APPENDIX 2

Employee Benefits Program

Dental Plan I
Adult/Child Orthodontic $2,000

Plan Document
Effective Date: July 1, 2008

Revised: July 1, 2015

CLAIM ADMINISTRATOR

Delta Dental Insurance Company
1130 Sanctuary Parkway
Suite 600
Alpharetta, GA 30009
(770) 641-5100
(800) 521-2651

AUTOMATED INFORMATION LINE

You may access Delta Dental's automated information line on a regular business day to obtain Employee eligibility and Benefits, group Benefit or claim status information or to speak to a Customer Service Representative for assistance.

(800) 521-2651

To find a Delta Dental Dentist, visit deltadentalins.com

Website:
Customer Service
Provider Directory
Other Features: deltadentalins.com

DENTAL BENEFIT PLAN FOR EMPLOYEES OF MONTANA MUNICIPAL INTERLOCAL AUTHORITY (MMIA)

PLAN OPERATION

Plan Name
Montana Municipal Interlocal Authority (MMIA) Employee Benefits Program

Plan Sponsor
Montana Municipal Interlocal Authority (MMIA)
3115 McHugh Drive
P.O. Box 6669
Helena, MT 59604-6669

Plan Number
PN 501

Plan Sponsor's Identification Number
81-0436312

Plan Benefit Year
January 1 through December 31

Plan Year
The date for purposes of maintaining the plan's fiscal records is July 1 through June 30.

Plan Administrator
Montana Municipal Interlocal Authority (MMIA)
3115 McHugh Drive
P.O. Box 6669
Helena, MT 59604-6669

Named Fiduciary(ies)
Montana Municipal Interlocal Authority (MMIA)
3115 McHugh Drive
P.O. Box 6669
Helena, MT 59604-6669

Claim Administrator
Delta Dental Insurance Company
1130 Sanctuary Parkway
Suite 600
Alpharetta, GA 30009
(770) 641-5100
(800) 521-2651

Claim Administrator's Disclosures

Delta Dental PPO is underwritten by not-for-profit dental service companies in these states: CA – **Delta Dental of California**, PA, MD – **Delta Dental of Pennsylvania**, NY – **Delta Dental of New York**, DE – **Delta Dental of Delaware**, WV – **Delta Dental of West Virginia** and by **Delta Dental Insurance Company** in AL, FL, GA, LA, MS, MT, NV, UT and the District of Columbia.

Funding Mechanism

Benefits under this Plan are funded from employee and employer contributions. Claim payments are made from this fund to pay benefits.

Type of Participants Covered by the Plan

An individual employed by an MMIA Member Entity who is eligible for coverage as determined by the MMIA Member Entity's personnel policy.

Source of Contribution

The MMIA Employee Benefits Program is funded by contributions from the MMIA Member Entity and the Member Entity's employees.

Type of Plan

The Plan provides dental coverage funded from premium contributions by MMIA Member Entities, the Member Entity employee payroll deductions, and premium contributions by self-pay Retirees and COBRA participants. Benefits are provided under the terms and conditions of the group dental benefit contract administered by Delta Dental Insurance Company.

Type of Administration

This is a self-funded plan. Contributions by the MMIA Member Entities, the Member Entity employee payroll deductions, and premium contributions by self-pay Retirees and COBRA participants are used to pay for claims.

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.

Amendment Termination or Modification of the Plan

MMIA reserves the right to amend or terminate the group dental plan in whole or in part at any time, subject to the applicable provisions of the contract and the practices of the insurer.

The Plan will make payment for the dental benefits named in this Plan Document subject to the following conditions:

1. Payments by the Plan will be subject to the terms, conditions, and limitations of the Plan Document and any amendments.
2. Payment will only be made for services that are provided to the Participants after the Effective Date of this Plan and before the date on which the Plan terminates.

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OUTLINE OF COVERAGE

Dental

SCHEDULE OF BENEFITS

Group Name:	**MMIA/DENTAL PLAN I**
Group Number:	***27-0237***
Effective Date:	**July 1, 2008**
Benefit Period:	**Calendar Year** The Benefits are subject to the Benefit Period unless otherwise specified.
Term of Plan Document:	**Monthly**

BENEFITS:	***In-Network***	***Out-of-Network***
*Diagnostic & Preventive Services:**	*100%*	*100%*
Basic Dental Services:	*80%*	*80%*
Major Restorative Services:	*50%*	*50%*
Orthodontic Services:	*50%*	*50%*
DEDUCTIBLES:	*$25 per Enrollee/$50 per family each Calendar Year* *Deductible applies to Basic, Major and Orthodontic Services*	
MAXIMUM AMOUNTS:		
Per Enrollee per Calendar Year:	*$2,000*	
Lifetime Amount for Orthodontic Services for each Enrollee:	*$2,000*	

**Diagnostic & Preventive Services are not subject to the Calendar Year Maximum Amount.*

CHOICE OF DENTIST

Participants are offered a choice in selecting a Dentist from Delta Dental's panel of PPO Dentists and Premier Dentists, or the Participant may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists can be obtained by accessing the Delta Dental National Dentist Directory at deltadentalins.com. The Participant is responsible for verifying whether the Dentist selected is a PPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, the Participant should always confirm with the dentist's office that a listed Dentist is still a contracted PPO Dentist or a Premier Dentist.

PPO Dentist

The PPO program potentially allows the Participant the greatest reduction in their out-of-pocket expenses, since this select group of Dentists in the Participant's area will provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the PPO Dentist.

Premier Dentist

The Premier Dentist, which include specialists (endodontists, periodontists or oral surgeons), has not agreed to the features of the PPO program; however, you may still receive dental care at a lower cost than if you use a Non-Delta Dental Dentist.

Non-Delta Dental Dentist

If a Dentist is a Non-Delta Dental Dentist, the amount charged to the Participant may be above that accepted by the PPO or Premier Dentists. Non-Delta Dental Dentists can balance bill for the difference between the MPA Dentist's Fee and the Non-Delta Dental Dentist's Approved Amount. For a Non-Delta Dental Dentist, the Approved Amount is the dentist's submitted charge.

Additional advantages of using a PPO Dentist or Premier Dentist

1. The PPO Dentist and Premier Dentist must accept assignment of Benefits, meaning PPO Dentists and Premier Dentists will be paid directly by Delta Dental after satisfaction of the deductible and coinsurance, and the Participant does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
2. The PPO Dentist and Premier Dentist will complete the dental claim form and submit it to Delta Dental for reimbursement.

ELIGIBILITY AND COVERAGE

Eligibility for Participation

A person's eligibility to participate in the MMIA Employee Benefits Program is as defined by the applicable MMIA Member Entity.

Declining Coverage

If the MMIA determines that the MMIA Member Entity is eligible to allow their Employees to decline coverage under this Plan, the Employee declining coverage may be required to provide documentation of similar coverage in force at the time this Plan's coverage is being declined.

Retiree Eligibility

A former covered Employee whose employment with the MMIA Member Entity terminates due solely to retirement from the MMIA Member Entity can continue coverage under the Plan as a Retiree. Requirements to be eligible as a Retiree are determined by the applicable MMIA Member Entity's personnel policy.

Coverage will continue for as long as the Retiree is enrolled under this Plan and the applicable premiums are paid either by the MMIA Member Entity or the Retiree or a combination of both the MMIA Member Entity and the Retiree, provided a break in coverage does not occur. If a break in coverage occurs, the Retiree is no longer eligible to participate or re-enroll in this Plan.

The Retiree's termination of coverage from the Plan does not apply to the Retiree's spouse, provided the retiree is terminating because of Medicare coverage. The spouse of a Retiree is permitted to maintain coverage unless the spouse is also eligible for Medicare coverage or the spouse has or is eligible for equivalent coverage.

Enrollment

1. Initial Periods of Enrollment.

   New Employees are eligible for participation within 31 days of eligibility. If the application is made within 31 days of the date of hire or the date the Employee first becomes eligible under the Plan, the Effective Date of coverage for the eligible Employee will be in accordance with the applicable MMIA Member Entity's personnel policy.

   Family Members for whom the eligible Employee becomes legally responsible by reason of birth, marriage, adoption, placement for adoption, guardianship or conservatorship are eligible for participation within 31 days of the date the Employee's responsibility began.

2. Annual Open Enrollment.

   If the Employee does not apply within 31 days of the Employee's hiring or eligibility, the Employee (and Family Members) may not enroll until the next annual open enrollment period, in which case the Effective Date of coverage will be the first day of the next Plan Year.

3. Late Enrollment.

   Employees and Family Members who do not apply within the initial period of eligibility may be considered Late Enrollees and will not be allowed to enroll except as stated below or during an annual open enrollment period.

   A Late Enrollee means an eligible Employee or dependent, other than a special enrollee under the special enrollment provision below, who requests enrollment in a group dental plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group dental plan if the initial enrollment period was a period of at least 31 days. However, an eligible Employee or dependent is not considered a Late Enrollee if a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's dental benefit plan and request for enrollment is made within 31 days after issuance of the court order.

   If an individual is employed by an Employer that offers multiple dental benefit plans, and the individual elects a different plan during an open enrollment period, that individual is not a Late Enrollee.

4. How to Enroll.

   A new Employee should complete the MMIA enrollment form at the time of employment. An enrollment form may be obtained from the MMIA. Coverage will be effective in accordance with the applicable MMIA Member Entity's personnel policy and upon receipt of application by the MMIA.

5. Plan Identification Card.

   All individuals who are enrolled in the Plan will be issued Plan identification cards. The identification card is an important document and should be protected from mutilation or loss. The Participant may need to present the identification card to the Dentist or pharmacies in order to receive benefits under the Plan.

6. Change of Status.

   Any addition or deletion of Family Members under the Plan requires completion of an enrollment form that the Participant may obtain from the MMIA, and may result in the issuance of a new identification card.

Special Enrollment Period

1. Special Enrollment for Loss of Coverage

   A Special Enrollment Period is allowed for eligible Employees and/or dependents who are not currently enrolled and who originally declined coverage because they had other coverage, and:

   - Whose other coverage was as a COBRA covered person and that coverage was exhausted; or
   - Who lost eligibility for the other coverage; or
   - Who were covered on a group plan and the employer terminated contributions to that plan; and
   - Who apply for coverage under this Plan within 31 days of the termination of the other coverage.

2. Special Enrollment for Family Members

   A Special Enrollment Period also occurs when there is a change in family status, such as a birth, adoption, or marriage.

   - In the event of birth or adoption, the Employee's child and the Employee's spouse may enroll within 31 days of the birth or adoption.
   - In the event of a marriage or Domestic Partnership, an Employee previously eligible, but not enrolled, may enroll within 31 days after the marriage. The Employee's new spouse and/or children under age 26 may enroll within 31 days after the marriage.
   - Disabled children, certified as such by a physician, may continue coverage regardless of age are dependent upon the Employee for support and are incapable of self-sustaining employment by reason of developmental disability or physical handicap. The Employee must submit proof of the child's incapacity and dependency within 31 days of the date the dependent's coverage would otherwise terminate. The Employee may be required to submit continuing proof of this dependency and incapacity from time to time.

Effective Date of Coverage

A Participant is entitled to the Benefits of this Plan beginning as of the Participant's Effective Date:

1. The Effective Date of Coverage for a child born to a Participant will be the moment of birth; however, within 31 days of the date of birth, the Plan must be notified and any additional premiums must be paid to the Plan, or the child's coverage will end.
2. The Effective Date of Coverage for a child adopted by or placed for adoption with the eligible Employee, or for whom the eligible Employee has been appointed guardian or conservator will be the date of adoption or placement for adoption. In the event that placement for adoption is disrupted prior to legal adoption and the child is removed from placement, coverage shall cease upon the date the placement is disrupted. Coverage shall cease upon the date that guardianship or conservatorship is legally terminated.
3. The Effective Date of Coverage due to marriage for a spouse or Domestic Partnership of the eligible Employee will be the 1st of the month following receipt of the application for coverage of the spouse.

4. The Effective Date of Coverage for those who had a special enrollment due to loss of coverage will be no later than the 1st of the month following receipt of the application.

   Individuals enrolling during a special enrollment period are **NOT** Late Enrollees.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Participant can obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Claim Administrator.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

1. The Family and Medical Leave Act of 1993 (FMLA) requires Employers, who employ at least 50 workers within a 75 mile radius of the workplace, to provide eligible Employees with up to 12 weeks of leave during any 12-month period for any of the following reasons:
   a. To care for a newborn child;
   b. Because a child has been placed with the Employee for adoption or foster care;
   c. To care for the Employee's spouse, child, or parent, who has a serious health condition;
   d. The Employee's own serious health condition makes the Employee unable to perform his or her job.
2. Eligible Employees are those who have been employed by that Employer for at least 12-months and who have worked at least 1,250 hours for that Employer during the previous 12-month period.
3. The health Benefits of an Employee and dependents, if any, will be maintained during FMLA leave on the same terms and conditions is if the Employee had not taken leave.
4. The health Benefits of an Employee and dependents, if any, may lapse at the Employer's discretion during FMLA leave if the Employee does not pay his or her share of the premiums in a timely manner or if the Employee does not elect health Benefits during the FMLA leave. Upon return from leave, the Employee and dependents, if any, will be reenrolled in the health Benefit plan as if the coverage had not lapsed.
5. The Employee's reenrollment in the health plan will be effective upon the date on which the Employee returned to work.
6. An Employee who takes FMLA leave and fails to pay any required premium contribution or fails to return from leave will be entitled to COBRA coverage for the maximum COBRA coverage period beginning when the FMLA coverage terminated.

TERMINATION OF COVERAGE

Coverage under the Plan will terminate under the following circumstances:

1. **Termination When the Participant is No Longer Eligible for Coverage**

   The Participant's and enrolled Family Member's participation in the Plan will terminate the last day of the month in which the Participant becomes ineligible for coverage.

2. **Termination for Nonpayment of Premium**

   If the Participant's premiums are not paid when due, coverage will terminate automatically for the eligible Employee and enrolled Family Members.

3. **Termination of Coverage of Children, Spouse and Domestic Partner.**

Coverage will terminate automatically at midnight, Mountain Standard Time, on the last day of the month in which a child reaches age 26. Coverage for a spouse or Domestic Partner will terminate at midnight, Mountain Standard Time, on the last day of the month in which the spouse's or Domestic Partner's marriage to the eligible Employee is terminated.

4. **Termination of Retiree Coverage**

Benefits for Retirees will terminate under the following circumstances:

- If premiums are not paid.
- When the Retiree or their dependents are no longer eligible to receive benefits in accordance with the applicable MMIA Member Entity's personnel policy.

It is the Retiree's legal responsibility to notify the MMIA if eligibility is lost, as defined above.

Termination of Benefits or Termination of Coverage

When the participation of an eligible Employee and/or Family Members is terminated for any reason listed in this section or any other section of this Plan, the Benefits of this Plan will no longer be provided, and the Plan will not make payment for services provided to the Employee and/or Family Members.

DISPUTE RESOLUTION PROCESS

Please note that in some instances, the Plan or Plan Sponsor may have delegated certain functions under this section to the Claim Administrator. The Participant may receive decisions and/or notices from the Claim Administrator instead of from the Plan or Plan Sponsor.

Dispute Resolution Process

In the event that a Participant is aggrieved by a coverage determination, the Participant may appeal the coverage determination in accordance with the following timelines and processes:

Level One

Within one hundred eighty (180) days of receipt of notice of a coverage determination, the Participant may request, in writing or verbally, that the Plan conduct a review of the coverage determination. The Participant's request will be acknowledged within ten (10) days of receipt of the request. The Plan will conduct the review and inform the Participant whether or not an error was made within sixty (60) days. Any errors will be corrected promptly.

Requests for a Level One review should include a copy of the Explanation of Benefits (EOB) and any other pertinent information. Send all information to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023
(800) 521-2651

Level Two

If the Participant is not satisfied with the results of the initial review, a written request for a second review may be submitted within thirty (30) days of receipt of the initial review determination. The request should state in clear and concise terms the reason for disagreement with the coverage determination. The request must be submitted to the MMIA's independent dental consultant for further review. The independent dental consultant will acknowledge the Participant's request shortly after receipt of the request. At this time the Participant may be asked by the independent dental consultant to provide additional information that the consultant may deem pertinent and necessary relative to the coverage determination being reviewed. The results of the Level Two

review will be furnished in writing to the Participant, in most cases within sixty (60) days, but in no case more than one hundred twenty (120) days.

Requests for a Level Two review should include a copy of the Explanation of Benefits (EOB) and any other pertinent information. Send all information to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023
(800) 521-2651

Level Three

The Plan Administrator, the Montana Municipal Interlocal Authority (MMIA), is the sole fiduciary of the Plan and exercises all discretionary authority and control over the administration of the Plan and the management and disposition of Plan assets. If the Participant is not satisfied with the results of the Level Two review, a written request may be submitted to the MMIA within thirty (30) days of the receipt of the Level Two review determination. As the Plan Administrator, the MMIA may convene a meeting during which the Participant may appeal the adverse determination to the Board of Directors or an appeals committee established by the Board of Directors. During this meeting the Participant and/or the Participant's representative may present the merits of the Participant's appeal. The MMIA may accept, reject, or modify in whole or in part the initial coverage determination which is the subject of the appeal Level One and Level Two and shall render its decision within ten (10) business days after the meeting. The decision of the MMIA under Level Three of the appeal process is final.

Requests for a Level Three review should include a copy of the Explanation of Benefits (EOB) and any other pertinent information. Send all information to:

Montana Municipal Interlocal Authority
P.O. Box 6669
Helena, MT 59604

Prior Authorization

Prior Authorization is **recommended** for some services and supplies to help the Participant identify potential expenses, payment reductions, or claim denials the Participant may have if the proposed services, supplies, medications, or ongoing treatment are not Dentally Necessary or not a Covered Dental Expense of the Plan. For Prior Authorization of services and/or supplies, the Participant should contact the Claim Administrator.

Prior Authorization is not a guarantee of payment by the Plan.

The Prior Authorization process may require additional documentation from the Participant's Dentist or pharmacist for some services. In these cases, a written request for Prior Authorization must be submitted to the Plan by the Dentist and should include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc.

If a Participant does not obtain Prior Authorization, a retrospective review will be performed after the claims have been submitted to determine whether or not the services, supplies, or treatment were Dentally Necessary and performed in the appropriate setting. The Participant will be responsible for charges for any services, supplies, or treatment which were not performed in the appropriate setting or which were not Dentally Necessary.

Contact the Plan at the number listed on the inside cover of this Plan Document for Prior Authorization.

CONTINUATION OF COVERAGE

USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if the Participant is covered under this Plan on the date USERRA leave of absence begins, the Participant may

continue dental coverage for themselves and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of: 24 months beginning on the date the leave of absence begins or the date the Participant fails to return to work within the time required by USERRA. For USERRA leave that extends beyond 31 days, the cost of coverage for continuation of coverage will be the same as for COBRA coverage.

COBRA

The following is a brief summary of the continuation of coverage provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments. Administration of the provisions will be in accordance with federal law.

Employers maintaining group health coverage plans must provide for the continuation of coverage for qualified beneficiaries when coverage is lost. To lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before the event. A loss of coverage need not occur immediately after the event so long as the loss of coverage occurs before the end of the maximum COBRA coverage period. A qualified beneficiary is entitled to the coverage made available to similarly situated employees.

1. Qualified Beneficiaries. Continuation of coverage is available to qualified beneficiaries. A qualified beneficiary is:

    a. Any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the spouse of a covered employee, or the dependent child of a covered employee; or

    b. Any child born to or placed for adoption with a covered employee during a period of COBRA continuation.

    Persons added to a qualified beneficiary's COBRA coverage (e.g., a new spouse or a person added as the result of a HIPAA Special Enrollment event) do not become qualified beneficiaries in their own right.

    Nonresidents – An individual is not a qualified beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who did not receive earned income from the individual's employer (within the meaning of Section 911(d)(2)) that constituted income from sources within the United States (within the meaning of Section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

2. Qualifying Events. A qualifying event is any of a set of specified events that occurs while a group health plan is subject to COBRA and the event causes the covered employee (or the spouse or dependent of a covered employee) to lose coverage under the Plan. The qualifying events are:

    a. Qualifying events for employees, for purposes of this section, are the following events, if such event results in a loss of eligibility or coverage under this Plan:

        1. The termination (other than by reason of gross misconduct) of the employee's employment.

        2. The reduction in hours of the employee's employment.

    b. Qualifying events for covered dependents, for purposes of this section are the following events, if such event results in a loss of eligibility or coverage under this Plan:

        1. Death of the employee.

        2. Termination of the employee's employment.

        3. Reduction in hours of the employee's employment.

        4. The divorce or legal separation of the employee from his or her spouse.

        5. The employee's entitlement to Medicare.

        6. A covered dependent child ceases to be a dependent as defined by the Plan.

c. Qualifying events for covered Retirees, for purposes of this section are:

Bankruptcy, if the covered Retiree retired on or before the date of any substantial elimination of group health coverage due to bankruptcy.

d. Qualifying events for the dependents of covered Retirees, for purposes of this section are:

Bankruptcy, if the dependent was a qualified beneficiary of a covered Retiree on or before the day before the bankruptcy-qualifying event.

3. Period of Coverage. A qualified beneficiary may continue coverage for up to 18 months when the covered employee lost coverage due to one of the following qualifying events:

a. A reduction in work hours; or

b. Voluntary or involuntary termination of employment for reasons other than gross misconduct.

4. Period of Coverage. A qualified beneficiary may continue coverage for up to 36 months when the covered employee or dependent lost coverage due to one of the following qualifying events:

a. Death of the employee;

b. The divorce or legal separation of the employee from his or her spouse;

c. The employee's entitlement to Medicare; or

d. A covered dependent child ceases to be a dependent as defined by the Plan.

5. Extension of Coverage. Coverage may be extended in the following instances:

a. Disability

A qualified beneficiary may be entitled to a disability extension of 11 additional months. If a qualified beneficiary is entitled to the extension, which shall not extend the total period of continuation coverage beyond 29 months, the extension applies to each qualified beneficiary who is not disabled, as well as to the disabled beneficiary, and applies to each qualified beneficiary independently. To qualify for a disability extension, the following requirements must be met:

1. The qualifying event is a termination or reduction of hours of a covered employee's employment;

2. The individual who is the qualified beneficiary in connection with the qualifying event described under 5.a.(1) above is determined under the Social Security Act to have been disabled at any time during the first 60 days of the COBRA continuation coverage. For this purpose, the period of the first 60 days of the COBRA continuation coverage is generally measured from the date of the qualifying event described 5.a.(1) above. In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption. An individual is determined to be disabled within the first 60 days of COBRA continuation coverage if the individual has been determined under Title II or XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage and has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage.

Each qualified beneficiary is responsible for notifying the COBRA administrator within 30 days after the date of any final determination under the Social Security Act that the qualified beneficiary is no longer disabled.

b. Second Qualifying Event

The qualified beneficiary may continue coverage up to 36 months if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month maximum coverage period (or within that 29-

month period, in the case of a disability extension) by a second qualifying event. In such cases the original 18-month period (or the 29-month period in the case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event. Limitations may apply to the second qualifying event. Contact the Claims Administrator at the customer service number and address listed on the back of this document for the specific information on the extension because of a second qualifying event.

c. Bankruptcy Extension

If the Participant is covered as a Retiree, the Participant may elect to continue coverage until the Participant's death if the Participant loses coverage because the employer files for bankruptcy protection under Chapter 11 of the U.S. Bankruptcy Code. The Participant's covered dependents may elect to continue their coverage for an additional 36 months after the Participant's death.

6. Trade Adjustment Assistance (TAA) Eligible Employees. Employees who lost coverage as the result of termination or reduction of hours and who qualify for TAA under the Trade Act of 1974 as amended in 2002 are entitled to a second opportunity to elect COBRA coverage, if such coverage was not elected within the first 60 days after coverage is lost.

The second COBRA election period provisions are effective for individuals with respect to whom petitions for certification for trade adjustment assistance are filed on or after November 4, 2002. The second election period begins on the first day the employee began receiving TAA (or would have become eligible to begin receiving TAA but for exhaustion of unemployment compensation), but only if made within six months after group health coverage is lost.

This coverage may continue for 18 months from the date COBRA coverage begins. When the employee elects coverage, the election can include coverage for previously covered Dependents. Dependents are not qualified beneficiaries in their own right under this provision and therefore do not have an independent election.

7. Notification. To ensure continuation of coverage, the following notices must be given:

a. The covered employee or a qualified beneficiary must notify the employer within 60 days of divorce or legal separation or changes in the dependent status. The Employee must also notify the employer of a Medicare disability determination. The notification requirement for a disability extension is set forth in Section 5.a.(2).

b. In the cases of divorce, legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, to ensure continuation of coverage, the covered employee or qualified beneficiary must notify the COBRA administrator or the Plan Administrator within 60 days of the date of the qualifying event. In the case of divorce or legal separation, a single notice sent by or on behalf of the covered employee or any one of the qualified beneficiaries affected by the qualifying event satisfies the notice requirement for all qualified beneficiaries.

c. If the employer is not the COBRA administrator, the employer must notify the COBRA administrator within 30 days of the following events:

1. The employee's death;

2. The employee's termination (other than for gross misconduct);

3. Reduction in work hours of employment;

4. The covered employee becoming entitled to Medicare; and

5. A proceeding in bankruptcy with respect to an employer from whose employment a covered employee retires.

d. The COBRA administrator will then notify qualified beneficiaries of their right to continued coverage within 14 days after receiving notice of the qualifying event.

   If the employer is the COBRA administrator, the employer must notify qualified beneficiaries of their right to continued coverage within 44 days after the occurrence of the qualifying events described in the section entitled "Qualifying Events."

8. Notification for Election of Coverage. If a qualified beneficiary elects to continue coverage, notice must be given to the employer or COBRA administrator within 60 days from the date the qualified beneficiary would lose coverage on account of the qualifying event or 60 days from the date that notice of continuation rights is provided to the qualified beneficiary, whichever is later. An election is deemed to be made when it is sent to the employer or the COBRA administrator.

9. Payment of Premium. The first premium payment must be made within 45 days of the date of the election of COBRA continuation coverage and must include payments retroactive to the date coverage would normally have terminated under the Plan. Subsequent payments must be made within 30 days after the first day of each coverage period. Payment is considered to be made on the date payment is sent to the Employer or COBRA administrator. If the premium is not paid by the first day of the coverage period, a grace period of 45 days will be allowed for payment.

10. Termination of Continued Coverage. Any of the following events will result in termination of coverage prior to expiration of the 18-month, 29-month, or 36-month period:

    a. The last day of the maximum required period under COBRA;

    b. The first day for which timely payment is not made to the Plan with respect to the qualified beneficiary;

    c. The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

    d. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan; and

    e. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

BENEFITS

The Plan will pay for the following Covered Dental Expenses when Dentally Necessary and provided by a licensed Dentist. Payment is based on the Contract Allowance and is subject to the Deductibles, Coinsurance and other provisions, as applicable.

Benefits outlined in this section are subject to any specific exclusions identified for that specific Benefit and to the exclusions and limitations outlined in the Exclusions and Limitations section.

Dental Services (Non-Accident)

Type 1 – Diagnostic and Preventive Services

Diagnostic:	procedures to assist the Dentist in choosing required dental treatment.
Preventive:	prophylaxis (cleaning, periodontal cleaning in the presence of gingival inflammation is considered to be periodontal (a Basic Benefit) for payment purposes), topical application of fluoride solutions and space maintainers.
Sealants:	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits for the purpose of preventing decay.
Palliative:	treatment to relieve pain.

Additional benefits during pregnancy

When the Participant or dependent spouse is pregnant, the Plan will pay for additional services to help improve the oral health of the Participant or dependent spouse during the pregnancy. The additional services each Calendar Year while the Participant or dependent spouse is covered under this Plan include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Participant or dependent spouse or her dentist when the claim is submitted.

Limitations on Diagnostic and Preventive Services

1. The Plan will pay for routine oral examinations and cleanings (including periodontal cleanings) no more than twice in any Calendar Year while the person is an Enrollee under the dental care program provided by MMIA. Note that periodontal cleanings are covered as a Basic Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.

2. Full-mouth x-rays and panoramic x-rays are limited to once every three (3) years while the person is an Enrollee under the dental care program provided by MMIA.. This will count as one (1) of two (2) sets of x-rays payable during the Calendar Year.

3. Bitewing x-rays are provided twice in any Calendar Year per Enrollee.

4. Topical application of fluoride solutions is provided twice in any Calendar Year for Enrollees under age 19.

5. Space maintainers are limited to the initial appliance only and to Enrollees under age 14.

6. Dental sealants are limited to Enrollees under age 16 (payable once per tooth in a lifetime).

Type 2 – Basic Dental Services

Oral Surgery:	extractions and other surgical procedures (including pre-and post-operative care).
General Anesthesia & I.V. Sedation:	when administered by a Dentist for covered oral surgery, implants or selected endodontic and periodontal surgical procedures.
Endodontics:	treatment of the tooth pulp.
Periodontics:	treatment of gums and bones supporting teeth.
Restorative:	amalgam, synthetic porcelain, plastic restorations (fillings), composite resin, prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay), crown repair and temporary crown.
Denture Repairs:	repair to partial or complete dentures including rebase procedures and relining.

Limitations on Basic Dental Services

1. The Plan will not pay to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated stainless steel restorations within 24 months of treatment if the service is provided by the same Dentist.

2. The Plan limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, the Plan may allow stainless steel crowns on permanent teeth as a Major Benefit.

3. Services for anesthesia and nitrous oxide are limited to Dependents under age 18.

Type 3 – Major Restorative Services

Crowns, Inlays/Onlays and Cast Restorations:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations and restorations using gold foil.
Prosthodontics:	procedures for construction or repair of fixed bridges, partial or completed denture; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

Limitations on Major Restorative Services

1. The Plan will not pay to replace any crowns, jackets or cast restorations which the Enrollee received in the previous five (5) years under any Delta Dental program or any program of the Contractholder.

2. Prosthodontic appliances and/or implants that were provided under the MMIA Dental program will be replaced only after five (5) years have passed, except when the Plan determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under the MMIA Dental program will be made if MMIA determines it is unsatisfactory and cannot be made satisfactory. The Plan will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.

3. The Plan limits payment for dentures to a standard partial or denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.

Type 4 – Orthodontic Services

Procedures performed by a Dentist, involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions.

Limitations on Orthodontic Services

1. Payment for orthodontics is provided monthly.

2. Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.

3. Benefits end with the next payment due after loss of coverage. Benefits end immediately if treatment stops or if the Plan is terminated, whichever occurs first.

4. Benefits are not paid to repair or replace any Orthodontic appliance furnished, in whole or in part, under this Plan.

5. X-rays or extractions are not subject to the Orthodontic maximum.

6. Surgical procedures are not subject to the Orthodontic maximum.

Exclusions and Limitations

The Plan will not pay for:

1. Treatment of injuries or illness covered under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

2. Cosmetic surgery or dentistry for purely cosmetic reasons.

3. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), unless the service is provided to a newborn or adopted dependent child for treatment of a medically diagnosed congenital defect.

4. Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. For example: equilibration, periodontal splinting, occlusal adjustment.

5. Any Single Procedure started prior to the date the person became covered for such services under this program.

6. Prescribed drugs, medication, pain killers or experimental procedures.

7. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

8. Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.

9. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

10. Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.

11. Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.

12. Services or supplies covered by any other dental plan of MMIA.

13. Services for any disturbances of the temporomandibular (jaw) joints.

Optional Services

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

1. a crown where a filling would restore the tooth;

2. a precision denture/partial where a standard denture/partial could be used; or

3. an inlay/onlay instead of an amalgam restoration.

If you receive Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

Maximum Allowances

1. The maximum allowance the Plan will pay for each Participant entitled to Benefits is shown on the Schedule of Benefits.

2. The Plan will not pay more than the amount which would have been paid to one Dentist providing the same service:

a. If the Participant transfers from the care of one Dentist to that of another during a course of treatment.

b. If more than one Dentist provides care to the Participant in the course of a single procedure.

General Provisions

1. Relationship of the Plan to the Dentist. The Participant is free to select any licensed Dentist. The Plan is not responsible for any Dentist's act, omissions, or conduct. Other than to pay allowances for services which are included as Benefits under this Plan, the Plan shall not be liable for any services provided by any Dentist.
2. Examination of Participant. The Plan has the right to request a physical examination of a Participant by a Dentist it chooses and pays with respect to Dental Services provided under this Plan.
3. Payment of Allowances. Payment of the Contract Allowance for Dental Services covered under the Plan may be made by the Claims Administrator, in its discretion, either to the Participant or the Dentist providing service to the Participant.

The Schedule of Benefits describes payment limitations for these services.

COORDINATION OF BENEFITS

Coordination of Benefits if the Participant Has Other Insurance

If the Participant is covered by any other plan that has benefits similar to this Plan, the payment of Benefits available under this Plan will be coordinated with the benefits available under the other plan. This means that payment under this Plan will be adjusted so that the combined payments under this Plan and the other plan will be no more than the Contract Allowance for the covered services the Participant receives. Payment by the Plan will never exceed the amount which would be payable in the absence of other coverage. "Other plan" means coverage by:

1. Any group, blanket, or franchise insurance.
2. Any prepayment plan.
3. An Alternate Delivery System.
4. Group automobile insurance medical expense coverage.
5. Homeowner or business liability coverage
6. Labor-management trusteed plan.
7. Union welfare plan.
8. Employer organization plan.
9. Employee benefit organization plan.
10. Any federal, state, or other government plan or law other than Medicaid.

Order of Benefit Determination

1. General

   The general order of Benefits is as follows:

   a. The Primary Plan must pay or provide its Benefits as if the Secondary Plan or Plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another plan as defined above into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

b. A Secondary Plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

c. The benefits of the plan which covers the person as an employee, participant, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

2. Dependent Child/Parents not Separated or Divorced

The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

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

b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

c. The word “birthday” refers only to month and day in a calendar year, not the year in which the person was born;

d. A group contract which includes Coordination of Benefits and which is issued or renewed, or which has an anniversary date on or after sixty days after the effective date of this subchapter shall include the substance of the provision in 2.a., b., and c. above. Until that provision becomes effective, the group contract may instead contain wording such as:

“Except as stated in 3. below, the benefits of a plan which covers a person as a dependent of a male are determined before those of a plan which covers the person as a dependent female.”

e. If the other plan does not have the rule described in 2.a., b., and c. above, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

3. Dependent Child/Separated or Divorced Parents

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. First, the plan of the parent with custody of the child;

b. Then, the plan of the spouse of the parent with the custody of the child; and

c. Finally, the plan of the parent not having custody of the child.

d. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

e. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in the Order of Benefit Determination Section 2. Dependent Child/Parents not Separated or Divorced.

4. Active/Inactive Employee

The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee’s dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that employee’s dependent). 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 is ignored.

5. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, participant, or subscriber longer are determined before those of the plan which covered that person for the shorter term.

a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.

b. The start of a new plan does not include:

(1) A change in the amount of scope of a plan's benefits;

(2) A change in the entity which 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. The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a participant of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

Coordination With Medicare

The Plan will coordinate benefits with Medicare according to the federal Medicare secondary payer laws and regulations ("MSP rules"). This means that the Plan and/or Medicare may adjust payment so that the combined payments by the Plan and Medicare will be no more than the charge for the Benefits received by the Participant. The Plan will never pay more than it would pay if the Participant was not covered by Medicare.

1. For Working Aged

Medicare pays secondary to the Plan for Benefits for Participants and their spouses who are Participants, covered by employers with 20 or more Employees, who qualify for age-based Medicare as a result of attaining age 65 and older and who are covered by virtue of the Participant's current employment status.

Medicare will be the primary for a Participant that refuses coverage under this Plan Document.

Medicare will pay primary to the Plan for the working aged Participants covered by employers with fewer than 20 Employees, including a multi-employer association if the Participant is covered by an employer within the multi-employer association with fewer than 20 Employees.

2. For Disabled Participants under Age 65

Medicare pays secondary to the Plan for Benefits for Participants under age 65, covered by employers with 100 or more Employees, who qualify for disability-based Medicare and are covered by virtue of a Participant's current employment status.

Medicare pays primary to the Plan for disabled Participants under age 65 covered by employers with fewer than 100 Employees.

3. For End-Stage Renal Disease

Medicare pays secondary to the Plan for Benefits for Participants who qualify for Medicare as a result of end-stage renal disease ("ESRD"), regardless of employer size, and are entitled to Benefits payable under this Plan Document, for the first 30 months that a particular Participant qualifies for Medicare as a result of ESRD. After the 30 month period, Medicare will pay primary to the Plan.

Special Coordination of Benefits rules apply if a Participant is entitled to Medicare based on ESRD and Medicare based on either age or disability.

a. If the Plan is required to pay before Medicare under 1 or 2 above for a Participant before the

Participant qualifies for Medicare based on ESRD, the Plan will continue to pay primary to Medicare after the Participant becomes covered under Medicare based on ESRD but only for the 30 month period above, after which Medicare will pay primary to the Plan.

b. If the Plan is required to pay primary to Medicare based on ESRD and the Participant that qualifies for Medicare based on ESRD above later becomes entitled to age-based or disability-based Medicare during the 30 month period, Medicare will pay second to the Plan for the duration of the 30 month period, after which Medicare will pay primary to the Plan. If the Participant qualifies for age-based or disability-based Medicare after the 30 month period, Medicare will pay primary to the Plan.

c. Medicare continues to be primary to the Plan after an aged or disabled Participant becomes eligible for Medicare based on ESRD if:

1. The Participant is already entitled to Medicare on the basis of age or disability when the Participant becomes eligible for Medicare based on ESRD; and

2. The Group has fewer than 20 Employees in the case of age-based Medicare or fewer than 100 Employees in the case of disability-based Medicare.

4. For Retired Persons

Medicare is primary to the Plan for Participants age 65 if the Participant is a qualified individual age 65 and over and retired.

Medicare is primary to the Plan for Participant's spouse who is also a Participant and who is a qualified individual if both the Participant and the Participant spouse are age 65 and over and retired.

5. Current Employment Status

Under the MSP rules, a Participant has current employment status if the Participant is:

a. Actively working as an Employee; or

b. Not actively working but is receiving disability benefits from an employer but only for a period of up to 6 months; or

c. Not actively working but retains employment rights in the industry (including but not limited to a Participant who is temporarily laid off or on sick leave, teachers and other seasonal workers), has not been terminated by an employer, is not receiving disability benefits from an employer for more than 6 months, is not receiving Social Security disability benefits and has group health coverage under this Plan Document that is not COBRA coverage.

CLAIMS INFORMATION

How to Obtain Benefits

When consulting a Dentist, the Participant should simply present his or her identification card. Billing and payments for services usually will be handled directly. There are, normally, no claim forms for the Participant to fill out.

Submit all claims no later than 12 months from the date the Participant received services.

Filing a Claim

A PPO Dentist and Premier Dentist will file claims for the Participants. Discuss filing arrangements with the Dentist. Be sure they have the most current coverage information. Showing them the Plan identification card, while not a guarantee of Benefits, will assist the Dentist in completing the claim form properly.

The Participant can file the claim, when the Dentist does not file the claim. The Participant should obtain an itemized bill from the Dentist and send it to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023
(800) 521-2651

A separate claim must be submitted for each patient. If the Participant needs assistance, call Customer Service at 1-800-521-2651.

Filing a Claims for Family Members/Dependents Living Out of Town or Out of State

Family Members living out-of-state should be using Dentists who are Delta Dental PPO and Delta Dental Premier Dentists in his or her local area. In most of those cases, the dentist will file claims, just as Delta Dental PPO and Delta Dental Premier Dentists will file claims. If they do not, follow the same procedures outlined in the section entitled "Filing a Claim."

Automated Information Line

The Participant can access Delta Dental's automated information line on a regular business day to obtain information on Member Eligibility and Benefits; Group Benefit Information; Claim Status or to speak to a Customer Service Representative for assistance. **AVA (800) 521-2651**

SELF-AUDIT INCENTIVE PROGRAM

MMIA offers an incentive to all Covered Persons to encourage thorough examination of dental charges. The Covered Person should review all dental charges and verify each itemized service was truly received. If this self-audit exposes a charge for a service not received or an overcharge an incentive may be awarded.

This error of charge must meet the following criteria:

1. Not detected by the provider of services; and
2. Not detected by the Plan; and
3. Part of the charges for services which are covered under this Plan.

If all of these elements are met, contact the provider of services so that the overcharge or incorrect charge is corrected. Submit a copy of the documentation examined to find the error and clearly mark it "Self-Audit Incentive". Send all pertinent documentation to:

MMIA Employee Benefits Program
Re: Dental Self-Audit Incentive
PO Box 6669
Helena, MT 59604

PRIVACY OF PROTECTED HEALTH INFORMATION

Protected Health Information about a Plan Participant will not be disclosed to the Plan Sponsor by the Health Plan or any Business Associate servicing the Health Plan, unless the Plan Sponsor certifies that the Plan Documents have been amended to include this section and the Plan Sponsor agrees to abide by this section. Any disclosure to and use by the Plan Sponsor will comply with all provisions of this section.

Definitions

For the purpose of this section, the following definitions apply:

1. Business Associate.

A person or entity who performs, or assists in performing or provides a function or activity that involves the use or disclosure of Protected Health Information on behalf of the Health Plan. Such functions or activities include, but are not limited to, claims processing, claims administration, data analysis, data processing, data administration, utilization review, quality assurance, billing, benefit management, legal services, marketing services, accounting services, and administration services.

2. Federal Regulations.

   Those regulations entitled Standards for Privacy of Individually Identifiable Health Information, 45 CFR §160 and §164.

3. Group Health Plan.

   A self-insured employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act (ERISA) that provides coverage for medical care.

4. Health Plan or Plan.

   The Group Health Plan, provided to the Plan Participants by or through the Plan Sponsor. The Group Health Plan may be administered by a third-party health insurance carrier or other third-party administrator. The health insurance issuer or third-party administrator is the Business Associate of the Group Health Plan.

5. Plan Participant.

   A person covered under the Group Health Plan.

6. Plan Sponsor.

   Montana Municipal Interlocal Authority (MMIA).

7. Protected Health Information (PHI).

   Individually identifiable health information transmitted, including electronic transmission, or maintained in any form or medium.

Purpose of Disclosure to Plan Sponsor

A Plan Participant's PHI will only be disclosed to the Plan Sponsor by the Health Plan, or a Business Associate servicing the Health Plan, subject to the following:

1. To permit the Plan Sponsor to carry out Plan administration functions that are in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. Disclosures to the Plan Sponsor of a Plan Participant's PHI will be explained in the Notice of Privacy Practices issued to Plan Participants by the Health Plan.
3. No Plan Participant's PHI will be disclosed to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other Benefit or employee benefit plan of the Plan Sponsor.

Restrictions on Plan Sponsor's Use and Disclosure of PHI

The Plan Sponsor will:

1. Not use or further disclose PHI except as permitted or required by the Plan Documents, as amended by this section, or required by law.
2. Ensure that any agent, including subcontractors, to whom it provides PHI agrees to the restrictions and provisions of the Plan Documents, including this section.
3. Not use or disclose PHI for the purpose of employment-related actions or decisions or in connection with any other Benefit or Employee Benefit plan of the Plan Sponsor.
4. Promptly report to the Health Plan any use or disclosure of PHI that does not comply with the provisions of this section upon learning of such noncompliance.

5. Make PHI, located in a Plan Participant's designated record set, available to the Plan Participant who is the subject of the information, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for their information.

6. Make PHI, located in a Plan Participant's designated record set, available for amendment, and amend PHI, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for amendment.

7. Provide an accounting of disclosure to Plan Participants in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for an accounting of disclosures.

8. Make its internal practices, books, and records, relating to its use and disclosure of PHI, available to the Health Plan and the United States Department of Health and Human Services to determine compliance with Federal Regulations.

9. If feasible, and subject to 9b below:

   a. Return or destroy all PHI, and retain no copies, when the PHI is no longer needed for the Plan administration functions for which the disclosure was made. This includes:

      1. PHI, in whatever form or medium (including any electronic medium under the Plan Sponsor's custody or control), received from the Health Plan or a Business Associate; and

      2. Any data or compilations derived from and allowing identification of any Plan Participant who is the subject of the PHI.

   b. If it is not feasible to return or destroy all PHI, the Plan Sponsor will limit the use or disclosure of any PHI that it cannot return or destroy to those purposes that make it unfeasible to return or destroy the PHI.

Adequate Separation Between the Plan Sponsor and the Plan

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to PHI received from the Health Plan or the Business Associate servicing the Plan. This includes those Employees who may receive PHI relating to payment under, health care operations of, or other matters pertaining to the Health Plan in the ordinary course of business:

Montana Municipal Interlocal Authority:	Alan W. Hulse, CEO
	Prudence Wigen, CFO
	Helen Gonsowski, Program Manager
	Debbie Vonada, Enrollment/Eligibility Specialist

Access to PHI will be given to the Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, only to perform the Plan administration functions that the Plan Sponsor provides for the Health Plan.

The Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, will be subject to disciplinary action and sanctions, up to and including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of PHI in breach or violation of, or noncompliance with the provisions of this section.

The Plan Sponsor will promptly report any breach or violation of, or noncompliance as required in the section entitled "Restrictions on Plan Sponsor's use of Disclosure of PHI," Item 4 of this section. The Plan Sponsor will cooperate with the Health Plan to:

1. Correct the breach or violation of or noncompliance.

2. Impose appropriate disciplinary action or sanctions on the person(s) responsible for causing the breach or violation of or noncompliance.

3. Mitigate any detrimental effect of the breach or violation of or noncompliance on any Plan Participant who

may have had the privacy of PHI compromised by the breach or violation of or noncompliance.

GENERAL PROVISIONS

Plan Administrator Powers and Duties

The Plan Administrator shall have total and exclusive responsibility to control, operate, manage, and administer the Plan in accordance with its terms. The Plan Administrator shall have all the authority that may be necessary or helpful to enable it to discharge its responsibilities with respect to the Plan. Without limiting the generality of the preceding sentence, the Plan Administrator shall have the exclusive right: to interpret the Plan; to determine eligibility for coverage under the Plan; to determine eligibility for Benefits under the Plan; to construe any ambiguous provisions of the Plan; to correct any default; to supply any omission; to reconcile any inconsistency; and to decide any and all questions arising in administration, interpretation, and application of the Plan.

The Plan Administrator shall have full discretionary authority in all matters related to the discharge of its responsibilities and the exercise of authority under the Plan, including, without limitation, the construction of the terms of the Plan, and the determination of eligibility for coverage and Benefits. The decisions of the Plan Administrator, as Plan Administrator, shall be conclusive and binding upon all persons having or claiming to have any right or interest in or under the Plan and no such decision shall be modified under judicial review unless such decision is proven to be arbitrary or capricious.

The Plan Administrator may delegate some or all of its authority under the Plan, or revoke such delegation to any person or persons provided that any such delegation or revocation of delegation is in writing. The Plan Administrator may delegate its authority to determine eligibility for Benefits to the Claim Administrator.

Entire Plan; Changes

This Plan supersedes any previous plan. This Plan, including the amendments and attached papers, if any, constitutes the entire Plan. No change in this Plan is valid until made pursuant to the section entitled Modification of Plan.

Modification of Plan

The Plan Sponsor and Plan Administrator reserve the right to amend the Plan in whole or in part at any time, including the right to make any amendments to a contract with an insurance company, and the right to amend any rules adopted for the administration of the Plan. The Plan Sponsor reserves the right to change or cancel the Plan, or any Benefits under the Plan, at any time. Any such change in Benefits will be based solely on the decisions of the Plan Sponsor and may apply to active Employees, future retirees and current retirees as either separate groups or as one group. If the Plan Sponsor cancels the Plan or any Benefits under the Plan, participation in the canceled Benefits terminates on the date of the cancellation, unless otherwise specified.

The Plan Sponsor may terminate the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Plan Sponsor, the Plan shall terminate, unless the Plan is continued by a successor to the Plan Sponsor. Any such termination in Benefits will be based solely on the decision of the Plan Sponsor and may apply to current Employees and their dependents, future retirees and current retirees as either separate groups or as one group.

Notice of Reduction of Benefits

All changes or amendments to this Plan that directly or indirectly relate to any Benefit or coverage under the Plan including any increase in contribution for coverage required from a Participant in accordance with federal law after the date such change or amendment is adopted.

Clerical Errors

No clerical error on the part of the Claim Administrator shall operate to defeat any of the rights, privileges, or Benefits of any Participant covered under this Plan. Upon discovery of errors or delays, an equitable adjustment of

charges and Benefits will be made. Clerical errors shall not prevent administration of this Plan in strict accordance with its terms.

Notices Under Plan

Any notice required by this Plan may be given by United States mail, postage paid. Notice to the Participant will be mailed to the address appearing on the records of the Plan. Notice to the Plan should be sent to the Plan Sponsor. Notices are effective on the date they are mailed.

Benefits Not Transferable

No person, other than the enrolled Employee or a Family Member listed on the application for participation accepted by the Plan, is entitled to Benefits under this Plan. This Plan is not transferable. This means that a Participant is not allowed to transfer, assign, or give that Participant's coverage under this Plan to another person.

Validity of Plan

If any part, term, or provision of this Plan is held by the courts to be illegal or in conflict with any law of the state of Montana, the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the Plan did not contain the particular part, term, or provision held to be invalid.

Participants Rights

A Participant has no rights or privileges except as specifically provided in this Plan. Nothing contained in the Plan shall be construed as a contract of employment between the Plan Sponsor or an MMIA Member Entity and any Participant, or as the right of any Participant to continue in the employment of the Plan Sponsor or an MMIA Member Entity or as a limitation of the right of the Plan Sponsor or an MMIA Member Entity to discharge any of its Employees with or without cause.

Benefit Maximums

If a Participant receives services payable under any section of this Plan and exhausts all Benefits available under that section, no Benefits are available under any other section for that same condition.

Pilot Programs

The Plan reserves the right to develop and enter into pilot programs to test the success of providing Benefits for care not normally covered under this Plan. The existence of a pilot program does not guarantee that all Participants are eligible for the pilot program Benefits or that such Benefits will be permanent.

Research Fees

The Plan reserves the right to charge a reasonable fee when extensive research is necessary to reconstruct information or documents which were previously provided in writing to the Participant by the Plan. Fees may be charged for the costs of copying labor, supplies, and postage. Fees will not be charged for searching for and retrieving the requested information.

Cooperation of Participant

The Participant must cooperate fully with the Plan, and any person or entity administering this Plan Document on behalf of the Plan, in providing documents and information requested to determine whether the Participant is or remains eligible for membership; to determine whether services are Covered Dental Expenses; to determine whether any term or exclusion of this Plan Document applies; and to make any other determination necessary to administer this Plan Document. Required cooperation by a Participant includes executing such consents, releases, disclosure authorizations and other documents as may be requested by the Plan in order to obtain documents or information from a third party necessary to make such determinations.

Required cooperation of a Participant includes but is not limited to providing or authorizing the provision of the following to the Plan:

1. All medical, hospital, dental, vision and other health care records relating to the diagnosis or treatment of or services or items provided to the Participant;
2. All information and documents regarding coverage, policy limits, claim payments, demands, litigation, settlement (including disputed and undisputed liability settlements) under any applicable or potentially applicable insurance, health plan, government benefit program or other health or medical payor plan or program, including but not limited to:
    a. Workers' compensation, FELA or other similar plan or program providing benefits for injury or illness arising out of employment;
    b. Personal, commercial or other automobile insurance, including but not limited to no-fault medical payment, liability or other coverages; and
    c. Personal, homeowners, commercial, or other premises insurance, including but not limited to no-fault medical payment, liability or other coverages.

Statements are Representations

In the absence of fraud, all statements by applicants or the Participant shall be deemed to be representations and not warranties.

Any representations or statements made to a Participant by the MMIA Member Entity, their representatives or agent, about being covered for Benefits under the Plan, which conflict with the provisions of the Plan shall:

(a) Not be considered as representations or statements made by, or on behalf of, the Plan Administrator. (b)

Not bind the Plan Administrator for Benefits under the Plan.

Any Participant who, with intent to defraud or knowing that he or she is facilitating a fraud against the Plan Sponsor, submits an application or files a claim containing a false, incomplete, or misleading statement is guilty of fraud. The Plan Sponsor reserves the right to take appropriate action in any instance where fraud is at issue.

Summary Plan Description

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. If dependents are included in the coverage, only one SPD will be issued for each family unit.

Relationship between the Claim Administrator and the Dentist

A Dentist furnishing care to a Participant do so as independent contractors with the Claim Administrator; however, the choice of a Dentist is solely the Participant's. Under the laws of Montana, the Claim Administrator cannot be licensed to practice medicine or surgery and the Claim Administrator does not assume to do so. The relationship between a Dentist and a patient is personal, private, and confidential.

Neither the Plan nor the Claim Administrator is responsible for the negligence, wrongful acts, or omissions of any Dentist, or Dentist's employees, providing services, or a Participant receiving services. Neither the Plan nor the Claim Administrator is liable for services or facilities that are not available to a Participant for any reason.

Recovery, Reimbursement, and Subrogation

By enrollment in this Plan, Participants agree to the provisions of this section as a condition precedent to receiving Benefits under this Plan. Failure of a Participant to comply with the requirements of this section may result in the pending of the payment of Benefits.

1. **Right to Recover Benefits Paid in Error**

If the Plan makes a payment in error on behalf of a Participant or an assignee of a Participant to which the Participant 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 benefited from the payment. The Plan can deduct the amount paid from the Participant's future Benefits or from the Benefits of 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 Participant authorizes the deduction of any excess payment of such Benefits or other present or future compensation payments.

The provisions of this subsection apply to any licensed Dentist who receives an assignment of Benefits or payment of Benefits under this Plan. If a licensed Dentist refuses to refund improperly paid claims, the Plan may refuse to recognize future assignments of Benefits to that Dentist.

2. **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 medical expenses on a Participant's behalf, and another party was actually responsible or liable to pay those medical expenses, the Plan has the right to be reimbursed for the amounts the Plan paid.

Accordingly, if a Participant, 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 Participant or whoever received the money, agrees to hold the money received in trust for the Benefit of the Plan. The Plan shall be reimbursed, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Participant 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 Participant 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, medical, disability, or other expenses or damages.

3. **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 Participant's rights and remedies in order to recover from third parties who are legally responsible to the Participant for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Participant, 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 medical bills or expenses related to the Participant's Accident, injury, condition, or Illness, which the Plan has 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 Participant for whom Benefits were paid, and to take any action the Participant could have undertaken to recover the money paid.

The Participant 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 Participant 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 Participant decides not to pursue a claim against any third party or insurer, the Participant will notify the Plan, and specifically authorize the Plan in its sole discretion, to sue for, compromise, or settle any such claims in the Participant'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.

4. **The Following Paragraphs Apply to Both Reimbursement and Subrogation:**

a. Under the terms of this Plan, the Plan Administrator is not required to pay any claims where there is evidence of liability of a third party. However, the Plan, in its discretion, may instruct the Claim Administrator not to withhold payment of Benefits while the liability of a party other than the Participant is being legally determined.

b. If the Plan makes a payment which the Participant, or any other party of the Participant's behalf, is or may be entitled to recover against any third party responsible for an Accident, injury, condition or Illness, the Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. The Participant 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.

c. The Participant 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 Participant 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; provide 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.

d. Participants 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 Participant will notify the Plan immediately of the name and address of any attorney whom the Participant engages to pursue any personal injury claim on his or her behalf.

e. The Participant 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 Participant will not conceal or attempt to conceal the fact that recovery occurred or will occur.

f. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Participant 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, notwithstanding any anti-subrogation, "made whole," "common fund," or similar statute, regulation, prior court decision, or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

5. **Right of Offset.**

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

decisions, or common law theories.

6. **Legal Actions.**

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

DEFINITIONS

This section defines certain words used throughout this Plan Document. These words are capitalized whenever they are used as defined.

APPROVED AMOUNT

The maximum amount a Dentist may charge for a Single Procedure.

BENEFIT (In-Network or Out-of-Network)

The amounts that the Plan will pay for dental services under the Contract. In-Network Benefits are those covered by the Contract and performed by a Delta Dental PPO Dentist. Out-of-Network Benefits are those covered by the Contract but performed by a Delta Dental Premier® Dentist or Non-Delta Dental Dentist.

BENEFIT PERIOD

For the Plan, the Benefit Period is the period set forth in the Schedule of Benefits.

For the Participant, the Benefit Period is the same as that described for the Plan except if the Participant's Effective Date is after the Effective Date of the Plan, the Participant's Benefit Period begins with his or her Effective Date and ends on the same date the Plan Benefit Period ends. Thus, the Participant's initial Benefit Period may be less than 12 months.

CLAIM ADMINISTRATOR

Claim Administrator 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 Claim Administrator is Delta Dental Insurance Company. The Claim Administrator 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.

CODE

The Internal Revenue Code of 1986, as amended.

COINSURANCE

The percentage of the Contract Allowance payable by the Participant for Covered Dental Expenses. The applicable Coinsurance is stated in the Schedule of Benefits.

CONTRACT ALLOWANCE

The maximum amount Delta Dental will use for calculating the Benefits for a Single Procedure. The Contract Allowance for services provided:

- by Delta Dental PPO Dentists is the lesser of the Dentist's submitted fee, the Delta Dental PPO Dentist's Fee or the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement.
- by Delta Dental Premier Dentists (who are not PPO Dentists) is the lesser of the Dentist's submitted fee, the Dentist's filed fee with Delta Dental in the Participating Dentist Agreement or the Maximum Plan Allowance; or
- by Non-Delta Dental Dentists is the lesser of the Dentist's submitted fee or the Maximum Plan Allowance.

COVERED DENTAL EXPENSE

Expenses incurred for Necessary services and supplies covered under this Plan and provided to a Participant by and/or ordered by a Covered Dentist for the diagnosis or treatment of illness or injury or in providing care. The Participant must be charged for such services and supplies.

DEDUCTIBLE

The dollar amount each Participant must pay for Covered Dental Expenses incurred during the Benefit Period before the Plan will make payment for any Covered Dental Expense to which the Deductible applies. Only the Contract Allowance for Covered Dental Expenses is applied to the Deductible. Thus, Participant responsibility for Coinsurance, noncovered services, or amounts billed by non-Delta Dental Dentist does not apply to the Deductible.

DELTAL DENTAL PPO DENTIST (PPO DENTIST)

A participating Delta Dental Dentist who agrees to accept Delta Dental's PPO Dentist's Fees as payment in full and to comply with Delta Dental's administrative guidelines. All PPO Dentists are also Delta Dental Premier Dentists. All PPO Dentists must be contracted in the Delta Dental Premier network.

DELTAL DENTAL'S PPO DENTIST'S FEE (PPO DENTIST FEE)

The fee outlined in the PPO Dentist Agreement. PPO Dentists agree to charge no more than this fee for treating PPO enrollees.

DELTA DENTAL PREMIER® DENTIST (PREMIER DENTIST)

A Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and who agrees to abide by certain administrative guidelines. Not all Premier Dentists are PPO Dentists; however, all Premier Dentists agree to accept Delta Dental's Maximum Plan Allowance for each Single Procedure as payment in full.

DENTALLY NECESSARY

A service, supply, or medicine provided by a Covered Dentist and determined by the Claim Administrator to be:

- Appropriate for the symptoms and diagnosis or treatment of the Participant's condition, Illness or injury;
- Provided for the diagnosis, or the direct care and treatment of the Participant's condition, Illness, or injury;
- In accordance with the standards of good medical practice and Medical Policy;
- Not primarily for the convenience of the Participant or the provider; and
- The most appropriate supply or level of service that can safely be provided to the Participant. When applied to Inpatient Care, this also means that the Participant requires acute care as a bed patient due to the nature of the services rendered or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

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

DENTAL POLICY

The Claims Administrator's policy which is used to determine whether dental procedures, medication, dental equipment, processes and technology, meet the nationally accepted criteria, such as:

1. Services must have final approval from the appropriate governmental regulatory agencies;
2. Scientific studies have conclusive evidence of improved net health outcome;
3. Must be in accordance with established standards of good dental practice. Dental Policy is reviewed and modified periodically as is necessary.

DENTAL SERVICES

Services provided by a Dentist or Denturist and which are covered under the Plan.

DENTIST

A person licensed to practice dentistry in the state where the services are provided.

DENTURIST

A person licensed as a Denturist in the state where the services are provided.

EFFECTIVE DATE

For a Participant: The Effective Date of a Participant's coverage means the date the Participant has met the requirements of the applicable MMIA Member Entity's personnel policy and is shown on the records of the Plan to be eligible for Benefits.

For the Plan: The Effective Date of the Plan is July 1, 2008. Notwithstanding the foregoing, certain provisions shall be effective as of the dates specified within those provisions. The effective date of any amendment to the Plan is the effective date set forth on such amendment.

EMPLOYEE

Any person (other than a nonresident alien who receives no U.S. source income from the MMIA Member Entity) who is employed by the MMIA Member Entity. Notwithstanding the foregoing, the term "Employee" shall also include any officer or former officer of the MMIA Member Entity for whom the MMIA Member Entity is contractually bound by written agreement to provide dental benefits. Employee shall not include any person who is classified by the MMIA Member Entity as an independent contractor or as a leased Employee.

EMPLOYER

MMIA Member Entity.

FAMILY MEMBER

A Participant who has been enrolled by an enrolled Employee and who is either:

1. His or her legal spouse or Domestic Partner. Domestic Partner means the person, regardless of gender, named in the Affidavit of Domestic Partnership that has been submitted to and approved by the Employer. Refer to the applicable MMIA Member Entity personnel policy to determine Domestic Partner coverage;
2. His or her biological or adopted child under the age of 26 years or stepchild under the age of 26 years; or
3. A child under the age of 26 years who has been placed for adoption with the enrolled Employee within the meaning of applicable state law, or for whom the enrolled Employee has been named as a guardian or conservator by a court having jurisdiction.

Coverage will be provided until the first day of the month following the date of the child's 26th birthday, provided the child is not an employee eligible for coverage under a group dental plan offered by the child's employer. Although there is not limiting age for handicapped children, the Plan reserves the right to require periodic certification from the enrolled Employee of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child's 26th birthday.

FAMILY MEMBERSHIP

The family unit including the enrolled Employee and all Family Members who have been accepted as Participants of the Plan.

INVESTIGATIONAL/EXPERIMENTAL SERVICE OR CLINICAL TRIAL

Surgical procedures or medical procedures, supplies, devices, or drugs, which, at the time provided or sought to be provided, are, in the judgment of the Claim Administrator, not recognized as conforming to accepted medical practice, or the procedure, drug, or device:

1. has not received the required final approval to market from appropriate government bodies;
2. is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
3. is not demonstrated to be as beneficial as established alternatives;

4. has not been demonstrated to improve the net health outcomes; or
5. is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Phase one, two and three clinical studies are considered investigational and are not covered.

LIFETIME MAXIMUM BENEFIT

Maximum Benefits paid to a Participant while covered by the Plan. The Lifetime Maximum Benefits are listed in the Schedule of Benefits, if applicable.

MAXIMUM PLAN ALLOWANCE (MPA)

The maximum amount Delta Dental will reimburse for a covered procedure. Delta Dental establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of participating Dentist.

MMIA MEMBER ENTITY

Those individual governmental entities that make up the members of Plan Administrator.

PARTICIPANT

An eligible Employee or eligible Family Member who has applied for participation in accordance with the section entitled Eligibility and Coverage, has been accepted as a Participant of the Plan, and maintains participation in the Plan.

PLAN

Plan means the dental benefit plan for Employees of the company, the Plan Document, or any other relevant documents pertinent to the operation and maintenance of the Plan.

PLAN ADMINISTRATOR

The MMIA and/or its designee that 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 MMIA will be deemed to be the Plan Administrator of the Plan unless by action of the board of directors, the MMIA designates an individual or committee to act as Plan Administrator of the Plan.

PLAN BENEFIT YEAR

The period specified as the Benefit Period in the Schedule of Benefits.

PLAN DOCUMENT

This document which sets forth and governs the rights and duties of the Plan Sponsor, Plan Administrator, Claim Administrator, and Participants under the Plan and modified by any policies, interpretations, rules, practices, and procedures made by the Sponsor.

PLAN YEAR

July 1 through June 30.

PRE-TREAMENT

Pre-treatment authorization is recommended for some services.

Additional documentation from the Participant's provider for some services may be needed for prior authorization. In these cases, a written request for prior authorization should be submitted to the Plan by the dentist and should include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan, and any other supporting documentation, study models, itemized repair and replacement cost statements, photographs, x-rays, etc.

If a Participant does not obtain prior authorization, a retrospective review will be performed after the claims have been submitted to determine whether or not the services, supplies, or treatment were Dentally Necessary, performed in the appropriate setting, and a Covered Dental Expense of the Plan Document. The Participant will be responsible for charges for any services, supplies, or treatment which were not performed in the appropriate setting, which were not Dentally Necessary or were not a Covered Dental Expense of this Plan Document.

PROOF OF LOSS

The documentation (claim form) accepted by the Claim Administrator upon which payment of Benefits is made.

RETIREE

For Montana governmental entities: "Retiree" means an Employee who retires under a retirement program authorized by law and who is eligible to continue coverage with the Employer pursuant to the terms of 2-18-704 MCA as amended from time to time.

SCHEDULE OF BENEFITS

The section of this document entitled Schedule of Benefits which lists percents and dollar amounts payable for Covered Dental Expenses and time periods of coverage under the Plan. The Schedule of Benefits is a part of the Plan.

SINGLE PROCEDURE

A dental procedure that is assigned a separate CDT number

SPECIAL ENROLLMENT PERIOD

The enrollment period for eligible Employees and/or Family Members who are not currently enrolled or who originally declined coverage because they had other coverage, and the enrollment period allowed when there is a marriage, birth, adoption, placement for adoption, as further defined in the section entitled Eligibility and Coverage.

SPONSOR/PLAN SPONSOR

Montana Municipal Interlocal Authority (MMIA).

SUMMARY PLAN DESCRIPTION

This document which sets forth and governs the rights and duties of the Plan Sponsor, Plan Administrator, Claim Administrator, and Participants under the Plan and modified by any policies, interpretations, rules, and practices, and procedures made by the Plan Sponsor.

Claims Administered by:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Suite 600
Alpharetta, Georgia 30009
(770) 641-5100
(800) 521-2651