



**Missoula County  
Employee Benefits Plan  
Summary Plan Description**

July 1, 2010

Risk and Benefits Office  
Phone (406)523-4876  
Fax (406)523-4731  
[www.co.missoula.mt.us/benefits](http://www.co.missoula.mt.us/benefits)



July 2010

Benefit Plan Members:

This booklet is a summary of the Missoula County Employee Benefits Plan (MCEBP). It contains information regarding the medical, dental and vision benefits available through MCEBP. Life insurance benefits are described in a separate document. This booklet and other benefit information are available on the internet at [co.missoula.mt.us/benefits](http://co.missoula.mt.us/benefits).

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

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

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

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

Sincerely,  
Hal K. Luttschwager, CPCU, CLU, ARM  
Plan Administrator



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## **Introduction**

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

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

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

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

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

Benefits described in this booklet are effective July 1, 2010.

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

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



# Missoula County Employee Benefits Plan HIPAA Notice

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

## Use and Disclosure of Health Information

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

### To Make or Obtain Payment

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

### To Conduct Health Care Operations

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

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

### For Treatment Alternatives

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

### For Distribution of Health-Related Benefits and Services

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

### For Disclosure to the Plan Sponsor

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

### When Legally Required

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

### To Conduct Health Oversight Activities

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

### In Connection With Judicial and Administrative Proceedings

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

### For Law Enforcement Purposes

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

### In the Event of a Serious Threat to Health or Safety

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

## For Specified Government Functions

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

## For Workers' Compensation

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

## Authorization to Use or Disclose Health Information

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

## Right to Request Restrictions

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

## Right to Receive Confidential Communications

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

## Right to Inspect and Copy Your Health Information

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

## Right to Amend Your Health Information

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

## Right to an Accounting

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

## Right to a Paper Copy of this Notice

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

## Duties of MCEBP

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

## Contact Person

MCEBP has designated the Plan Administrator as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person by mail at 200 West Broadway, Missoula, MT 59802, by telephone at (406) 523-4873, by fax at (406) 523-4731, or by email at [benefits@ho.missoula.mt.us](mailto:benefits@ho.missoula.mt.us).

## Effective Date

This notice is effective April 14, 2004

## **Definitions**

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

### **Accident**

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

### **Alternative medicine**

A benefit category limited to acupuncture, biofeedback/neurofeedback, massage therapy, rolfing therapy and phototherapy light boxes.

### **Ambulance**

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

### **Ambulatory surgical facility/surgical center**

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

### **Amendment**

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

### **Benefit year**

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

### **COBRA**

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

### **Coinsurance**

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

### Cosmetic procedure

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

### Covered person

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

### Custom orthotics

A medically necessary custom-molded orthotic which requires a prescription from a physician.

### Deductible

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

### Dependent

The legal spouse of an employee or retired employee, the domestic partner of an employee or retired employee, or any unmarried child of the employee or domestic partner who is under 25 years of age.

### Domestic partner

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

### Durable medical equipment

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

### Elective surgical procedure

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

## Employee

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

## Employer

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

## Expenses incurred

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

## Experimental/investigational treatment

See Medical Expenses Not Covered beginning on page 36.

## Extended care facility

A facility licensed under applicable laws to provide inpatient care under the supervision of medical staff or a medical director for ten or more patients. It must provide continuous 24-hour-a-day nursing services supervised by registered nurses. The facility must be qualified to receive payments from Medicare. The facility must be engaged primarily in custodial care or treatment/care for chemical dependency or alcoholism.

## Hospice

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

## Hospital

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

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

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

## Illness

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

### Incidental procedure

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

### Injury

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

### Inpatient/outpatient psychiatric or chemical dependency treatment facility

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

The chemical dependency treatment center must be approved by the Department of Institutions. The mental and nervous treatment facility must be certified as an eligible provider by Medicare.

### Maternity care

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

### Maximum allowable charge/usual, customary or reasonable (UCR)

Plan payment allowance for eligible procedures, processed according to the plan's provisions.

- Usual: An amount a professional provider normally charges for a given procedure.
- Customary: An amount which falls within the typical range of charges for a given procedure billed by most professional providers in the same geographic area, who have similar training and experience as determined by a professional third party supplier of prevailing fee data.
- Reasonable: An amount which is 1) usual and customary or 2) because of unusual circumstances, inadequacy of data, or other reasons, is established by the plan on an individual basis.

### Medical emergency

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

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

## Medically necessary

Those covered services and supplies that are required for diagnosis or treatment of illness or injury and which, in the judgment of the Plan Administrator, are:

- Consistent with the symptoms or diagnosis and treatment of the covered person's condition,
- Appropriate with regard to standards of good medical practice,
- The least costly of the alternative supplies or levels of service which can be safely provided to the covered person,
- Not primarily for the mere convenience of the covered person, or a provider of services or supplies, and
- Not primarily custodial care.

Note: The fact that a professional provider may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply medically necessary.

## Outpatient

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

## Plan

The Missoula County Employee Benefits Plan (MCEBP).

## Plan Administrator

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

## Plan document

The written legal description of the plan.

## Plan sponsor

Missoula County.

## Pre-existing condition

An injury or illness for which a covered person consulted a physician, was diagnosed, received treatment or was prescribed medication within the six months immediately preceding the effective date of coverage.

## Professional provider

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

- Advanced practice registered nurse,
- Acupuncturist,
- Chiropractor,

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

### Psychiatric treatment

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

### Qualified medical support order

A medical child support order that creates the right to receive benefits by court order. Plan Administrator approval is required.

### Retired employee

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

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

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

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

### Risk and Benefits Office

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

### Surgery

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

### Trust

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

## Benefit Charts

### Chart of Medical Benefits

#### Standard Deductible Plan

Benefit Year Deductible.....	\$500 Individual/\$1,500 Family
(Family deductible is cumulative.)	
Benefit Year Deductible for Prescription Card.....	\$150 per Individual
Benefit Year Out-of-Pocket Maximum .....	\$4,000 Individual/\$8,000 Family
(Family out-of-pocket maximum is reached when two family members have met the individual out-of-pocket maximum.)	
(Out-of-pocket maximums do not include prescriptions.)	
Lifetime Benefit Maximum .....	\$2,000,000
(This includes all other maximums.)	

#### High Deductible Plan

Benefit Year Deductible.....	\$2,500 Individual/\$7,500 Family
(Family deductible is cumulative.)	
Benefit Year Deductible for Prescription Card.....	\$500 per Individual
Benefit Year Out-of-Pocket Maximum .....	\$4,000 Individual/\$8,000 Family
(Family out-of-pocket maximum is reached when two family members have met the individual out-of-pocket maximum.)	
(Out-of-pocket maximums do not include prescriptions.)	

Lifetime Benefit Maximum ..... \$2,000,000  
 (This includes all other maximums.)

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

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

After the deductible has been met, eligible medical expenses are covered at 70% of the first \$13,333, then 100% for the remainder of the benefit year.

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

### Chart of Medical Benefits

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Alternative Medicine (acupuncture, rolfing therapy, massage therapy, biofeedback/neurofeedback, phototherapy boxes)	30%	70%	Maximum benefit payable is \$500 per benefit year.
Ambulance	30%	70%	Services must be to nearest hospital qualified to provide necessary treatment.
Anesthesia	30%	70%	
Catastrophic Case Management	30%	70%	Individual treatment program arranged by MCEBP.
Chiropractic Care	30%	70%	Maximum benefit payable for eligible services is \$1,000 per benefit year.
Colonoscopy (Standard)	30%	70%	
Colonoscopy (Virtual)	30%	70%	Maximum benefit payable is \$700, limited to once in any 60-consecutive month period.

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Convalescent/Skilled Nursing Facility	30%	70% with utilization review; otherwise 50% of payable benefit.	Confinement must be within 14 days of a hospital stay; 120 days lifetime maximum.
Custom Orthotics	30%	70%	Maximum benefit payable for eligible services is \$250 per benefit year. Note: Physician referral required.
Diagnostic X-ray and Laboratory	30%	70%	Payment is made for treatment of illness, injury or tests related to routine office visit.
Durable Medical Equipment and Supplies	30%	70%	Maximum benefit payable is \$15,000 per benefit year.
Emergency Room	30%	70%	
Hearing Aids	30%	70%	Maximum benefit payable for each ear is \$1,200, limited to once in any 60-consecutive month period.
Hospice	30%	70%	
Hospital Inpatient	30%	70% with utilization review; otherwise 50% of payable benefit.	Payment is made for semi-private room and necessary services and supplies; coverage for intensive or coronary care unit, when needed.
Hospital Outpatient	30%	70%	Payment is limited to the covered facility charges.
Immunizations	30%	70%	Coverage is limited to children through age 7.
Maternity Hospital Services	30%	70%	Payment is made only for covered employee or covered spouse of an employee. No benefit will be paid if coverage has ended before the date of delivery or the date the pregnancy otherwise terminates.

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Mental, Nervous Disorder, Chemical Dependency (including Alcoholism)	Inpatient-30%	Inpatient-70% with utilization review; otherwise 50% of payable benefit.	
	Outpatient-30%	Outpatient-70%	
Naturopathy	30%	70%	See page 33 for covered services.
Nutrition Counseling	30%	70%	Maximum benefit payable is \$250 per benefit year.
Physical Therapy	30%	70%	Coverage is limited to therapy performed by a qualified physical therapist or physician. Maximum benefit payable is \$2,000 per benefit year.
Physician Visits: Office/Hospital/Emergency Room	30%	70%	
Radiation/Chemotherapy	30%	70%	
Routine Medical Exam	30%	70%	Note: Deductible does not apply. Coverage is limited to one office visit each benefit year.
Sleep Apnea	30%	70%	Lifetime maximum benefit payable is \$3,000 for testing and treating sleep apnea.
Surgery	30%	70%	A second opinion may be required for payment.
Assistant Surgeon (medically necessary)	30%	70%	Payment is limited to 25% of primary surgeon's allowable expense, based on UCR; 15% if physician's assistant is used in lieu of assistant surgeon.
Well Child Care	30%	70%	Note: Deductible does not apply. Payment is limited to two office visits each benefit year through age 7.

## Chart of Prescription Drug Benefits

### Standard Deductible Plan

Benefit Year Deductible..... \$150 per individual

### High Deductible Plan

Benefit Year Deductible..... \$500 per individual

Note: Deductible does not apply to mail-order prescriptions. Drug card use is required for all covered prescriptions.

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Prescription Drugs	30%	70%	See page 34 for complete explanations of coverages and limitations.

## Chart of Dental Benefits

Deductible ..... None

Maximum Benefits Payable per Benefit Year ..... \$1,200 per Individual  
(Annual maximum applies to all services, including orthodontia.)

Lifetime Maximum Benefits Payable for Orthodontia..... \$1,700 per Individual

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

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Type A Preventive Services		100%	Coverage includes cleaning and fluoride treatment paid twice in each benefit year. Exam and bitewing x-rays will be paid once in each benefit year.
		100%	Payment is made for sealants of pits or fissures, as needed.

Benefit Description	Coinsurance Amount	MCEBP Amount	Limitations and Explanations
Type B Restorative Services	20%	80%	Coverage includes fillings, extractions, periodontal and endodontic treatment. See plan text for all services.
Type C Major Services	30%	70%	Coverage includes dentures, inlays, gold fillings, crowns, veneers, bridges. See plan text for all services.
Orthodontia	50%	50%	Lifetime maximum benefit payable is \$1,700, including, but not limited to, examinations, orthodontic extractions, banding of teeth and appliances. See plan text for all services.

### Chart of Vision Benefits

Note: There is no late enrollment provision for vision coverage.

Deductible .....None

Benefit Description	Payment by MCEBP	Limitations and Explanations
Exam	Up to schedule maximum.	Coverage is limited to one exam per benefit year. See schedule of maximum benefits payable on page 45.
Lenses and Frames or Contact Lenses or Corrective Eye Surgery	Up to schedule maximum.	Standard lenses and frames or contact lenses or corrective eye surgery will be covered once per benefit year. See schedule of maximum benefits payable on page 45.

## Chart of Eligibility

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

If This...	Then This...
<b>Employee (E.)</b>	
<b>E.1</b> Employee enrolls within 31 days of initial eligibility.	Coverage is effective on the 1st day of the month, following 90 continuous days of employment.
<b>E.2</b> Employee does not enroll within 31 days of initial eligibility, but signs a waiver on account of other coverage and later wants to enroll due to losing other coverage. A waiver is not required for those employed before July 1, 1998.	Employee may enroll in a special enrollment if he loses other coverage and can document it. Employee must enroll within 31 days of losing other coverage. Coverage is effective on the 1st day of the month following enrollment.
<b>E.3</b> Employee does not enroll within 31 days of initial eligibility, but signs a waiver on account of other coverage and later wants to enroll for reasons other than losing other coverage.	Employee is able to enroll only in a late enrollment in the month of May with coverage effective July 1st. However, employee may enroll in a special enrollment upon gaining new dependents, e.g., spouse, domestic partner, dependent child(ren). Employee must enroll within 31 days of gaining the spouse, domestic partner or dependent child(ren). Coverage is effective on the 1st day of the month following enrollment; however, coverage added for newborn, newly adopted or newly placed for adoption dependent children (and other eligible dependents added at this time) will be effective retroactive to the date of birth, adoption or placement.

If This...

Then This...

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**E.4**

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

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

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

**E.5**

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

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

**Employee Dependent (ED.)**

**ED.1**

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

Coverage is effective on the 1st day of the month following 90 continuous days of employment.

**ED.2**

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

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

If This...

Then This...

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**ED.3**

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

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

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

**ED.4**

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

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

**ED.5**

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

Employee and eligible dependent(s) may enroll only in a late enrollment in the month of May with coverage effective July 1st.

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

If This...

Then This...

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**ED.6**

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

Employee and eligible dependent(s) may not enroll in a special enrollment if they lose other coverage. Employee and eligible dependent(s) may enroll only in a late enrollment in the month of May with coverage effective July 1st. However, employee and eligible dependent(s) may enroll in a special enrollment when employee gains a spouse, domestic partner or other dependent child(ren). Employee and eligible dependent(s) must enroll within 31 days of employee gaining the spouse, domestic partner or dependent child(ren). Coverage is effective on the 1st day of the month following enrollment; however, coverage added for newborn, newly adopted or newly placed for adoption dependent children (and other eligible dependents added at this time) will be effective retroactive to the date of birth, adoption or placement.

**ED.7**

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

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

**ED.8**

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

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

**ED.9**

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

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

If This...

Then This...

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**ED.10**

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

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

**Retiree (R.)**

**R.1**

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

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

**R.2**

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

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

**Termination with Flex (TF.)**

**TF.1**

Employee is enrolled, participates in flex plan premium conversion and wants to terminate coverage.

Employee may terminate coverage during flex plan open enrollment, with termination effective July 1st. Employee may also terminate within 31 days of a qualifying event, e.g., marriage, divorce, death of a spouse, birth, adoption, death of a dependent, leave of absence. Termination is effective on the 1st day of the month following completion of the change of enrollment.

If This...

Then This...

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**TF.2**

Employee and eligible dependent(s) are enrolled; employee participates in flex plan premium conversion and wants to terminate coverage.

Employee and dependent(s) may terminate coverage during flex plan open enrollment, with termination effective July 1st. Employee and dependent(s) may also terminate within 31 days of a qualifying event, e.g., marriage, divorce, death of a spouse, birth, adoption, death of a dependent, leave of absence. Termination is effective on the 1st day of the month following completion of the change of enrollment. Employee and dependents may terminate coverage by providing written notification to the Human Resources Office or an employee representative. Termination is effective on the last day of the pay period after providing the notification (last day of the month for outside agencies); however, flex plan premiums must continue until July 1st.

**TF.3**

Employee and eligible dependent(s) are enrolled; employee participates in flex plan premium conversion and wants to terminate coverage of dependent(s).

Eligible dependent(s) may terminate coverage during open enrollment, with termination effective July 1st. Eligible dependent(s) may also terminate within 31 days of a qualifying event, e.g., marriage, divorce\*, birth, adoption, marriage of dependent child\*, loss of dependent child eligibility. Termination is effective on the 1st day of the month following completion of the change of enrollment. Eligible dependents may terminate coverage by providing written notification to the Human Resources Office or an employee representative. Termination is effective on the last day of the pay period after providing the notification (last day of the month for outside agencies); however, flex plan premiums must continue until July 1st.  
\*Within 60 days of the qualifying event.

**Termination (T.)**

**T.1**

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

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

If This...

Then This...

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**T.2**

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

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

Under HIPAA, special enrollment rights are triggered when an employee or dependent loses other coverage or eligibility. Loss of eligibility includes loss of coverage due to legal separation, divorce, voluntary or involuntary termination of employment, reduction in hours, children's aging out of coverage, or movement out of an HMO service area. It also includes the termination of employer contributions toward an individual's other coverage, regardless of whether the individual is still eligible for coverage under the other plan. It does not include loss of coverage due to premium increases or to a failure of the individual to pay premiums on a timely basis or termination of coverage for cause.

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

## **Eligibility and Participation in MCEBP**

### **Employee**

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

### **Dependent**

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

- Your lawful spouse as defined by applicable state law. (Spouses or domestic partners may be dependents of each other when both are employed and eligible for this plan.)
- Your natural child, and/or your stepchild. (Children may be dependents of both parents who are employed and eligible for this plan.)
- Your adopted child, from the date of placement for adoption, regardless of whether the adoption is final.

- A child related to you by blood or marriage for whom you are the legal guardian. (A court order showing legal guardianship is required.)
- Your domestic partner as defined by the plan.
- The natural child, stepchild, adopted child of your domestic partner, or child related to your domestic partner by blood or marriage for whom your domestic partner is the legal guardian. (Evidence of legal guardianship is required.)
- Your dependent for whom you are, by court order, obligated to provide health insurance support, or the child is the subject of a qualified medical support order.
- Any mentally or physically disabled child shall remain covered beyond the maximum age, provided the child is incapable of performing self-sustaining employment and is receiving principal support from the employee. The child must reside with the employee and continue to qualify for coverage in all aspects other than age. MCEBP may require you, at any time, to obtain a physician's statement certifying the mental or physical disability. You may be required to provide a determination of disability from Social Security after 12 months of coverage beyond the maximum age limitation of the plan.

## **Retired Employee**

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

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

At retirement, the retired employee has the option to select the standard deductible – \$500 medical and \$150 prescription; or the high deductible – \$2,500 medical and \$500 prescription. Note: Once the deductible selection is made, it cannot be changed.

## **Pre-existing Conditions**

A pre-existing condition is a physical or mental condition for which a covered person consulted a physician, received treatment, was prescribed medication or was diagnosed with an illness or injury in the six months immediately preceding the effective date of coverage for the covered person. Pregnancy is never considered a pre-existing condition.

If you are a late enrollee and have a pre-existing condition, you will be required to wait 6 months for coverage of expenses related to the pre-existing condition. If your dependent is a late enrollee and has a pre-existing condition, he will be required to wait 12 months for coverage of expenses related to the pre-existing condition. The 6-month or 12-month waiting period begins on the coverage effective date.

## **Creditable Coverage**

Creditable coverage is health insurance you or your dependents had under another group health plan or other health insurance program, prior to the date of hire for eligibility of coverage in this plan.

Coverage under MCEBP will be credited on a day-to-day basis against any pre-existing condition exclusion imposed by the terms of this plan, provided that the prior creditable coverage included coverage for the pre-existing condition.

Creditable coverage does not include coverage that you or your dependents had prior to a break in coverage of 63 consecutive days during which either you and/or your dependents did not have creditable coverage.

The term, “creditable coverage”, is coverage under any of the following:

- A group health plan sponsored by an employer,
- Health insurance coverage (including individual coverage) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance company or organization,
- Medicare,
- Medicaid,
- Medical and dental care for members of the uniformed services,
- A medical care program of the Indian Health Service or of a tribal organization,
- The health benefits risk pool of any state,
- The Federal Employees Health Benefits Program,
- The health plan of any state, county, municipality or other political subdivision of a state,
- The health plan provided to members of the Peace Corps.

The term, “creditable coverage,” does not include coverage consisting solely of the following excepted benefits:

- Accident insurance,
- Disability insurance,
- Liability insurance, including automobile insurance,
- Coverage supplemental to liability insurance,
- Workers’ Compensation insurance,
- Automobile medical payment insurance,
- Credit-only insurance,
- Coverage for on-site medical clinics,
- Dental or vision benefits that are not part of a hospital/medical/surgical benefit package,

- Long-term care insurance.

You have the right to demonstrate periods of creditable coverage by obtaining a certificate from the health plan or insurance company that provided you with creditable coverage. The Missoula County Risk and Benefits Office will assist you in obtaining a certificate of creditable coverage, if necessary.

## **Adding and Deleting Dependents**

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

Family status changes include the following:

Event	Action
Marriage/Children acquired through marriage	You must complete a Benefits Enrollment/Change form within 31 days.
Divorce	You must notify the Human Resources Office or your employer representative, in writing, within 60 days. (See Continuation of Health Care Coverage section on page 53.)
Domestic Partner	You must notify the Human Resources Office or your employer representative, and complete a Benefits Enrollment/Change form within 31 days.
Death/Birth/Adoption Placement/ Legal Guardianship	You must complete a Benefits Enrollment/Change form within 31 days.
Dependent child marries or no longer meets the definition of an eligible dependent	You must notify the Human Resources Office or your employer representative, in writing, within 60 days. (See Continuation of Health Care Coverage on page 53.)

If you do not take the appropriate action outlined, within the time stated, you will lose your COBRA rights or become subject to late enrollment requirements. If you have previously revoked coverage for eligible dependents and not re-enrolled them under the provisions for regular enrollment or special enrollment, the eligible dependents may only be re-enrolled in a late enrollment. They will be subject to the plan's provisions regarding pre-existing conditions and are subject to limitations for dental benefits.

## **End of Coverage**

Coverage under MCEBP ends as follows:

- For outside agencies, coverage ends the last day of the month for which premium payment is paid.

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

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

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

## **Loss of Eligibility**

Following any qualified loss of eligibility, your coverage may continue at your own expense, unless the reason for termination was gross misconduct. You or your dependents must provide a written request to the Human Resources Office or your employer representative to extend coverage in this way. (See Continuation of Health Care Coverage on page 53 for further information.)

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

## **Medical Benefits**

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

You and your eligible dependents have a plan applicable worldwide for health care services provided by covered licensed professional providers for illness, injury and certain preventive care. For a summary of these benefits, refer to the Chart of Medical Benefits beginning on page 11.

You are responsible for an individual deductible: 1) standard deductible \$500 and family \$1,500 or, 2) high deductible \$2,500 individual and \$7,500 family.

You are responsible for coinsurance for some services up to the maximum out-of-pocket limit of \$4,000 per person and \$8,000 per family. Once the individual limit is reached, 100% payment will be made for covered services during the same benefit year. However, when two family members have each paid their out-of-pocket expenses, 100% payment will be made for them and for any other eligible family member incurring covered services during the same benefit year.

After satisfaction of the deductible, eligible medical expenses are covered at 70% of the first \$13,333; then 100% for the remainder of the benefit year, unless otherwise stated.

Payment is based on maximum allowable charges/(UCR), provided by a data collection firm. The maximum lifetime benefit is \$2,000,000 per person. Benefits are subject to eligibility and enrollment requirements, pre-existing condition limitation, utilization review, and limitations and exclusions described later in this section.

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

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

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

### **Utilization Review (UR) for Inpatient Hospital Admission**

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

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

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

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

If an emergency situation requires a hospital admission, you or your authorized representative must call MCEBP within 48 hours of the admission, or on the first

business day following weekend or holiday admissions. You need to provide the same information as noted above.

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

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

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

## **Case Management**

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

## **Covered Medical Expenses**

### **Accidental injury to natural teeth**

If services or treatments are received within six months of the accident, coverage is 70% of maximum allowance. Injury to teeth from chewing is not accidental for purposes of this coverage. Other expenses may be covered under the dental plan. See Dental Benefits beginning on page 39, if you are covered under that program.

### **Alternative medicine**

This benefit is limited to acupuncture, biofeedback/neurofeedback, massage therapy, rolfing therapy and phototherapy light boxes. Covered expenses are paid at 70% of maximum allowance, up to a combined maximum of \$500 each benefit year, subject to all other terms and conditions of MCEBP.

### **Ambulance**

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

## Blood transfusions

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

## Catastrophic case management

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

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

Benefits for the treatment of chemical dependency are paid only when it is certified that the covered person has completed the program. A chemical dependency treatment center must be approved by the Department of Public Health and Human Services. A facility providing treatment of mental and nervous conditions must be certified as an eligible provider by Medicare.

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

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

## Chiropractic care

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

## Circumcision

Services are covered at 70% of maximum allowance.

## Colonoscopy

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

## Compression stockings

Stockings are covered only for post surgical treatment.

## Convalescent/skilled nursing facility

Confinement in an inpatient facility that is not designated as a full-service hospital, such as a skilled nursing or convalescent facility, must be pre-certified through UR and approved by the Plan Administrator.

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

### Cosmetic surgery

Services are covered at 70% of maximum allowance when necessary as a result of an accident which occurs while the person has coverage under MCEBP. The procedure must be performed within six months of the accident, except when it is medically advisable to do the procedure later and it has been approved by the Plan Administrator. Breast implants and other cosmetic prostheses are not covered.

### Custom orthotics

Casting, molding and fitting, are covered at 70% of maximum allowance with a maximum benefit payable of \$250 per benefit year. A prescription is required from the attending physician (medical doctor, osteopath or podiatrist).

### Diabetic supplies

Glucometer and testing supplies are covered at 70% of maximum allowance.

### Diagnostic X-ray and lab services

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

### Durable medical equipment and supplies

Medically necessary casts, splints, trusses, braces, crutches, artificial limbs, eyes, rental of wheelchair, hospital bed, oxygen equipment, traction or similar equipment are covered at 70% of maximum allowance, when ordered by a physician. General maintenance and repairs are covered at 70% of maximum allowance. The Plan Administrator may approve the purchase versus rental of an item. The maximum benefit payable is \$15,000 per benefit year.

### Emergency room

Facility charges are covered at 70% of maximum allowance.

### Hearing aid

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

## Hearing aid repairs

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

## Home health care/Nursing services

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

## Hospice

The plan covers hospice services, including palliative and supportive care, to terminally ill patients and to eligible family members. The treatment plan must be pre-approved by the Risk and Benefits Office.

## Hospital services

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

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

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

## Immunizations

Services are covered through age seven.

## Mastectomy

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

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

## Maternity

MCEBP covers maternity care expenses the same as any other illness for a covered employee or a covered spouse of an employee. You should notify MCEBP as soon as the due date is known. Coverage is 70% of maximum allowance. Under federal law, the minimum hospital stay in connection with childbirth is 48 hours following a normal

vaginal delivery or 96 hours following a delivery by cesarean section. The plan does not require pre-certification for a hospital stay for childbirth within the applicable 48-hour or 96-hour period.

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

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

### Medical supplies

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

### Naturopathy

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

### Nursery inpatient care

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

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

### Nutritional counseling

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

### Occupational and speech therapy

A referral and treatment plan is required. Services are covered at 70% of maximum allowance.

### Physical therapy

Treatment must be provided by a qualified physical therapist or physician, not a chiropractor, masseur, physical culturist, physical education instructor or health club attendant. Services are payable at 70% up to a maximum of \$2,000 per benefit year.

## Physician services

### Coverage includes:

- Surgery and surgical supplies are covered for both inpatient and outpatient treatment. Surgery is defined as an operative or diagnostic procedure for treatment of illness or injury through an incision or natural body opening by cutting or by using an instrument or laser. Surgery also includes treatment of fractures, dislocations, and burns. Coverage applies to the primary surgeon. A second opinion may be required.
- Eligible procedures are paid at 70% of the maximum allowance.
- Charges by an assistant surgeon, if medically necessary, are eligible for coverage of 25% of the surgical maximum allowance or 15%, if a physician assistant is used in lieu of an assistant surgeon. Once maximum allowance is determined, 70% will be paid.
- Anesthesiologist or certified anesthetist fees are covered at 70% of maximum allowance.
- Office visits, hospital visits and maternity care are covered at 70% of maximum allowance.

## Prescription drugs

- If enrolled in the standard deductible plan, the deductible is \$150 per person per benefit year, for all covered medications purchased with the prescription drug card provided by MCEBP. If enrolled in the high deductible plan, the deductible is \$500 per person per benefit year for all covered medications purchased with the prescription drug card provided by MCEBP.
- The deductible does not apply to the plan's mail-order drug purchase pharmacy.
- Medication requiring a written prescription and provided by a licensed pharmacist or physician is covered at 70%, unless stated otherwise. Your 30% coinsurance does not accrue toward the benefit year out-of-pocket maximum for covered medical expenses.
- If a generic drug is available, but a brand name is purchased, the plan will make payment based upon the cost of the generic drug. This provision does not apply to the plan's mail-order drug purchase program.
- MCEBP does not pay for prescription drugs unless it is the primary plan. A prescription drug card is provided, if MCEBP is your primary plan. MCEBP will not pay for prescription drugs unless they are purchased with this prescription drug card, except for hospital take-home drugs, medical emergencies, or preauthorized drug expenses, subject to the medical deductible.
- You may apply to the Plan Administrator for coverage under Catastrophic Case Management if your eligible prescription drug charges will exceed \$10,000 in a benefit year.

- The prescription, Oxycontin, requires preauthorization. A copy of the treatment plan and medical records must be provided to the Plan Administrator. An independent medical review and examination may be requested.

### Radiation/chemotherapy

Cancer treatments are covered at 70% of maximum allowance.

### Reduction mammoplasty

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

### Routine physical exams

The deductible does not apply. An office visit is covered at 70% of maximum allowance, and is limited to one per person per benefit year.

### Sleep apnea

Testing for, and treatment of, sleep apnea is covered. Lifetime maximum benefit payable is \$3,000.

### Sterilization surgery

When performed by a licensed physician, coverage is 70% of maximum allowance.

### Surgery

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

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

### Transplant surgery

Only certain human organ or tissue-to-tissue transplant procedures are covered: cornea, renal (kidney), bone marrow (including stem cell, when treatment is identified as the standard of care), heart, lung, liver, pancreas and small bowel. Other transplants are excluded. When a transplant is medically necessary and approved, the coverage is 70% of maximum allowance. Contact the Risk and Benefits Office as soon as you become aware of a possible transplant procedure. If any other group or individual insurance does not cover the donor of the transplant organ, benefits for surgical, medical and hospital services may be approved under MCEBP through a claim made by the organ recipient. The plan participant's maximum lifetime donor benefit is \$5,000, regardless of the number of donors.

## Well-child care

The deductible does not apply. Services are covered at 70% of maximum allowance. Well-child care coverage is limited to two office visits each benefit year through age 7.

## Medical Expenses Not Covered

MCEBP does not cover the following:

- Any illness or injury as a result of war or an act of war.
- Bariatric surgery, gastric bypass surgery, or any other weight loss surgery by any other name.
- Birth control implants and related treatment.
- Breast implant(s), reconstruction, or replacement of breast implants, except as required by the Women's Health and Cancer Rights Act of 1998 (See page 32.).
- Breast reduction, except a preauthorized mammoplasty.
- Care in a facility not licensed as a hospital, or alcoholism or drug abuse treatment center.
- Charges exceeding maximum allowable charges (UCR).
- Charges incurred prior to effective date of coverage or after coverage has ended.
- Charges for providing and preparing medical records and reports or itemized bills for services.
- Charges for any services or treatment for which the covered person is not obligated to pay, or for charges which would not have been made without medical coverage in force.
- Chiropractic or acupuncture expenses for supplies, appliances, or other expenses, except as stated elsewhere in the plan.
- Convalescent care or custodial care, including skilled nursing.
- Cosmetic surgery, except to correct conditions from accidental injury, which occurs while the person has coverage under MCEBP, and is performed within six months of the accident, or as approved by the Plan Administrator.
- Court-ordered or employer-mandated services and treatments, such as alcohol counseling resulting from a DUI conviction, or drug counseling resulting from a failed drug test.
- Custodial treatment related to, or the result of, chronic brain syndrome or senile deterioration, for example, Alzheimer's disease or dementia.
- Drugs and medicines available without a prescription, even when a prescription is written.
- Expenses for additional treatment of a fractured jaw, or accidental injury to natural teeth after six months following an accident.

- Experimental/investigational treatment – Experimental or investigational drugs, devices, medical treatments or procedures in or out of a hospital. The terms, “experimental or investigational,” are defined as follows:
  - If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished.
  - If the drug, device, medical treatment or procedure, or the patient-informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval.
  - If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, or is in the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.
  - If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.

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

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

- Eye refractions, orthoptics, radial keratotomy, lasik surgery, corrective eye surgery, visual therapy, or providing, replacing or fitting glasses (See Vision Benefits on page 43.)
- Fertility drugs.
- Hair transplant procedures.
- Holistic medical procedures and supplies.
- Hospitalization determined during UR to be medically unnecessary.
- Hospitalization for experimental services, dental treatment, custodial care or cosmetic surgery, except as allowed by the plan.

- Hospitalization primarily for diagnostic tests, observation or examination, when treatment of illness or injury does not require bed care.
- Incidental procedure performed through the same incision.
- Items such as heating pads, hot water bottles, blood pressure cuffs, mastectomy bras, compression stockings (except when following surgery), wheelchair lifts and ramps, motor vehicle parts or labor, modifications to homes or vehicles, or other health aids readily available.
- Items that may be useful to persons in the absence of sickness or injury, such as air conditioners, hearing aid batteries, purifiers, special furniture, bicycles, wigs, breast pumps, whirlpools, humidifiers, exercise equipment or health club memberships.
- Items such as arch supports, inserts, heel lifts, orthotic appliances and corrective shoes, or charges for casting, molding or fitting, except as covered under Custom Orthotics (See page 31.).
- Knee braces, or other medical equipment, related to participation in sports or recreational activities.
- Naturopath non-prescription items such as herbs, remedies, vitamins, or wellness/health maintenance items.
- Psychoanalysis or psychotherapy that can be credited toward earning a degree or furthering education.
- Prescription drugs, services or supplies, when the quantity requested would extend into the following benefit year, or after coverage is terminated.
- Prescription drugs when medical consultants named by the Plan Administrator determine that there is overuse or evidence of drug abuse.
- Reversal of sterilization.
- Routine health examinations, screening tests or physician check-ups not associated with any disease, injury or condition requiring professional services or treatment, except as stated in MCEBP.
- Routine immunizations, except as stated on page 32.
- Services, care or treatment for non-organic sexual dysfunction, transsexualism, gender dysphoria, sexual reassignment or change.
- Services, supplies or prescriptions for weight reduction or treatment of obesity, except as provided on page 33. Nutritional counseling is covered.
- Services related to, and complications resulting from, artificial insemination, in vitro impregnation, or any treatment of infertility.
- Services and supplies to change the position of a bone of the upper or lower jaw, except when necessary due to an accidental injury that occurred while covered under the plan.
- Services related to damaged or injured teeth as a result of chewing.

- Services provided under any government-sponsored medical or health plan, except as coordinated with Medicare, or charges billed by the United States Government for:
  - Services rendered by Veterans' Administration facilities to a veteran for treatment of a non-service connected disability,
  - Inpatient medical care provided by military hospitals to non-active military personnel and their dependents.
- Services or supplies not specifically listed as a benefit of the plan.
- Services or supplies for which no charge is made or for which a charge is increased because insurance is available.
- Special duty nursing ordinarily provided by hospital staff, requested for convenience of the patient and/or family, or provided by a private duty nurse who is a relative.
- Special education, counseling, therapy or care for learning deficiencies or behavioral problems.
- Telephone consultations or electronic communications, including, but not limited to, internet and telecommuting.
- Travel or lodging expenses of 1) a covered person, 2) a physician treating a covered person, or 3) a person accompanying a covered person.
- Treatment that is not considered medically necessary, except for preventive care as specified by the plan.
- Treatment of paring of calluses, corns and toenails.
- Treatment of temporomandibular joint dysfunction (TMJ) and associated myofacial pain and related diagnoses.
- Treatment of teeth, gums or alveolar processes.
- Treatment of an illness or accident when Workers' Compensation has accepted liability, or any claim which would have been covered if you had followed Workers' Compensation guidelines for filing a claim.
- Treatment for an injury to you, or your dependent, while engaging in any illegal activity.
- Treatment of complications, infections, or any other conditions arising out of services or supplies not covered by the plan.

## **Dental Benefits**

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

In addition to the definitions (See page 5.), the following words relate to dental care:

## Dentist

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

## Denturist

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

## Dental hygienist

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

### **Type A – Preventive**

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

Services for routine care available twice each benefit year:

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

Services available once each benefit year:

- Routine oral examination of the mouth and teeth,
- Bitewing x-rays.

Services available as stated:

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

### **Type B – Basic Restorative**

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

- Diagnostic services.
- Space maintainers.
- Extractions.
- Nitrous oxide
- Oral surgery, including surgical extractions.
- Fillings, including sedative fillings.
- General anesthesia when medically necessary and administered for oral surgery.

- Treatment of periodontal and other diseases of the gums and tissues of the mouth, including periodontal surgery.
- Endodontic treatment, including root canal therapy.
- Injection of antibiotic drugs.
- Repair or recementing of crowns, veneers, inlays, onlays, bridgework or dentures; or relining of dentures.
- Prophylaxis for periodontal treatment.
- Emergency dental treatment rendered by a physician.

### **Type C – Major Restorative**

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

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

### **Orthodontic Treatment**

- MCEBP provides benefits for orthodontic treatment, including extractions of permanent teeth for orthodontic treatment. Also included under orthodontic treatment is the non-surgical treatment of the following conditions: temporomandibular joint dysfunction, sleep apnea, bruxism and myofacial pain.

- Coverage for dental services and supplies related to orthodontia is 50% of covered expenses. The maximum lifetime benefit for an individual is \$1,700. Any orthodontic payments made by the plan will be included in calculating the covered person's benefit year maximum.

### **Treatment Plan Provision**

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

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

### **Pre-existing Condition**

MCEBP will not pay for expenses incurred for any procedure(s) or treatment(s) started before the effective date of your coverage.

### **Dental Benefit Year Maximum**

The maximum benefit for dental expenses, including orthodontia, is \$1,200 per person per benefit year. If a person is a late enrollee, the maximum benefit is \$250 per person for the first 12 months of coverage and \$500 per person for the 13th through 24th month of coverage. After 24 months, the maximum payable per benefit year is \$1,200 per person.

### **Alternate Procedures Covered**

- If a tooth can be restored with a silver amalgam, but a gold restoration is used, covered expenses will be limited to the maximum allowance for a silver amalgam.
- If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, and the dentist and/or covered person elect(s) a more elaborate or precision appliance, the covered expenses will be limited to the maximum allowable charges appropriate to the standard procedure, unless excluded by the plan.

### **Dental Expenses Not Covered**

MCEBP does not cover the following:

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

- Services or supplies cosmetic in nature, including bleaching, personalization, or characterization of dentures.
- Dentures, veneers, crowns, inlays, onlays, bridgework or other appliances or services to increase vertical dimension, except for orthodontia.
- Charges for any services or treatments for which the covered person is not obligated to pay, or for charges which would not have been made without dental coverage in force.
- Charges that exceed maximum allowable charge/UCR.
- Any procedure or treatment started before coverage under the plan.
- Dental expenses for disease, defect, or injury from employment, or for which the covered person is entitled to benefits under any Workers' Compensation or occupational disease law.
- Extracoronary and other periodontal splinting.
- Temporary dental work.
- Root canal therapy for which the pulp chamber was opened before coverage under the plan.
- Periodontal charting.
- Oral hygiene and dietary instructions.
- Recording of jaw movements and positions.
- Services or supplies for which no charge is made, or for which a charge is either made or increased because insurance is available.
- A fee for writing a prescription for drugs, or for filling out claim forms.
- Services provided by a dentist or a denturist which are beyond the scope of his license.
- Specialized dental technology.
- Dentures, veneers, crowns, inlays, onlays, bridgework or other appliances or services which were ordered before coverage under the plan.
- Services and items not specifically covered by the plan.

## **Vision Benefits**

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

In addition to the definitions (See page 5.), the following words relate to vision care:

Blended/progressive lenses

Multifocals with no visible dividing line.

### Coated lenses

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

### Materials

Lenses, frames, contact lenses and related professional services.

### Orthoptics

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

### Photochromatic lenses

Lenses, which change color with intensity of sunlight.

### Provider

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

### Plano lenses

Lenses with no refractive power.

### Professional service

Examination, material selection, fitting, and related adjustments.

### Tinted lenses

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

### Necessary contact lenses

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

## **Vision Examination**

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

## **Vision Materials**

You are covered for either one pair of lenses and frames, or contact lenses, or corrective eye surgery during each benefit year subject to the maximum benefits schedule.

## **Benefit Year Schedule of Maximum Benefits Payable**

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

Vision Examination.....	\$70
Single Vision Lenses/Frames.....	\$125
Bifocal Lenses/Frames.....	\$155
Trifocal Lenses/Frames.....	\$190
Progressive Lenses/Frames.....	\$190
Contact Lenses .....	\$125
Necessary Contact Lenses .....	\$200
Corrective Eye Surgery .....	\$125 both eyes

## **Vision Expenses Not Covered**

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

## **Claims Administration**

### **Claims Procedures**

#### Claim Forms

The Plan Administrator will provide forms to assist in filing claims. Claim forms are available in the Human Resources Office, from your employer representative, at the Risk and Benefits Office, or on the Missoula County Website (<http://www.co.missoula.mt.us/benefits>).

#### Notice of Claim

When you submit a claim for payment, every attempt will be made to process it promptly and accurately. Claims submitted later than 12 months after the date of service will be paid only if you are able to show reasonable cause for the delay.

Completed claim forms can be personally delivered to the Missoula County Human Resources Office or mailed to:

Missoula County Risk and Benefits Office  
200 West Broadway Street  
Missoula, Montana 59802-4292

Care provided by a physician or hospital to which the plan makes payment in the regular course of business will be considered written notice. Benefits will be

automatically paid to the employee, unless an assignment of benefits is submitted at the time of claim submission.

You must file a completed claim form for the family under the following circumstances:

- If a claim form has not been filed within 12 months.
- For each non-occupational accident or injury, explaining when, where, and how the accident occurred.
- Whenever requested by the Risk and Benefits Office.

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

## **Appealing a Claim**

If you feel that action on all or part of your claim is incorrect, you can request a claim review. Address a written appeal to the Plan Administrator at 200 West Broadway, Missoula, MT 59802-4292, and provide any relevant documentation to support your appeal.

You must appeal within 60 days of the date of action on the claim. Your appeal will be reviewed by the Plan Administrator, and you will receive a written decision within 60 days after receipt of the appeal. If more extensive review is needed, the decision will come within 120 days. An appeal is presumed to be denied if no written decision is made. The decision of the Plan Administrator is final. The Board of County Commissioners will not participate in appeals of claims or determination of eligibility for benefits of MCEBP.

## **Determining Continued Medical Necessity**

If a covered person is receiving benefits and a question arises about the medical necessity of continued care, the Risk and Benefits Office can ask the attending physician to submit evidence to support the judgment that continued care is medically necessary. Unless the physician provides medical information clearly indicating that continued care is medically necessary, the plan can discontinue benefits for that care. The claims adjuster can request proof of medical necessity once every 30 days.

## **Submitting Medical Information**

When necessary to process claims, the claims adjuster can require a covered person to submit information concerning Medicare benefits to which he is entitled. The claims adjuster can also require a covered person to authorize any hospital or physician to furnish information concerning a condition for which the person claims benefits. The plan retains the right to review medical information received by, or provided to, the Risk and Benefits Office.

## Benefits not Transferable

The right to receive benefits under MCEBP is not assignable or transferable to any other party. Any attempted assignment or transfer will not be binding on the plan.

By enrolling in MCEBP, you agree to the provisions of this section as a prerequisite for receiving plan benefits. Breach of your agreement may result in plan suspension of benefit payments, among other actions.

## Recovery and Subrogation

### Benefits Paid in Error

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

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

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

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

### Right to Reimbursement

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

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

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

## Right to Subrogation

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

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

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

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

## Additional Reimbursement/Subrogation Provisions

The following provisions apply to both reimbursement and subrogation:

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

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

a reduction or compromise settlement is agreed to, in writing, or required pursuant to a court order.

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

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

This cooperation includes the following:

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

### Right of Offset

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

### **Fraud and Abuse**

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

## **Fraudulent and abusive acts**

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

Acts considered fraud or abuse against MCEBP include the following:

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

### **Misstatement of Age**

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

### **Misrepresentation of Eligibility**

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

### **Misuse of Identification Card**

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

### **Reimbursement to Plan**

A covered person must reimburse the plan for payment of benefits for ineligible persons, if the payment was based on 1) inaccurate, erroneous or false information, 2)

concealed, withheld, omitted, or undisclosed information, or 3) falsified or altered documents. Failure to reimburse the plan after demand is made may result in interruption or loss of benefits to the person and dependents.

## **Coordination of Benefits (COB)**

### **Purpose of COB**

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

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

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

### **Coordination Procedures**

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

MCEBP determines its order of benefits using these rules.

If	Then																
The other plan does not have a provision for coordination of benefits.	The other plan becomes the primary plan and pays first.																
Both plans have a coordination of benefits provision.	MCEBP is a secondary plan; the other plan will pay benefits first.																
	But Coverage for dependents will be paid first by the plan of the parent whose birthday falls earlier in the year. If both parents have coordination of benefits, but one does not use the birthday rule, the father's coverage is primary for the dependent(s).																
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The plan of an active employee pays before the plan of an inactive employee.

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

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

## **Continuation of Health Care Coverage**

### **Consolidated Omnibus Budget Reconciliation Act (COBRA)**

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

### **Eligibility**

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

### **Employee**

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

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

### **Spouse**

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

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

### **Dependent Child**

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

- Your employee-parent’s death.
- The termination, for reasons other than gross misconduct, of your employee-parent’s employment.
- Reduction in the hours of your employee-parent’s employment.
- Your employee-parent’s divorce or legal separation.

- Ceasing to be a dependent child under the plan.
- Your employee-parent's entitlement to Medicare benefits.

## **Loss of Coverage under COBRA**

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

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

A loss of coverage need not occur immediately after the event, as long as it occurs before the end of the maximum coverage period described on page 68.

### **Notices and Election**

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

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

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

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

Whether you contact the Human Resources Office or employer representative first or the Risk and Benefits Office contacts you first, you have 60 days from receiving the COBRA notice, or from the date your coverage would otherwise be lost, whichever is later, to elect continued coverage. Continuation of coverage must be elected within 60 days after plan coverage ends, or if later, 60 days after the date of the notice of the right to elect continuation of coverage. If continuation of coverage is not elected within the 60-day period, the right to elect coverage under the plan will end.

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

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

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

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

## **Maximum Continuation of Coverage Period**

Continuation of coverage may last up to:

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

## **Disability**

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

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

### Additional Qualifying Event

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

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

### Termination Before the End of Maximum Coverage Period

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

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

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

### Type of Coverage

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

## Payment for Continuation of Coverage

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

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

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

## Employment Affected by International Trade

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

## Plan Contact Information

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

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

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

## **Family and Medical Leave Act of 1993 (FMLA)**

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

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

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

### **Eligibility**

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

### **Payment for Continuation of Coverage**

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

### **Duration of Continuation of Coverage**

Continuation of coverage under USERRA continues until the earliest of:

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

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

## Summary Plan Description

Plan Sponsor.....Missoula County, Montana

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

Employer Identification No. ....81 6001397

Plan Number .....501

Plan Year .....Fiscal year, which ends June 30  
.....of each year

Type of Plan .....Medical, Dental, Vision

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

Type of Funding .....Majority of cost paid by employer

Plan Administrator .....Hal K. Luttschwager  
.....Risk Manager  
.....Missoula County  
.....438 W. Spruce St.  
.....Missoula, MT 59802-4292

Agent for Legal Services .....Hal K. Luttschwager  
.....Risk Manager  
.....Missoula County  
.....438 W. Spruce St.  
.....Missoula, MT 59802-4292

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