

EXHIBIT 8.19 - Missoula County Employee Benefits Plan

PPACA CLAIMS AND APPEALS COMPLIANCE AMENDMENT

TO THE MISSOULA COUNTY EMPLOYEE BENEFITS PLAN

Effective July 1, 2011, the Missoula County Employee Benefits Plan is amended as follows:

1. The “**DEFINITIONS**” section is revised to add the following terms:

Adverse Benefit Determination

A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is:

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

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

Internal Appeal

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

External Appeal

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

Authorized Representative

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

Claim

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

Claimant

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

Incorrectly Filed Claim

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

Incomplete Claim

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

2. The "CLAIMS PROCEDURES" section is replaced as follows:

PROCEDURES FOR CLAIMING BENEFITS

Claims will be considered for payment according to the Plan's terms and conditions, as well as industry-standard claims processing guidelines and administrative practices and policies not inconsistent with the terms of the Plan.

Claims must be submitted to the Plan within twelve (12) months after the date services or treatments are received or completed. Claims submitted later than 12 months after the date of service will be paid only if the Claimant is able to show reasonable cause for the delay; however, a delay of more than 90 days beyond the 12-month period is presumed unreasonable. Non-electronic Claims may be submitted on any approved Claim form, available from the provider of services. A complete Claim must include the following information:

- Date of service;
- Name of the Participant;
- Name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- Diagnosis [code] of the condition being treated;
- Treatment or service [code] performed;
- Amount charged by the provider for the treatment or service; and
- Sufficient documentation, in the sole determination of the Plan Administrator, to support the medical necessity of the treatment or service being provided and to enable the Plan Administrator to adjudicate the claim pursuant to the terms and conditions of the Plan, which may include your Social Security Number if you are over 44 years of age or are covered by Medicare

The Claim must be completed in full with sufficient information as requested by the Plan Administrator or it will be considered an Incomplete Claim.

When completed, the Claim must be sent to the MCEB Claims Administrator, Missoula County, Attn: Hal K. Luttschwager, at 200 West Broadway Street, Missoula, Montana 59802-4292, 406-523-4876.

Claims submitted later than 12 months after the date of service will be paid only if the Claimant is able to show reasonable cause for the delay; however, a delay of more than 90 days beyond the 12-month period is presumed unreasonable.

Upon termination of the Plan, final Claims must be received within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

Any Claim not submitted properly will be an Incorrectly Filed Claim.

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

MEDICAL EXAMINATION, CONSULTATION

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

The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims that involve specialized medical knowledge or judgment.

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

INITIAL DECISIONS ON CLAIMS AND ELIGIBILITY

Eligibility and initial Claims decisions will be made within the time periods stated below. For purposes of this section,

1. **Urgent Care Claims** – An Urgent Care Claim is any Claim for medical care or treatment with respect to which, according to a determination by the attending health care provider, application of the non-urgent claim determination timelines:
 - A. could seriously jeopardize the life or health of the Claimant or the ability of the claimant to regain maximum function; or
 - B. would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Initial claims decisions on Urgent Care Claims will be made as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claim by the Plan.

If the Plan is unable to process an Urgent Care Claim because it is an Incorrectly Filed Claim, then the Plan Administrator will provide the claimant with oral or written notice of the Incorrectly Filed Claim within twenty-four (24) hours after receipt of the claim by the Plan.

If the Urgent Care Claim is correctly filed but it is an Incomplete Claim, then the Plan Administrator will provide the Claimant with a notification requesting the specific additional information necessary to complete the Claim. The notification will be provided to the Claimant within twenty-four (24) hours after receipt of the Claim by the Plan. The Claimant must submit the additionally requested information to the Plan within forty-eight (48) hours of the notification. The Plan Administrator will then issue its initial claim decision as soon as possible, taking into account the medical exigencies, but not later than forty-eight (48) hours after (a) the Plan's receipt of additional information; or (b) the end of the period given to the Claimant to provide the additional information; whichever is earlier.

2. **Pre-Service Claims** – Pre-Service Claims must be submitted to the Plan before the Claimant receives medical treatment or service. A Pre-Service Claim is any Claim for a medical benefit which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Initial claims decisions on Pre-Service Claims will be made within a reasonable time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the Claim by the Plan Administrator.

If the Plan is unable to process a Pre-Service Claim because it is an Incorrectly Filed Claim, then the Plan Administrator will provide the Claimant with oral or written notice of the Incorrectly Filed Claim within five (5) days after receipt of the claim by the Plan.

If the Pre-Service Claim is correctly filed but it is an Incomplete Claim, then the Plan Administrator will provide the Claimant with a notification extending the deadline for the initial Claim decision. The extension notification will request the specific additional information necessary to complete the Claim and will be provided to the Claimant within fifteen (15) days after receipt of the Claim by the Plan. The Claimant must submit the additionally requested information to the Plan within forty-five (45) days of the notification. The Plan Administrator will then issue its initial Claim decision within a reasonable time appropriate to the medical circumstances, but not later than fifteen (15) days after the Plan's receipt of additional information.

3. **Post-Service Claims** – A Post-Service Claim is any Claim for a medical benefit under the Plan that is not a Pre-Service Claim.

Initial claims decisions on Post-Service Claims will be made within a reasonable time, but not later than thirty (30) days after receipt of the claim by the Plan.

If the Plan is unable to process a Post-Service Claim because it is an incorrectly filed claim, then the Plan Administrator will provide the claimant with oral or written notice of the incomplete claim within five (5) days after receipt of the claim by the Plan.

If the Post-Service Claim is correctly filed but it is an incomplete claim, then the Plan Administrator will provide the claimant with a notification extending the deadline for the claim decision. The extension notification will request the specific additional information necessary to complete the claim and will be provided to the claimant within thirty (30) days after receipt of the claim by the Plan. The claimant must submit the additionally

requested claim information to the Plan within forty-five (45) days of the notification. The Plan Administrator will then issue its initial claim decision within a reasonable time, but not later than fifteen (15) days after the Plan's receipt of additional information.

4. **Concurrent Care Claims** – For Covered Persons who face early termination or reduction of benefits for a course of treatment previously approved by the Plan, a decision by the Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the Plan's benefit maximums is not an Adverse Benefit Determination.) The Plan will notify such Covered Person sufficiently in advance to allow the Covered Person/Claimant to make a Claim for uninterrupted continuing care before the benefit is reduced or terminated.

For any request to extend a Pre-Service or Post-Service course of treatment beyond the initially prescribed period of time, the initial Claims decisions will be made according to the normal decision deadlines otherwise applicable to those types of claims.

Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time will be decided within twenty-four (24) hours of the Plan's receipt of the request. The Claim for ongoing care or treatment must be made to the Plan within twenty-four (24) hours before the expiration of the initially-prescribed period.

INTERNALLY APPEALING AN INITIAL CLAIMS DECISION

If a Claim is denied in whole or in part, the Claimant will receive written notification of the Adverse Benefit Determination. A Claim denial will be provided by the Plan showing:

1. The reason the Claim was denied;
2. Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Information sufficient to identify the Claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
4. Any additional information needed to perfect the Claim and why such information is needed; and
5. An explanation of the Claimant's right to an Internal Appeal of the Adverse Benefit Determination for a full and fair review, the potential right to an External Appeal, and the right to bring a civil action after exhausting internal claims and appeals procedures.

Further:

1. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, then the notice shall include a statement that a copy of such rule, guideline, protocol, or other criterion relied upon will be provided free of charge to the Claimant upon request; and

2. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the plan to the Claimant's medical circumstances) or a statement that such explanation will be provided free of charge upon request.

If a Claimant does not understand the reason for any Adverse Benefit Determination, or wishes to know diagnosis/treatment codes applicable to the Claim, he or she should contact the Missoula County Employee Benefits Plan Office (the "MCEBP") at the address or telephone number shown on the claim denial. Upon request, the MCEBP or designated claims administrator will provide, as soon as practicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. A request for such diagnosis and treatment information, in itself, shall not be considered a request for further internal or external appeal.

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan Administrator in writing to 200 West Broadway Street, Missoula, MT 59802-4292. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

The Internal Appeal is done by the Plan Administrator. The Plan Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information.

1. **Urgent Care Claims** – Notice of the decision regarding an Internal Appeal for an Adverse Benefit Determination for an Urgent Care Claim will be sent to the Claimant as soon as possible, taking into account medical exigencies, but no later than seventy-two (72) hours following the date the Plan Administrator receives the request for appeal.
2. **Pre-Service Claims** – Notice of the decision regarding an Internal Appeal for an Adverse Benefit Determination for a Pre-Service Claim will be sent to the Claimant within a reasonable time appropriate to the medical circumstances, but no later than thirty (30) days following the date the Plan Administrator receives the request for appeal.
3. **Post-Service Claims** – Notice of the decision regarding an Internal Appeal for an Adverse Benefit Determination for a Post-Service Claim will be sent to the Claimant within a reasonable time, but not later than sixty (60) days following the date the Plan Administrator receives the request for appeal.

4. **Concurrent Care Claims** – For a request to extend a Concurrent Care treatment, notice of the decision regarding an Internal Appeal for an Adverse Benefit Determination will be sent to the Claimant according to the normal decision deadlines otherwise applicable to those types of Claims. For Concurrent Care treatment that will be reduced or terminated early by the Plan, notice of the decision regarding an Internal Appeal for an Adverse Benefit Determination will be sent to the Claimant before the benefit is reduced or terminated. The Plan will provide continuing coverage for Concurrent Care Claims pending the outcome of the Internal Appeal process.

INDEPENDENT EXTERNAL APPEAL


The Plan Administrator shall develop written Independent External Appeal Procedures, and shall communicate such procedures to participants, in accordance with applicable law.

Drafting Note: Regulations and Technical Guidance concerning external review were published June 24, 2011, to be effective July 24, 2011, and additional guidance is expected during 2011.

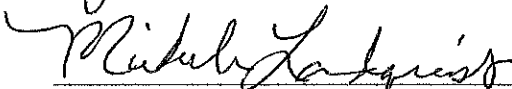
Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

Passed and adopted this 7th day of July, 2011

BOARD OF COUNTY COMMISSIONERS



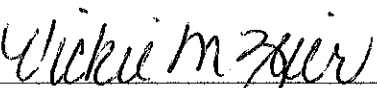
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