

**PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION**

for the

**DENTAL BENEFIT PLAN
FOR THE EMPLOYEES OF
CITY OF HELENA**

This booklet describes the Plan Benefits
in effect as of March 1, 2013

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

CITY OF HELENA

Claims Processed By:

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.

2806 South Garfield Street
PO Box 3018
Missoula, MT 59806-3018

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

TABLE OF CONTENTS

| | |
|--|----|
| INTRODUCTION | 1 |
| SCHEDULE OF DENTAL BENEFITS | 2 |
| DENTAL BENEFITS | 3 |
| ELIGIBLE EXPENSES | 3 |
| DEDUCTIBLE AND BENEFIT PERCENTAGE | 3 |
| APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT | 3 |
| DEDUCTIBLE CARRYOVER PROVISION | 3 |
| MAXIMUM BENEFIT PAYABLE | 3 |
| EXPENSES INCURRED | 4 |
| PREDETERMINATION OF BENEFITS | 4 |
| DENTAL EXPENSES | 4 |
| TYPE A (PREVENTIVE CARE) EXPENSES | 4 |
| TYPE B (BASIC CARE) EXPENSES | 4 |
| TYPE C (MAJOR RESTORATIVE) EXPENSES | 5 |
| ORTHODONTIC TREATMENT BENEFIT | 6 |
| PROSTHESIS REPLACEMENT RULE | 6 |
| COVERED EXPENSES IN NEW YORK STATE | 6 |
| DENTAL BENEFIT LIMITATIONS | 7 |
| GENERAL PLAN EXCLUSIONS AND LIMITATIONS | 8 |
| COORDINATION OF BENEFITS | 12 |
| DEFINITIONS | 12 |
| COORDINATION PROCEDURES | 13 |
| ORDER OF BENEFIT DETERMINATION | 13 |
| Non-Dependent/Dependent | 13 |
| Child Covered Under More Than One Plan | 13 |
| Active or Inactive Employee | 14 |
| Longer or Shorter Length of Coverage | 14 |
| No Rules Apply | 14 |
| COORDINATION WITH MEDICAID | 14 |
| COORDINATION WITH CHAMPUS | 15 |
| PROCEDURES FOR CLAIMING BENEFITS | 16 |
| CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY | 16 |
| APPEALING AN UN-REIMBURSED CLAIM | 17 |
| ELIGIBILITY PROVISIONS | 19 |
| EMPLOYEE ELIGIBILITY | 19 |
| WAITING PERIOD | 19 |
| DEPENDENT ELIGIBILITY | 19 |
| PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE | 20 |
| RETIREE ELIGIBILITY | 20 |
| EFFECTIVE DATE OF COVERAGE | 21 |
| PARTICIPANT COVERAGE | 21 |
| DEPENDENT COVERAGE | 21 |
| TRANSFER OF COVERAGE | 22 |
| QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION | 23 |
| PURPOSE | 23 |
| DEFINITIONS | 23 |

| | |
|--|----|
| CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER | 23 |
| PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS | 24 |
| NATIONAL MEDICAL SUPPORT NOTICE | 24 |
| | |
| FAMILY AND MEDICAL LEAVE | 25 |
| DEFINITIONS | 25 |
| EMPLOYERS SUBJECT TO FMLA | 26 |
| ELIGIBLE EMPLOYEES | 26 |
| REASONS FOR TAKING LEAVE | 26 |
| ADVANCE NOTICE AND MEDICAL CERTIFICATION | 26 |
| PROTECTION OF JOB BENEFITS | 26 |
| UNLAWFUL ACTS BY EMPLOYERS | 26 |
| ENFORCEMENT | 27 |
| | |
| TERMINATION OF COVERAGE | 28 |
| PARTICIPANT TERMINATION | 28 |
| REINSTATEMENT OF COVERAGE | 28 |
| DEPENDENT TERMINATION | 29 |
| | |
| CONTINUED COVERAGE AFTER TERMINATION | 30 |
| NOTIFICATION RESPONSIBILITIES | 30 |
| ELECTION OF COVERAGE | 31 |
| MONTHLY PREMIUM PAYMENTS | 31 |
| DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE | 31 |
| SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE | 32 |
| MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE | 32 |
| WHEN COBRA CONTINUATION COVERAGE ENDS | 32 |
| QUESTIONS | 33 |
| INFORM THE PLAN OF ADDRESS CHANGES | 33 |
| | |
| COVERAGE FOR A MILITARY RESERVIST | 34 |
| | |
| COVERAGE FOR A MONTANA NATIONAL GUARD MEMBER | 35 |
| | |
| FRAUD AND ABUSE | 36 |
| MISSTATEMENT OF AGE | 36 |
| MISREPRESENTATION OF ELIGIBILITY | 36 |
| MISUSE OF IDENTIFICATION CARD | 37 |
| REIMBURSEMENT TO PLAN | 37 |
| | |
| RECOVERY/REIMBURSEMENT/SUBROGATION | 38 |
| RIGHT TO RECOVER BENEFITS PAID IN ERROR | 38 |
| REIMBURSEMENT | 38 |
| SUBROGATION | 39 |
| RIGHT OF OFF-SET | 40 |
| | |
| PLAN ADMINISTRATION | 41 |
| PURPOSE | 41 |
| EFFECTIVE DATE | 41 |
| PLAN YEAR | 41 |
| PLAN SPONSOR | 41 |
| PLAN SUPERVISOR | 41 |
| NAMED FIDUCIARY AND PLAN ADMINISTRATOR | 41 |
| PLAN INTERPRETATION | 41 |
| CONTRIBUTIONS TO THE PLAN | 41 |

| | |
|--|----|
| PLAN AMENDMENTS/MODIFICATION/TERMINATION | 42 |
| NOTICE OF REDUCTION OF BENEFITS | 42 |
| TERMINATION OF PLAN | 42 |
| SUMMARY PLAN DESCRIPTIONS | 42 |
| GENERAL PROVISIONS | 43 |
| EXAMINATION | 43 |
| PAYMENT OF CLAIMS | 43 |
| LEGAL PROCEEDINGS | 43 |
| NO WAIVER OR ESTOPPEL | 43 |
| VERBAL STATEMENTS | 43 |
| FREE CHOICE OF DENTAL SERVICE PROVIDER | 43 |
| WORKERS' COMPENSATION NOT AFFECTED | 44 |
| CONFORMITY WITH LAW | 44 |
| MISCELLANEOUS | 44 |
| FACILITY OF PAYMENT | 44 |
| PROTECTION AGAINST CREDITORS | 44 |
| PLAN IS NOT A CONTRACT | 44 |
| GENERAL DEFINITIONS | 45 |
| RETIREMENT OF PUBLIC EMPLOYEES | 53 |
| SPOUSE AND DEPENDENT CHILDREN COVERAGE | 53 |
| NOTICES | 54 |
| NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT | 54 |
| IDENTIFICATION OF FUNDING | 54 |
| HIPAA PRIVACY AND SECURITY STANDARDS | 55 |
| DEFINITIONS | 55 |
| PRIVACY CERTIFICATION | 55 |
| SECURITY CERTIFICATION | 56 |
| PLAN SUMMARY | 57 |

INTRODUCTION

Effective August 1, 1989, hereinafter, referred to as the "City" or "Employer", established the benefits, rights and privileges which will pertain to participating Employees, referred to as "Participants," and the eligible Dependents of such Participants, as defined, and which benefits are provided through a fund established by the City and referred to as the "Plan." **This Summary Plan Description includes changes reflected by Amendment #1, #2, Corrected Amendment #2, #3, #4, #5, #6, #7, HIPAA Privacy and Security Standards Amendment, USERRA Compliance Amendment-2005, MMSERA Amendment, COBRA Compliance Amendment-2005 and the FMLA Compliance Amendment to the Plan Document dated February 1, 2003.** This booklet describes the Plan in effect as of March 1, 2013.

Coverage provided under this Plan for Employees and their Dependents will be in accordance with the Eligibility, Effective Date, Qualified Medical Child Support Order, Termination, Family and Medical Leave Act and other applicable provisions as stated in this Plan.

The CITY OF HELENA (the Plan Sponsor) has retained the services of an independent Plan Supervisor, experienced in claims processing, to handle health claims. The Plan Supervisor for the Plan is:

Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

We recommend that you read this booklet carefully before incurring any dental expenses. If you have specific questions regarding coverage or benefits, you are urged to refer to the Plan Document which is available for your review in the Personnel Office or at the office of the Plan Supervisor. If you wish, you may call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions you may have concerning the Plan.

This Plan is not intended to, and cannot be used as workers compensation coverage for any employee or any covered dependent of an employee. Therefore, this plan generally excludes claims related to any activity engaged in for wage or profit including, but not limited to, farming, ranching, part-time and seasonal activities. See Plan Exclusions for specific information.

The information contained in this Plan Document/Summary Plan Description is only a general statement regarding FMLA, COBRA, USERRA, and QMCSO's. It is not intended to be and should not be relied upon as complete legal information about those subjects. Covered Persons and Employers should consult their own legal counsel regarding these matters.

**SCHEDULE OF DENTAL BENEFITS
FOR
ELIGIBLE GROUPS OF PARTICIPANTS**

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE TERMS, LIMITATIONS AND EXCLUSIONS OF THE PLAN AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

ELIGIBLE CLASSIFICATION OF PARTICIPANTS

- A. All Eligible Employees of the City
- B. Retirees

THE BENEFIT PERIOD IS A CALENDAR YEAR

DENTAL BENEFIT PAYMENT PROVISIONS

| | |
|--|---------------|
| Annual Deductible Per Covered Person | \$50 |
| Annual Deductible per Family | \$150 |
| Benefit Period | Calendar Year |

DENTAL BENEFITS

| | |
|--|---------|
| Type A (Preventive Care) Dental Expenses | |
| Deductible | Waived |
| Benefit Percentage | 100% |
| Type B (Basic Care) Dental Expenses | |
| Deductible | Applies |
| Benefit Percentage | 80% |

NOTE: Type C Expenses will only be payable after the Covered Person has been continuously covered under the Plan for a period of six (6) consecutive months.

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

MAXIMUM BENEFIT PER BENEFIT PERIOD PER COVERED PERSON \$ 1,000
(Type A, B and C Expenses)

ORTHODONTIC TREATMENT BENEFIT

(For eligible Dependent children)¹

| | |
|--------------------------------|--|
| Deductible | Annual Deductible Applies - No Separate Orthodontic Deductible |
| Benefit Percentage | 50% |
| Maximum Lifetime Benefit | \$1,500 |

Note: Any individual who became covered under this Plan and is eligible for Orthodontic Treatment Benefits under this Plan, and who was covered for Orthodontic Treatment Benefits immediately prior to this Plan will receive credit toward the deductible under this Plan. Any Orthodontic Treatment Benefits received under the prior plan which were applicable to the Maximum Lifetime Benefit for Orthodontic Treatment Benefits will also be applied to the Maximum Lifetime Benefit for Orthodontic Treatment Benefits under this Plan, and such Maximum Lifetime Benefit payable by this Plan will be reduced accordingly.

¹ Statement below "Orthodontic Treatment Benefit" (Schedule of Dental Benefits) is replaced by Corr Amd #2 7/1/2007

DENTAL BENEFITS

ELIGIBLE EXPENSES

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

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

DEDUCTIBLE AND BENEFIT PERCENTAGE

The Deductible applies to Eligible Expenses incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period. Also, if members of a Family have satisfied individual Deductible amounts that collectively equal the Deductible per Family, as stated in the Schedule of Dental Benefits, during the same Benefit Period, no further Deductible will apply to any member of that Family during that Benefit Period. **An individual Covered Person cannot receive credit toward the Family Deductible for more than the Individual Annual Deductible as stated in the Schedule of Dental Benefits.**

Eligible Expenses Incurred by a Covered Person will be paid by the Plan according to the applicable Benefit Percentage stated in the Schedule of Dental Benefits. The Plan will pay the percentage of the Eligible Expense indicated as the Benefit Percentage.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

Deductibles will be applied to Eligible Expenses in the chronological order in which they are adjudicated by the Plan. Eligible Expenses will be paid by the Plan in the chronological order in which they are adjudicated by the Plan. The manner in which the Deductible is applied and Eligible Expenses are paid by the Plan will be conclusive and binding on all Covered Persons and their assignees.

DEDUCTIBLE CARRYOVER PROVISION

Eligible Expenses Incurred during the last three (3) months of a Benefit Period which are applied to the Deductible will be "carried over" and applied against the Deductible applicable in the following Benefit Period.

MAXIMUM BENEFIT PAYABLE

The Maximum Benefit per Benefit Period as specified in the Schedule of Dental Benefits is the maximum amount that may be paid by the Plan for Eligible Expenses Incurred by each individual Covered Person in each Benefit Period as indicated in the Schedule of Dental Benefits. The amount payable by the Plan will not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Dental Benefits, for any reason.

EXPENSES INCURRED

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

PREDETERMINATION OF BENEFITS

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

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

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

DENTAL EXPENSES ²*TYPE A (PREVENTIVE CARE) EXPENSES*

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

1. Oral Examination (including prophylaxis--scaling and cleaning of teeth), but not more than twice in any Benefit Period.
2. Topical application of sodium fluoride or stannous fluoride. Benefits for topical application of sodium fluoride or stannous fluoride will be provided only once every twelve (12) months.
3. Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment; also other dental x-rays, but not more than one full mouth x-ray or series in any three Benefit Periods and not more than two sets of supplementary bitewing x-rays in any Benefit Period.
4. Emergency palliative care to relieve dental pain.

TYPE B (BASIC CARE) EXPENSES

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

1. Space maintainers
2. Extractions, except for orthodontic extractions

² Dental Expenses (Dental Benefits) Type A (Preventive Care) is replaced by Amendment #7 effective 03/01/2013

3. Oral surgery
4. Fillings
5. Sealants for Dependents under age twenty-three (23) but not more than one treatment per permanent tooth every thirty-six (36) consecutive months.
6. Injection of antibiotic drugs
7. Nitrous Oxide when administered in connection with covered dental services
8. General anesthesia or conscious intravenous "IV" sedation when Dentally Necessary and administered in connection with oral surgery or other Covered Dental Benefits.
9. Treatment, including periodontal surgery of diseased periodontal structures for periodontal and other diseases affecting such structures.
10. Endodontic treatment, including root canal therapy.
11. Repair or recementing of crowns, inlays, bridgework or dentures; or relining of dentures
12. Prophylaxis for periodontal treatment

TYPE C (MAJOR RESTORATIVE) EXPENSES

Type C Expenses will only be payable after the Covered Person has been continuously covered under the Plan for a period of six (6) consecutive months. The following general dental expenses will be considered "Type C" for reimbursement purposes:

1. Gold fillings, inlays, onlays or crowns (including precision attachments for dentures.)
2. Initial installation of fixed bridgework (including crowns and inlays to form abutments) to replace one or more natural teeth extracted while the individual is a Covered Person. If initial installation of fixed bridgework is to replace a tooth or teeth extracted prior to the individual's effective date of coverage under this Plan, the individual must be a Covered Person for a minimum of six (6) consecutive months.
3. Replacement of an existing partial denture or fixed bridgework by a new fixed bridgework, or the addition of teeth to an existing fixed bridgework. However, this item will apply only to replacements and additions that meet the "Prosthesis Replacement Rule" below.
4. Initial installation of partial or full removable dentures (including adjustments for the six (6) month period following installation) to replace one or more natural teeth extracted while the individual is covered. If initial installation of partial or full removable dentures is to replace a tooth or teeth extracted prior to the individual's effective date of coverage under this Plan, the individual must be a Covered Person for a minimum of six (6) consecutive months.
5. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or the addition of teeth to an existing partial denture. However, this item applies only to replacements and additions that meet the "Prosthesis Replacement Rule" below.
6. Appliances to reduce or prevent pain or damage from bruxism (grinding of the teeth).

ORTHODONTIC TREATMENT BENEFIT

(For Covered Dependent Children less than twenty-three (23) years of age only)

The following expenses will be considered "Orthodontic" for reimbursement purposes and will be payable as stated in the Schedule of Dental Benefits and subject to any separate Deductible or Maximum Lifetime Benefit applicable to Orthodontic Treatment:

1. Treatment for a diagnosed malocclusion.
2. Cephalometric X-ray once in any twenty-four (24) consecutive month period.
3. One set of study models per Covered Person.
4. Initial placement of braces or appliances, ongoing treatment adjustment, removal and follow-up related to said initial placement.
5. Orthodontic extractions.

If Orthodontic Treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received.

PROSTHESIS REPLACEMENT RULE

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

1. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed and after the individual has been a Covered Person for a minimum of twelve (12) months.
2. The existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement.
3. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

COVERED EXPENSES IN NEW YORK STATE

Covered expenses incurred in the State of New York will be limited to only those emergency procedures necessary to treat and stabilize an eligible dental condition or dental disease and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time, to a hospital or other appropriate treatment facility at a location outside the State of New York. Further, covered expenses in the State of New York will not include any surcharge or tax imposed by the State of New York upon dental services, treatments or supplies to the extent that the surcharge or tax exceeds 8.18% of the total claim for such dental services, treatments or supplies.

DENTAL BENEFIT LIMITATIONS

The following examples describe limitations in coverage under the Plan.

1. Restorative:
 - A. Gold, baked porcelain restorations, crowns, jackets: If a tooth can be restored with a material such as amalgam, and the Covered Person and dental service provider select another type of restoration, the Eligible Expense for the dental procedure actually performed will be limited to the Usual, Customary and Reasonable fee appropriate to the procedure using amalgam or a similar material.
 - B. Reconstruction. Eligible Expenses will include only the appropriate Usual, Customary and Reasonable charges for those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and are not covered.

2. Prosthodontics:
 - A. Partial Dentures. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, and the Covered Person and the dental service provider elect a more elaborate appliance, Eligible Expenses for the Covered Dental Service performed will be limited to the Usual, Customary and Reasonable charges appropriate to the cast chrome or acrylic denture.
 - B. Complete Dentures. If the Covered Person and the dental service provider decide on personalized or specialized techniques as opposed to standard procedures, the eligible expense for the dental procedure actually performed will be limited to the Usual, Customary and Reasonable charges appropriate to the standard procedure.
 - C. Replacement of existing dentures or removable or fixed bridgework. Charges for the replacement of existing dentures or removable or fixed bridgework will be considered an eligible expense only if the existing appliance is not serviceable and cannot be repaired. Otherwise, the Eligible Expense for the procedure performed will be limited to the Usual, Customary and Reasonable charges appropriate for those services which would be necessary to render such appliances serviceable.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following Exclusions and Limitations of the Plan apply to Dental Benefits:

1. Charges for treatments, services or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by a Participant's employer, to the extent that the expenses have been paid by another applicable portion of this Plan or any other insurance or employee benefit plan.
2. Charges for treatment which is not rendered by or in the presence of a Dentist or other Licensed Health Care Provider covered by the Plan except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if the treatment is rendered under the supervision or the direction of the Dentist.
3. Charges for Dentists' fees for any treatment which is not rendered by or in the physical presence of a Dentist or appropriate Licensed Health Care Provider.
4. Charges for dentures, crowns, inlays, onlays, bridgework or other appliances which are not dentally necessary and performed solely or primarily for Cosmetic or personal reasons, personal comfort, convenience, or beautification items, including charges for personalization or characterization of dentures. Charges for veneers, composite, plastic, silicate or similar restorations placed on or replacing any teeth other than the ten (10) upper and lower anterior teeth are considered optional services and not dentally necessary. Eligible Expenses will include only the charge for a corresponding amalgam restoration.
5. Charges for the replacement of a lost, missing, or stolen appliance device or for an additional (spare) appliance.
6. Charges for any services or supplies which are for Orthodontic Treatment, including orthodontic extractions, except as specifically provided for by the Plan.
7. Charges for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth. Services include, but are not limited to, dentures, crowns, inlays, onlays, bridgework or other appliance or service to increase vertical dimension, equilibrium and extracoronal or other periodontal splinting.
8. Charges by the Covered Person for all services and supplies resulting from any Dental condition or dental disease which occurs in the course of employment for wage or profit, or in the course of any volunteer work when the Covered Person's employer has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including Employees' compensation or liability laws of the United States (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Dental condition or dental disease even though:
 - A. Coverage for the Covered Person under Workers' Compensation provides benefits for only a portion of the services Incurred;
 - B. The Covered Person's employer has failed to obtain such coverage required by law;
 - C. The Covered Person waived his/her rights to such coverage or benefits;
 - D. The Covered Person fails to file a claim within the filing period allowed by law for such benefits;
 - E. The Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits; or

- F. The Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective.
- G. The Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

This exclusion will not apply to household and domestic employment, employment not in the usual course of the trade, business, profession or occupation of the Covered Person or employer, or employment of a Dependent member of an employer's family for whom an exemption may be claimed by the Employer under the Internal Revenue Code.

- 9. Charges for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage, as for example, when a Family member provides services to a spouse or Dependent child.
- 10. Charges for oral hygiene and dietary instructions.
- 11. Charges for root canal therapy for which the pulp chamber was opened before the individual became a Covered Person.
- 12. Charges for temporary dentures.
- 13. Charges incurred for services rendered or started, or supplies furnished prior to the effective date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions. This includes charges for dentures, crowns, inlays, onlays, bridgework or other appliances or services which were not ordered while the individual was a Covered Person. The date a prosthetic dental appliance is placed in the mouth is considered the date of service.
- 14. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature, including but not limited to correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia. This includes expenses incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.
- 15. Charges for any services, supplies or appliances which are not specifically listed as a benefit of this Plan.
- 16. Facility, Ambulatory Surgery Center and hospital charges, if there is no satisfactory, documented and dentally necessary reason, at the Plan Administrator's sole discretion, the treatment or surgery cannot be performed in the dental service provider's office.
- 17. Charges which are caused by or arising out of war or act of war, (whether declared or undeclared), civil unrest, armed invasion or aggression or caused during service in the armed forces of any country.
- 18. Broken or missed appointments.
- 19. Charges for infection control (OSHA) fees or claim filing.
- 20. Travel Expenses Incurred by any person for any reason.
- 21. Charges that are incurred outside of the United States if the Covered Person traveled to such a location for the purpose of obtaining treatment, services, drugs, or supplies.

22. Charges for non-dental services such as training, education, instructions or educational materials, even if they are performed or provided by a dental service provider.
23. Facility Miscellaneous Charges as defined in the Plan.
24. Hypnosis, prescribed drugs, premedications or any euphoric drugs, with the exception of nitrous oxide.
25. Charges for local anesthesia administered in conjunction with covered dental services or procedures, when billed separately (unbundled) from the charge for the covered service or procedure.
26. Biopsies or oral pathology, except as specifically provided for under Covered Dental Services.
27. To the extent that the Covered Person could have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid.
28. Charges for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Dentally Necessary for the diagnosis and/or treatment of an active Dental condition or dental disease, or which are Experimental or Investigational, except as specifically stated as a Covered Benefit of this Plan.
29. Charges for services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body.
30. Expenses Incurred by persons other than the person receiving treatment.
31. Charges in connection with services and supplies which are in excess of Usual, Customary and Reasonable charges.
32. Charges for services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person, or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services.
33. Charges for local anesthesia administered in conjunction with covered dental services or procedures, when billed separately (unbundled) from the charge for the Covered Service or procedure.
34. Charges for professional services on an Outpatient basis in connection with disorders of any type or cause, that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis.
35. Charges for services, treatment or supplies not considered legal in the United States.
36. Charges for preparation of reports or itemized bills in connection with Eligible Expenses, unless specifically requested and approved by the Plan.
37. Charges for incidental supplies or common first-aid supplies, such as, but not limited to, adhesive tape, bandages, antiseptics, analgesics, etc., except as specifically listed as a covered benefit. **Payment for these expenses will only be made upon prior approval from the Plan.**
38. Charges in connection with treatment, services or supplies provided for complications resulting from treatment, services or supplies that are excluded from the Plan.

39. Charges for dental services or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by a Participant's employer, to the extent that the expenses have been paid by another applicable portion of this Plan or any other insurance or employee benefit plan.
40. Charges for facility, Ambulatory Surgery Center and Hospital charges, if there is no satisfactory, documented and dentally necessary reason, at the Plan Administrator's sole discretion, the treatment or surgery cannot be performed in the dental service provider's office.
41. Charges in excess of the Usual, Customary and Reasonable amount.
42. Charges for implantology.
43. Charges for any services, treatments or supplies Incurred in the State of New York, except for those specifically set out as a Covered Benefit of this Plan. The Plan will not pay any surcharge or tax of any nature imposed by the State of New York upon services, treatments or supplies to the extent that the surcharge or tax exceeds 8.18% of the total claim for such services, treatments or supplies.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Eligible Expenses. It applies when the Participant or Dependent who is covered by this Plan is or may also be covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

In the event of a motor vehicle or premises accident, this Plan is not the primary coverage including, but not limited to, auto medical, no fault or homeowners, liability insurance and medical payments insurance.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization is hereby given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision.

DEFINITIONS

“Allowable Expenses” means any necessary item of expense, the charge for which is Usual, Customary and Reasonable, regular and customary, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

“Plan” as used herein will mean any Plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
 - A. Hospital indemnity benefits; and
 - B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims; or
2. Hospital, medical or dental service organizations on a group basis, group practice and other group pre-payment plans; or
3. Hospital, medical or dental service organizations on an individual basis having a provision similar in effect to this provision; or
4. A licensed Health Maintenance Organization (H.M.O.); or
5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or
6. Any coverage under a Governmental program, and any coverage required or provided by any statute; or
7. Automobile insurance; or
8. Individual automobile insurance coverage on an automobile leased or owned by the City or any responsible third-party tortfeasor; or

9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage; or
10. Homeowner or premise liability insurance, individual or commercial.

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

COORDINATION PROCEDURES

1. The Plan will coordinate benefits with all other benefit programs under which the Covered Person is eligible for benefits if the Allowable Expense is less than the sum of:
 - A. The benefits of this Plan; and
 - B. The benefits of other plans.
2. Except as provided in subsection 3 below, the Plan will reduce its benefits so that the sum of:
 - A. The Plan benefits, and
 - B. The benefits of other Programs,do not exceed the total Allowable Expenses up to the amount of Incurred Expenses.
3. This Plan will not reduce its benefits if:
 - A. The following rules would require the other program to:
 - 1) Coordinate benefits with this Plan; and
 - 2) Determine benefits after this Plan; and
 - B. The following rules require this Plan to determine its benefits first.

ORDER OF BENEFIT DETERMINATION

1. **Non-Dependent/Dependent**

The plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. **Child Covered Under More Than One Plan**

- A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - 1) The parents are married;
 - 2) The parents are not separated (whether or not they have ever been married), or
 - 3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.
- B. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

- C. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph will not apply with respect to any claim determination period, Benefit Period or Plan Year during which benefits are paid or provided before the entity has actual knowledge.
- D. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:
 - 1) the plan of the custodial parent.
 - 2) the plan of the spouse of the custodial parent.
 - 3) the plan of the non-custodial parent.
 - 4) the plan of the spouse of the non-custodial parent.

3. Active or Inactive Employee

The Plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.

4. Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.

- A. To determine the length of time a person has been covered under a plan, two plans will be treated as one if the Covered Person was eligible under the second within 24 hours after the first ended.
- B. The start of a new plan does not include:
 - 1) A change in the amount or scope of a plan's benefits;
 - 2) A change in the entity that pays, provides, or administers the plan's benefits; or
 - 3) A change from one type of plan to another (such as from a single employer plan to that of a multiple-employer plan).
- C. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. No Rules Apply

If none of these preceding rules determines the primary plan, the Allowable Expenses will be determined equally between the plans.

COORDINATION WITH MEDICAID

If a Covered Person is also entitled to and covered by Medicaid, the Plan will always be primary and Medicaid will always be secondary coverage.

COORDINATION WITH CHAMPUS

“CHAMPUS” means the medical benefits and programs provided by the Civilian Health and Medical Program of the Uniformed Services.

If a Covered Person is also entitled to and covered under CHAMPUS, the Plan will always be primary and CHAMPUS will always be secondary coverage. CHAMPUS coverage will include programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

PROCEDURES FOR CLAIMING BENEFITS

Claims must be submitted to the Plan within twelve (12) months after the date services or treatment are received or completed. Claims may be submitted on any approved claim, available from the provider. The claim must be completed in full with all the requested information. A complete claim must include the following information:

- the date of service;
- the name of the Participant;
- the name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- the diagnosis [code] of the condition being treated;
- the treatment or service [code] performed;
- the amount charged by the provider for the treatment or service; and
- sufficient documentation, in the sole determination of the Plan Administrator, to support the medical necessity of the treatment or service being provided and sufficient to enable the Plan Supervisor to adjudicate the claim pursuant to the terms and conditions of the Plan.

When completed, the claim must be sent to the Plan Supervisor, Allegiance Benefit Plan Management, Inc., at P.O. Box 3018, Missoula, Montana 59806-3018, (406) 721-2222 or 1-800-877-1122 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

In no event will any claim be considered for payment of benefits if it is initially submitted to the Plan more than twelve (12) months from the date that such claim was incurred.

Upon termination of the Plan, final claims must be received within three (3) months of termination or such lesser time as is established by the Plan Administrator.

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

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

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims will be considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines and administrative practices. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims decisions will be made within the time periods stated below. For purposes of this section, "Covered Person" will include the claimant and the claimant's authorized representative; however, "Covered Person" does not include a health care provider or other assignee, and said health care provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim. Upon written notice to the Covered Person of the circumstances requiring an extension and the date by which the Plan expects to render a decision, this time period may be extended fifteen (15) days for reasons beyond the Plan's control. If the extension is necessary due to a failure of the claimant to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the claimant will be afforded forty-five (45) days from receipt of the notice within which to provide the specified information. Once sufficient information is received to decide the claim, the Plan will provide timely notice of the determination after receiving sufficient information.

APPEALING AN UN-REIMBURSED CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan Supervisor at the address or telephone number shown on the EOB form.

A Covered Person has no more than one hundred eighty (180) days after an Adverse Benefit Determination to appeal the denial. When appealing an Adverse Benefit Determination, the Covered Person should include any additional information supporting the claim or the information required by the Plan which was not initially provided and forward it to the Plan Supervisor within the permitted time period. Failure to appeal the Adverse Benefit Determination within the permitted time period will render the determination final; appeals received after the permitted time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing, and supporting materials may be submitted via mail, the electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

If a claimant requests review of an Adverse Benefit Determination, this Plan provides two (2) levels of benefit determination review.

FIRST LEVEL OF BENEFIT DETERMINATION REVIEW

The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within sixty (60) days following the date the Plan Supervisor receives the request for reconsideration.

If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same, the Covered Person has the right to a second level of review as stated below. To obtain a second level of review, the Covered Person must request the second review in writing and send it to the Plan Supervisor not later than sixty (60) days after receipt of the Plan Supervisor's decision from the first level of review.

SECOND LEVEL OF BENEFIT DETERMINATION REVIEW

The Plan Administrator will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Plan Administrator who is neither the original decisionmaker nor the decisionmaker's subordinate. The Plan Administrator cannot give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of medical necessity or experimental treatment, the Plan Administrator will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, within a reasonable time, but no later than sixty (60) days from the date the appeal is received by the Plan. Such notice will contain the same information as notices for the initial determination.

All claim payments are based upon the terms and provisions contained in the Plan Document which is on file with the Plan Administrator and the Plan Supervisor. The Covered Person may also request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

ELIGIBILITY PROVISIONS

EMPLOYEE ELIGIBILITY

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

1. Is employed by the City or other affiliated agencies, Lewis and Clark County Library, Helena Regional Airport, Helena Parking Commission and City-County Administration Building, on a continuing and regular basis as a permanent full-time or permanent part-time Employee for at least twenty (20) hours per week or is a Retiree; and
2. Is in a Classification of Participants listed in the Schedule of Benefits; and
3. Is not a temporary or seasonal employee.

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

WAITING PERIOD

With respect to a person covered by a previous plan or previous group dental insurance of the Employer on the effective date of this Plan, the effective date of coverage under this Plan will be the effective date of the Plan.

With respect to an eligible person who becomes employed by the City after the effective date of the Plan, the Employee's effective date of coverage will be the first day of the month immediately following thirty (30) days after the Employee's Enrollment Date.

DEPENDENT ELIGIBILITY³

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant has been assigned by the Employer, and who is either:

1. The Participant's legal spouse of the opposite sex, according to the marriage laws of the state where the marriage was first solemnized or established.

An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant by having met all requirements of a legal separation or divorce decree in the state granting such separation or divorce.

2. The Participant's Dependent child who meets all of the following "Required Eligibility Conditions":
 - A. Is a natural child; step-child; legally adopted child; a child who has been placed with the Participant for adoption and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement;
 - B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time; and

³ Dependent Eligibility (Eligibility Provisions) is replaced by Amd #5 effective 7/11/2011, previously replaced by Amd #4

3. The Participant's or Retiree's Domestic Partner and their children only if eligibility is allowed by the City as specifically stated in the written personnel policy. Domestic Partner means the person, regardless of gender, named in the Affidavit of Domestic Partnership that has been submitted to and approved by the City. See General Definitions.

Refer to the City's written personnel policy to determine eligibility for Domestic Partner or children of a Domestic Partner.

Dependents on active military duty for more than thirty-one (31) consecutive days are not eligible.

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

A Participant eligible for Dependent Coverage will be any Participant whose Dependents are eligible for coverage. Each Participant will become eligible for Dependent Coverage on the latest of the following:

1. The date he/she becomes eligible for Participant coverage; or
2. The date on which he/she first acquires a Dependent; or
3. The date he/she first becomes eligible for Dependent Coverage.

RETIREE ELIGIBILITY

"Retiree" will mean an Employee who retires under a retirement program authorized by law and eligible to continue coverage with the Employer pursuant to the terms of 2-18-704 MCA as amended from time to time.

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan will commence at 12:01 A.M. in the time zone in which the Covered Person permanently resides, on the date such coverage becomes effective.

PARTICIPANT COVERAGE

Participant coverage under the Plan will become effective on the date the Employee satisfies the applicable eligibility requirements and Waiting Period, provided that application for such coverage is made on the Plan's enrollment form on or before the last day of the Waiting Period imposed by this Plan.

An eligible Employee who declines Participant coverage under the Plan during the Initial Enrollment Period will be able to become covered later only if the employee enrolls during an Open Enrollment, upon application on the Plan's enrollment form within thirty (30) days of the date a Dependent is acquired as provided by the Plan or the date coverage under another Health Benefit Plan is lost.

An eligible Employee who declines Participant coverage under the Plan during the Initial Enrollment Period will be able to become covered later only during an Open Enrollment.

DEPENDENT COVERAGE

Each Participant who requests Dependent Coverage on the Plan's enrollment form will become covered for Dependent Coverage as follows:

1. On the Participant's effective date of coverage, if an enrollment form is received by the Plan on or before the date he or she becomes eligible for Dependent coverage under this Plan. This subsection only applies to Dependents who are eligible on the Participant's effective date of coverage.
2. In the event a Dependent who meets all other eligibility requirements of this Plan is acquired after the Participant's effective date of coverage as a result of one of the events below, and provided such application is made on the Plan's enrollment form, the dependent so acquired may become covered within thirty (30) days of the event:
 1. Marriage of the employee. Coverage will become effective as of the date of marriage;
 2. A legal guardianship. Dependent coverage will become effective on the first day of the month following the Plan's receipt of an enrollment form;
 3. In the event that a Participant is required to provide coverage as a result of a valid court order such as a QMCSO. Coverage will become effective the first day of the month following the Plan's receipt of an enrollment form;
 4. Adoption of, or placement of a child with the Participant for adoption, provided the child is under the age of nineteen (19)--coverage will become effective on the date of adoption or placement for adoption; and
 5. If application for coverage is received at any time other than as stated in (1) or (2) above, or as a newly acquired Dependent, the Dependent may not enroll until the Plan's next Open Enrollment Period.

OPEN ENROLLMENT PERIOD ⁴

The Open Enrollment Period will be May 15th through June 15th of each year. A person who enrolls during an Open Enrollment Period will be considered a Late Enrollee, except for individuals eligible for the first time or whose initial eligibility coincides with the Open Enrollment Period.

An Employee or the Employee's eligible Dependents who are not covered under this plan may enroll for coverage on the Plan's enrollment form during any Open Enrollment Period. Coverage for an employee who requests coverage during any Open Enrollment Period will begin on July 1st immediately following the end of the Open Enrollment Period.

TRANSFER OF COVERAGE

If a Covered Dependent under this Plan becomes an eligible Employee of the City, he/she may continue his/her coverage as a Dependent or elect to be covered as a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of the City, but is eligible to be covered as a Dependent under another Employee/Participant, he/she may elect to continue his/her coverage as a Dependent of such Employee/Participant.

Application for such Transfer of Coverage must be made on the Plan's enrollment form, within thirty (30) days immediately following the date the Employee becomes or ceases to be an eligible Employee. Transfer of Coverage will not be deemed to be a break or termination of coverage and will not operate to reduce or increase any coverage or accumulations toward satisfaction of the deductible and Out-of-Pocket Maximum to which the Covered Person was entitled prior to a Transfer of Coverage.

⁴ Open Enrollment Period (Effective Date of Coverage) as amended, is replaced by Amendment #6 effective 07/01/2011

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

PURPOSE

Pursuant to Section 609(a) of ERISA, the Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified in accordance with ERISA's requirements, to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. Employer adopts ERISA standards to comply with child support enforcement obligation of Part D of Title IV of the Social Security Act of 1975 as amended.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.
2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:
 - A. Provides for child support for a child of a Participant under this Plan, or;
 - B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and
 - C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act;
3. "Plan" means this self-funded Employee Health Benefit Plan, including all supplements and amendments in effect.
4. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Plan Administrator to meet the qualification requirements as outlined under "Procedures" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

To be qualified, a Medical Child Support Order must clearly:

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and
2. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

In the case of any Medical Child Support Order received by this Plan:

1. The Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the plan's procedures for determining whether Medical Child Support Orders are qualified orders; and
2. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination.

NATIONAL MEDICAL SUPPORT NOTICE

If the Plan Administrator of a group health plan which is maintained by the Employer of a noncustodial parent of a child, or to which such an employer contributes, receives an appropriately completed National Medical Support Notice as described in Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the criteria shown above for a qualified order, the Notice will be deemed to be a Qualified Medical Child Support Order in the case of such child.

FAMILY AND MEDICAL LEAVE ACT OF 1993⁵

The Family and Medical Leave Act (FMLA) requires Employers who are subject to FMLA to allow their "eligible" Employees to take unpaid, job-protected leave. The Employer may also require or allow the Employee to substitute appropriate paid leave, including, but not limited to, vacation and sick leave, if the Employee has earned or accrued it. The maximum leave required by FMLA is twelve (12) workweeks in any twelve (12) month period for certain family and medical reasons and a maximum combined total of twenty-six (26) workweeks during any twelve (12) month period for certain family and medical reasons and for a serious injury or illness of a member of the Armed Forces to allow the Employee, who is the spouse, son, daughter, parent, or next of kin to the member of the Armed Forces, to care for that member of the Armed Forces. In certain cases, this leave may be taken on an intermittent basis rather than all at once, or the Employee may work a part-time schedule.

DEFINITIONS

For these Family and Medical Leave Act of 1993 provisions only, the following definitions apply:

1. "Member of the Armed Forces" includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation, or therapy
2. "Next of Kin" means the nearest blood relative to the service member
3. "Parent" means Employee's biological parent or someone who has acted as Employee's parent in place of Employee's biological parent when Employee was a son or daughter.
4. "Serious health condition" means an illness, injury impairment, or physical or mental condition that involves:
 - A. Inpatient care in a hospital, hospice, or residential medical facility; or
 - B. Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services).
5. "Serious injury or illness" means an injury or illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform his or her military duties.
6. "Son or daughter" means Employee's biological child, adopted child, stepchild, foster child, a child placed in Employee's legal custody, or a child for which Employee is acting as the parent in place of the child's natural blood related parent. The child must be:
 - A. Under the age of eighteen (18); or,
 - B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.
7. "Spouse" means Employee's husband or wife as defined or recognized under State law in the State where the Employee resides.

⁵ "Family and Medical Leave Act of 1993" is replaced by the FMLA Compliance Amendment effective 1/1/2009

EMPLOYERS SUBJECT TO FMLA

In general, FMLA applies to any employer engaged in interstate commerce or in any industry or activity affecting interstate commerce who employs 50 or more Employees for each working day during each of 20 or more calendar work weeks in the current or preceding Calendar Year. FMLA also applies to those persons described in Section 3(d) of the Fair Labor Standards Act, 29 U.S.C. 203(d). The FMLA applies to government entities, including branches of the United States government, state governments and political subdivisions thereof.

ELIGIBLE EMPLOYEES

Generally, an Employee is eligible for FMLA leave only if the Employee satisfies all of the following requirements as of the date on which any requested FMLA leave is to commence: (1) has been employed by the Employer for a total of at least twelve months (whether consecutive or not); (2) the Employee has worked (as defined under the Fair Labor Standards Act) at least 1,250 hours during the twelve-(12) month period immediately preceding the date the requested leave is to commence; (3) the Employee is employed in any state of the United States, the District of Columbia or any Territories or possession of the United States; and (4) at the time the leave is requested, the Employee is employed at a work site where 50 or more Employees are employed by the Employer within 75 surface miles of the work site.

REASONS FOR TAKING LEAVE

FMLA leave must be granted (1) to care for the Employee's newborn child; (2) to care for a child placed with the Employee for adoption or foster care; (3) to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; (4) because the Employee's own serious health condition prevents the Employee from performing his or her job; or (5) because of a qualifying exigency, as determined by the Secretary of Labor, arising out of the fact that a spouse, son, daughter or parent of the Employee is on active duty or has been called to active duty in the Armed Forces in support of a contingency operation (i.e., a war or national emergency declared by the President or Congress).

ADVANCE NOTICE AND MEDICAL CERTIFICATION

Ordinarily, an Employee must provide thirty (30) days advance notice when the requested leave is "foreseeable." If the leave is not foreseeable, the Employee must notify the Employer as soon as is practicable, generally within one to two working days. An employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee's serious health condition, the Employer may require second or third opinions, at the Employer's expense, and a certification of fitness to return to work prior to allowing the Employee to return to work.

PROTECTION OF JOB BENEFITS

For the duration of FMLA leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same conditions as coverage would have been provided if the Employee had been in Active Service during FMLA leave period. Taking FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave, unless the loss would have occurred even if the Employee had been in Active Service.

UNLAWFUL ACTS BY EMPLOYERS

Employers cannot interfere with, restrain or deny the exercise of any right provided under the FMLA or to manipulate circumstances to avoid responsibilities under the FMLA. Employers may not discharge, or discriminate against any person who opposes any practice made unlawful by the FMLA or who may be involved in a proceeding under or relating to the FMLA.

ENFORCEMENT

The U.S. Department of Labor is authorized to investigate and resolve complaints of FMLA violations. An eligible Employee may also bring a civil action against an employer for FMLA violations. The FMLA does not supersede any federal or state law prohibiting discrimination, and does not supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. For additional information, contact the nearest office of Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Participant's employment terminates; or
2. On the last day of the month in which the Participant ceases to be in a class of Participants eligible for coverage; or
3. The date the Participant fails to make any required contribution for coverage; or
4. The date the Plan is terminated; or with respect to any Participant benefits of the Plan, the date of termination of such benefit; or
5. The date the City terminates the Participant's coverage; or
6. The date the Participant dies; or
7. The date the Participant enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days; or
8. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Participant.

A Participant whose Active Service ceases because of illness or injury or as a result of any other approved leave of absence may remain covered as an Employee in Active Service for a period of twelve (12) weeks, or such other length of time that is consistent with and stated in the City's current Employee Personnel Policy Manual or pursuant to the Family and Medical Leave Act. Coverage under this provision will be subject to all the provisions of FMLA if the leave is classified as FMLA leave. This provision will not apply to any Participant whose employment has been terminated.

A Participant whose Active Service ceases due to temporary layoff will be considered employed by the City for the purposes of his/her coverage under this Plan, and such coverage may continue until the end of the month in which the layoff began. After a temporary layoff, if the Participant resumes active employment within one year after termination of benefits under this Plan, he or she may resume coverage under the Plan immediately; otherwise, he or she will be considered a new Employee for purposes of this Plan.

If a Participant's coverage is to be continued during disability, approved leave of absence or temporary lay off, the amount of his or her coverage will be the same as the Plan benefits in force for an active Employee, subject to the Plan's right to amend coverage and benefits.

REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of termination of employment and who resumes employment with the Employer within six (6) months immediately following the date of such termination of employment will become eligible for reinstatement of coverage the date he or she resumes employment.

If renewed eligibility occurs under any circumstances other than as stated in this sub-section, enrollment for coverage for the Employee and his/her Dependents will be treated as if initially hired for purposes of eligibility and coverage under this Plan.

Any Retiree who ends or terminates coverage under the Dental Benefit Plan for a period exceeding sixty (60) days from the date of retirement, or anytime thereafter, will have no further eligibility or right to eligibility under this Plan.

DEPENDENT TERMINATION

Each Covered Person, whether Participant or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continued Coverage After Termination.

The Dependent Coverage of a Participant will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan; or
2. On the last day of the month in which the Participant's coverage terminates under the Plan; or
3. On the last day of the month in which the Participant ceases to be eligible for Dependent Coverage; or
4. The date the Participant fails to make any required contribution for Dependent Coverage; or
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit; or
6. The date the City terminates the Dependent's coverage; or
7. On the date the Participant dies; or
8. The date the Dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty-one (31) days; or
9. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Dependent whose coverage is to be terminated.

CONTINUED COVERAGE AFTER TERMINATION⁶

Under the Public Health Service Act, as amended, Employees and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more Employees. **A Participant's Domestic Partner is not eligible for COBRA Continuation Coverage.**⁷

The Plan Administrator is City of Helena, 316 N. Park Ave, Helena, MT 59623; 406-447-8333. COBRA Continuation Coverage for the Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, 406-721-2222.

COBRA Continuation Coverage is available to any Qualified Beneficiary whose coverage would otherwise terminate due to any Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day following the date of the Qualifying Event.

1. Qualifying Events for Participants, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:
 - A. The termination (other than by reason of gross misconduct) of the Participant's employment.
 - B. The reduction in hours of the Participant's employment.
2. Qualifying Events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:
 - A. Death of the Participant or Retiree.
 - B. Termination of the Participant's employment.
 - C. Reduction in hours of the Participant's employment.
 - D. The divorce or legal separation of the Participant or Retiree from his or her spouse.
 - E. A covered Dependent child ceases to be a Dependent as defined by the Plan.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Employer of a Qualifying Event within sixty (60) days after the date of the Qualifying Event. The Employer must notify the Plan Administrator of any of the following:

1. Death of the Participant or Retiree.
2. The divorce or legal separation of the Participant or Retiree from his or her spouse.
3. The Participant's entitlement to Medicare.
4. A covered Dependent child ceases to be a Dependent as defined by the Plan.

The Notification to the Plan Administrator must occur within thirty (30) days after the applicable event or within thirty (30) days after the Employer receives notice of the applicable event, whichever occurs later.

⁶ Continuation Coverage After Termination section replaced in COBRA Compliance Amendment-2005.

⁷ First paragraph under "Continued Coverage After Termination" is replaced by Amendment #4 effective 7/1/2010

ELECTION OF COVERAGE

When the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than fourteen (14) days after the Plan Administrator is notified of the Qualifying Event.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notification from the Plan Administrator, whichever is later, to notify the Plan Administrator that he or she elects to continue coverage under the Plan. Failure to elect continuation within that period will cause coverage to end.

MONTHLY PREMIUM PAYMENTS

A Qualified Beneficiary is responsible for the full cost of continuation coverage. Monthly premium for continuation of coverage must be paid in advance to the Plan Administrator. The premium required under the provisions of COBRA is as follows:

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).
2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.
3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:
 - A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce, legal separation or Medicare entitlement, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.
 - B. If the second Qualifying Event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Employer of the applicable monthly premium for such coverage. The monthly premium for continuation coverage under this provision is due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Employer.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the former employee dies or becomes divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

The dependents of a former employee are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of the former employee's enrollment in Part A or Part B of Medicare, whichever occurs earlier.

When the former employee enrolls in Medicare before the Qualifying Event of termination (or reduction of hours) of employment occurs, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends on the later of:

1. Eighteen (18) months after the Qualifying Event of termination of employment or reduction in hours of employment; or
2. Thirty-six (36) months after the former employee's enrollment in Medicare.

When the former employee enrolls in Medicare after the Qualifying Event of termination (or reduction of hours) of employment, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends eighteen (18) months after the Qualifying Event, unless a second Qualifying Event, as described above occurs within that eighteen (18) month period.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage and any coverage under the Plan that has been elected with respect to any Qualified Beneficiary will cease on the earliest of the following:

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance, unless the other group health plan contains a provision excluding or limiting coverage for a Pre-existing Condition applicable to a condition of the Qualified Beneficiary under this Plan. However, if the exclusionary period does not apply due to prior Creditable Coverage, COBRA continuation coverage ends. Coverage will not be terminated as stated until the pre-existing exclusionary period of the other coverage is no longer applicable.

This exception applies to all Qualified Beneficiaries.

2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A or B);
3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to the Plan Administrator.
4. On the date the Employer ceases to provide any group health plan coverage to any Employee.
5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.

6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:
 - A. Eighteen (18) months for a former employee who is a Qualified Beneficiary as a result of termination (or reduction of hours) of employment;
 - B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen month period entitling that Dependent to an additional eighteen (18) months;
 - C. For the Dependent who is a Qualified Beneficiary as a result of termination (or reduction of hours) of employment of the former employee if that former employee enrolled in Medicare before termination (or reduction of hours) of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.
 - D. On the first day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.
 - E. Twenty-nine (29) months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.
 - F. Thirty-six (36) months for all other Qualified Beneficiaries.
7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806 or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

In order to protect the Employee's family's rights, the Employee should keep the Plan Administrator informed of any changes in the addresses of family members. The Employee should also keep a copy, for his/her records, of any notices sent to the Plan Administrator.

COVERAGE FOR A MILITARY RESERVIST⁸

To the extent required by the Uniform Services Employment and Reemployment Rights Act (USERRA), the following provisions will apply:

1. In any case in which a Covered Person has coverage under this Plan, and such Covered Person is absent from employment with Employer by reason of service in the uniformed services, the Covered Person may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:
 - A. The twenty-four (24) month period beginning on the date on which the Covered Person's absence begins; or
 - B. The period beginning on the date on which the Covered Person's absence begins and ending on the day after the date on which the Covered Person fails to apply for or return to a position of employment, as required by USERRA.
2. An eligible person who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.
3. In the case of a person whose coverage under the Plan is terminated by reason of service in the uniformed services, an exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who notifies the Employer of his or her intent to return to employment in a timely manner as defined by USERRA, and is reemployed, and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee. **This provision will not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.**

⁸ Coverage for a Military Reservist section replaced entirely in USERRA Compliance Amendment-2005.

COVERAGE FOR A MONTANA NATIONAL GUARD MEMBER⁹

To the extent required by the Montana Military Service Employment Rights Act (MMSERA), the following provisions will apply:

“State Active Duty” means duty performed by a Montana National Guard member when a disaster is declared by the proper State authority and shall include the time period as certified by a licensed physician to recover from an Illness or Injury incurred while performing the state active duty.

1. In any case in which a Covered Person has coverage under this Plan, and such Covered Person is absent from employment with Employer by reason of State Active Duty, the Covered Person may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election shall be the period beginning on the thirty-first consecutive day of State Active Duty and ending on the day immediately before the day the Covered Person returns to a position of employment with the Employer, provided the Covered Person returns to employment in a timely manner, or ending on the day immediately after the day the Covered Person fails to return to a position of employment in a timely manner.
 - A. For purposes of this subsection, a timely manner means the following:
 - 1) For State Active Duty of thirty (30) days but not more than one hundred eighty (180) days, the next regularly scheduled day of Active Service following fourteen (14) days after the termination of State Active Duty.
 - 2) For State Active Duty of more than one hundred eighty (180) days, the next regularly scheduled day of Active Service following ninety (90) days after the termination of State Active Duty.
2. An eligible Covered Person who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan associated with such coverage for the Employer’s other Employees, except that in the case of a Covered Person who performs State Active Duty for less than one hundred eighty (180) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.
3. In the case of a person whose coverage under the Plan is terminated by reason of State Active Duty, a Pre-Existing Condition Exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if such an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who is reemployed in a timely manner as defined by MMSERA and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee.
4. **In no event will this Plan cover any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State Active Duty.**

⁹ Coverage for a Montana National Guard Member section added in MMSERA Amendment.

FRAUD AND ABUSE

THIS PLAN IS SUBJECT TO FEDERAL LAWS WHICH PROVIDE THAT CRIMINAL PENALTIES MAY BE IMPOSED AGAINST THOSE WHO RECEIVE OR ATTEMPT TO RECEIVE HEALTH CARE PLAN BENEFITS BY COMMITTING FRAUD OR ABUSE AGAINST THE PLAN. STATE FRAUD AND ABUSE LAWS MAY ALSO APPLY.

Any person who commits a fraudulent act against the Plan may be subject to criminal prosecution, fine or imprisonment as provided by law. The following list is illustrative, but not exhaustive, of acts that may be considered fraud or abuse against the Plan:

1. Falsifying, withholding, omitting or concealing information to obtain coverage;
2. Misrepresenting eligibility criteria for Dependents (for example, marital status, age, full-time student status, dependent child or the right to claim a Dependent for Federal income tax purposes) to obtain or continue coverage for a person who would not otherwise meet the Dependent eligibility criteria, as defined in the Plan, and qualify for coverage;
3. Withholding, omitting, concealing, or failing to disclose any dental history or health status where required to calculate benefit payments;
4. Making or using any false writing or document in connection with obtaining coverage or payment for dental benefits;
5. Permitting a person who is not covered under the Plan to use a Plan identification card or other Plan identifying information to obtain Covered Services or payment under this Plan;
6. Making false or fraudulent representations in connection with delivery of or payment for health benefits, or being untruthful to obtain reimbursement under this Plan; or
7. Obtaining, or attempting to obtain, dental care or Covered Services under this Plan by false or fraudulent pretenses.

The Plan Administrator, in its sole discretion, may take additional action against the Participant or Covered Person as appropriate, including, but not limited to giving the Participant written notice that his or her (and the family's) coverage will be terminated at the end of 31 days from the date written notice is given.

MISSTATEMENT OF AGE

If age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of a Covered Person's age in an enrollment form or claims filing, the Covered Person's eligibility or amount of benefits, or both, will be adjusted in accordance with the Covered Person's true age. Upon the discovery of a Covered Person's misstatement of age, benefits affected by such misstatement will be adjusted immediately. If the Covered Person's true age is such that the person was not eligible for coverage or the amount of benefits received, the Plan is entitled to recover any such benefits paid as outlined in the Right of 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 Participant misrepresents a Dependent's eligibility criteria (including, but not limited to marital status, age, full-time student status, dependent child relationship or the right to claim the person as a tax dependent) to obtain coverage for a person who would not meet the Plan's definition of Dependent if the true facts were known, coverage for that person will be terminated as though never effective.

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not an eligible Covered Person to use any identification card issued, the Plan Sponsor may, at the Plan Sponsor's sole discretion, terminate the coverage of the Covered Person who permits such usage.

REIMBURSEMENT TO PLAN

Payment of benefits by the Plan for Participants' spouses, ex-spouses or children or other persons who are not eligible for coverage under this Plan but for whom benefits were paid based upon:

1. inaccurate, erroneous or false information provided by the Participant; or
2. information concealed, withheld, omitted or not disclosed by the Participant as required;
3. falsified or altered documents provided by the Participant to the Plan for the purpose of obtaining coverage;

must be reimbursed to the Plan by the Participant. Participant's failure to reimburse the Plan after demand is made may result in interruption or loss of benefits by the Participant and his or her Dependents.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefitted from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits, or from the benefits for any covered Family member even if the erroneous payment was not made on that Family member's behalf.

Payment of benefits by the Plan for Participants' spouses, ex-spouses, or children, who are not eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate, erroneous, false information or omissions of information provided or omitted by the Employee will be reimbursed to the Plan by the Employee. The Employee's failure to reimburse the Plan after demand is made may result in an interruption in or loss of benefits to the Employee, and could be reported to the appropriate governmental authorities for investigation of criminal fraud and abuse.

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

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

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. Reimbursement means to repay a party who has paid something on another's behalf. If the Plan pays benefits for dental expenses on a Covered Person's behalf, and another party was actually responsible or liable to pay those dental expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid.

Accordingly, if a Covered Person, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any accident, Injury, condition or Illness for which benefits were provided by the Plan, the Covered Person agrees to hold the money received in trust for the benefit of the Plan. The Covered Person agrees to reimburse the Plan, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that will be paid as a result of said accident, Injury, condition or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Covered Person is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, dental, disability or other expenses or damages.

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from third parties who are legally responsible to the Covered Person for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover the money paid under the Plan. In other words, if another person or entity is, or may be, liable to pay for dental bills or expenses related to the Covered Person's accident, Injury, condition or Illness, which the Plan paid, then the Plan is entitled to recover, by legal action or otherwise, the money paid; in effect, the Plan has the right to "stand in the shoes" of the Covered Person for whom benefits were paid, and to take any action the Covered Person could have undertaken to recover the money paid.

The Covered Person agrees to subrogate to the Plan any and all claims, causes of action or rights that he or she has or that may arise against any entity who has or may have caused, contributed to or aggravated the accident, Injury, condition or Illness for which the Plan has paid benefits, and to subrogate any claims, causes of action or rights the Covered Person may have against any other coverage, including but not limited to liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event that a Covered Person decides not to pursue a claim against any third party or insurer, the Covered Person will notify the Plan, and specifically authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Covered Person's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

1. Under the terms of this Plan, the Plan Supervisor is not required to pay any claim where there is evidence of liability of a third party unless the Covered Person signs the Plan's Third-Party Reimbursement Agreement and follows the requirements of this section. However, the Plan, in its discretion, may instruct the Plan Supervisor not to withhold payment of benefits while the liability of a party other than the Covered Person is being legally determined. If a repayment agreement is requested to be signed, the Plan's right of recovery through Reimbursement and/or Subrogation remains in effect regardless of whether the repayment agreement is actually signed.
2. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any third party responsible for an accident, Injury, condition or Illness, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. The Covered Person receiving payment from this Plan will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the Plan's right of recovery.
3. The Covered Person will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any monies paid by the Plan for any party other than the Covered Person who is liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Plan Administrator, upon request and in a timely manner, of all material facts regarding the accident, Injury, condition or Illness; all efforts by any person to recover any such monies; providing the Plan Administrator with any and all documents, papers, reports and the like regarding demands, litigation or settlements involving recovery of monies paid by the Plan; and notifying the Plan Administrator of the amount and source of any monies received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.
4. Covered Persons will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers, including but not limited to liability, no-fault, uninsured and underinsured insurance coverage. The Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.

5. The Covered Person will not act, fail to act, or engage in any conduct directly, indirectly, personally or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Covered Person will not conceal or attempt to conceal the fact that recovery has occurred or will occur.
6. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, except as limited by 2-18-901 and 902, MCA, as amended.

RIGHT OF OFF-SET

The Plan has a right of off-set to satisfy reimbursement claims against Covered Persons for money received by the Covered Person from a third party, including any insurer. If the Covered Person fails or refuses to reimburse the Plan for funds paid for claims, the Plan may deny payment of future claims of the Covered Person, up to the full amount paid by the Plan and subject to reimbursement for such claims. This right of off-set applies to all reimbursement claims owing to the Plan whether or not formal demand is made by the Plan, and notwithstanding any anti-subrogation, "common fund," "made whole" or similar statutes, regulations, prior court decisions or common law theories.

PLAN ADMINISTRATION

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of Eligible Expenses for dental services. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees and their covered Dependents.

EFFECTIVE DATE

The effective date of the Plan is August 1, 1989.

PLAN YEAR

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

PLAN SPONSOR

The Plan Sponsor is City of Helena.

PLAN SUPERVISOR

The Supervisor of the Plan is Allegiance Benefit Plan Management, Inc.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is the City of Helena, a political subdivision of the State of Montana, who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits under this Plan.

PLAN INTERPRETATION

The Named Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Final authority to interpret and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator made in good faith will be final and binding.

CONTRIBUTIONS TO THE PLAN

The amount of contributions to the Plan are to be made on the following basis:

The City will periodically evaluate the costs of the Plan and determine the amount to be contributed by the City, if any, and the amount to be contributed, if any, by each Participant.

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

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Plan Document contains all the terms of the Plan and may be amended at any time by the Plan Administrator. Any changes will be binding on each Participant and on any other Covered Persons referred to in this Plan Document. The authority to amend the Plan is delegated by the Plan Administrator to the City Manager, as recommended by the Insurance Committee or any other individual designated by the City's management. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the City Manager or any other individual designated by the City management, pursuant to a resolution by the City Council, granting that individual the authority to amend, modify, revoke or terminate this Plan. A copy of said resolution will be supplied to the Plan Supervisor. Written notification of any amendments, modifications, revocations or terminations will be given to Plan Participants within one-hundred and twenty (120) days of such decision, except for notices of reduction of benefits.

NOTICE OF REDUCTION OF BENEFITS

All changes or amendments to this Plan that directly or indirectly reduce any benefit or coverage under the Plan, including any increase in contribution for coverage required from a Participant, will be reported to all eligible Participants and Dependents within sixty (60) days of the date such change or amendment is adopted.

TERMINATION OF PLAN

The City reserves the right at any time to terminate the Plan by a written notice. All previous contributions by the City will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

SUMMARY PLAN DESCRIPTIONS

Each Participant covered under this Plan will be issued a Summary Plan Description (SPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits, the limitations and exclusions of the Plan and summarizing the provisions of the Plan.

GENERAL PROVISIONS

EXAMINATION

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

PAYMENT OF CLAIMS

All Plan benefits are payable to a Participant, Qualified Beneficiary or Alternate Recipient, whichever is applicable. All or a portion of any benefits payable by the Plan may, at the Covered Person's option and unless the Covered Person requests otherwise in writing not later than the time of filing the claim, be paid directly to the health care provider rendering the service, if proper written assignment is provided to the Plan. No payments will be made to any provider of services unless the Covered Person is liable for such expenses.

If any benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate. The Plan, in its sole option, may require that an estate, guardianship or conservatorship be established by a court of competent jurisdiction prior to the payment of any benefit. Any payment made under this subsection will constitute a complete discharge of the Plan's obligation to the extent of such payment and the Plan will not be required to oversee the application of the money so paid.

LEGAL PROCEEDINGS

No action at law or equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor will such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan will be waived, and there will be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

VERBAL STATEMENTS

Verbal statements or representations of the Plan Administrator, its agents and Employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and Employees, or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF DENTAL SERVICE PROVIDER

The Covered Person will have free choice of any legally qualified Dental Service Provider.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the applicable law. Only that provision which is contrary to applicable law will be amended to conform; all other parts of the Plan will remain in full force and effect.

MISCELLANEOUS

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which will become due to any Participant, the Plan Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Plan Document constitutes the primary authority for plan administration. The establishment, administration and maintenance of this Plan will not be deemed to constitute a contract of employment, give any Participant of the City the right to be retained in the service of the City, or to interfere with the right of the City to discharge or otherwise terminate the employment of any Participant.

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below. If the defined term is not used in this document, the term does not apply to this Plan.

Masculine pronouns used in this Plan Document will include either the masculine or feminine gender unless the context indicates otherwise.

Any words used herein in the singular or plural will include the alternative as applicable.

ACTIVE SERVICE

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

ADVERSE BENEFIT DETERMINATION

“Adverse Benefit Determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Dentally Necessary or appropriate.

AMBULATORY SURGICAL CENTER

“Ambulatory Surgical Center” (also called same-day surgery center or outpatient surgery center) means a licensed establishment with an organized staff of physicians and permanent facilities, either freestanding or as a part of a hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for surgical facilities in the state in which the facility is located. “Ambulatory Surgical Center” does not include an office or clinic maintained by a dentist or physician for the practice of dentistry or medicine, a hospital emergency room or trauma center.

BENEFIT PERCENTAGE

“Benefit Percentage” means that portion of Eligible Expenses payable by the Plan, which is stated as a percentage in the Schedule of Benefits.

BENEFIT PERIOD

“Benefit Period” refers to a time period of one year, which is either a Calendar Year or Plan Year, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or
2. The day the Maximum Lifetime Benefit applicable to the Covered Person becomes paid; or
3. The date the Plan terminates.

CALENDAR YEAR

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

CHAMPUS

“CHAMPUS” means the medical benefits and programs provided by the Civilian Health and Medical Program of the Uniformed Services. CHAMPUS will include programs established under its authority, known as TRICARE standard, TRICARE Extra and TRICARE Prime.

CLOSE RELATIVE

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

COBRA

“COBRA” means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. §300bb-1 through §300bb-8], which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

“COBRA Continuation Coverage” means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of “COBRA”.

CITY

“City” means the City of Helena or any affiliated agencies or boards that have adopted this Plan for its Employees.

COSMETIC

“Cosmetic” means services or treatment ordered or performed solely to change a Covered Person's appearance rather than for the restoration of bodily function.

COVERED PERSON

“Covered Person” means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

DEDUCTIBLE

“Deductible” means a specified dollar amount of Eligible Expenses that must be incurred before the Plan will pay any amount for any Eligible Expense during each Benefit Period.

DENTAL HYGIENIST

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

DENTALLY NECESSARY

“Dentally Necessary” means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose a Dental condition or dental disease; and,
2. Are ordered by a Dentist or Licensed Health Care Provider and consistent with the symptoms or diagnosis and treatment of the dental condition or dental disease; and,
3. Are not primarily for the convenience of the Covered Person, Dentist or other Licensed Health Care Provider; and,
4. Are the standard or level of services most appropriate for good dental practice that can be safely provided to the Covered Person; and,
5. Are not of an Experimental/Investigational or solely educational nature; and,
6. Are not provided primarily for dental, medical or other research; and,
7. Do not involve excessive, unnecessary or repeated tests; and,
8. Are commonly and customarily recognized by the dental profession as appropriate in the treatment or diagnosis of the diagnosed condition; and,
9. Are approved procedures or guidelines by the Food and Drug Administration, Healthcare Financing Administration (HCFA), the American Dental Association, pursuant to that entity’s program oversight authority based upon the dental treatment circumstances.

DENTIST

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

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

DENTURIST

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

DEPENDENT

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

DEPENDENT COVERAGE

“Dependent Coverage” means eligibility for coverage under the terms of the Plan for benefits payable as a consequence of Eligible Incurred Expenses for a dental condition or dental disease of a Dependent.

DOMESTIC PARTNER¹⁰

“Domestic Partner” means a person who meets the following definition:

1. Neither partner is or has been for the past 6 months, married, legally separated, a cohabiter or a Domestic Partner to another;
2. The partners have cohabitated for at least 6 months and continue to cohabitate;
3. The partners are at least 18 years of age and mentally competent to consent to contract and mentally competent to execute the required Affidavit;
4. The partners are not related by blood to a degree that would bar marriage in the State of Montana;
5. The partners are each other’s sole Domestic Partner and intend to remain so indefinitely; and
6. The partners are responsible for each other’s common welfare and have a financial interdependent relationship evidenced by any of the following:
 - A. Mutually granted financial or health care powers of attorney;
 - B. Designation of each other as primary beneficiary in wills, life insurance policies or retirement plans;
 - C. Executed a joint least, mortgage or deed; or
 - D. Have joint ownership of a banking account.

ELIGIBILITY DATE

“Eligibility Date” means that first day of the first week during which the Employee is regularly scheduled to work the number of hours per week required by this Plan to become eligible for coverage.

ELIGIBLE EXPENSES

“Eligible Expenses” means the maximum amount of any charge for treatment, service or supplies listed as Covered Services and that are not specifically excluded by the Plan and which meet all the requirements outlined in the Covered Expenses provision may be considered for payment by the Plan, including any portion of that charge that may be applied to the Deductible. Eligible Expenses are equal to the actual billed charge or UCR, whichever is less.

EMPLOYEE

“Employee” means a person employed by the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer’s W-2 payroll.

Employee does not include any employee leased from another employer, including but not limited to those individuals defined in Code Section 414(n), or an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such persons are on the Employer’s W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as “Kelly,” “Manpower,” etc.

¹⁰ “Domestic Partner” definition (General Definitions) is added by Amendment #4 effective 7/1/2010

EMPLOYER

“Employer” means the City or any affiliated agencies or boards that have adopted this Plan for its Employees.

ERISA

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

EXPERIMENTAL/INVESTIGATIONAL

“Experimental/Investigational” means:

1. Any drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The services, supplies, treatments or procedures are not recognized in the dental community as an accepted standard of dental care or not dentally necessary for the diagnosis and/or treatment of an active dental condition or dental disease; or
3. Any drug, device, dental treatment or procedure for which the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
4. Based upon Reliable Evidence, any drug, device, treatment or procedure that is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under ongoing study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally dentally accepted means of treatment or diagnosis; or
5. Based upon Reliable Evidence, any drug, device, treatment or procedure that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally accepted means of treatment or diagnosis; or
6. Any drug, device, treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, Health Care Financing Administration, American Dental Association, American Medical Association).

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

FACILITY MISCELLANEOUS EXPENSE

“Facility Miscellaneous Expense” means the actual charges made by a health care facility on its own behalf for services and supplies rendered to a Covered Person which are dentally necessary for the treatment of such Covered Person. Facility Miscellaneous Expenses will also include additional fees charged by the dental service provider which fees are for the use of the facility or professional service fees which are increased for the use of the facility.

FAMILY

“Family” means a Participant and his or her eligible Dependents as defined herein.

FMLA

“FMLA” means Family and Medical Leave Act.

HOSPITAL

“Hospital” means an institution which meets all of the following conditions:

1. It is engaged primarily in providing dental care and treatment to ill and injured persons on an Inpatient basis at the patient's expense; and
2. It is licensed as a Hospital under authority of the laws of the jurisdiction in which the facility is physically located; and
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and dental and surgical treatment of an Illness or an Injury; and
4. It provides treatment for compensation by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses (R.N.'s); and
5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and
6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

ILLNESS

“Illness” means a bodily disorder, Pregnancy, disease, physical sickness, mental illness, or functional nervous disorder of a Covered Person.

INCURRED EXPENSES OR EXPENSES INCURRED

“Incurred Expenses” or “Expenses Incurred” means those services and supplies rendered to a Covered Person. Such expenses will be considered to have occurred at the time or date the treatment, service or supply is actually provided.

INITIAL ENROLLMENT PERIOD

“Initial Enrollment Period” means the time allowed by this Plan for enrollment when a person first becomes eligible for coverage.

INJURY

“Injury” means physical damage to the Covered Person's natural teeth or gums sustained as a result of an external force or forces and which is not caused by disease or bodily infirmity.

LATE ENROLLMENT OR LATE ENROLLEE

“Late Enrollment” or “Late Enrollee” means an eligible person who makes application for Participant or Dependent Coverage under this Plan other than during the Initial Enrollment Period or any other enrollment opportunity provided under the terms of this Plan.

LICENSED HEALTH CARE PROVIDER

“Licensed Health Care Provider” means any provider of health care services who is licensed or certified by any applicable regulatory authority to the extent that services are within the scope of its license or certification.

MAXIMUM LIFETIME BENEFIT

“Maximum Lifetime Benefit” means the maximum benefit payable while a person is covered under this Plan. It will not be construed as providing lifetime coverage, or benefits for a person’s Dental condition or dental disease after coverage terminates under this Plan.

MEDICAID

“Medicaid” means that program of dental care and coverage established and provided by Title XIX of the Social Security Act, as amended.

MEDICARE

“Medicare” means the programs established under the “Health Insurance for the Aged Act,” Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those age 65 or older, those with end-stage renal disease, or with disabilities.

NAMED FIDUCIARY

“Named Fiduciary” means the Plan Administrator which has the authority to control and manage the operation and administration of the Plan.

ORTHODONTIC TREATMENT

“Orthodontic Treatment” means an appliance or the surgical or functional/myofunctional treatment of dental irregularities which either result from abnormal growth and development of the teeth, gums or jaws, or from Injury which requires the positioning of the teeth to establish normal occlusion.

ORTHODONTIST

“Orthodontist” means a Dentist with special training who uses braces or corrective appliances to straighten teeth, correct jaw position and improve facial balance.

PARTICIPANT

“Participant” means an Employee of the City who is eligible and enrolled for coverage under this Plan.

PLAN

“Plan” means the Dental Benefit Plan for Employees of the City, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

“Plan Administrator” means the City and/or its designee which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purposes of the Employee Retirement Income Security Act of 1974, as amended, and any applicable state legislation of a similar nature, the City will be deemed to be the Plan Administrator of the Plan unless the City designates an individual or committee to act as Plan Administrator of the Plan.

PLAN SUPERVISOR

“Plan Supervisor” means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Plan Supervisor is Allegiance Benefit Plan Management, Inc. The Plan Supervisor provides ministerial duties only, exercises no discretion over plan assets and will not be considered a fiduciary as defined by ERISA (Employee Retirement Income Security Act) or any other State or Federal law or regulation.

PROSTHETIC APPLIANCE

“Prosthetic Appliance” means a device or appliance that is designed to replace all or part of a missing tooth or teeth.

QUALIFIED BENEFICIARY

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

“Qualified Beneficiary” will also include a child born to, adopted by or placed for adoption with an Employee or former Employee at any time during COBRA Continuation Coverage.

QMCSO

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

RETIREE

“Retiree” means an Employee who retires under a retirement program authorized by law and eligible to continue coverage with the Employer pursuant to the terms of 2-18-704 MCA as amended from time to time.

USERRA

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act, as amended.

USUAL, CUSTOMARY AND REASONABLE FEE (UCR)

The “UCR” means the amount established by the commercially published data base utilized by the Plan Supervisor and adopted by the Plan Administrator which commercial data base provides published UCR fees for Eligible Expenses.

RETIREMENT OF PUBLIC EMPLOYEES¹¹

Unless otherwise provided for by collective bargaining agreement or City policy, for groups composed of public employees and officers, an employee who retires from Active Service while the Plan is still in force and subject to the terms of 2-18-704 MCA, or other applicable law, may continue to remain a member of the Health Benefits Plan.

SPOUSE AND DEPENDENT CHILDREN COVERAGE

The spouse of a retired covered employee may remain a member of the group subject to the terms of 2-18-704 MCA, as long as the spouse is eligible for retirement benefits accrued by the deceased covered employee.

The surviving spouse of a retired covered employee shall be provided the opportunity to remain a member of the group subject to the terms of 2-18-704 MCA, as long as the spouse is eligible for retirement benefits accrued by the deceased covered employee.

The surviving children of a deceased covered employee may remain members of the group subject to the terms of 2-18-704 MCA, as long as they meet the eligibility provisions of this plan and are eligible for retirement benefits accrued by the deceased covered employee.

¹¹ Retirement of Public Employees section replaced entirely in Amendment #1 (1/1/06).

NOTICES

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

IDENTIFICATION OF FUNDING: Your benefits under this plan will be paid from employee or employer contributions up to the limits defined in the Plan Document and Summary Plan Description (SPD).

HIPAA PRIVACY AND SECURITY STANDARDS¹²

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

“Protected Health Information” (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the physical or mental health of an individual; health care that individual has received; or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an employer.

“Summary Health Information” means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the zip code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or plan participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Documents have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law. Such uses or disclosures may be for the purposes of plan administration, including but not limited to, the following:
 - A. Operational activities such as quality assurance and utilization management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.
 - B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for medical necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.
 - C. For purposes of this certification, plan administration does not include disclosing Summary Health Information to help the plan sponsor obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a participant in; is an enrollee of or has disenrolled from the group health plan.
2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

¹² HIPAA Privacy Information section replaced in HIPAA Privacy and Security Standards Amendment 4-20-2005.

3. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;
6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;
7. Make available the information required to provide an accounting of disclosures as required by the regulations;
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document or employees designated by the Plan Administrator(s) who need to know that information to perform plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan Documents have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.
2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.
3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.
4. Report to the Plan Administrator or the Named Fiduciary of the Plan any attempted breach, or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

**DENTAL BENEFIT PLAN FOR EMPLOYEES OF
CITY OF HELENA
PLAN SUMMARY**

The following information, together with the information contained in this booklet, form the Summary Plan Description.

1. PLAN

The name of the Plan is the DENTAL BENEFIT PLAN FOR THE EMPLOYEES OF CITY OF HELENA, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

This Plan provides benefits for covered expenses incurred by eligible participants for:

Dental and other eligible dentally related, necessary expenses.

3. PLAN EFFECTIVE DATE

This Plan was established effective August 1, 1989.

4. PLAN SPONSOR

Name: City of Helena
Address: 316 N. Park Ave.
Helena, MT 59623

5. PLAN ADMINISTRATOR

The Plan Administrator is the Plan Sponsor.

6. NAMED FIDUCIARY

Name: City of Helena
Address: 316 N. Park Ave.
Helena, MT 59623

8. PLAN FISCAL YEAR

The Plan fiscal year ends June 30.

9. PLAN TERMINATION

The right is reserved by the Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

10. IDENTIFICATION NUMBER

Plan Number: 501
Group Number: 0010652
Employer Identification Number: 81-6001276

11. PLAN SUPERVISOR

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

12. ELIGIBILITY

Employees and dependents of employees of the Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

13. PLAN FUNDING

The Plan is funded by contributions from the employer and employees.

14. AGENT FOR SERVICE OF LEGAL PROCESS

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