of internal review on a Concurrent Care Determination;
- 60 days of the Claimant's receipt of the first level of internal review on a Post-Service Claim.

The written request for review should be addressed to:

Plan Administrator
℅ Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. Failure to appeal the determination from the first level of review within the prescribed time period will render that determination final. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within:

- 15 days of the Plan's receipt of Claimant's second level appeal on a Pre-Service Claim (non-Urgent Care);
- 15 days of the Plan's receipt of Claimant's second level appeal on a Concurrent Care Determination;
- 30 days of the Plan's receipt of Claimant's second level appeal on a Post-Service Claim.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may be eligible for an External Review. The claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review. In certain circumstances, the Claimant may also request an expedited External Review.

External Review Procedure

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the final internal adverse benefit determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final adverse benefit determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or services is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.

- Application of treatment limits to a Claim for a Mental Disorder.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. ***Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.***

Assignment of Benefits

"Assignment of benefits" means an arrangement whereby the Covered Person assigns the right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of the Plan, to a provider. If a provider accepts said arrangement, the provider's rights to receive Plan benefits are equal to those of a Covered Person, and are limited by the terms of the Plan. A provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.
Benefits that are payable by the Plan to PPO network providers are automatically assigned to the provider of services or supplies unless evidence of previous payment is submitted. All other benefits payable by the Plan may be assigned to the provider of services or supplies at the Covered Person's option. Payments made in accordance with an assignment are made in good faith and release the Plan's obligation to the extent of the payment. Reimbursement to Medicaid will be made in accordance with applicable law.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person, in any manner have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider that accepts an assignment of benefits, in accordance with this Plan as consideration in full services rendered, is bound by the rules and provisions set forth within the terms of this document.

PROVIDER OF SERVICE APPEAL RIGHTS – CLAIM REVIEW AND AUDIT PROGRAM

A Covered Person may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Covered Person to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a Covered Person's appeal, and will respond to the provider with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeals of Adverse Benefit Determinations" above. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Charges directly from the Plan, waiving any right to**

recover such expenses from the Covered Person, and comply with the conditions for appeal above.

For purposes of this section, the provider's waiver to pursue covered medical expenses does not include the following amounts, which are the responsibility of the Covered Person:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program."** The provider must agree to waive billing the Covered Person for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB or on a Form HCFA (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeals.

COORDINATION OF BENEFITS

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

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

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

(1) Group or nongroup insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and nongroup coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical components of long-term care contracts, such as skilled nursing care;

(6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;

(7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;

(8) Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Allowable Charge" in the Defined Terms section.)

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

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

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

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

(A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(B) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:

(1) The benefits of the plan which covers the person directly (that is, as a Member/Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

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

(2) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

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

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

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

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's spouse does, the plan of that parent's spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.

- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);

- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

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

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

4th The plan covering the spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (5) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

(3) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or as a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Member/Employee. This rule does not apply if Rule (1) can be used to determine the order of benefits If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(4) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.

(5) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(C) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(D) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

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

Defined Terms

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

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

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

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

Right to Reimbursement

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

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

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

Right to Subrogation

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

The Covered Person agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Covered Person may have now or in the future against a Third Party who has or may have caused, contributed, aggravated, and/or been responsible for the Covered Person's Injury, Sickness, condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits. The Covered Person further agrees that the Plan is subrogated to any and all claims or rights that the Covered Person may have against any Recovery, including the Covered Person's rights under the Plan to bring an action to clarify his rights under the Plan. The Plan may assert this Right of Subrogation independently of the Covered Person. The Plan is not obligated to pursue this right independently or on behalf of the Covered Person, but may choose to exercise this right, in its sole discretion.

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

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

(1) Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;

(2) Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;

(3) Provide to the Plan in a timely manner any and all facts, documents, papers, information or other data reasonably related to the Covered Person's Injury, Sickness, condition, and/or accident, including any efforts by another individual to Recover on the Covered Person's behalf;

(4) Execute all assignments, liens, or other documents that the Plan or its agents may request to protect the Plan's rights under this section;

(5) Obtain the Plan's consent before releasing a Third Party from liability for payment of expenses related to the Covered Person's Injury, Sickness, condition, and/or accident;

(6) Hold in trust that portion of any Recovery received by the Covered Person or on the Covered Person's behalf equal to the Plan's equitable lien until such time as the Plan is repaid in full;

(7) Agree not to impair, impede or prejudice in any way, the rights of the Plan under this section; and

(8) Do whatever else the Plan deems reasonably necessary to secure the Plan's rights under this section.

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

(1) The Plan may require the Covered Person as a condition of paying benefits for the Covered Person's Injury, Sickness, condition, or accident, to execute documentation acknowledging the Plan's rights under this section;

(2) The Plan may withhold payment of benefits to the extent of any Recovery received by or on behalf of a Covered Person;

(3) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Covered Person;

(4) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible; or

(5) The Plan may, to the extent of any benefits paid by the Plan which have not otherwise been reimbursed to the Plan, offset any future benefits otherwise payable under the Plan to the Covered Person or on the Covered Person's behalf.

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

Right to Recover Benefits Paid in Error

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

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA. ***A domestic partner is not a Qualified Beneficiary.***

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

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

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

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

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

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

The Plan Administrator is:
MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

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

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18 month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18 month period.

Disability extension of 18-month period of COBRA Continuation Coverage

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

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

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

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

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

The Plan Administrator:
MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

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

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;

- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

The Plan Administrator:
MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

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

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

- The date your Employer ceases to provide a group health plan to any Employee;

- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;

- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;

- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or

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

How Do I Pay for COBRA Continuation Coverage?

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Information

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

Plan Administrator
MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

COBRA Administrator
Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION AND DESIGNATED DECISION MAKER

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of the Plan Documents to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain fiduciary responsibility to ELAP Services, LLC *(the "Designated Decision Maker" or "DDM")*. The fiduciary responsibility allocated to the DDM is limited to discretionary authority and ultimate decision-making authority with respect to any appeals of denied claims, which shall be referred to the DDM by the Plan Administrator (the "Referred Appeals"). The Plan Sponsor has allocated additional fiduciary responsibility to the DDM, limited to discretionary authority and ultimate decision-making authority with respect to the review and audit of certain claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program". Such claims selected as eligible for review and audit shall be identified under guidelines to which the Plan Sponsor has agreed, and shall be referred to the DDM by the Plan Administrator. The DDM shall have no authority, responsibility or liability other than with respect to the Referred Appeals and its duties under the Claim Review and Audit Program.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator and the Designated Decision Maker shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and the Designated Decision Maker shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or the Designated Decision Maker as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or the Designated Decision Maker decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

(1) To administer the Plan in accordance with its terms;

(2) To determine all questions of eligibility, status and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise a third party administrator to pay claims;

(9) To perform all necessary reporting as required by ERISA;

(10) To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;

(11) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

(12) To perform each and every function necessary for or related to the Plan's administration.

Duties of the Designated Decision Maker

The Designated Decision Maker (DDM) shall have the following duties with respect to the Referred Appeals and the Claim Review and Audit Program:

(1) To administer the Plan in accordance with its terms;

(2) To determine all questions of eligibility, status and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To review Referred Appeals and to uphold or reverse any denials;

(7) To keep and maintain records pertaining to the Referred Appeals;

(8) To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and

(9) To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of the DDM shall be limited to those set forth above.

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

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding may be derived from the funds of the Employer and contributions made to the MADA Insurance Trust by the covered Employees.

For Dependent Coverage: Funding may be derived from contributions made by the covered Employees.

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

AMENDING AND TERMINATING THE PLAN

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

The Plan Sponsor or Plan Administrator reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

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

Disclosure of Summary Health Information to the Plan Sponsor

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

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

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

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

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

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Office Manager of the MADA Insurance Trust
Executive VP (MADA Insurance Trust Office)

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

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

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

Disclosure of Certain Enrollment Information to the Plan Sponsor

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

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

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

Other Disclosures and Uses of PHI

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

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

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

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

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

(3) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

(4) Report to the Plan any security incident of which it becomes aware.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

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

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

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

Review this summary plan description and the documents governing the Plan or the rules governing COBRA Continuation Coverage rights.

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

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

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

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

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from contributions by Employers and covered Employees to the MADA Insurance Trust. The Plan is not insured.

PLAN NAME

MADA Insurance Trust

PLAN NUMBER: 501

TAX ID NUMBER: 81-0380275

PLAN EFFECTIVE DATE: January 1, 2012

PLAN YEAR ENDS: December 31st

PLAN SPONSOR

MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

PLAN ADMINISTRATOR

MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601
(406) 442-1233

NAMED FIDUCIARY

MADA Insurance Trust
501 N. Sanders
Helena, Montana 59601

AGENT FOR SERVICE OF LEGAL PROCESS

Smith Law Firm, P.C.
26 W. Sixth Ave.
P.O. Box 1691
Helena, Montana 59624

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

Plan Name: MADA Insurance Trust

Plan Option: Traditional 60/40

Effective Date: January 1, 2012

Restatement Date: January 1, 2017

I, _____, certify that I am the _____
Name Title

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

Signature: _____

Print Name: _____

Date: _____