PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

MONTANA CREDIT UNION LEAGUE GROUP BENEFITS TRUST EMPLOYEE HEALTH BENEFIT PLAN

VISION PLAN

EFFECTIVE: JANUARY 1, 2012

RESTATED: JANUARY 1, 2021

NOTICE

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

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INTRODUCTION

This document is a description of **Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan – Vision Plan** (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain expenses.

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

Where a court order, administrative order, judgement, new or changed law or regulation applies to the provisions of this Plan, the Plan will be deemed to have been automatically amended (without further action on the part of the Plan Administrator), to ensure that the Plan conforms to such change. For example, where Plan provisions involve stated maximums, exclusions or limitations, and the change would cause the Plan Administrator to provide greater benefits than what would have been available prior to the change, payment of the greater benefit will be considered to have been made in accordance with the terms of this Plan. For the avoidance of doubt, it is the intent of the Plan Administrator that the Plan conform at all times to the requirements of any and all controlling law, including by way of example and not exclusion, the Employee Retirement Income Security Act of 1974, as amended.

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

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

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

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the notice of the Plan Administrator's determination on the second level of review.

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

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

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

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

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

Vision Care Benefits. Explains when the benefit applies and the types of charges covered.

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

How to Submit a Claim. Explains the rules for filing claims and the claim appeal process.

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

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

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

Certain Plan Participant Rights Under ERISA. Explains the Plan's structure and the Participants' rights under the Plan.

SCHEDULE OF BENEFITS

ASSIGNMENT OF BENEFITS

A Plan Participant may assign benefits for vision expenses covered under this Plan to a provider as consideration in full for services rendered; however, whether such benefits are paid directly to the Plan Participant or to the provider, the Plan will be deemed to have fulfilled its obligations with respect to such benefits.

The Plan will not be responsible for determining whether any such Assignment of Benefits is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment has been received before the proof of loss is submitted.

The Plan Participant may not, at any time either during a period of participating in the Plan or following a coverage termination, assign the Plan Participant's right to sue to recover benefits under the Plan, to enforce rights due under the Plan, or to any other causes of action which the Plan Participant may have against the Plan or its fiduciaries.

A provider which accepts an Assignment of Benefits does so in accordance with this Plan and does so as consideration in full for services rendered. Any such provider is bound by the rules and provisions set forth within the terms of this document.

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

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second vision opinion.

SCHEDULE OF VISION CARE BENEFITS

MAXIMUM BENEFIT AMOUNT FOR VISION CARE BENEFITS PER CALENDAR YEAR $1,500

Benefit for Eye exam

One exam per Calendar Year maximum .... 100% up to the Maximum Benefit Amount per Calendar Year.

Benefit for Frames

Frames and hardware once per Calendar Year.......... 100% up to the Maximum Benefit Amount per Calendar Year.

Benefit for Lenses

One pair per Calendar Year .... 50% up to the Maximum Benefit Amount per Calendar Year.

Benefit for Contact Lenses in lieu of frames and lenses

Per Calendar Year .... 100% up to $150 maximum

When the Plan Participant's visual acuity cannot be made 20/70 or better with Spectacle Lenses, per Calendar Year.......... 100% up to $320 maximum

Note: The Contact Lenses maximum benefit amounts per Calendar Year applies to the VISION CARE BENEFITS MAXIMUM for Contact Lenses.

For more information regarding the vision care benefits, refer to the separate VISION CARE BENEFITS section under this Plan.

SELF-AUDIT BILLING CREDIT

Effective for Covered Charges incurred on or after February 1, 2015.

The Plan offers an incentive credit to all covered Employees to encourage examination and self-auditing of eligible vision bills to ensure the amounts billed by the provider or service accurately reflect the services and supplies received by the covered Employee or a covered Dependent.

The covered Employee is voluntarily asked to review all provider bills and verify that he or she has received each itemized service and the bill does not represent either an overcharge, or a charge for services never received, regardless of the reason.

The Claims Administrator agrees to assist the covered Employee (at his or her request) in determination of errors, and recovery attempts.

Plan Participants may receive a refund if they discover an overcharge on their vision bill that:

1) Was not detected by the provider of services; and
2) Was not detected by the Plan; and
3) Was part of the charges for services which are covered under this Plan

In the event a covered Employee's self-audit results in elimination or reduction of charges, up to 50% of the amount eliminated or reduced may be paid directly to the covered Employee provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Claims Administrator (e.g. a copy of the incorrect bill and a copy of the corrected billing).

- The credit could be up to a maximum $1,000 refund based on an overcharge of $2,000. The minimum overcharge eligible to qualify under the Self-Audit Program is a $50 overcharge with a minimum refund of $25.

If an overcharge is discovered by the Plan Participant, they should ask the provider to correct the overcharge and send the Plan Participant a revised itemized bill. The Plan Participant should clearly mark both itemized bills "Self-Audit Program" and send them to the Claims Administrator at:

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

This self-audit credit is in addition to the payment of all other applicable Plan benefits for legitimate vision expenses.

Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Plan Participant, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the Plan Participant's liability) on an incorrect billing.

This credit will not be payable for charges in excess of the Usual and Reasonable Charge regardless of whether the charge is or is not reduced, and may not be payable for Covered Charges.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees.

- All Active Employees of the Employer;
- All Retired Employees of the Employer.

ELIGIBILITY REQUIREMENTS

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

(a) Is a Full-Time, Active Employee of the Employer. The Employee shall be considered "Full-Time" if he or she normally works at least the minimum number of hours per week as designated by the Employer, but no less than 20 hours per week, and is on the regular payroll of the Employer for that work.

If the Employer is an applicable large employer (50 Full-Time Employees or more), the Employer may use either a monthly measurement method or a look-back measurement method (as defined by applicable law) to determine an Employee's Full-Time status.

For Employers utilizing the monthly measurement method, the Employer determines the status of an Employee as a Full-Time Employee on a month-by-month basis by looking at whether the Employee has the required number of hours of service for each month.

- If an Employee changes employment status from part-time to Full-Time, and the Employer utilizes the monthly measurement method, the Employee will be eligible for coverage on the first day of the month following any applicable Waiting Period. Such Waiting Period shall begin on the date of the Employee's status change from part-time to Full-Time. In no event shall coverage begin later than the first day of the fourth month following the Employee's change in status from part-time to Full-Time.

For Employers utilizing a look-back measurement method, the Employer determines the status of an Employee as a Full-Time Employee during what is referred to as a stability period, based on the hours of service in the preceding period, which is referred to as the measurement period.

If the Employer utilizes the look-back measurement method, the following rules apply:

- *An Employee's initial measurement period begins the first day of the month following the date of hire. The Employee must average the required minimum hours of service* during the initial measurement period to be considered Full-Time for the corresponding stability period.
- If the Employee is considered Full-Time for the corresponding stability period, *coverage is effective the first day of the stability period following the applicable measurement period.* If there is a gap between the end of the Employee's first stability period and the start of the Employer's standard stability period, the Employee will remain eligible until the first day of the standard stability period as long as the Employee is actively working for the Employer.
- To remain eligible for coverage, the Employee must average the required minimum hours of service during each subsequent standard measurement period.

(b) Completes the applicable employment Waiting Period imposed by the Employer. A "Waiting Period" is the time between the first day of employment as an otherwise eligible Employee and the first day of coverage under the Plan not to exceed 90 days. The Waiting Period will be waived for any Employee whose Full-Time status was determined by the Employer using the look-back measurement method with an initial measurement period of three months or more.

If an Employee changes from a non-qualifying position to a Full-Time, Active Employee as defined under this Plan, the Employee will be credited with any time worked in the non-qualifying position toward the employment Waiting Period.

For more information on minimum number of hours required, benefit measurement periods, or the Employer's applicable Waiting Period, contact the Employer's Human Resources Department.

(2) Eligibility Requirements for Retired Employee (Retiree) Coverage. An individual is eligible for Retired Employee Coverage if the Retired Employee:

(a) Has worked 10 continuous years as an Active Employee for the participating Employer;

(b) Has been a covered Employee under the Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan for three consecutive years prior to retirement;

(c) Is younger than the limiting age of 65 years; and

(d) Is at least age 60 and has not yet reached age 65.

When the Retired Employee reaches the limiting age of 65, coverage will end on the first day of the Retired Employee's birthday month. A Retired Employee's coverage will end prior to reaching the limiting age of 65 if he or she becomes eligible for Medicare prior to that time as set forth below. Any Dependents covered under the Retired Employee's coverage at that time will have an additional 18 months of coverage before their coverage terminates as long as they continue to satisfy the eligibility requirements for said coverage.

For Credit Unions joining the Montana Credit Union League Group Benefits Trust as a participating Employer, those eligible Employees must meet the same requirements as set forth above, and to satisfy item (b) as set forth above they must be covered under their prior plan for three consecutive years to be eligible. If there was no prior plan or the Employee was not on the prior plan for the three consecutive previous years, the Employee will not be eligible for Retired Employee coverage until they satisfy the eligibility requirements set forth herein.

Upon Retirement: For Employers that are subject to COBRA Continuation Coverage, a Retired Employee can choose between COBRA Continuation Coverage or continuing coverage under the terms of the Plan as a Retired Employee if the Retired Employee satisfies the criteria as set forth above. If the Employee is eligible and chooses to continue coverage under the terms of the Plan as a Retired Employee, they will forfeit their right to elect COBRA Continuation Coverage at a later date. If the Employee elects COBRA Continuation Coverage, they will forfeit their right to elect continuing coverage under the terms of the Plan as a Retired Employee.

Dependents: If a Retired Employee and his or her Spouse and/or Dependent child(ren) satisfy the criteria as set forth herein, his or her Spouse and/or Dependent child(ren) will be eligible for coverage if the Retired Employee elects Retired Employee coverage. Any Spouse and/or Dependent child otherwise eligible must have also been covered under the Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan for the three consecutive years prior to being eligible for the Retired Employee coverage.

Spouses and Dependent child(ren) will not be eligible for Retired Employee coverage under this plan if they have access to employer sponsored health care elsewhere, regardless if they are enrolled in the other employer sponsored coverage. The Spouse and/or Dependent child(ren) must notify the Plan when he or she becomes eligible for employer sponsored coverage when enrolled under the Retired Employee's coverage.

Retired Employees and their Spouse and/or Dependent child(ren) who become eligible for Medicare for any reason will no longer be eligible for the Retired Employee coverage regardless if they are enrolled in Medicare.

Grandfathered Provision: An Employee will be Grandfathered and eligible for Retired Employee coverage if the Employee:

1. Satisfies **(2) (a)** above;
2. Is enrolled as of January 1, 2020, under the Montana Credit Union League Group Benefits Trust Employee Health Benefits Plan;
3. Is between the ages of 55 and 60;
4. Was contemplating retirement before the age of 60; and
5. Will retire by January 1, 2021.

Anyone between the ages of 55 and 60 already enrolled as a Retired Employee will remain eligible for Retired Employee coverage as set forth above.

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

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

The term "**Spouse**" shall mean an individual of the opposite or same sex recognized as the covered Employee or Retired Employee's husband or wife by the laws of the state in which the marriage was formalized and **will** also include a common-law Spouse or the person who is currently registered with the Employer as the Domestic Partner of the Employee or Retired Employee.

An individual is a **Domestic Partner** of an Employee or Retired Employee if that individual and the Employee or Retired Employee meet each of the following requirements:

(a) The Employee or Retired Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee or Retired Employee and the individual are not married to anyone.

(c) The Employee or Retired Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The Employee or Retired Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least 12 consecutive months and be continuing during the period that the applicable benefit is provided. The Employee or Retired Employee and the individual must have the intention that their relationship will be indefinite.

(e) The Employee or Retired Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee or Retired Employee must contact the Plan Administrator.

In the event the domestic partnership is terminated, either partner is required to inform Montana Credit Union League Group Benefits Trust of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

Unless otherwise specified, all references to "Spouse" shall also include Domestic Partner.

The term "**children**" shall include natural children or step-children of the covered Employee, Retired Employee or Domestic Partner, adopted children, children placed with the covered Employee, Retired Employee or Domestic Partner in anticipation of adoption or Foster Children. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

If a covered Employee, Domestic Partner or Retired Employee is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents. The Plan Administrator may require documentation proving a legal guardianship.

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

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax-free benefits (i.e. Domestic Partner or non-IRC Section 152 Dependent). There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

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

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

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

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

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

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

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

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

FUNDING

Cost of the Plan. The Employer shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Employer.

The level of any Employee contributions is set by the Employer. The Employer reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If Dependent coverage is desired, the covered Employee is also required to enroll for Dependent coverage.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee **will be** automatically enrolled in this Plan from the date of birth. Coverage will continue for the child unless within **60** days of birth, the Employee notifies the Plan to terminate the child's coverage or does not pay the additional contributions to continue the child's coverage. However, after **60** days, coverage will not continue for any newborn child of a covered Dependent child unless the Employee adopts the newborn child or is the legal guardian of the newborn child.

Coverage for the newborn will be provided only if the Plan Participant remains covered on the Plan during the **60** day period. If the Plan Participant does not remain covered for **60** days, the newborn will only be covered for the amount of time (during the **60** days) that the Plan Participant is effective.

TIMELY, LATE, OR OPEN ENROLLMENT

(1) **Timely Enrollment** – The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period or no later than **60** days after birth, Foster Child placement, adoption, or placement for adoption.

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

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

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

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

(i) Open Enrollment –Each year there is an annual open enrollment period designated by the Employer during which eligible Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan or covered Employees may change their and their covered Dependents' benefit elections under the Plan.

Benefit choices made during the open enrollment period will become effective **January 1** and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, domestic partnership, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

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

Plan Participants will receive detailed information regarding open enrollment from their Employer.

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

SPECIAL ENROLLMENT RIGHTS

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

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

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

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. *(**Note:** A Retired Employee who declines coverage at retirement and later loses other coverage will not be entitled to special enrollment, nor will the Retired Employee's eligible Spouse, Domestic Partner, or Dependent children.)*

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions (**Note:** The following provisions will not be applicable to a Retired Employee and/or their Spouse, Domestic Partner, or Dependent children):

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

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

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

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

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

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

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

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

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

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

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

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

(b) The Retired Employee is a participant under this Plan; and

(c) A person becomes a Dependent of the Employee or Retired Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage.

In the case of marriage, domestic partnership, birth, adoption or placement for adoption, the Spouse, Domestic Partner, or Dependent child of a covered Retired Employee may be enrolled as a Spouse, Domestic Partner or Dependent child of the covered Retired Employee if the Spouse, Domestic Partner, or Dependent child is otherwise eligible for coverage under the Plan.

If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. *If the Retiree is not enrolled at the time of the event, this Special Enrollment right will not be applicable.*

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage or the date of registration of domestic partnership; or 60 days that begins on the date of Foster Child placement, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee or Retired Employee must request enrollment during this period.

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

(a) In the case of marriage, the day of marriage, or

(b) In the case of Domestic Partner relationship, on the date of registration of the Domestic Partner relationship; or

(c) In the case of a Dependent's birth, as of the date of birth; or

(d) In the case of a Dependent's adoption, placement for adoption, or Foster Child placement, the date of the adoption, placement for adoption, or Foster Child placement.

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

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

(a) The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or

(b) The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

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

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

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

For more information regarding special enrollment rights, contact the Plan Administrator.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the first calendar month or as otherwise dictated by the Employer, and under no circumstances to exceed the 91st day following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

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

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

TERMINATION OF COVERAGE

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

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

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes, or if the Employer is a large employer (more than 50 full-time Employees), the last day of the benefit stability period during which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

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

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

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

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff in accordance with the Employer's policies and procedures. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance, or 90 days from the first day of approved disability leave, whichever comes first. This 90-day period may be extended if required by applicable law.

For leave of absence or layoff only: the date the Employer ends the continuance, or 90 days from the first day of approved leave of absence or layoff, whichever comes first. This 90-day period may be extended if required by applicable law.

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

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations. This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

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

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

Rehiring a Terminated Employee. A terminated Employee who is rehired prior to the end of a 13 consecutive week period after the date of termination will be credited with time met towards the employment Waiting Period as of the date of termination. Coverage will begin the first day of the first calendar month following the date of rehire or the first day of the first calendar month following completion of the Waiting Period.

Otherwise, a terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

However, if the Employee is returning to work directly from COBRA Continuation Coverage, this Employee will be credited with time met towards the employment Waiting Period as of the date the Employee elected COBRA Continuation Coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The date the Plan is terminated;

(2) The date the covered Retired Employee's Eligible Class is eliminated;

(3) The date the Retired Employee's coverage under the Plan terminates due to death;

(4) The last day of the calendar month in which the Retired Employee reaches age 65 or becomes eligible for Medicare for any reason;

(5) If a Retired Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Retired Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage;

(6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

(7) As otherwise specified in the Eligibility section of this Plan.

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

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

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

(3) The last day of the calendar month a covered Spouse or Domestic Partner lose coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.) *In the event the domestic partnership is terminated either partner is required to inform the Plan Administrator of the termination of the domestic partnership.*

(4) The last day of the calendar month in which the Spouse of a Retired Employee reaches age 65.

(5) The last day of the calendar month in which the Spouse or Dependent child of a Retired Employee becomes eligible for Medicare for any reason or becomes eligible for other employer-sponsored coverage.

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

(7) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

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

(9) As otherwise specified in the Eligibility section of this Plan.

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

VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Plan Participant for services that are recommended and approved by a Physician or Optometrist.

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

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second vision opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the notice of the Plan Administrator's determination on the second level of review.

BENEFIT PAYMENT AND COINSURANCE

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

Once the Plan has made the applicable benefit payment, the remaining percentage owed is the Plan Participant's "Coinsurance" responsibility. For example, if the Plan's reimbursement rate is 100%, the Plan Participant's responsibility (or coinsurance) is 0%.

Coinsurance will apply to the maximum benefit amount.

VISION CARE CHARGES

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Vision Care Benefits for each vision care service or supply.

LIMITS

No benefits will be payable for the following:

(1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

(4) **No prescription.** Charges for lenses ordered without a prescription.

(5) **Orthoptics.** Charges for orthoptics (eye muscle exercises).

(6) **Sunglasses.** Charges for safety goggles or sunglasses, including prescription type.

(7) **Training.** Charges for vision training or subnormal vision aids.

DEFINED TERMS

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

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

Assignment of Benefits means an arrangement whereby the Plan Participants assigns its right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of the Plan, to a provider. If a provider accepts said arrangement, the provider' rights to receive Plan benefits are equal to those of the Plan Participant, and are limited by the terms of this Plan. A provider that accepts this arrangement indicates acceptance of an Assignment of Benefits as consideration in full for services, supplies, and treatment rendered.

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

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

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

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

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

Employer means any credit union that i) has been approved by the Plan Administrator to participate in the MCUL Group Benefit Trust and ii) has executed a Subscription Agreement.

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

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

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

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

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing and treatment has not been given at the time the drug or device is furnished; or

(2) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

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

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Illness means a bodily disorder, disease, physical sickness or mental disorder.

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

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

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

Medically Necessary care and treatment is recommended or approved by a Physician practicing within the scope of his or her license; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the patient's condition; is approved by the FDA, if applicable; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

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

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

Plan means Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan – Vision Plan, which is a benefits plan for certain Employees and Retired Employees of the Employer and is described in this document.

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

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

Retired Employee (Retiree) is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is a Plan Participant's Illness or disease.

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

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider that furnished the care, service or supply and does not exceed the general level of charges made by most providers of like service in the same geographic area. This charge means an amount equivalent to the **90th percentile** of a commercially available database or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan. If there are insufficient charges submitted for a given procedure, the Plan will determine a Usual and Reasonable Charge based upon charges made or fees accepted for similar services. Determination of the Usual and Reasonable Charge will consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the coast and quality data for that provider.

In circumstances where a network arrangement or other discounting or negotiated arrangement exists, the Usual and Reasonable Charge means the contracted amount established by the network arrangement, or other discounting or negotiated arrangement with a provider.

In no event, except as noted above, will the Usual and Reasonable Charge exceed the actual charge billed.

The Plan Administrator or its designee has the ultimate discretionary authority to determine whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

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

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

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

(3) **Cosmetic Surgery.** Services, supplies, drugs and devices related to non-covered cosmetic and reconstructive services or treatment.

(4) **Educational or vocational testing.** Services for educational or vocational testing or training except as specifically stated as a benefit under this Plan.

(5) **Errors.** Charges based on billing mistakes, improprieties or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard; it is in the Plan Administrator's sole discretion to determine what constitutes an error under the terms of this Plan.

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

(7) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(8) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders.

(9) **Foreign travel.** Care, treatment or supplies administered outside of the U.S. if the Plan Participant traveled to the location where the care, treatment or supply was received for the purpose of obtaining the care, treatment or supply.

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

(11) **Hazardous activities.** Charges for services received that result from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Plan Participant's customary occupation or if it involves activities commonly considered as involving unusual or exceptional risks, characterized by a threat of danger or risk of bodily harm including reckless operation of machinery, travel to countries with advisory warnings, use of weapons and explosives, and other activities reasonably deemed hazardous by the Plan Administrator, in its sole discretion.

(12) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or skilled nursing facility and paid by the Hospital or facility for the service.

(13) **Illegal acts.** Charge s for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed.

This Plan also excludes charges for services, supplies, care or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant operating a motor vehicle while under the influence of alcohol or drugs or a combination thereof or operating a motor vehicle with a blood or breath alcohol content (BAC) above the legal limit. The arresting officer's determination of inebriation will be sufficient for this exclusion. Such charges will be excluded regardless of whether such motor vehicle operation rises to the level of a Serious Illegal Act. Expenses will be covered for injured Plan Participants other than the person operating the vehicle while under the influence or a BAC above the legal limit, and expenses may be covered for chemical dependency treatment as specified in this Plan.

This exclusion does not apply if the Injury resulted from being the victim of an act of domestic violence or from a medical (including both physical and mental health) condition whether or not diagnosed before the incident.

(14) **Incarcerated.** Care, treatment, services, and supplies incurred and/or provided to a Plan Participant by a government entity while housed in a governmental institution.

(15) **Invalid charges.** Charges: (a) that are found to be based on errors, unbundled charges, misidentification or unclear description; (b) charges for fees or services determined not to have been Medically Necessary or (c) charges found by the Plan Administrator to be in excess of the Usual and Reasonable Charge (d) charges that are otherwise determined by the Plan Administrator to be invalid or impermissible based on any applicable law, regulation, rule, or professional standard; and/or (e) charges in excess of the negotiated rate.

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

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

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

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

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

(21) **Occupational Injury.** Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies regardless of the availability of or coverage by Workers' Compensation or occupational disease benefits, even if the Plan Participant:

- **(a)** Has waived his/her rights to Workers' Compensation benefits;
- **(b)** Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits;
- **(c)** The Plan Participant is permitted to elect not to be covered under Workers' Compensation but has failed to properly file for such election; or
- **(d)** Executed a disputed liability settlement with Worker's Compensation.

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

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

(24) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is the Plan Participant's family member or relative.

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

(26) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined or as otherwise specifically stated as a Covered Charge.

(27) **Unbundled charges.** Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

(28) **Vitamins and supplements.** Charges for vitamins and supplements.

(29) **War.** Any loss that is due to or aggravated by any a declared war or undeclared act of war.

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

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second vision opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the notice of the Plan Administrator's determination on the second level of review.

HOW TO SUBMIT A VISION CLAIM

When services are received from a vision provider, a Plan Participant should show his or her **EBMS/Montana Credit Union League Group Benefits Trust – Vision Plan** identification card to the provider. Providers may submit claims on a Plan Participant's behalf.

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

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

- A copy of the itemized bill
- Group name and number (**Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan – Vision Plan**, Group / **0000530**)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

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

WHERE TO SUBMIT VISION CLAIMS

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

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

WHEN VISION CLAIMS SHOULD BE FILED

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

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator and/or Plan Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second vision opinion.

CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims. A Claim for benefits is not a Claim that has been previously submitted, denied, appealed, and re-denied upon appeal.

A "Claim" is a Post-Service Claim under the terms of the Plan. A **Post-Service Claim** means a Claim for covered vision services that have already been received by the Plan Participant.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment. The Plan Administrator shall have full responsibility to adjudicate all Claims and to provide a full and fair review of the initial Claim determination in accordance with the following Claims review procedure.

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

For the purposes of this section, **Claimant** means the Plan Participant or the Plan Participant's authorized representative. A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives. A Claimant does not include a healthcare provider simply by virtue of an assignment of benefits.

An Adverse Benefit Determination shall mean a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. An inquiry regarding eligibility or benefits without a Claim for benefits is not a Claim and, therefore, cannot be appealed.

Initial Benefit Determination

The Initial Benefit Determination on a Post-Service Claim will be made within 30 days of the Claim Administrator's receipt of the Claim. If the Claims Administrator requires an extension due to circumstances beyond the Plan's control, the Claims Administrator will notify the Claimant of the reason for the delay within the initial 30-day period. A benefit determination on the Claim will be made within 15 days of the date the notice of the delay was provided to the Claimant. If additional information is necessary to process the Claim, the Claims Administrator will request the additional information from the Claimant within the initial 30-day period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.** A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Adverse Benefit Determination

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

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

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

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

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

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

If applicable:

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

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

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

If the Claimant does not understand the reason for the Adverse Benefit Determination, the Claimant should contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

Claims Review Procedure - General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by either an appropriate Plan fiduciary or the Claims Administrator on the Plan's behalf, who is neither the individual who made the Initial Benefit Determination, nor a subordinate of that individual. The review will take into account all comments, documents, records and other information submitted by the Claimant related to the Claim, without regard as to whether this information was submitted or considered in the Initial Benefit Determination.

If the Adverse Benefit Determination was based in whole or in part upon medical judgment, including determinations on whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary, the Plan Administrator or its designee will consult with a health care professional who has the appropriate training and experience in the applicable field of medicine; was not consulted in the Initial Benefit Determination; and is not the subordinate of the initial decision-maker. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

The Plan Administrator will provide free of charge upon request by the Claimant, reasonable access to and copies of, documents, records, and other information as described in Items 5 through 8 under "Notice of Adverse Benefit Determination".

First Level of Claims Review

The written request for review must be submitted within 180 days of the Claimant's receipt of notice of an Adverse Benefit Determination. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

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

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the initial Adverse Benefit Determination within the 180 day period will render that determination final.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal.

Second Level of Claims Review

If the Claimant does not agree with the Claims Administrator's determination from the first level review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the first level of review, along with any additional supporting information to:

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

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the determination from the first level of review within the 60 day period will render that determination final.

The second level of review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal. The determination by the Plan Administrator upon review will be final, binding, and conclusive and will be afforded the maximum deference permitted by law.

If upon review, the Adverse Benefit Determination remains the same and the Claimant still does not agree with the determination, the Claimant has the right to bring an action for benefits under Section 502(a) of ERISA. **Before filing a lawsuit, the Claimant must exhaust both levels of review as described in this section. A legal action to obtain benefits must be commenced within one year of the date of the notice of the Plan Administrator's determination on the second level of review.**

COORDINATION OF BENEFITS

Coordination of the Benefit Plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans, including Medicare, are paying. When a Plan Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

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

Effect on Benefits

Application to Benefit Determinations. The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

(1) The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.

(2) The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination. For the purposes of the provision entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

(1) A plan without a coordinating provision will always be the primary plan.

(2) The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent.

(3) If the person for whom claim is made is a Dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

(4) When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a Dependent of the parent without custody.

(5) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a Dependent of the stepparent, and the benefits of a plan which covers that child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that child as a Dependent of the parent without custody.

(6) Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a Dependent child.

(7) When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

(8) To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information. The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Plan Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment. A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery. Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Plan Participant or his or her Dependents.

Excess Insurance. If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

(1) Any primary payer besides the Plan.

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

(3) Any policy of insurance from any insurance company or guarantor of a third party.

(4) Workers' compensation or other liability insurance company.

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation. When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Defined Terms for this section:

Allowable Expense(s) means the Usual and Reasonable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in this section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Other Plan includes, but is not limited to:

(1) Any primary payer besides the Plan.

(2) Any other group health plan.

(3) Any other coverage or policy covering the Plan Participant.

(4) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

(5) Any policy of insurance from any insurance company or guarantor of a responsible party.

(6) Any policy of insurance from any insurance company or guarantor of a third party.

(7) Workers' compensation or other liability insurance company.

(8) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Participant shall be a trustee over those Plan assets.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Participant(s) fails to so pursue said rights and/or action.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

(1) The responsible party, its insurer, or any other source on behalf of that party.

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

(3) Any policy of insurance from any insurance company or guarantor of a third party.

(4) Workers' compensation or other liability insurance company.

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant's/Plan Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Plan Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Plan Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Plan Participant's/Plan Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

PLAN PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

Any Plan Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Participant understands that he or she is required to:

(1) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

(2) Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

(3) In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

(4) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Participant disputes this obligation to the Plan under this section, the Plan Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Plan Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

RELEASE OF LIABILITY

The Plan's right to reimbursement extends to any incident related care that is received by the Plan Participant(s) (Incurred) prior to the liable party being released from liability. The Plan Participant's/Plan Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Plan Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

(1) The responsible party, its insurer, or any other source on behalf of that party.

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

(3) Any policy of insurance from any insurance company or guarantor of a third party.

(4) Workers' compensation or other liability insurance company.

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

Obligations

It is the Plan Participant's/Plan Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

(1) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

(2) To provide the Plan with pertinent information regarding the Sickness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.

(3) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

(4) To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

(5) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

(6) To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

(7) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

(8) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

(9) To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

(10) In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

(11) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved.

If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant's/Plan Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Plan Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan. This provision applies even if the Plan Participant has disbursed settlement funds.

Minor Status

In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

<u>Defined Terms for this section:</u>

Incurred. A Covered Charge is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire procedure or course of treatment are not Incurred upon commencement of the stage of the procedure or course of treatment.

COBRA CONTINUATION COVERAGE

Note: Not all Employers are subject to COBRA. If your Employer is not subject to COBRA, you will not be eligible for COBRA CONTINUATION COVERAGE. You must check with your Employer to determine whether COBRA Continuation Coverage is available to you and your Dependents.

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). If applicable, COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage will not be available to those Retired Employees that elected, at the time of retirement, to continue coverage under the terms of the Plan as a Retiree. However, the following COBRA Continuation Coverage may apply to a Retired Employee's Qualified Beneficiaries.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

Domestic Partners and Dependent children of a covered Employee's Domestic Partner, who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision and are covered under this Plan, will also be offered the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated.

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the

following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

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

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18 month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18 month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

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

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

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

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.HealthCare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

Plan Administrator	COBRA Administrator
League Services Group	Employee Benefit Management Services, LLC
101 N Rodney St.	P.O. Box 21367
Helena, Montana 59601-4226	Billings, MT 59104
(406) 442-9081	(406) 245-3575 or (800) 777-3575

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA CONTINUATION COVERAGE
FOR RETIREE'S DEPENDENTS

Note: Not all Employers are subject to COBRA. If your Employer is not subject to COBRA, you will not be eligible for COBRA CONTINUATION COVERAGE. You must check with your Employer to determine whether COBRA Continuation Coverage is available to you and your Dependents.

COBRA Continuation Coverage will not be available to those Retired Employees that elected, at the time of retirement, to continue coverage under the terms of the Plan as a Retiree. However, the following COBRA Continuation Coverage may apply to a Retired Employee's Qualified Beneficiaries.

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). If applicable, COBRA Continuation Coverage can become available to certain Plan Participants when group health coverage would otherwise end.

The Retired Employee's family members may have other options available when they lose group health coverage. For example, they may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, an individual may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which the individual is eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." Certain covered family members could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

Domestic Partners and children of a covered Retiree's Domestic Partner, who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision and are covered under this Plan, will also be offered the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated.

If you are the Spouse of a covered Retired Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Dependent children of the covered Retired Employee will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-covered Retired Employee dies;
- The parent-covered Retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

Filing a proceeding in bankruptcy with respect to the Employer under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is death of the covered Retiree, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

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

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Retirees may elect COBRA Continuation Coverage on behalf of their Spouse and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally lasts for 18 months. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

If the Qualifying Event is the death of the covered Retiree, divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Retiree dies, gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

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

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your former Employer ceases to provide a group health plan to any Retired Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.HealthCare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the

COBRA Administrator:

Plan Administrator	COBRA Administrator
League Services Group	Employee Benefit Management Services, LLC
101 N Rodney St.	P.O. Box 21367
Helena, Montana 59601-4226	Billings, MT 59104
(406) 442-9081	(406) 245-3575 or (800) 777-3575

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan is the benefit plan of Montana Credit Union League Group Benefits Trust, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Montana Credit Union League Group Benefits Trust to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Montana Credit Union League Group Benefits Trust shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

DISTRIBUTION OF ASSETS

Subject to the requirements of ERISA §402, in the event of a termination or partial termination of the Plan or Trust (if applicable), Montana Credit Union League Group Benefits Trust by action of its Trustees, shall direct the disposition of Plan assets, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

(2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

(7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Executive Director MCUL Group Benefit Trust
Human Resource Benefits, MCUL Group Benefits Trust
Insurance Agent

(b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

(c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE “PRIVACY STANDARDS”) ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

(d) Report to the Plan any security incident of which it becomes aware.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or Dependents may have to pay for such coverage.

- Review this summary plan description and the documents governing the Plan or the rules governing COBRA Continuation Coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan – Vision Plan

PLAN NUMBER: 501

TAX ID NUMBER: 37-6420195

PLAN EFFECTIVE DATE: January 1, 2012

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Montana Credit Union League Group Benefits Trust
101 N Rodney St.
Helena, Montana 59601-4226
(406) 442-9081

PLAN ADMINISTRATOR

League Services Group
101 N Rodney St.
Helena, Montana 59601-4226
(406) 442-9081

NAMED FIDUCIARY

Montana Credit Union League Group Benefits Trust
101 N Rodney St.
Helena, Montana 59601-4226

AGENT FOR SERVICE OF LEGAL PROCESS

Montana Credit Union League Group Benefits Trust
101 N Rodney St.
Helena, Montana 59601-4226

Service of process may also be made on the Plan Administrator.

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, LLC
PO Box 21367
Billings, Montana 59104-1367
(406) 245-3575 or (800) 777-3575

Plan Name: Montana Credit Union League Group Benefits Trust Employee Health Benefit Plan

Plan Option: Vision

Effective Date: January 1, 2012

Restatement Date: January 1, 2021

I, Tracie Kenyon (Name), certify that I am the Chairman (Title)

of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms described herein and am hereby authorizing the implementation of the restated Plan as of the restatement date noted above.

Signature:

Print Name: Tracie Kenyon

Date: 2/26/21