MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

February 6, 1981

The meeting of the Public Health, Welfare, and Safety Committee was called to order by Chairman Tom Hager on Friday, February 6, 1981 at 1:00 p. m. in Room 410 of the State Capitol Building.

ROLL CALL: All members were present with the exception of Senator Johnson. Kathleen Harrington, Staff Researcher, was also present.

Many visitors were also in attendance. (See Attachment.)

CONSIDERATION OF SENATE BILL 129: Senator Jean Turnage, of Senate District 13, Chief Sponsor of SB 129, gave a brief resume. This bill is an act regulating conversions of group life insurance and group disability insurance and providing for continuation of group coverage under certain circumstances; amending sections 33-20-1209, and 33-20-1210, MCA, and providing for an effective date.

If an individual's life insurance would be terminated because of termination of employment or group membership, this bill would allow for the right of conversion of the policy. The insurer must give written notice of the right of conversion and pending termination of coverage. This bill also includes term insurance in the conversion options and requires that benefits be equal to those under the group coverage. The bill eliminates consideration of other life insurance held by the insured when a conversion policy is determined. The premium must be the customary rate charged other members of the group. If the employer consents, the insured has the option of staying under the group policy unless he is covered under another group policy at his new place of employment. If the group life insurance is terminated then the insured if covered for one year rather than five, is entitled to be covered by a new policy that is the same amount as the previous policy. If the group is disbanded, then the insured is entitled to have issued an individual policy of disability insurance, and group hospital or medical service plan without evidence of insurability if application is made within 31 days after written notice. The benefits and premium rates must remain the same. The individual will also enjoy these rights if for continuation of group hospital or medical services contract if he terminates or reduces his work schedule.

Frank Stock from First Security Bank in Polson, stood in support of SB 129 because he feels that it is fair as it extends coverage

to people who must terminate employment due to health reasons. The insurance company accepted the premiums to cover a disaster and should, therefore, pay for the disaster when it occurs.

Mike Anderson, himself a Senator and also a life underwriter, stated that if SB 129 does pass it will cause group insurance to increase in cost.

With no further proponents, Senator Hager called on the opponents.

Jo Driscoll from the Insurance Commissioner's Office, stated that SB 129 would do away with the reason for group insurance. Group insurance is for the benefit of the employees, 75% of the employees must participate. Group rates vary with each company. Group insurance was intended to cover members during employment at a low cost. Mrs. Driscoll stated that in the past 15 years her office has received no complaints regarding this problem. Mrs. Driscoll stated that it is the responsibility of the employee to read the fine print on the insurance contract. She stated that this bill is not in the best interest of the consumer. There is no definition of "eligible employee".

Les Loble II, representing the American Council of Life Insurance, stood in opposition to the bill. He stated that group insurance was meant to be for the employee while they were working only. Someone moving from job to job can buy lots of insurance under this bill. Montana must have laws that the insurance company can live with or else they will not come into Montana. At the present time an employee must have been covered for at least five years with the group coverage to be eligible for an individual policy subject to the same conditions and limitations. Life insurance shall not exceed $2,000 if all the requirements are met.

Alan Cain, representing Blue Shield and also Montana Physicians' Service, stood in opposition to the bill. Mr. Cain addressed only the health aspects. Mr. Cain stated that M.P.S. has 1,800 individual groups covered at the present time. To be eligible for health insurance the individual must work a minimum of 20 hours per week. This would bring about individual coverage at group rates.

Elmer Hausken, representing the Montana Association of Life Underwriters stated that he supports the testimony of Mr. Cain and Mr. Loble. SB 129 would bring about a big problem in marketing group insurance. Mr. Hausken stated SB 129 "smacks of Kennedy approach". He then urged the committee to use caution in considering this bill.

With no further opponents Senator Turnage closed. He stated that it is time the people got a break. Senator Turnage stated that all he wants is fairness to the people. Industry has been invading the profits rightfully belonging to the people. He then stated that he is willing to work with others to improve the bill and make it workable for all concerned.

The meeting was then opened to a question and answer period from the committee.

Senator Himsl asked if insurance premiums were tax deductible to the employee. Senator Anderson stated "yes, this is the case".

CONSIDERATION OF SENATE BILL 332: Senator Mike Anderson of Senate District 40, Chief Sponsor of SB 332, gave a brief resume. This bill is an act to require the opportunity in certain circumstances for an individual to continue his participation in a group disability insurance plan if he leaves the group, to require the opportunity in certain circumstances for an individual to convert his group insurance to an individual policy if his group insurance coverage is terminated; and establishing standards and conditions for continuation of coverage and conversion; and providing for a delayed effective date.

This bill provides that an employee may continue hospital, surgical, and major medical coverage when he terminates his employment if he has been covered by the policy continuously for three months and he is not covered by medicare or another insurance coverage. The employer must request this coverage within 10 days of either his termination of employment or a notice of the right to request continuation of coverage. In order to obtain continuation of the policy the terminated employee must pay the required contribution in advance, and submit it with a letter requesting continuation within 31 days of the expiration date of the policy. The continuation privilege will terminate 6 months after the original expiration date of the policy, or earlier if the group policy is terminated or if payment is not made. At the end of six months the insured will be under a converted policy. The converted insurance premium will be based on the age and class of risk for each person covered. The insurer may be denied coverage of a converted policy if the insured is 1) covered by other policy and thus would be over insured; 2) has misrepresented the facts when applying; 3) is covered by medicare or 4) other reasons approved by the commissioner of insurance. Benefits for the converted will be no greater than the group policy. Pre existing conditions will be covered but benefits may be reduced by the amount of benefits payable under the group policy.

The employee may choose from two basic hospital or surgical plans. It specifies the major medical and catastrophic coverage that may be provided.

The benefits deductible means that the benefits from any other insurance policy will be deducted from the benefits of the converted policy. If the benefits required by this act exceed the benefits of the group policy the converted policy may offer the benefits of the group policy. The insurer may offer a combined benefits policy which must conform to the major medical coverage. There will be a low deductible option. The insurer may offer alternative plans for group disability conversion. A retiree may opt for a conversion rather than a continuation of group insurance. The converted policy may have a reduction of benefits if the insured is covered by medicare. The conversion benefit is also available for the family on the death of a spouse, upon divorce, or to the child if he is no longer a family member. There is a bill drafting error on page 9, line 2. "(5) (a) (ii) "and" should be struck. In order to obtain continuation of the policy the terminated employer must pay the required contribution in advance and submit it with a letter requesting continuation within 31 days of the expiration date of the policy. The continuation privilege will terminate 6 months after the original expiration date of the policy; or earlier if the group policy is terminated or if payment is not made. At the end of six months the insured will be under a converted policy. The converted insurance premium will be based on the age and class risk for each person covered. The insurer may be denied coverage of a coverted policy if the insured is 1) covered by other policy and thus would be over-insured; 2) has misrepresented the facts when applying; 3) is covered by medicare or 4) other reasons approved by the Commissioner of Insurance. Benefits for the converted will be no greater than the group policy. Pre-existing conditions will be covered but benefits may be reduced by the amount of benefits payable under the group policy. The employee may choose from two basic hospital or surgical plans. It specifies the major medical and catastrophic coverage that may be provided. The benefits deductible means that the benefits from any other insurance policy will be deducted from the benefits of the coverted policy.

Jo Driscoll from the Insurance Commissioner, stated there is a definite need for this bill and that it is a good piece of legislation. I would take at least six months, and more realistically 18 months to implement this bill.

Elmer Hausken of the Montana Life Underwriters, stood in support of the bill.

Allan Cain representing Blue Shield and also Montana Physicians' Service, felt that SB 332 provides more workable ideas, and stated his support of the bill.

With no further proponents, Chairman Hager called on the opponents.

Senator Jean Turnage stated that SB 332 gives some advantages in one section and takes away the advantages in another section. He then cited a few examples and stated his opposition to the bill.

Bill Erickson of Transystems, Inc., stated that he was very concerned with this bill and, therefore, opposes this bill.

With no further opponents, Senator Anderson closed. Senator Anderson stated that state's rights on insurance cannot be under federal law. He asked for a favorable recommendation from the Committee.

There were no questions from the Committee.

CONSIDERATION OF SENATE BILL 314: Senator Mike Anderson of Senate District 40, Chief Sponsor of SB 314, gave a brief resume of this bill. This bill is an act to allow family members the right to continue individual family disability insurance coverage upon the death of the named insured or the divorce, separation, or annulment of marriage of the spouse from the named insured.

When there is a death, divorce, separation or annulment, the spouse and/or children have the right for continued and/or converted by medicare or other federal or state disability insurance program. They must be offered a conversion policy similar to the one held by the spouse. The coverage may not require additional evidence of insurability except as to over-insurance for which benefits must be reduced, and may not impose pre existing conditions limitations or other contractual time limitations other than those on the original policy. The family must notify the carrier of the desire for continuation or conversion and payment must be made. Benefits may not be in excess of the original policy.

Jo Driscoll of the Insurance Commissioner's Office, stated her support of the bill and stated that she feels that this bill is in the best interest of the consumer.

With no further proponents, Chairman Hager opened the hearing to the opponents.

Senator Jean Turnage rose in opposition to the bill.

With no further opponents, Senator Anderson closed by saying that SB 314 is a simple little bill and asked for a DO PASS recommendation.

APPOINTMENTS: Senator Hager appointed Senators Norman and Olson, himself, and the sponsors of SB 129, 314, and 332 to work as a subcommittee reviewing these bills and to come up with a workable solution and report back to the Committee.

ANNOUNCEMENTS: The next meeting of the Public Health, Welfare, and Safety Committee will meet on Monday, February 9, 1981 to consider Senate Bills 348, 351, and House Joint Resolution 6.

ADJOURNMENT: With no further business the meeting was adjourned.

CHAIRMAN, TOM HAGER

eg

ROLL CALL

PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

47th LEGISLATIVE SESSION - - 1981 Date Feb. 6

NAME	PRESENT	ABSENT	EXCUSED
Tom Hager	✓		
Matt Himsl	✓		
S. A. Olson	✓		
Jan Johnson		✓	
Dr. Bill Norman	✓		
Harry K. Berg	✓		
Michael Halligan	✓		

Each day attach to minutes.

DATE ____________

COMMITTEE ON ____________

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
Tom Hyard	Amer. Council of Life Insurance	129		—
Emmer Hanken	Mont Assn Life Und	~~???~~ 129		✓
[illegible]		129/332		
Dennis M[illegible]		332/129		✓
Tony Sumner	Blue Cross	332/129		✓
Diana M-Schiedel	Blue Cross	332/129		—
Cindy Hickens	Blue Cross	332/129		—
Tom Mullaney	" Shield	"		
[illegible]	Blue Cross	"		✓
Josephine Driscoll	Ins. Dept.	129		✓
[illegible] Driscoll	" "	332+314	✓	
Donnie Nelson	self	129	✓	
Louise M Stock		129	✓	
Eula Mae Turnage		129	✓	
Ed Sheehy, Jr.	Mt. Assoc. of Life Underwriters	129		✓
[illegible]	MHA[illegible] MMCA MCA	129	Amend	
C.L. Fischer	Blue Cross	129	Amend	
Virgil E Miller	Blue Cross	129	"	
[illegible]	Blue Cross	129	"	
Jerry Driscoll	Laborers Union	129	✓	
[illegible]	Blue Cross	129/332	129 —	332 ✓
[illegible]	[illegible] Turnage	129		—
Joe Connelly	Blue Cross	129	Amend	
[illegible]	Hennessy	129	✓	
Bill Erickson	Transystems Inc.	332		✓

(Please leave prepared statement with Secretary)

NAME: Loren Hess DATE: 2-2-21

ADDRESS: Box 514 Helena

PHONE: 443-3070

REPRESENTING WHOM? Mont Auto Dealers Assoc., Mont Coal. Assoc.

APPEARING ON WHICH PROPOSAL: SB 69

DO YOU: SUPPORT? _____ AMEND? / OPPOSE? _____

COMMENTS: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

NAME: [illegible] DATE: 2-6-87

ADDRESS: Bethel Park - Helena

PHONE: 445-2996

REPRESENTING WHOM? St of Montana Dept. Agr

APPEARING ON WHICH PROPOSAL: 129 - 314 - 332

DO YOU: SUPPORT? 314 & 332 AMEND? ~~7~~ OPPOSE? 129

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

NAME: Frank S Stark DATE: Feb 6, 1981

ADDRESS: PO Box 1001 Polson, Montana

PHONE: Work 883-5363 Home 883-2642

REPRESENTING WHOM? My self

APPEARING ON WHICH PROPOSAL: SB 129

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: I support SB 129 because it is fair and because it extends coverage to people who must terminate employment due to health reasons. The insurance company accepted the premium to cover a disaster and should pay for the disaster which occurred

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

NAME: Alan F. Cain DATE: 2/6/81

ADDRESS: 404 Fuller Helena

PHONE: 442-5450

REPRESENTING WHOM: Blue Shield

APPEARING ON WHICH PROPOSAL: SB 314, 332, 129

DO YOU: SUPPORT 314 AMEND? 332 OPPOSE? 129

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

NAME: Edward Hansen DATE: 2-6-81

ADDRESS: 111 No. Last Chance Gulch, Helena

PHONE: 443 6300

REPRESENTING WHOM? Montana Assn of Life Underwriters

APPEARING ON WHICH PROPOSAL: 129 -

DO YOU: SUPPORT? _____ AMEND? ✓ OPPOSE? ✓

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

NAME: Les Loble II DATE: 2/6/81

ADDRESS: PO B 176

PHONE: 442 0070

REPRESENTING WHOM? Am. Council of Life Insurance

APPEARING ON WHICH PROPOSAL: SB 129

DO YOU: SUPPORT? ~~XXX~~ AMEND? _____ OPPOSE? ✓

COMMENTS: _____

PLEASE ATTACH ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

GR 332

Approved GR Committee
May 24, 1978

HIAA MODEL GROUP HEALTH INSURANCE CONTINUATION AND CONVERSION LAW

A. Definitions* - As used in this Act:

1. "Group policy" means a group health insurance policy issued by an insurance company and a group contract issued by a health service corporation or health maintenance organization or similar corporation or organization.

2. "Individual policy" or "converted policy" means an individual health insurance policy issued by an insurance company or an individual health services contract issued by a health service corporation or health maintenance organization or similar corporation or organization.

3. "Insurer" means the entity issuing a group policy or an individual or converted policy.

4. "Insurance", "Insures" and "Insured" refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided solely as an accrued liability or by reason of a disability extension.

5. "Premium" includes any premium or other consideration payable for coverage under a group or individual policy.

6. "Medicare" means Title XVIII of the United States Social Security Act as amended or superseded.

*Each jurisdiction should determine the advisability of inserting language to include uninsured plans.

Continuation of Group Hospital, Surgical and Major Medical Coverage After Termination of Employment or Membership. - A group policy delivered or issued for delivery in this state which insures employees or members for hospital, surgical or major medical insurance on an expense incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment or membership shall be entitled to continue their hospital, surgical and major medical insurance under that group policy, for themselves and their eligible dependents, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

1. Continuation shall only be available to an employee or member who has been continuously insured under the group policy (and for similar benefits under any group policy which it replaced) during the entire three months' period ending with such termination.

2. Continuation shall not be available for any person who is or could be covered by Medicare. Neither shall continuation be available for any person who is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination. \ what about double coverage (COB) situations

3. Continuation need not include dental, vision care or prescription drug benefits, or any other benefits provided under the group policy in addition to its hospital, surgical or major medical benefits.

4. An employee or member who wishes continuation of coverage must request such continuation in writing within the ten day period following the later of (i)

this is therefore requir

the date of such termination, or (ii) the date the employee is given notice of the right of continuation by either his employer or the group policyholder. In no event, however, may the employee or member elect continuation more than 31 days after the date of such termination.

5. An employee or member electing continuation must pay to the group policyholder or his employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, but not more than the group rate for the insurance being continued under the group policy on the due date of each payment. The employee's or member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within thirty-one days of the date the employee's or member's insurance would otherwise terminate.

Same rate as the group

6. Continuation of insurance under the group policy for any person shall terminate when he fails to satisfy condition 2 above or, if earlier, at the first to occur of the following:

   (a) The date six months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership.

   (b) If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made.

   (c) The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this (c) applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following shall apply:

(i) The employee or member shall have the right to become covered under that other group policy, for the balance of the period that he would have remained covered under the prior group policy in accordance with condition 6 had a termination described in this (c) not occurred.

(ii) The minimum level of benefits to be provided by the other group policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy.

(iii) The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

7. A notification of the continuation privilege shall be included in each certificate of coverage.

Right to Obtain Individual Policy Upon Termination of Group Hospital, Surgical or Major Medical Coverage. - A group policy delivered or issued for delivery in this state which insures employees or members for hospital, surgical or major medical insurance on an expense incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy has been terminated shall be entitled to have a converted policy issued to him by the insurer under whose group policy he was insured, without evidence of insurability, subject to the following terms and conditions:

1. A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred:

(a) because of termination of employment or membership and either he was not entitled to continuation of group coverage under Section B

or failed to elect such continuation, or

(b) because he failed to make timely payment of any required contribution, or

(c) for any other reason and he had not been continuously covered under the group policy (and for similar benefits under any group policy which it replaced) during the entire three months' period ending with such termination, or

(d) because the group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within thirty-one days of the date of termination.

2. Written application and the first premium payment for the converted policy shall be made to the insurer not later than thirty-one days after such termination. Its effective date shall be the day following the termination of insurance under the group policy.

3. The premium for the converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

4. The converted policy shall cover the employee or member and his dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

5. The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by Medicare. Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(a) (i) such person is covered for similar benefits by another individual policy, or

(ii) such person is or could be covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured, or

(iii) similar benefits are provided for or available to such person, by reason of any state or federal law, and

(b) the benefits under sources of the kind referred to in (i) above for such person, or benefits provided or available under sources of the kind referred to in (ii) and (iii) above for such person, together with the converted policy's benefits would result in overinsurance according to the insurer's standards for overinsurance.

6. A converted policy may provide that the insurer may at any time request information of any person covered thereunder as to whether he is covered for the similar benefits described in 5 (a) (i) above or is or could be covered for similar benefits described in 5 (a) (ii) and (iii) above. The converted policy may provide that as of any premium due date the insurer may refuse to renew the policy or the coverage of any insured person for the following reasons only:

(a) either those similar benefits for which such person is or could be covered, together with the converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance, or the policyholder of the converted policy fails to provide the requested information;

(b) fraud or material misrepresentation in applying for any benefits under the converted policy;

(c) eligibility of the insured person for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy;

(d) other reasons which may be approved by the Commissioner of Insurance:

7. An insurer shall not be required to issue a converted policy providing benefits in excess of the hospital, surgical or major medical insurance under the group policy from which conversion is made.

8. The converted policy shall not exclude, as a preexisting condition, any condition covered by the group policy. However, the converted policy may provide for a reduction of its hospital, surgical or medical benefits by the amount of any such benefits payable under the group policy after the individual's insurance terminates thereunder. The converted policy may also provide that during the first policy year, the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.

9. Subject to the provisions and conditions of this Act, if the group insurance policy from which conversion is made insures the employee or member for basic hospital or surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing, at his option, coverage on an expense incurred basis under any of the following plans:

Plan A

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the

major metropolitan area of this state, for a maximum duration of seventy days,

(b) miscellaneous hospital expense benefits up to a maximum amount of ten times the hospital room and board daily expense benefits, and

(c) surgical expense benefits according to a surgical procedures schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of eight hundred dollars.

Plan B

Same as Plan A, except that (a) the maximum hospital room and board daily expense benefit is 75% of the corresponding Plan A maximum and (b) the surgical schedule maximum is six hundred dollars.

Plan C

Same as Plan A, except that (a) the maximum hospital room and board daily expense benefit is 50% of the corresponding Plan A maximum and (b) the surgical schedule maximum is four hundred dollars.

The maximum dollar amount for Plan A's hospital room and board daily expense benefits shall be determined by the Commissioner of Insurance and may be redetermined by him from time to time as to converted policies issued subsequent to such redetermination. Such redetermination shall not be made more often than once in three years. Such Plan A maximum, and the corresponding maximums in Plans B and C, shall be rounded to the nearest multiple of $10., provided that

rounding may be to the next higher or lower multiple of $10. if otherwise exactly midway between.

0. Subject to the provisions and conditions of this Act, if the group policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(a) A maximum benefit at least equal to either, at the option of the insurer, (i) or (ii) below:

(i) A maximum payment per covered person for all covered medical expenses incurred during that person's lifetime, equal to the smaller of:

(1) The maximum benefit provided under the group policy; or

(2) $250,000.

(ii) A maximum payment for each unrelated injury or sickness, equal to the smaller of:

(1) The maximum benefit provided under the group policy; or

(2) $250,000.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000., after which benefits will be paid at the rate of 100% during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50%.

(c) A deductible for each benefit period which, at the option of the insurer,

shall be (i) the sum of the benefits deductible and $100., or (ii) the corresponding deductible in the group policy. The term "benefits deductible", as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other group or individual hospital, surgical, or medical insurance policy or medical practice or other prepayment plan, or any other plan or program whether insured or uninsured, or by reason of any state or federal law and if, pursuant to condition 11, the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by (a) (ii) above, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is $100. or less, and not less than six months if the deductible exceeds $100.

(d) The benefit period shall be each calendar year when the maximum benefit is determined by (a) (i) above or twenty-four months when the maximum benefit is determined by (a) (ii) above.

(e) The term "covered medical expenses" as used above, shall include at least, in the case of hospital room and board charges, the dollar amount in Plan A of condition 10, and at least twice such amount for charges in an intensive care unit. Any surgical procedures schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a $1200. maximum benefit.

11. At the option of the insurer, such plans of benefits set forth in conditions 9 and 10 may be provided under one policy, or, in lieu thereof, the insurer may provide a policy of Comprehensive Medical Expense Benefits without first dollar coverage. Said policy shall conform to the requirements of condition 10, provided, however, that an insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100., a high deductible option between $500. and $1000., and a third deductible option midway between the high and low deductible options. Alternatively, such a policy may provide for deductible options equal to the greater of the benefits deductible and the amount specified in the preceding sentence.

12. The insurer may, at its option, offer alternative plans for group health conversion in addition to those required by this Act. Furthermore, if any insurer customarily offers individual policies on a service basis, that insurer may, in lieu of converted policies on an expense incurred basis, make available converted policies on a service basis which, in the opinion of the Commissioner of Insurance, satisfy the intent of this Act.

13. In the event coverage would be continued under the group policy on an employee or member following his retirement prior to the time he is or could be covered by Medicare, the employee or member may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had that insurance terminated at retirement.

14. The converted policy may provide for reduction or termination of coverage of any person upon his eligibility for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.

15. Subject to the conditions set forth above, the conversion privilege shall also be available (i) to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or if the group policy provides for continuation of dependents coverage following the employee's or member's death, at the end of such continuation, (ii) to the spouse of the employee or member upon termination of coverage of the spouse, by reason of ceasing to be a qualified family member under the group policy, while the employee or member remains insured under the group policy, including such children whose coverage under the group policy terminates at the same time, or (iii) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

16. If the benefit levels required in conditions 9 and 10 above exceed the benefit levels provided under the group policy, the converted policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in conditions 9 and 10.

17. The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

18. A notification of the conversion privilege shall be included in each certificate of coverage.

9. A converted policy which is delivered outside this state may be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

The provisions of this Act shall take effect (insert a date not less than 12 months after the date of enactment) and shall apply to group policies delivered, issued for delivery or amended on or after said date.

S.E. 1

(1) Amend Section 1, Page 2, Line 25

Following: "date"

Strike: remainder of line 25

Insert: individual as if he had commenced coverage under an individual policy identical to the group policy at the time he qualified for such group coverage.

(2) Amend Section 1, Page 3, Line 1

Strike: Line 1

(3) Amend Section 1, Page 3, Line 3

Following: "employed"

Add: and/or Trustee of the plan

(4) Amend Section 1, Page 3, Line 10

Following: "group."

Add: Such person shall be responsible for payment of all premiums directly to the insurer and the employer and trustee of the plan are not liable for collection of premium, notice of default, or other such obligations owed to full time employ

Western Life Insurance Company

A Stock Company

385 WASHINGTON STREET ST. PAUL, MINNESOTA 55102

(HEREINAFTER CALLED THE COMPANY)

CERTIFIES that the Insured Person named below is insured for the coverage listed in the Schedule for which an amount is shown under Limit of Benefits, subject to the terms, conditions and limitations of the Group Policy (certain provisions of which are summarized in this Certificate). Any reference to "the Policy" or "the Group Policy" means the Group Policy under which this Certificate of Insurance is issued. The Group Policy is on file at the office of the Policyholder and may be examined upon request.

This Certificate of Insurance is issued in accordance with the terms of the Group Policy. As a Certificate, it explains but does not constitute the contract of coverage.

SAMPLE

Ralph E. Young

President

GROUP TERM LIFE INSURANCE CERTIFICATE

GL-243

51376

SCHEDULE

Group Policy Number	Issued to: (hereinafter called the Policyholder)	Effective Date*
3—1760	Trustees of the St. Paul Employers Group Insurance Trust	
Participating Employer:		*If actively at work for the Participating Employer full time performing all the duties of his regular occupation at his customary place of employment at least 20 hours per week.
Certificate Number	Issued to: (hereinafter called the Insured Person)	
Name and Relationship of Beneficiary: Unless changed as provided in this certificate, the beneficiary shall be as designated in the application for this insurance.		

LIMIT OF BENEFITS	DESCRIPTION OF BENEFITS
	Life Insurance (This amount of Life Insurance is subject to change in accordance with the Group Policy.)
	Total and Permanent Disability Benefits (The amount of Life Insurance for which premiums will be waived.)

51377

DEFINITIONS

(1) The term "Person" as used in the Policy means any employee who is employed and compensated by a Participating Employer and who is actively at work full time performing all of the duties of his regular occupation at his customary place of employment at least 20 hours per week. The term shall include, if the Participating Employer is a sole proprietorship or partnership, only the sole proprietor or partners who devote full time to the business of the proprietorship or partnership. The term shall include, if the Participating Employer is a corporation, any member of the board of directors whose annual compensation for services from the Participating Employer exceeds $2,000, provided such individual is actively at work full time for remuneration or profit by performing all the duties of his regular occupation at his customary place of employment at least 20 hours per week. The term shall nevertheless exclude, with respect to each Participating Employer, that class of individuals designated to be excluded, if any, on his "Application for Group Coverage and Trust Participation".

(2) The term "Insured Person" as used in the Policy means a Person who has become insured and only while he remains insured under the Policy.

(3) The term "Scheduled Amount of Life Insurance" as used in the Policy means the amount of life insurance for which a Person is eligible in accordance with the Benefit Schedule elected by and appearing on his Participating Employer's "Application for Group Coverage and Trust Participation".

SCHEDULE

Group Policy Number	Issued to: (hereinafter called the Policyholder)	Effective Date*
3–1730	Trustees of the St. Paul Employers Group Insurance Trust	
Participating Employer:		*If actively at work for the Participating Employer full time performing all the duties of his regular occupation at his customary place of employment at least 20 hours per week.
Certificate Number	Issued to: (hereinafter called the Insured Person)	

Name and Relationship of Beneficiary:
Unless changed as provided in this certificate, the beneficiary shall be as designated in the application for this insurance.

LIMIT OF BENEFITS	DESCRIPTION OF BENEFITS
	Life Insurance (This amount of Life Insurance is subject to change in accordance with the Group Policy.)
	Total and Permanent Disability Benefits (The amount of Life Insurance for which premiums will be waived.)

CERTIFICATE AMENDMENT

Definitions: Wherever used in this Amendment:

"Group Deposit Accumulation Policy" means Group Deposit Accumulation Policy No. 3-1900, issued to the Policyholder by the Company.

"Unit of Deposit" means the units of any deposit accumulation plan available under the Group Deposit Accumulation Policy in connection by a Person to provide benefits on his behalf when his life insurance under the Group Policy terminates.

The provisions of the Certificate to which this Amendment is attached are hereby amended as follows:

(1) Regardless of anything to the contrary in the Amount of Insurance provision, the amount of a Person's life insurance under the Group Policy shall in no event be reduced to less than $1,000 for each of his Units of Deposit in force under the Group Deposit Accumulation Policy.

(2) Item (4) of the Termination of Insurance provision is amended to read as follows:

"(4) the end of the policy month preceding the month in which he attains age 70 unless he is then covered under the Group Deposit Accumulation Policy, in which case his insurance shall terminate when his coverage under the Group Deposit Accumulation Policy terminates."

(3) The Conversion Privilege provision is amended to add the following paragraph:

(D) If an Insured Person is covered under the Group Deposit Accumulation Policy and his life insurance under the Group Policy terminates because of termination of the Group Policy, termination of the Group Policy with respect to the Participating Employer, or amendment of the Group Policy so as to terminate all life insurance for the class to which the Insured Person belongs, the Insured Person shall be entitled to convert his terminated life insurance in the same manner and to the same type of individual policy as described in paragraph (A) above, subject to the following conditions and limitations:

(i) the amount of the individual conversion policy shall be limited to $1,000 for each of the Insured Person's Units of Deposit in force under the Group Deposit Accumulation Policy on the date his life insurance terminated, and

(ii) if any of the Insured Person's Units of Deposit have been in force for less than three years as of the date his life insurance terminated, the Insured Person must furnish evidence of his insurability satisfactory to the Company, otherwise the amount of the individual conversion policy shall be limited to the greater of the following:

(1) the amount of the conversion policy which would be issued under paragraph (B) above, or

(2) an amount equal to $1,000 for each of the Insured Person's Units of Deposit which had been in force for at least three years on the date his life insurance terminated.

(4) Regardless of anything to the contrary in the Conversion Privilege provision, if an Insured Person is covered under the Group Deposit Accumulation Policy and, upon the termination of his life insurance under the Group Policy, he converts such insurance to an individual life insurance policy on the plan which forms the basis for his Units of Deposit under the Group Deposit Accumulation Policy, a separate individual conversion policy will be issued for each election of the Insured Person's Units of Deposit in force when his life insurance terminated. The amount of each individual conversion policy so issued shall be equal to $1,000 multiplied by the number of Units of Deposit corresponding to that election. The premium for each individual conversion policy shall be based on the Insured Person's class of risk and age nearest birthday on the date he elected the Units of Deposit and on the Company's rates applicable to the amount and form of the individual conversion policy on such date.

(over)

If the amount of life insurance that the Insured Person converts exceeds the sum of the amounts of the individual conversion policies which are issued in accordance with the preceding paragraph, an additional conversion policy shall be issued for the excess. The premium for this individual conversion policy shall be based on the Insured Person's class of risk and age nearest birthday on the date his life insurance under the Group Policy terminated and on the Company's rates applicable to the amount and form of the individual conversion policy on such date.

This Amendment is hereby made a part of the Certificate to which it is attached and is effective as of the effective date of said Certificate.

SECRETARY

PRESIDENT

DEATH BENEFIT

Upon receipt of due proof of the Insured Person's death, the Company will pay the amount of insurance in force on his life at the date of death.

AMOUNT OF INSURANCE

The amount of insurance in force on the life of the Insured Person shall be in accordance with the Benefit Schedule elected by and appearing on his Participating Employer's "Application for Group Coverage and Trust Participation".

Initial and subsequent amounts of life insurance of any Person who has attained age 66 prior to becoming insured under the Group Policy shall be equal to his Scheduled Amount of Life Insurance reduced by 20% of such Scheduled Amount of Life Insurance for each year that his age exceeds age 65.

The amount of life insurance of any Person who attains age 66 while insured under the Group Policy shall, on the first day of the policy month in which he attains age 66 and on the same day of each succeeding year, be reduced by 20% of his Scheduled Amount of Life Insurance.

Any increase in the amount of insurance on the life of the Insured Person for any reason, including any subsequent change in plan election by his Participating Employer, shall become effective subject to the Effective Date of Insurance provision of the Group Policy.

Any decrease in the amount of insurance on the life of the Insured Person for any reason shall become effective on the date he becomes subject to such decrease. In no event shall the Insured Person be entitled to any benefits provided under the conversion privilege of the Group Policy with respect to any decrease in the amount of his insurance.

SUICIDE

If the Insured Person, whether sane or insane, shall commit suicide within two years from the effective date of his insurance, the liability of the Company with respect to such insurance shall be limited to the amount of premiums paid therefor.

If the Insured Person, whether sane or insane, shall commit suicide within two years from the effective date of any increase in the amount of his insurance, the liability of the Company with respect to such increase in amount of insurance shall be limited to the amount of premiums paid therefor.

TERMINATION OF INSURANCE

The insurance of any Person shall automatically terminate on the earliest of the following dates:

(a) the date of termination of the Policy;

(b) the date he ceases to be eligible as a Person as defined in the Policy;

(c) the date of cessation of the Person's Participating Employer's participation under the Trust Agreement or the Policy;

(d) if the Person fails to make the required premium contribution, the end of the policy month for which he made his last premium contribution;

(e) the date he enters the armed forces of any country or the service of any governmental agency which involves employment outside the United States;

(f) the end of the policy month preceding the month in which he attains age 70.

If a Person ceases to be eligible as a Person by reason of termination of employment, termination shall be deemed to have occurred when the Person ceases active work with his Participating Employer. If a Person ceases active work because of disability, an approved leave of absence or a temporary lay-off, he will nevertheless be considered as employed for a period of 31 days following the date he ceases active work unless the Policyholder, acting in accordance with rules precluding individual selection, discontinues such Person's insurance by giving written notification to the Company to that effect, or by discontinuing premium payments for such insurance. However, upon notice to and approval by the Company such Person's insurance may be extended for an additional 12 months in case of disability or an approved leave of absence, subject to payment of the required premium.

CONVERSION PRIVILEGE

(A) At any time within thirty-one (31) days after termination of his insurance or any portion of it, because of termination of employment for any reason whatsoever, the Person shall be entitled to convert all or part of his insurance so terminated, without evidence of insurability, to an individual policy of life insurance only on one of the forms then customarily issued by the Company (except term insurance and any policy containing disability or other supplementary benefits) in an amount not in excess of the amount of life insurance which ceases because of such termination, provided application for such policy shall be made and the first premium paid within thirty-one (31) days after such termination of insurance. Such premium shall be based on the class of risk to which he belongs and on the form and amount of the policy at his then attained age on the effective date of the individual policy.

(B) If the Group Policy terminates, or if the Group Policy terminates with respect to the Participating Employer, or if the Group Policy is amended so as to terminate the insurance of any class of Insured Persons, each such Person insured on the date of such termination whose insurance terminates and who has been so insured under the Group Policy for at least five (5) years prior to such termination date shall be entitled to have issued to him by the Company an individual policy of life insurance, subject to the same conditions and limitations of paragraph A above except that the amount of such individual policy shall not exceed the smaller of (a) the amount of the Person's life insurance ceasing because of termination or amendment of the Group Policy, less the amount of any life insurance for which he is or becomes eligible under any group policy issued or reinstated by the Company or any other insurer within thirty-one (31) days after such termination, and (b) Two Thousand Dollars ($2,000 00).

(C) If a Person insured under the Group Policy dies during the period within which he would have been entitled to apply to the Company to have an individual policy issued to him in accordance with operation of either paragraph A or B above and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued to him under such individual policy shall be payable as a claim under the Group Policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

OPTIONAL METHODS OF SETTLEMENT

In lieu of payment in one sum, the Insured Person may elect by filing written request at the Home Office of the Western Life Insurance Company, or if no such election has been filed by the Insured Person prior to death, the beneficiary may elect that payment of the amount of any death benefit be made in accordance with the following table, the first installment to be paid immediately upon receipt of due proof of death. If the election of the optional method of settlement has been made by the Insured Person, the beneficiary shall not have the right to change the method of settlement unless such right is given to the beneficiary by the Insured Person in writing and is endorsed on this Certificate of Insurance.

TABLE OF INSTALLMENT PAYMENTS PER $1,000 OF DEATH BENEFIT

Number of Years During Which Installments Will Be Paid	Amount of Each Installment Payment	
	Annual	Monthly
1	$1,000.00	$84.28
2	506.17	42.66
3	341.60	28.79
4	259.33	21.86
5	210.00	17.70
10	111.47	9.39
15	78.80	6.64
20	62.58	5.27

If the beneficiary or beneficiaries shall die before receiving all of the installments to which such individual or individuals may be entitled under this provision, the unpaid installments will be commuted at the rate of two and one-half per cent (2 ½ %) per annum compound interest and paid in one sum to the executors or administrators of the beneficiary.

INSURED PERSON MAY CHANGE BENEFICIARY

The Insured Person may from time to time change his beneficiary without notice to or consent of such beneficiary by filing written notice of such change with the Company. No such change shall take effect until received and recorded by the Company at its Home Office. Upon being recorded, any such change will be effective as of the date it was executed, whether or not the Insured Person is living when such change is recorded; except that the Company shall not be prejudiced by any payment made or action taken inconsistent with such change before recording.

BENEFICIARY DESIGNATION

Any sum becoming due on account of the death of the Insured Person shall be payable to the beneficiary or beneficiaries designated by him and filed at the Home Office of the Western Life Insurance Company or at the Principal Office of the Policyholder, provided that if any designated beneficiary predeceases the Insured Person, the share which such beneficiary would have received if living, shall, except as may be otherwise specifically provided, be payable equally to the remaining designated beneficiary or beneficiaries, if any, who survive the Insured Person and that if no designated beneficiary survives, or if no beneficiary has been designated, such sum shall be payable to the widow or widower surviving the Insured Person; if not surviving, in equal shares to the Insured Person's children who survive him; if none survive him, to his parents, equally, if both survive him, or to the survivor if only one survives; if neither survive, in equal shares to the Insured Person's brothers and sisters who survive him; or if none survive, to the Insured Person's estate; provided further that the Company may deduct from the sum payable an amount not to exceed Two Hundred Fifty Dollars ($250.00), and pay to any person appearing to the Company to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or the death of the Insured Person.

If a beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due, the Company may, at its option, and until claim is made by the duly appointed guardian or committee of such beneficiary, make payment to such beneficiary or to any relative by blood or by marriage of such beneficiary or to any other person or institution appearing to have assumed the custody and principal support of such beneficiary.

Payment to any one of the above named shall, to the extent thereof, release Western Life Insurance Company from all further liability.

RIGHTS OF ASSIGNMENTS

Ownership of all rights afforded under the Policy to the Insured Person vests in such Person in the absence of an assignment made pursuant to this provision. The Insured Person, or the assignee to whom such Person may have assigned pursuant to this provision, may assign the Insured Person's personal group life insurance under the Policy, subject to the following terms and conditions:

(a) No assignment shall affect the Company's rights or obligations under the Policy unless it is in writing on a form acceptable to the Company and until a duplicate thereof is received and recorded by the Company at its Home Office. Upon being recorded, any such assignment will be effective as of the date it was executed, whether or not the assignor is living when the assignment is recorded; except that the Company shall not be prejudiced by any payment made or action taken inconsistent with such assignment before recording. The Company assumes no responsibility for the effect, sufficiency or validity of any assignment.

(b) An assignment must transfer absolutely to the assignee all the rights, privileges, options and incidents of ownership accruing to the Insured Person under the Policy and this Certificate of Insurance, including but not limited to the rights to change beneficiaries and exercise the conversion privilege. All previous designations of beneficiaries and all previous directions for the payment of proceeds are cancelled and revoked by the making of an assignment.

(c) An assignment may be made only with the written consent of an irrevocable beneficiary, if any.

(d) An assignment may be made only if the Insured Person's amount of personal group life insurance is at least $15,000 at the date of assignment. Personal group life insurance as used herein means group life insurance provided under the Policy on the life of the Insured Person.

INCONTESTABILITY

No statement made by the Insured Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two (2) years during such Person's lifetime nor unless it is contained in a written instrument signed by him.

MISSTATEMENT OF AGE

If the age of the Insured Person has been misstated, the amount payable shall be the full amount of insurance to which he is entitled at his true age. A premium adjustment shall be made so that the Policyholder shall pay the Company the actual premium called for at such age.

AGREEMENT

MONTANA PHYSICIANS' SERVICE
404 Fuller Avenue • P.O. Box 4309 • Helena, Montana 59601 • (406) 442-5450

BLUE SHIELD
Medical • Surgical • Hospital

THIS AGREEMENT, which provides for payments to the extent set forth herein, and in any Endorsement hereto, for specified medical, surgical and hospital services as herein defined, is issued this 1st day of October, 19 80

By MONTANA PHYSICIANS' SERVICE, a non-profit health service corporation organized and existing under the laws of the State of Montana (hereinafter called MPS) to

Security State Bank

Box 1291 - Polson, Montana

(hereinafter called the Group).

IN CONSIDERATION OF (a) statements in any applications, and (b) payment in advance by the Group of the enrollment fee and monthly dues as set forth in the "Group Application for Membership," which is by this reference made a part of this Agreement, and upon actual receipt of such consideration, MPS agrees to make payment for such services subject at all times to the terms, conditions and provisions of this Agreement, and in any Endorsements by MPS hereto.

ARTICLE ONE — DEFINITIONS

"AGREEMENT" means this Agreement, together with any Endorsements made by MPS hereto, and the same constitutes the only agreement between MPS and the Group.

"BENEFICIARY MEMBER" means a person in said Group who has applied for beneficiary membership, has been accepted as a Beneficiary Member of MPS, and who maintains such membership in MPS through said Group in accordance with this Agreement.

"BENEFICIARY MEMBERSHIP CERTIFICATE" means and is the same as the Identification Card.

"BENEFITS" means the payments, to the extent herein set forth, for specified Professional Services and Hospital Services rendered, furnished or supplied to a Beneficiary Member, under the provisions and conditions of and recognized by this Agreement.

"BENEFIT PERIOD" means the period of time specified in Article Six, Section III thereof, during which Professional Services as set forth in Article Four and Hospital Services as set forth in Article Five will be paid.

"EFFECTIVE DATE" means the date on which an Applicant who has met the requirements of the Agreement is, as shown on the records of MPS, accepted by MPS as a Beneficiary Member and becomes eligible for benefits under this Agreement. The effective date for any Endorsement shall be the same unless otherwise stated on such Endorsement.

"FAMILY MEMBER" means a person who has been enrolled as such by a Beneficiary Member and who is either his spouse, his unmarried child under the age of 23 years, or an unmarried child under the age of 23 years for whose support the Beneficiary Member is legally responsible.

"GROUP" means the organization, employing unit or trust which has accepted this Agreement and to which it has been issued, together with the Beneficiary Members and their Family Members.

"HOSPITAL SERVICES" means the services itemized under Article Five hereof when rendered in a Hospital as herein defined and when prescribed by a physician duly licensed to practice medicine. Hospital Services not specifically itemized under Article Five are hereby specifically excluded from the operation of this Agreement, and are not a subject of benefits hereunder.

"MEMBERSHIP YEAR" in the calendar year in which a Member's coverage under this Agreement becomes effective, means the period between the effective date of a Member's coverage under this Agreement and January 1st of the ensuing year, and thereafter shall mean calendar year. All benefits paid by MPS (under this Agreement and under other MPS Agreement(s) under which the Member was previously covered), in the calendar year in which the Member's coverage under this Agreement becomes effective, shall be included in computation of maximum benefits payable per membership year hereunder. Amounts credited toward satisfaction of deductibles under other MPS Agreements, under which the Member was previously covered in the calendar year during which the Member's coverage hereunder becomes effective, shall be credited toward satisfaction of deductibles imposed in this Agreement.

"INPATIENT" means a Member who has been admitted to a Hospital and registered by it as a registered bed patient and who is receiving services under the direction of a physician duly licensed to practice medicine.

"HOSPITAL" means any Hospital licensed as such by the state of its situs which is primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment, and in the care of obstetrical cases by or under the supervision of a staff of physicians who are duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing service under the supervision or direction of registered graduate nurses, and which is not, other than incidentally, a nursing home, a rest home, a convalescent home, a rehabilitation facility, a place for the care and treatment of drug addicts and/or alcoholics, a place for the care and treatment of pulmonary tuberculosis or a place for the care or treatment of mental or emotional disorders.

"MEMBER" means both Beneficiary Member and Family Members.

"MONTH" means a period of thirty (30) days. Monthly periods shall be computed as having thirty (30) days in each such period, irrespective of calendar overage or shortage.

"MONTHLY DUES" means the amounts of money to be paid monthly by the Group to keep this Agreement in force from month to month and includes both the payments required under this Agreement and the additional payments required under any Endorsements to this Agreement.

"MPS" whenever appearing in this Agreement, means "Montana Physicians' Service," a non-profit health service corporation organized and existing under the laws of the State of Montana.

"NECESSARY" as used in Article Eight, Subparagraph (L) or elsewhere in this Agreement and its Endorsements when reference is made to professional or hospital services, means that the services are based on valid medical need according to accepted standards of medical practice and are reasonably required for the treatment of active illness or injury. The fact that professional or hospital services were recommended or performed by a licensed physician does not automatically qualify such services as being necessary. It is understood by the parties to this Agreement that the determination of whether or not hospital or professional services were necessary involves questions of medical judgment which can only be made by physicians. The parties also understand that a determination as to whether or not services were medically necessary can normally be made only after the services have been rendered to the Member and a claim for benefits is submitted to MPS. In determining whether services were necessary, and therefore the subject of benefits under this Agreement, MPS has the right to consult with a physician, groups of physicians or national medical specialty organizations for advice on such matters.

"OUTPATIENT" means a Member who receives services from a physician duly licensed to practice medicine outside a hospital or who receives services in a hospital but for whom no room charge is made.

"PHYSICIAN DULY LICENSED TO PRACTICE MEDICINE" means any physician duly licensed to practice medicine and includes a licensed podiatrist.

"PROFESSIONAL CALL" means a personal interview between the Member and a Professional Member of MPS in the [illegible] of the Member or the office of the Professional Member, in which the Professional Member examines the Member in his immediate presence, and renders or prescribes medical treatment for active illness or injury. "Professional Calls" shall not include telephone calls or any other communications in which the Member's person is not examined by the Professional Member.

"PROFESSIONAL MEMBER" means any physician duly licensed to practice medicine who has applied and been accepted as a Professional Member of MPS by its Board of Trustees acting in compliance with the Articles of Incorporation and the By-Laws of MPS.

"PROFESSIONAL SERVICES" means the services itemized under Article Four when rendered by a physician duly licensed to practice medicine. Services not specifically set forth under Article Four are hereby specifically excluded from the operation of this Agreement, and are not a subject of benefits hereunder.

ARTICLE TWO—PREREQUISITES FOR BENEFITS

Section I: Payment of Enrollment Fee and Monthly Dues. The first month's dues must be paid to, and accepted by, MPS before this Agreement is in effect.

Section II: Monthly Dues. Dues are payable to MPS by each Beneficiary Member through the Group in advance at the times and in the amounts computed in accordance with the single or family status of each particular Beneficiary Member as set forth in the "Group Application for Membership."

Section III: Disqualification for Benefits. Failure to comply with the following prerequisites for benefits shall constitute complete disqualification for any and all benefits to which the Member would otherwise be entitled under this Agreement:

(A) An MPS Member must truthfully identify himself to the Professional Member as a Member of MPS in good standing upon first applying for Professional Services.

(B) Claims for Benefits payable under this Agreement must be submitted to MPS at its office herein designated no later than December 31 of the calendar year following the year in which the covered care or service was provided. Such claim must identify the services for which payment is sought in sufficient detail as will permit MPS to determine whether or not such services are covered under the Agreement.

(C) An MPS Member must make any and all claims for benefits under this Agreement to MPS at its office herein designated upon such forms and in such manner as MPS may from time to time prescribe.

ARTICLE THREE—CONDITIONS OF MEMBERSHIP

Section I: Enrollment of Beneficiary Member. A Period of Eligibility is the period set forth in the "Group Application for Membership," during which MPS will enroll Applicants for beneficiary membership. MPS may, in its discretion, accept or reject applications for membership submitted after the Period of Eligibility subject to such regulations as it may from time to time establish.

Section II: Enrollment of Family Members. Application may be made for enrollment of Family Members when an Applicant applies for their membership before the end of this period of eligibility OR application may be made by a Beneficiary Member for enrollment of Family Members when the Beneficiary Member applies for their membership within sixty (60) days after such Beneficiary Member has acquired them whether by birth, marriage, adoption or otherwise. The Benefits of this Agreement will, however, be available to the newborn child of a Member who is entitled to Benefits hereunder from the date of birth of such child subject to payment of appropriate dues, if any, on behalf of such child.

Section III: Commencement of Benefits. An Applicant who is a member of the organization or employing unit or beneficiary of the trust to which this Agreement is issued, upon acceptance by MPS of his Application for Membership, is entitled to the benefits of this Agreement as a Beneficiary Member, provided the required dues have been paid in advance, upon his Effective Date, except that if he, or any enrolled Family Member, is confined to a hospital on his Effective Date, benefits will not be available to such Member until the first day following such Member's discharge from the hospital.

Section IV: Eligibility for Membership. An Applicant for beneficiary membership in MPS and for benefits under this Agreement must be in a class of employees specified as eligible for coverage under this Agreement in a Group Application for Membership which is attached hereto and made a part of this Agreement.

ARTICLE FOUR – PROFESSIONAL SERVICES, SERVICE BENEFITS AND REIMBURSEMENT

Section I: Service Benefits. Professional Members of MPS rendering Professional Services hereinafter specified in Section II of this Article Four shall render the services for the fees allowed by MPS, and no additional charge shall be made for such services by such Professional Members.

Section II: Professional Services Rendered by Professional Members of MPS. MPS will pay for the following Professional Services when rendered to Members by Professional Members of MPS for diagnosis and treatment of active illness or injury, subject at all times to the maximum benefit period set forth in Article Six of this Agreement EXCEPT THAT SERVICES rendered in connection with diagnosis and treatment of alcoholism, insanity, neuropsychiatric or mental conditions will be paid by MPS only while the Member is a hospital inpatient and shall be paid only for services rendered during a maximum period of thirty (30) days in each membership year. Payment by MPS shall at all times be subject to the terms, provisions, limitations and conditions contained in this Agreement, viz.:

(A) **Medical Services:** Such non-surgical Professional Services (i.e., hospital visits and consultations) as may be required by a Member while confined to a hospital as an Inpatient, including scoping procedures (i.e., entry by endoscope into the hollow organs or body cavities). For Members covered under Part B of Medicare, Medical Services shall also include Professional Calls as defined in Article One of this Agreement irrespective of the fact that Professional Calls for outpatient services may not be included as benefits for Members not covered under Part B of Medicare.

(B) **Surgical Services:** Such surgical procedures as involve cutting or incision, care of fractures and dislocations, suturing of wounds, treatment of burns, removal of foreign bodies, aspirations for drainage, scoping procedures for excision and destruction of tissue by electrical, mechanical or chemical methods, and postoperative care directly and immediately related to the foregoing surgical procedures, but no others.

(C) **Outpatient Emergency Service:** Professional Services required in and for the treatment of accidental injuries as an Outpatient within seventy-two (72) hours of the time such injuries are sustained. Professional Services will include professional calls for medical or surgical services and x-ray and laboratory examinations relating to the injury.

(D) **Radiation Therapy:** Including isotope, x-ray and radium therapy.

(E) **Anesthesia:** Including general anesthesia administered for care of a condition for which Professional Services are payable. Anesthesia services are not payable by MPS when rendered by the doctor in charge of the case.

Section III: Professional Services Rendered by a Physician Duly Licensed to Practice Medicine or Surgery who is not a Professional Member of MPS. For Professional Services specified in Section II of this Article Four, rendered to a member by a physician duly licensed to practice medicine or surgery (includes a licensed podiatrist) who is not a Professional Member of MPS, the Beneficiary Member shall be reimbursed by MPS in the amount of the physicians' charge OR the average charge for the service that is payable to Professional Members of MPS; which ever amount is lesser.

ARTICLE FIVE – HOSPITAL SERVICES

(A) **Hospital Room, Services and Supplies:** MPS hereby agrees to reimburse the Beneficiary Member, up to the limits hereinafter stated, toward the expense of the following Hospital Services when the same are regularly furnished by a Hospital, as herein defined, when the Member requires hospital care as an Inpatient, for such period as does not exceed the Maximum Benefit Period set forth in Article Six of this Agreement, viz.:

(1) Up to the sum of Eighty Dollars ($ 80.00) per day for hospital room charges which includes hospital room, meals, dietitian services and general nursing care. The foregoing amount can be applied to charges for intensive care units or coronary care units.

(2) The customary and reasonable cost of the following services: Laboratory Procedures, Operating Room, Cystoscopic Room, Anesthesia Administered by a Hospital Employee, Oxygen, Splints, Casts, Dressings, Surgical Supplies, Anesthetic Supplies, X Rays and Electrocardiograms, Drugs and Medications which are listed in the U.S. Pharmocopoeia, U.S. Formulary or New and Non-official Remedies, Intravenous Feedings, Physical Therapy.

LIMITATION:

1. The foregoing Hospital Services, when rendered in connection with diagnosis or treatment of insanity, neuropsychiatric or mental conditions, will be paid by MPS as provided in this Article Five ONLY while the Member is hospitalized as a hospital inpatient.

2. The foregoing Hospital Services, when rendered in connection with diagnosis or treatment of alcoholism will be paid by MPS as provided in this Article Five ONLY while the Member is hospitalized for detoxification as a hospital inpatient.

3. The maximum period during which benefits will be payable in (1) and (2) of this paragraph will be limited to thirty (30) days in the aggregate in each membership year.

(B) **Emergency Room Service:** For services required in and for the treatment of accidental injuries as an Outpatient within seventy-two (72) hours of the time such injuries are sustained and for surgical services as defined in Article Four of this Agreement, MPS will pay the cost of the following: use of operating room, surgical and anesthetic supplies, anesthesia services, splints, casts, dressings and approved drugs and medications regularly furnished by the Hospital.

(C) **Ambulance Service:** MPS will provide payment of reasonable charges for professional ambulance service to the nearest appropriate facility providing Inpatient hospital accommodations up to a maximum of one hundred (100) miles of ambulance travel for any one accident or sudden acute illness.

(D) **Nursery Care:** MPS will pay the customary and reasonable charges of a licensed Hospital for nursery care of newborn infants during the necessary confinement of the mother as a Hospital Inpatient as the result of childbirth.

(E) Dental Services: MPS will provide payment of reasonable charges for the following services:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such injuries have occurred while the Member is covered under this plan.

Excision of exostoses of the jaws and hard palate.

Treatment of fractures of facial bones.

Incision of accessory sinuses, salivary glands or ducts.

Reduction of dislocations of, and excisions of, the temporomandibular joints.

ARTICLE SIX – BENEFIT PERIOD, MAXIMUM BENEFIT PERIOD, PERIOD OF DISABILITY, WAITING PERIOD

Section I: Maximum Benefit Period Applicable to both Professional Services and Hospital Services. Payment and/or reimbursement by MPS for Professional Services and/or Hospital Services as specified and defined in this Agreement shall be limited to services rendered during a maximum period of one hundred twenty (120) days in each period of disability, hereby designated the Maximum Benefit Period, except where other limits of shorter duration and/or maximum allowances are specifically set forth limiting services.

Section II: Period of Disability. A "period of disability" as used in this Agreement means: (a) an unbroken succession of one hundred twenty (120) days during which services covered under this Agreement are continuously rendered; OR (b) a series of shorter terms of successive days (i.e., 1, 5, 10, 20 or 30 days) which in the aggregate do not exceed one hundred twenty (120) days. Upon the expiration of an unbroken succession of one hundred twenty (120) days OR upon the expiration of shorter terms aggregating one hundred twenty (120) days, the Member shall not be entitled to any further benefits until discharged from the hospital and until a full period of seven (7) days shall have elapsed in which readmission to the hospital has not occurred. In no case will a Member be entitled to another period of disability until the Member has been out of the hospital for a full period of seven (7) days. Any day upon which service is rendered shall be counted as one (1) day of service in computation of maximum benefits available for each Period of Disability.

ARTICLE SEVEN – COORDINATION OF BENEFITS

If a Member entitled to benefits hereunder is covered by any other plan* providing benefits similar to the benefits provided in this Agreement, then in any such case MPS shall be liable for the benefits enumerated herein only after the Member first duly exhausts all benefits available to him under such other plan.

*Plan means any program of group, blanket or franchise insurance coverage, Blue Cross, Blue Shield or other prepayment coverage, coverage under a labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan, including any federal or state or other government plan or law.

ARTICLE EIGHT – EXCLUSIONS FROM ANY BENEFITS UNDER THIS AGREEMENT

The following conditions, services, treatments and procedures are wholly EXCLUDED from any conditions, services, treatments and procedures which are the subject of payment or reimbursement under this Agreement, and MPS will not make any payment or reimbursement for or on account of any thereof under any circumstances whatsoever, viz:

(A) Services and supplies for any injuries or any disease which arose or shall arise out of and/or in the course of the Member's employment by any employer, public or private, who, prior to the occurrence of such injury or disease, has been required by law, or has elected, to come under or be bound by the Workers' Compensation Act or the Occupational Disease Act of the State of Montana, or the Workers' Compensation Laws (however entitled) or Occupational Disease Laws (however entitled) of any state or any country, or Employer's Liability Laws of the United States, the State of Montana, or of any state or any country, whether or not the employee has received or shall receive any compensation by reason of such injury or such disease.

(B) Services and supplies which the Member is entitled to receive or which are provided by the government of the United States or are furnished to a Member in conjunction with any facility or program which exists under or by virtue of the laws of the United States, the State of Montana, or any political subdivision, department, agency, or instrumentality of the United States, the State of Montana, or any state or country, and in no event for services or supplies provided by the Veterans' Administration. The fact that any Member has not availed himself of the benefits of any such laws, or has been wholly or only partially reimbursed thereunder, shall not operate to entitle such Member to any Benefits under this Agreement.

(C) Services and supplies received by a Member for which payment and/or reimbursement is provided to or on behalf of such Member under the so-called "no fault" or "first party benefit" provisions of any automobile insurance policy - or for which such payment or reimbursement would have been provided but for the existence of this Agreement.

(D) Services and supplies for any injuries sustained or diseases contracted as a result of war, declared or undeclared, or any act of war, occurring on or after the Effective Date of enrollment.

(E) Dental care and treatments, dental surgery, dental appliances and any other services performed by dentists or oral surgeons except as such services are specifically included in Article Five, Section (E).

(F) Eyeglasses, contact lenses, and hearing aids and examinations for the prescription or fitting thereof.

(G) Services related to cosmetic surgery, a term meaning surgical procedures performed to improve appearance or to correct a deformity without restoring a bodily function; in the instance of the following and other procedures which might be considered "cosmetic", e.g., rhinoplasty (nose), rhytidectomy, surgical planning (dermabrasion), blepharoplasty (eyelid), mammoplasty (suspension, augmentation or reduction) and superficial chemosurgery (acid peel of the face) etc., benefits may only be provided if advance approval of coverage was obtained from MPS.

(H) Travel, whether or not recommended by a Physician.

(I) Convalescent or custodial care, and rest cures.

(J) Rehabilitation or rehabilitation therapy, whether as an Inpatient or Outpatient, and services and supplies in connection therewith.

(K) Surgery, medical treatment and services of any nature not necessary for treatment of active illness or injury (except sterilization operations) and surgery, medical treatment and services of any nature which are experimental in nature or which do not constitute accepted medical practice.

(L) Reversal of sterilization operations.

(M) Services or supplies for routine foot care including but not limited to surgical services involving the treatment or removal of corns, callosities, hypertrophy hyperplasia of the skin or any subcutaneous tissues, the cutting, trimming of the nails, treatment of flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet.

(N) Alcoholism, drug addiction, insanity, neuropsychiatric or mental conditions except as specifically included under Article Five as respects Hospital and other services and Article Four as respects Physicians' services.

(O) Services and supplies for which the Member has no legal duty to pay.

(P) Such benefits as are afforded by this Agreement shall be reduced to the extent that Benefits otherwise covered hereunder: (a) are provided or for which reimbursement is paid or payable, or (b) would have been provided or for which reimbursement would have been paid or payable had the Member who is or was entitled or eligible to enroll, been so covered under any state or federal program or programs of health care including but not limited to Title XVIII of the Social Security Act, 79 Stat. 291, et seq. (commonly referred to as "Medicare"), Parts A and B, and any amendments thereto.

(Q) Any charges for services commencing prior to the Member's coverage hereunder or after the termination of coverage.

(R) Services or charges incurred for acupuncture, transsexuality or related procedures, or any surgical or medical procedures determined by the medical staff of MPS, with appropriate consultation, to be experimental or not accepted medical practice.

(S) Services, supplies or charges for premarital, preemployment, or routine physical examinations, well-baby care, circumcision and immunizations.

(T) Admissions or portions thereof for (1) sanitarium care, rest cures and convalescent care, (2) physical or occupational therapy, or (3) custodial care, that being defined as care designated essentially to assist an individual to meet his activities of daily living such as, but not limited to services which constitute personal care including: help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered and which does not entail or require the continuous attention of trained medical personnel.

(U) Any medical social services or occupational, visual, speech, recreational, educational or milieu therapy.

(V) Any service or supply rendered to a Member for treatment of obesity or weight reduction by intestinal bypass or other surgery **except** when advance approval of coverage was obtained from MPS.

(W) Any service or supply rendered by a member of the patient's immediate family (parent, child, spouse, grandparent or in-law.)

(X) Any charges for services or supplies which are not listed as a benefit of this Agreement.

ARTICLE NINE — TRANSFER OF MPS MEMBERSHIP — REQUISITES — TERMINATION FOR CHILDREN

Section I: Transfer from Group. In the event any Beneficiary Member entitled to benefits under this Agreement loses affiliation with the Group, his MPS membership is thereby terminated, and such Member as of the date of loss of such affiliation is not entitled to any benefits hereunder. Such Member may, however, apply to MPS to transfer (with his Family Members if desired) to the MPS Direct Payments Program and if transfer is approved such person may be issued an appropriate MPS membership under the Agreement form then current and applicable to Members who do not have group affiliation.

In the event MPS declines to renew this Agreement because the Group fails to meet minimum participation percentages or minimum group size, as prescribed in the MPS Underwriting Regulations, Members holding membership in such Group will not be permitted to transfer to the MPS Direct Payments Program.

Section II: Termination of Benefits for Children. When a child who is enrolled as a Family Member reaches the age of twenty-three (23), or is married before reaching that age, benefits for such Family Member under this Agreement shall AUTOMATICALLY TERMINATE, without notice to the Beneficiary Member, Family Member or the Group.

Section III: Transfer or Continuation of Membership of Family Members. (A) The following persons are entitled to transfer membership to the Direct Payments Program, provided an application for such transfer is made in writing to MPS within thirty (30) days of the date of termination of their membership under this Agreement:

(1) Children of a Beneficiary Member, previously enrolled as Family Members whose eligibility as Family Members has terminated by reason of such child having reached the age of twenty-three (23) years or having married before reaching that age; and

(2) The spouse of a Beneficiary Member whose marriage to said Beneficiary Member has terminated by divorce or annulment; and

(3) Family Members of a Beneficiary Member who has died.

Section IV: Benefits to Member Hospitalized on Date of Transfer. Subject to the provisions of Sections II and III of this Article Nine, if on the effective date of transfer of his membership to the Montana Physicians' Service Direct Payments Program, a Member is confined to a hospital as an inpatient, MPS will continue to provide payment and/or reimbursement under the terms of this Agreement until such Member's discharge from the hospital or until the Maximum Benefit Period as herein defined in Article Six has elapsed from the date of the Member's admission to the hospital, whichever event occurs sooner.

ARTICLE TEN — GENERAL PROVISIONS

Section I: Articles of Incorporation and By-Laws of MPS Part of this Agreement. The parties hereto agree that the Articles of Incorporation of MPS and the By-laws of MPS, and any alterations and additions to such Articles and/or By-laws, are by this reference made a part of this Agreement, as fully and effectively as if set forth at length herein, and that the same are binding upon the parties hereto.

Section II: Identification Cards. Identification Cards will be issued by MPS to Beneficiary Members for presentation to Professional Members and hospitals in order that Professional Members and/or hospitals may determine the identity of such Beneficiary Members.

Section III: Acts of Third Parties. If the Member is injured through the act or omission of another person, MPS shall provide the benefits of this Agreement (excluding at all times the conditions, treatments and procedures beyond the scope of this Agreement), only on condition that the Members shall agree in writing to:

(A) Reimburse MPS to the extent of benefits provided, immediately upon collection of damages by him, whether by action of law, settlement or otherwise;

(B) Provide MPS with a lien, to the extent of benefits provided by MPS. The lien may be filed with the person whose act caused the injuries, his agent or the court.

Section IV: Persons Providing Services, Relation of MPS Thereto. Under the laws of Montana MPS cannot be licensed to practice medicine or surgery in any form, and MPS does not in any respect assume to do so. The relation between physician and patient is personal, private, and confidential. MPS is not liable for the negligence, wrongful acts, or omissions of any person, Professional Member, firm or corporation, physician duly licensed to practice medicine, physician, surgeon, podiatrist, Beneficiary Member, hospital or hospital employee, receiving or providing services, and in no instance shall MPS be liable for services or facilities which for any reason are unavailable to a Member.

Section V: Modification of Agreement. No agent or representative of MPS has power to change or modify any part or provision of this Agreement or any Endorsement hereto, or to waive any rights, limitations or requirements of MPS. No waiver of any provision hereof may be accomplished or shall be valid unless the same be in writing and signed by the President of MPS.

Section VI: Agreement Not Transferable. No person other than the Beneficiary Member or a Family Member listed on an application for Membership accepted by MPS shall be entitled to any benefits under this Agreement. This Agreement is not transferable. Services provided to any Member through a prior MPS Agreement shall be included in computing maximum benefits available to such Member under this Agreement.

Section VII: Payment of Professional Services and Hospital Services, Assignment Prohibited.

(A) Payment for Professional Services rendered by Professional Members of MPS will be made by MPS directly to Professional Members.

(B) Benefits payable to or for a Member under this Agreement are NOT assignable by the Member to any third party. MPS reserves the right, however, in its sole discretion, to make any payment or reimbursement due hereunder to the Member, or directly to the person or organization rendering service to the Member, or to them jointly or to any person, firm or corporation who has paid for such services on behalf of the Member.

Section VIII: Gender and Number. Wherever appearing herein, the masculine gender includes the feminine; the singular includes the plural.

ARTICLE ELEVEN — DURATION, RENEWAL AND TERMINATION OF AGREEMENT

Section I: Term. The term of this Agreement shall be one (1) month from its date of issue appearing on the face hereof. This Agreement may be renewed from month to month for a further term of one (1) month, subject to the consent of MPS, at such monthly dues rates as may be determined by MPS.

Section II: Modification of Agreement. This Agreement may be modified, altered, or amended by MPS by giving written notice to the Group, as provided in Article Twelve hereof, of the proposed modification, alteration, or amendment, at least fifteen (15) days prior to the expiration of any term as hereinabove in Section I of this Article Eleven provided, and payment of dues for the ensuing term pursuant to this Agreement, as so modified, altered or amended, shall constitute acceptance of such modification, alteration, or amendment, effective as of the first day of said ensuing term. Failure to pay dues to MPS as provided for in this Agreement, as so proposed to be modified, altered or amended, shall constitute a rejection of the proposed modification, alteration, or amendment, and this Agreement shall automatically terminate without notice, effective at the expiration of the term hereof during which said notice is given.

Section III: Termination of Agreement. This Agreement shall be AUTOMATICALLY TERMINATED without notice if there is any failure to pay dues to MPS when the same become due as scheduled in the "Group Application for Membership."

Section IV: Termination of Benefits on Termination of Agreement. Upon termination of this Agreement, for any reason whatsoever, all benefits for services provided in this Agreement to Beneficiary Members and their Family Members entitled to payment and/or reimbursement under this Agreement shall also terminate and MPS will not make any such payment and/or reimbursement for or on account of services rendered after the date of termination, irrespective of the fact that a Member may be hospitalized and/or receiving Professional Services on the date of termination.

Section V: Termination of Membership and Termination of Benefits.

(A) Subject to the provisions of Article Nine, the membership of a Beneficiary Member and his Family Members shall TERMINATE AUTOMATICALLY without notice:

(1) If required dues as scheduled in the "Group Application for Membership" for such Beneficiary Member and/or his Family Members are not paid when the same become due;

(2) If Beneficiary Member's employment by, membership in, or association with, the Group terminates;

(B) Subject to the provisions of Article Nine, Family Membership shall TERMINATE AUTOMATICALLY without notice in the case of a child enrolled by a Beneficiary Member, at 12:00 o'clock midnight, Mountain Standard Time, on the day preceding the 23rd birthday of such child, or on the day preceding the marriage of such child, whichever date occurs earlier.

(C) Subject to the provisions of Article Nine, upon termination of the membership of a Beneficiary Member and/or his Family Members, for any reason whatsoever, all benefits provided in this Agreement for services rendered to such Beneficiary Member and/or his Family Members shall terminate and MPS will not make any payment and/or reimbursement for or on account of such services rendered after the date of termination, irrespective of the fact that such Member may be hospitalized and/or receiving Professional Services on the date of termination.

ARTICLE TWELVE — NOTICES UNDER AGREEMENT

Any notice for which provision is herein made may be given by United States mail, postage prepaid, by deposit of such notice in any United States Post Office. Any notice may be addressed to the Group, and such notice shall be effective as of the date on which it is mailed. Notice to the Group may be mailed to the address of the Group appearing on the records of MPS. Any notice to MPS shall be addressed to Montana Physicians' Service, at the principal offices of the corporation which are located at 404 Fuller Avenue, Helena, Montana.

ARTICLE THIRTEEN — ENDORSEMENTS TO AGREEMENT

Nothing contained in any Endorsement hereafter made applicable to this Agreement shall affect any of the conditions, provisions or limitations of this Agreement, except as expressly provided in the Endorsement; all conditions, provisions and limitations of this Agreement shall apply to any Endorsements if they are not in conflict with it.

ARTICLE FOURTEEN — CLAIMS SOLE PROPERTY OF BENEFICIARY MEMBER

All claims for benefits hereunder arising out of medical, surgical, hospital or other services rendered or furnished to or for a Family Member shall vest in and be the sole property of the Beneficiary Member.

ARTICLE FIFTEEN — ACCEPTANCE OF THIS AGREEMENT

Section I: Acceptance of Agreement. Acceptance of the application for membership and payment of the first month's dues shall constitute acceptance of the Agreement, and all of its provisions, terms, and conditions by MPS and the Group.

Section II: Previous Agreements Superseded. This Agreement supersedes and renders null and void any and all previous agreements between MPS and the Group to which this Agreement is issued, and MPS and the Beneficiary Member.

IN WITNESS WHEREOF, this Agreement is executed be MPS through its duly authorized officers, undersigned, to take effect at 12:01 o'clock a.m., Mountain Standard Time, on the date of issue set forth on the face of this Agreement.

ATTEST:

MONTANA PHYSICIANS' SERVICE

A. R. Little, M.D.
Secretary

Michael E. Donovan
Its President

MAJOR MEDICAL ENDORSEMENT

MONTANA PHYSICIANS' SERVICE BLUE SHIELD
406 Fuller Avenue • P.O. Box 4309 • Helena, Montana 59601 • (406) 442-5450
Medical • Surgical • Hospital

Attached to and forming a part of that certain MONTANA PHYSICIANS' SERVICE GROUP MEDICAL-SURGICAL-HOSPITAL BENEFITS AGREEMENT issued this 1st day of October, 19 80
By MONTANA PHYSICIANS' SERVICE (MPS) to

Security State Bank

Box 1291 - Polson, Montana

(Hereinafter called the Group)

In consideration of the regular payment of monthly dues as specified under the Basic Agreement, this Endorsement providing payment for specified services and supplies is issued to become effective on the effective date shown hereon.

SECTION A — DEFINITIONS:

1. "**Covered medical expense**" means usual, customary and reasonable charges incurred by a Member for necessary services performed or prescribed by a physician duly licensed to practice medicine for illness or accidental injury, subject to the exclusions and limitations set forth in Section C and to the limitations set forth below:

(a) Physicians' Services. The services of a physician duly licensed to practice medicine for home, office or hospital visits; consultations and surgery. Charges shall be considered "covered medical expense" to the extent that such charges are reasonable and do not exceed the maximum amount payable under the Basic Agreement to doctors who are Participating Members of MPS for the same or similar services.

(b) "Hospital services" as defined in the Basic Agreement. Allowance payable for room and board (including special diets, general nursing care), however, will be made only up to Ten Dollars ($10.00) in excess of allowance payable under the Basic Agreement.

(c) Anesthetics and administration thereof;

(d) Diagnostic examinations including but not limited to, X-ray, radioisotope, laboratory, basal metabolism, electrocardiogram, and electroencephalogram;

(e) Radiation therapy;

(f) Oxygen and use of equipment for its administration;

(g) Blood transfusions, service, blood bank service charge and administration charges. (Cost of blood not included);

(h) Drugs and medicines, excluding those used for birth control, of the kind which require a written prescription of a Physician, listed in the U. S. Pharmacopoeia, U. S. Formulary, and New and Non-Official Remedies purchased for use outside a Hospital.

(i) Services of a licensed Physical Therapist;

(j) Services of a professional Registered Nurse (R.N.) while Member is confined to hospital as an inpatient, when directed by attending physician. Nursing services rendered by a member of the patient's family are not covered medical expenses;

(k) Rental of durable medical equipment required for therapeutic use for conditions arising out of accidental injury occurring or illness commencing after the Member's effective date of coverage hereunder.

(l) Professional ambulance service to the nearest appropriate facility providing inpatient hospital accommodations;

(m) Prosthetic appliances necessary for the alleviation or correction of conditions arising out of accidental injury occurring or illness commencing after the Member's effective date of coverage hereunder;

(n) Intensive and coronary care units for inpatient hospital care.

2. "**Benefit period**" means a period of twelve (12) months commencing on (and including) January 1 and ending on (but excluding) January 1 of the following year. In the calendar year in which the Member's coverage hereunder becomes effective the "benefit period" shall be the period between the effective date of the Member's coverage hereunder and January 1st of the ensuing year. All expenses shall be deemed to have been incurred on the date the service or supply for which the charge is made is rendered or received.

3. "**Deductible Amount**" means One Hundred Dollars ($100.00) of covered medical expenses which the Member has paid or for which he has assumed payment. Except as provided in (a) and (b) hereafter the deductible amount shall be applied to the covered medical expense incurred by each Member in each benefit period. (a) In the event that two or more Members who are under the same family membership incur charges for covered medical expenses as the result of injuries received in the same accident then only one deductible amount for a benefit period shall be applied to the aggregate of all charges for covered medical expenses which are incurred by such Members as a result of injuries received in the same accident. (b) In the event two Members who are under the same family membership incur charges for covered medical expenses of One Hundred Dollars ($100.00) each in the same benefit period, payment of the benefits herein provided shall be available thereafter to other Members covered under the same family membership without application of the deductible amount in said benefit period. The deductible amount for a benefit period for a Member shall be reduced by the amount of covered medical expenses incurred by such Member in the last three months of the preceding benefit period but only to the extent that such covered medical expenses have been applied to such Member's deductible amount in the preceding benefit period. In no event shall such reduction exceed the amount of the deductible.

SECTION B — BENEFITS PROVIDED:

1. If a Member shall incur in a calendar year covered medical expenses not payable under the Basic Agreement in excess of the deductible amount, subject to the exclusions and limitations contained in the Basic Agreement and herein, the Member shall be reimbursed:

(a) In an amount equal to eighty percentum (80%) of such excess expenses up to the sum of five thousand dollars ($5,000.00) and

(b) In an amount equal to one hundred percentum (100%) of such excess expenses over the sum of five thousand dollars ($5,000.00)

Notwithstanding the exclusion contained in Article Eight, sub-paragraph (m), benefits for outpatient treatment of alcoholism, drug addiction, insanity, neuropsychiatric or mental conditions the Members shall be reimbursed to the extent of fifty percentum (50%) of the amount of such excess expenses up to a maximum of five hundred dollars ($500.00) in each benefit period.

2. The aggregate amount payable to or for a Member for covered medical expenses incurred by each Member during his lifetime shall not exceed the amount of five hundred thousand dollars ($500,000.00).

SECTION C — EXCLUSIONS AND LIMITATIONS:

No benefit shall be provided under this Endorsement for:

1. Services and supplies which are excluded under Article Eight of the Basic Agreement, except as such exclusions may be specifically modified in this Endorsement.

2. Services and supplies for conditions and procedures upon which a waiting period is imposed in Article Six of the Basic Agreement prior to the expiration of said waiting period.

3. Services and supplies listed as covered medical expenses to the extent that such services or supplies are provided or reimbursement therefore is provided, under the Basic Agreement of any other medical, surgical or hospital service plan or insurance policies. However if the Member is entitled to benefits under any other medical, surgical or hospital service plan or insurance policy, MPS shall reduce equitably the benefits payable under this Endorsement, but such reduction of benefits shall in no event cause the Member to receive less benefits from all sources than would otherwise be payable under this endorsement where no other coverage is involved.

SECTION D — NOTICE OF CLAIM, ASSIGNMENT PROHIBITED:

The Member claiming benefits under this Endorsement must notify MPS by presentation of a written claim to MPS at its Helena, Montana offices on forms supplied by MPS, and each claim must be presented to MPS with receipts or bills supporting such claim not later than sixty (60) days after the date on which the deductible is satisfied. However, in no event will payment or reimbursement be made where claims for covered medical expenses are not submitted within ninety (90) days of the end of each benefit period. Benefits payable to or for a Member under this Endorsement are NOT assignable by the Member to any third party. MPS reserves the right, however, in its sole discretion to make any payment or reimbursement due hereunder to the Member or directly to the person or organization rendering service to the Member, or to them jointly.

SECTION E — BENEFITS FOLLOWING TERMINATION OF MEMBERSHIP OF TOTALLY DISABLED MEMBER UNDER CERTAIN CIRCUMSTANCES:

Notwithstanding the provisions of the Basic Agreement for termination of all benefits upon termination of Membership for any reason whatsoever, if a Member, having satisfied the deductible amount prior to the date of termination of his membership in MPS, was receiving benefits under this Endorsement and was totally disabled on the date of termination of said membership, and if said termination of membership did not result from the termination of this Endorsement and the Basic Agreement by action of the group, then and in such event, MPS will continue its reimbursement of the Member in accord with the provisions of this Endorsement for services and supplies required by said totally disabled Member on account of the illness causing total disability and such reimbursement shall continue until the occurrence of the earliest of the following events:

1. Recovery from the illness causing total disability, or
2. The expiration of the benefit period in which the Member was receiving benefits upon the date of termination of his membership, or
3. Payment by MPS of the sum of twenty-five thousand dollars ($25,000.00) in the benefit period in which the Member was receiving benefits on the date of termination of his membership.

SECTION F — FORCE OF BASIC AGREEMENT:

All provisions of the Agreement to which this Endorsement is attached and of which said Endorsement is a part, not in conflict herewith, continue in full force and effect and apply to this Endorsement.

IN WITNESS WHEREOF, MONTANA PHYSICIANS' SERVICE, a non-profit corporation, by its undersigned officers, hereto duly authorized, has executed this Endorsement to take effect at 12:01 a.m., on the effective date shown hereon.

ATTEST:

MONTANA PHYSICIANS' SERVICE

A. R. Little, M.D.
Secretary

Michael E. Donovan
Its President

ACCIDENT EXPENSE ENDORSEMENT

MONTANA PHYSICIANS' SERVICE
404 Fuller Avenue • P.O. Box 4309 • Helena, Montana 59601 • (406) 442-5450

BLUE SHIELD
Medical • Surgical • Hospital

Attached to and forming a part of that certain MONTANA PHYSICIANS' SERVICE MEDICAL-SURGICAL-HOSPITAL BENEFITS AGREEMENT issued this 1st day of October, 19 80 by MONTANA PHYSICIANS' SERVICE (MPS) to

Security State Bank

Box 1291 - Polson, Montana

(Hereinafter called the Group)

In consideration of the regular payment of the monthly dues to MPS as set forth in the Group Application for Membership, to this Endorsement issued to the Group identified by name hereon, and by this reference to said Agreement and attachment thereto, this Endorsement is made a part of said Agreement and is dependent thereon.

This Endorsement, issuance of which is evidenced by attachment to said Agreement, entitles the Beneficiary Member to reimbursement up to the maximum hereinafter set forth for medical-surgical-hospital and other services hereinafter listed which are rendered to or on behalf of the Member in the treatment of a bodily injury effected through accidental means, in addition to any benefits which are available under the Agreement for treatment of such accidental injuries, subject at all times to the conditions and limitations specified in this Endorsement and in the Agreement of which it is a part. All provisions of said Agreement not in conflict herewith continue in full force and apply with equal force to this Endorsement.

SECTION A—DEFINITIONS:

The term **"Reasonable Charges"** as it applies to the charges of physicians for services payable hereunder is defined as that charge which the physician normally makes to all his patients for such services and which does not exceed the maximum amount payable under the Basic Agreement to doctors who are Professional Members of MPS for the same or similar services.

SECTION B—BENEFITS: MPS hereby agrees to reimburse the Beneficiary Member up to the maximum hereinafter specified for usual, customary and reasonable charges incurred for the services herein specified when the same are necessary and rendered in connection with treatment of a member for bodily injuries effected through accidental means after the effective date of this Endorsement and such treatment is rendered by or at the direction of a physician licensed to practice medicine. The maximum amount payable by MPS as reimbursement to the Beneficiary Member for the services specified under this Endorsement shall be the sum of Three Hundred Dollars ($300.00) in connection with a single accident sustained by a Member. The services which are a subject of reimbursement under this Endorsement are, viz:

(A) Services of a physician duly licensed to practice medicine and/or licensed hospitals rendered in connection with actual treatment of injuries and for which payment is not provided under Article Four or Article Five of the Agreement or for which payment under said Article has been exhausted.

(B) Services of graduate registered nurses (R.N.) who are not members of the family of the Member and who do not ordinarily reside in the home of the Member. These nursing services are payable while the Member is an inpatient in a licensed hospital and are limited to services of a maximum of three (3) registered nurses per day.

(C) X-Ray examinations not otherwise payable under the Agreement.

(D) Oral surgery and dental examinations performed by doctors of dental surgery and ordered by a licensed doctor of medicine including the initial repair or replacement of sound natural teeth.

(E) Physical Therapy rendered by a licensed physical therapist.

(F) Casts, splints, trusses, braces, artificial limbs or eyes and prosthetic devices. Reimbursement for such items shall be limited to the purchase of the least expensive equipment of its type.

(G) Rental of crutches, manually operated wheel chair and hospital type bed. Reimbursement for such items shall be limited to the rental of the least expensive equipment of its type.

(H) Licensed ambulance service.

(I) Drugs and medicines, of the kind which require a written prescription, purchased for use outside a hospital.

NOTE: This Endorsement is operative according to its provisions only if the underlying Medical-Surgical-Hospital Benefits Agreement is in full force and effect.

SECTION C—EXCLUSIONS:

1. Services, procedures and treatments excluded from benefits under the Agreement, and not specifically included in Section A hereof as a benefit of this Endorsement.

2. Any professional hospital or other services rendered to the Member which are not rendered in connection with treatment of accidental bodily injury.

SECTION D—DURATION, TERMINATION AND MODIFICATION OF ENDORSEMENT:

1. This Endorsement is subject to the terms and conditions set forth in the Agreement with respect to Duration, Renewal and Termination and may be terminated and modified as provided therein.

2. This Endorsement shall terminate automatically, without notice, upon termination for any reason whatsoever, of the Agreement.

IN WITNESS WHEREOF, MONTANA PHYSICIANS' SERVICE, by its undersigned officers, hereto duly authorized, has executed this Endorsement to take effect at 12:01 a.m., on the effective date shown hereon.

ATTEST:

MONTANA PHYSICIANS' SERVICE

James J. McCabe, M.D.
Secretary

Michael E. Donovan
Its President

READ THE BASIC MEDICAL-SURGICAL-HOSPITAL BENEFITS AGREEMENT
OF WHICH THIS ENDORSEMENT IS A PART
AND UPON WHICH THE ENDORSEMENT IS DEPENDENT

ALCOHOLISM AND
DRUG DEPENDENCY

ENDORSEMENT

MONTANA PHYSICIANS' SERVICE
404 Fulle Avenue • P.O. Box 1677 • Helena, Montana 59601 • (406)442-5450

BLUE SHIELD
Medical • Surgical • Hospital

Attached to and forming a part of that certain MONTANA PHYSICIANS' SERVICE GROUP MEDICAL-SURGICAL-HOSPITAL BENEFITS AGREEMENT issued this 1st day of October, 19 80 By MONTANA PHYSICIANS' SERVICE (MPS) to

Security State Bank

Box 1291 - Polson, Montana
(Hereinafter called the Group)

In consideration of the regular payment of monthly dues as specified under the Basic Agreement, this Endorsement providing payment for specified services and supplies is issued to become effective on the effective date shown hereon.

MPS agrees to pay the usual, customary and reasonable cost of the services listed below for Necessary treatment of alcoholism and drug addiction in addition to any Benefit which may otherwise be available under this Agreement for treatment of such conditions up to a maximum of One Thousand Dollars ($1,000.00) of Benefits in each Membership Year.

1. Outpatient Professional calls by a Physician for Necessary treatment of a Member.

2. Necessary services rendered by an Alcoholism Treatment Center. Alcoholism Treatment Center is defined as a facility which provides a program for the treatment of alcoholism pursuant to a written treatment plan approved and monitored by a Physician duly licensed to practice medicine and which facility is also; (a) affiliated with a hospital under a contractual agreement with an established system for patient referral, or; (b) licensed, certified or approved as an Alcoholism Treatment Center by the state.

NOTE: This Endorsement is operative according to its provisions only if the underlying Medical-Surgical-Hospital Benefits Agreement is in full force and effect.

(OVER)

READ THE BASIC MEDICAL-SURGICAL-HOSPITAL BENEFITS AGREEMENT
TO WHICH THIS ENDORSEMENT IS A PART
TO WHICH THE ENDORSEMENT IS DEPENDENT

3. Lifetime Maximum. The services payable under this Section for treatment of alcoholism and drug addiction shall be payable by MPS up to the maximum of Ten Thousand Dollars ($10,000.00) during the lifetime of each Member.

IN WITNESS WHEREOF, MONTANA PHYSICIANS' SERVICE, a non-profit corporation, by its undersigned officers, hereto duly authorized, has executed this Endorsement to take effect at 12:01 a.m., on the effective date shown hereon.

MONTANA PHYSICIANS SERVICE

By _____
Michael E. Donovan
Its President

ATTEST:

_____
A. R. Little, M. D.
Secretary

MPS END GP76

Application is hereby made to

Montana Physicians' Service

(If Applicant is an Association, "employee" as used herein means member)

for a Group Medical-Surgical-Hospital Benefits Agreement (herein called the Agreement), covering the eligible employees of

Security State Bank
(Herein called the Applicant)

Address of Applicant Box 1291 Polson, Mt.

Name of person designated Group Leader A.E. Robinson

Total number eligible employees 41 **Dues payable:** ☒ **Monthly** ☐ **Other** _____

Benefits and monthly dues shall be in accord with the type of plan shown hereon. Benefits for which application is herein made shall not be available to employees until the effective date shown on the Group Medical-Surgical-Hospital Benefits Agreement.

ELIGIBILITY: All employees, unless in a class excluded from coverage, who are actually employed twenty (20) hours per week shall be eligible to apply for benefits under the Agreement and they shall be eligible to receive benefits under the Agreement on its effective date (except employees hospitalized on the effective date) provided individual applications of such employees for membership in Montana Physicians' Service have been accepted and the required dues have been paid to Montana Physicians' Service by the employer of such applicant.

PERIOD OF ELIGIBILITY: Future new employees shall be eligible to submit applications for membership within thirty (30) days following the completion of a probationary period of 90 days from the date of employment. Applications submitted to the Helena Office of Montana Physicians' Service during the eligibility period will be made effective on the 1st or 15th of the month (depending on group's effective date) following receipt provided they are received in the Helena Office of Montana Physicians' Service ten (10) days in advance of the assigned effective date.

Employees who fail to make application for coverage during the period in which they are initially eligible, as set forth above, who at a later date apply for membership and coverage hereunder will be required to submit to MPS, together with the application for membership, a Statement of Health evidencing good health satisfactory to MPS as a condition precedent to acceptance of such application by MPS.

PARTICIPATION STANDARDS

No. of Eligible Employees	Participation Requirement	Minimum Number
3 - 5	All	
6 - 8	All less 1	
9 - 12	All less 2	
13 - 15	All less 3	
16 - 19	All less 4	
20 - 24	All less 5	
25 - 27	All less 6	
*28 - 50	75%	21
*51 & Over	65%	38

*The percentage requirement or minimum number will apply, whichever is greater

Type of Plan

☒ Preferred — Room Allowance $ 60.00

Waiting Periods:
☒ Waived ☐ Not Waived
☐ Waived for Initial Enrollment

Endorsements: (list)
A Maj. Med C _____
B Supp. Acc. D _____

Monthly Dues

Employee Only	37.64
Two Party	74.77
Family	96.33
Employee-Age 65 and Over	16.83
Employee and Spouse-Age 65 and Over	33.66

It is requested that the coverage herein applied for shall be effective as of the ☒ 1st day ☐ 15th day of October, 1980

Dated at Kalispell, Montana this 19th day of September 1980

WITNESS

Signature of Applicant

By Lynn Weaver

MPS APP. FORM NO. 108.14

MPS reserves the right to accept or reject this application for issuance of a ... Acceptance of the ... shall be evidenced by issuance of the Agreement and no notice of rejection hereof ... applied for.

LETTER OF AGREEMENT NO. 1

TO

MASTER AGREEMENT

FOR

STATE OF MONTANA, DEPARTMENT OF ADMINISTRATION

It is mutually agreed that the responsibilities of The Department of Administration and Blue Cross of Montana shall be as follows:

Department Responsibilities

1. The department shall collect the premium through payroll deduction on or before the tenth (10th) of the month in which the premium is due and transmit the premium payment promptly to The Plan.

2. The department shall keep records of self-pay employees, reimbursements and premium adjustments. The adjustments may be added to or deducted from the monthly premium payment to The Plan.

3. The department shall provide The Plan with the list of employees with payroll deductions, employees who self-paid, employees who had premium adjustments and employees requiring reimbursements. In addition, a tape of payroll deductions will be provided.

4. The department shall provide and make available to The Plan such records and reports as may be reasonably necessary for the purpose of enrolling employees, processing terminations, effecting enrollment changes or for other purposes reasonably related to the administration of the Agreement.

5. The department agrees to establish necessary policies and procedures and make reasonable efforts to inform employees of their eligibility for coverage under this Agreement. The department shall make available to employees and submit the enrollment forms and materials for employees to The Plan.

6. No clerical error on the part of the department or employing agency shall operate to defeat any of the rights, privileges or benefits of any member covered under this Agreement.

7. This Agreement may be terminated by the department by giving The Plan thirty-one (31) days written notice. Premium paid by the department on behalf of Members for a period of time beyond the date of termination shall be refunded to the department by The Plan.

Blue Cross of Montana Responsiblities

1. The Plan shall provide the services listed in the Agreement and attached amendments for the following monthly rates:

Employee Only	$39.69
Additional for spouse	$26.30
Additional for spouse and child(ren)	$33.76
Additional for child(ren)	$11.68
Medicare eligible	$21.60
Family rate — both parents employed by the State — rate for each parent	$44.69

2. The quoted rates are guaranteed for the first policy year (September 1, 1979 through July 31, 1980). The total rate for employee and/or dependents for the second policy year (August 1, 1980 through July 31, 1981) shall be increased by no more than twenty-two percent (22%) for the period of August 1, 1980 through July 31, 1981.

3. The department shall be notified of a proposal to change rates ninety (90) days before they are effective.

4. The Plan shall provide the department and its consultant with relevant reports including:

   a. A monthly report listing premium income, number of subscribers, paid claims and numbers of claims paid. This report will be organized into catagories of active employees and retirees with data separated between employees and dependents in each catagory.

   b. A monthly report listing the amount of claims paid by the month in which they were incurred. After August, 1980, this report should include a total of claims paid in each month that were incurred in a prior contract year.

   c. An annual Health Insurance Utilization Review Report detailing claim activity by type of service provided and highlighting problem areas.

5. The retention charge shall be six point fifteen percent (6.15%) of the premium for the period of September 1, 1979 through July 31, 1981.

6. Upon the discretion of the department, the surplus premium shall be returned to the department within one hundred twenty (120) days of the end of each contract year. Surplus premium shall be calculated as follows:

   Surplus Premium = Paid Premium — Paid Claims — Retention Charge (+) — changes in the Incurred but Unreported Claim Reserve.

   Deficits occurring in the contract year will be carried forward and charged against future surpluses.

   In the event of termination of the Master Contract, The Plan will be accountable for any experience surpluses and the residual balance of the Incurred but Unreported Claim Reserve, with interest at six percent (6%) from date of termination, one year after the contract termination date, a final accounting will be rendered to the Department.

7. The Plan agrees to maintain adequate financial records and reports, records of claim payments, and records concerning the progress of this Agreement and make them available for audit by the department or its agents and also by the Legislative Auditor of the State of Montana.

8. No agent or representative of The Plan other than the Board of Trustees or the President is authorized to change this Agreement or waive any of its provisions; provided the department agrees with such waiver of provisions.

9. The Plan shall not accept assignments for payments of benefits under this Agreement except those made by a Member to a physician or hospital and no assignment made by a Member will bind The Plan without its written consent.

10. The Plan agrees to accept a written grievance procedure established by the department as a fair and systematic method of resolving employee claim disputes.

11. The Plan agrees that it will not discriminate against any person under this Agreement with administering this Agreement because of race, color, religion, sex or national origin.

FOR BLUE CROSS OF MONTANA	FOR STATE OF MONTANA
Virgil E. Miller, President	David Lewis, Director Department of Administration
2-12-80 Date	Date

LETTER OF AGREEMENT NUMBER 2

TO

MASTER AGREEMENT

FOR

STATE OF MONTANA, DEPARTMENT OF ADMINISTRATION

It is mutually agreed that new employees and/or dependents shall be granted credit toward any waiting periods for previous Blue Cross or Blue Shield membership. Any claims paid as a result of granting such credit shall not be charged to the experience of the State.

FOR
BLUE CROSS OF MONTANA

Virgil E. Miller, President

2-12-86
Date

FOR
STATE OF MONTANA

David Lewis, Director
Department of Administration

Date

LETTER OF AGREEMENT NUMBER 3

TO

MASTER AGREEMENT

FOR

STATE OF MONTANA, DEPARTMENT OF ADMINISTRATION

It is mutually agreed that newborn children and newly married spouses will be covered from the dates of birth and marriage respectively provided an application form has been signed and premiums are paid within thirty-one (31) days commencing on the first of the month following birth or marriage.

FOR BLUE CROSS OF MONTANA	FOR STATE OF MONTANA
Virgil E. Miller, President	David Lewis, Director Department of Administration
2-12-80 Date	Date

COMPREHENSIVE MAJOR MEDICAL AGREEMENT

BLUE CROSS OF MONTANA
(A Non-Profit Hospital Service Plan Corporation
Herein Called "The Plan")

AGREES TO PROVIDE

The benefits herein described for a period of eleven (11) months beginning at 12:01 A.M. Standard Time at Great Falls, Montana, on September 1, 1979 (9-1-79), (herein call the Effective Date) through July 31, 1980 (7-31-80), and from year to year thereafter, unless this Agreement is modified or terminated as provided herein. The subscription charges shall be due and payable in advance of the Effective Date and thereafter as provided herein.

THE STATE OF MONTANA, DEPARTMENT OF ADMINISTRATION
(Herein Called "The State")

AGREES TO

The methods and practices outlined in the Agreement, relative to submission of monthly dues and information as may be required for The Plan to adequately administer its obligations and to receive on behalf of the covered Members all notices delivered by The Plan and to forward such notices to such Members.

This Agreement is issued and delivered in the State of Montana and is governed by the Laws thereof and is subject to the terms and conditions recited on the subsequent pages hereof which are part of this Agreement as fully as if recited over the signature hereto affixed.

BLUE CROSS OF MONTANA

Virgil E. Mallet, President

2-12-80
Date

STATE OF MONTANA

Name Title

Name Title

Date

SECTION I
GENERAL

ARTICLE I — DEFINITIONS

A. "Subscriber" means the enrolled individual who is an employee of "The State" and satisfies the conditions of eligibility hereinafter set forth.

B. "Member" means the Subscriber and his Dependents as defined above.

C. "Effective Date" means the date of this Agreement or the date on which the Member's coverage commences.

D. "Member Hospital" means any hospital with which The Plan has, at the time a Member is admitted to a hospital, a contract in effect to provide payment for hospital services rendered under the terms of this Agreement.

E. "Non-Member Hospital" means a Licensed General Hospital other than a Member Hospital, which, for compensation from or on behalf of its patients, provides therapeutic facilities for surgical-medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed physicians and surgeons and which continually provides twenty-four (24) hour a day nursing service by or under the supervision of registered graduate nurses, and which is not primarily a nursing home, a place for rest, the aged, treatment of drug addiction or alcoholism or for the treatment of pulmonary tuberculosis or mental and nervous disorders.

F. "Agreement" means this Agreement between The State and The Plan and shall include the attached Endorsements or Riders, if any, and the notices of election (application cards) of the Members, indicating their participation in the coverage provided hereunder. The Agreement constitutes the entire Agreement between the parties.

G. "Contract Year" means the eleven (11) month period commending on September 1, 1979 (9-1-79), through July 31, 1980 (7-31-80), and the twelve (12) month period commencing on August 1 through July 31 each year thereafter.

H. "Licensed Physicians and Practioners" means an individual duly licensed in the area in which services are rendered, and said physician or practioner must be practicing within the scope of his license. The following are considered covered physicians and practioners: Medical doctor, osteopath, psychologist listed on the National Register of Health Care Providers, chiropractor, podiatrist, dentist or Christian Science Practitioners.

I. "Custodial Care" means the provision of Room and Board, with or without routine nursing care, training and personal hygiene and other forms of self care or supervisory care by a physician for a person who is mentally or physically disabled as a result of retarded development or body infirmity, and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable such person to live outside an institution providing medical care.

J. "Skilled Nursing Facility" means a facility which, at the time of admission to such facility, keeps patients regularly overnight, provides twenty-four (24) hour nursing service by licensed nursing personnel who are under the direction of a full-time registered professional nurse and under the supervision of a licensed physician. An approved skilled nursing facility will not include any institution principally used as a place for rest, educational care, the aged, drug addicts or alcoholics and must be approved by Blue Cross of Montana.

K. "Physical Rehabilitation Services" shall mean services which are necessary to restore or improve lost functions following acute injury or disease. Services must be rendered in, furnished and billed by a hospital that has a specialized department for rehabilitation care, as determined by Blue Cross of Montana, which is supervised full time by a physician specializing in physical medicine.

L. "Alcoholism Treatment Center" and "Drug Addiction Treatment Center" means a treatment facility which provides a program for the treatment of alcoholism or drug addiction pursuant to a written treatment plan approved and under the direct supervision of a physician, and which facility is also:

a. Affiliated with a hospital under a contractual agreement with an established system for patient referral; or

b. Licensed, certified or approved as an alcoholism or drug addiction treatment center by the State.

M. "Usual, Reasonable and Customary" shall mean Blue Cross of Montana will take into consideration the following criteria in the determination of the actual amount payable for any given service or supply:

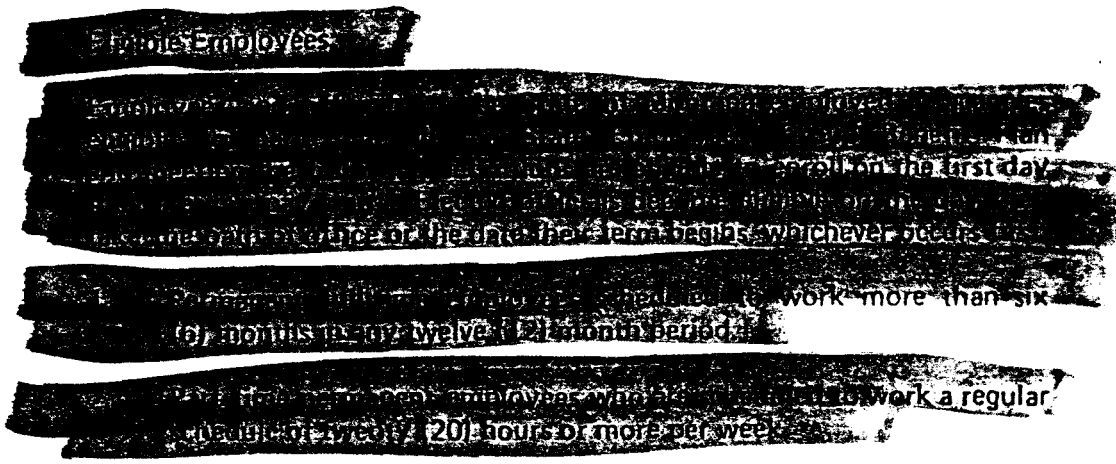
The USUAL charge or fee which the provider of service most frequently charges to the majority of his/her patients for a similar service or medical procedure;

The REASONABLENESS of charges for unusual or complicated services requiring additional time, skill and experience in connection with the particular service or procedure;

The CUSTOMARY range of charges or fees in a locality for the performance of a similar service or medical procedure. Determination of the actual amount payable for any given service or supply is within the discretion of Blue Cross of Montana. Charges or fees in excess of the usual, reasonable and customary charge or fee as determined by The Plan shall be the responsibility of the Member.

ARTICLE II CONDITIONS OF ELIGIBILITY

A. Every "Eligible Employee" as defined herein, employed by an agency of the State of Montana which has elected to participate in the Blue Cross of Montana Health Plan, is eligible to apply for coverage in the health plan under the provisions described below:



3. Seasonal employees who are scheduled to work six (6) months or more a year.

4. Elected officials.

5. Officers and employees of the legislative branch.

6. Judges and employees of the judicial branch.

7. Temporary employees who are scheduled to work more than six (6) months a year or who work for a continuous period of more than six (6) months.

8. Members of the legislature.

Dependent Eligibility:

1. Eligible employees may cover their spouse and unmarried dependent children under twenty-five (25) years of age.

2. Dependent children under the eligible age including an employee's natural or adopted children, or any other child who depends on the employee for support in a regular parent-child relationship and is dependent within the current meaning of the Internal Revenue Code.

3. The coverage for dependents will be effective on the same date as for an employee provided he requests dependent coverage upon initial enrollment. New dependents may be enrolled within thirty-one (31) days after being gained by the employee. A health statement will be required for dependents who are enrolled after thirty-one (31) days of their eligibility date.

4. The medical plan may be continued for a fully handicapped child after he reaches the maximum age for dependent coverage, provided coverage for the employee does not terminate for any reason.

   a. A child will be considered handicapped if he is unable to earn his own living because he is mentally retarded or physically handicapped, and must depend primarily on the employee for support and maintenance.

   b. The Plan may require proof that the child is fully handicapped to be submitted periodically.

5. An employee of The State eligible for the group plan cannot be covered as a dependent of his spouse who is also eligible for the group plan.

6. The surviving spouse of a state employee or retiree may remain with the medical plan through retirement withholding or self-payment of the premium provided he has elected to receive retirement benefits accrued by the deceased employee. A spouse may not elect to remain with the medical plan if he is employed, and by virtue of that employment, eligible to participate in another group plan with equivalent benefits and cost or if he remarries.

7. The surviving dependent children of a state employee may remain with the state employee medical plan provided they are eligible to elect retirement benefits accrued by the deceased employee. The surviving dependent children may not remain with the medical plan if they are employed, and by virtue of that employment, eligible for another group plan, are over the age of twenty-five, or are eligible for an equivalent plan from the other surviving parent.

B. Retired State Employees under the age of sixty-five (65) who receive State Retirement benefits are eligible to remain with the group plan. They may also purchase optional dependent coverage.

   Retired employees over the age of sixty-five (65) or who are Medicare eligible may remain with the medical plan. They may purchase optional dependent coverage.

C. Employees who are on an approved leave without pay status may remain on the group benefit plan through self-payment of the premium. The self-payment of premium for employees on approved leave without pay shall be limited to one (1) year. Employees who terminate with the State, or accept employment with another employer while on leave without payment forfeit their right to stay with the plan.

D. Evidence of insurability is required under the following circumstances:

   Employees who do not enroll within thirty-one (31) days of eligibility; or drop insurance and then request reinstatement; or request the addition of a dependent after thirty-one (31) days of the dependent's eligibility to join the plan, may be required to complete a BLUE CROSS HEALTH STATEMENT FORM.

E. The effective date for dependent coverage, when evidence of insurability is not required, is the first of the month following the date the employee enrolls in the insurance plan provided premium is paid. When evidence of insurability is required, the coverage will be effective on the first of the month following approval, provided premium is paid.

The effective date of new employee coverage, when evidence of insurability is not required, is the first of the month following enrollment, provided premium is paid.

The effective date for new dependents, when evidence of insurability is not required, is the first of the month following the date the application is signed and premium paid. Newborn children shall be covered from birth and newly married spouses shall be covered from the date of marriage, provided an application form has been signed and premiums paid within thirty-one (31) days after the date of birth or marriage.

F. Coverage will end on the last day of the month for which full premium has been paid.

G. Any special considerations granted a Member as a result of being an eligible employee and/or dependent of this group on a specific date (such as a waiver of waiting period on initial enrollment of the group, etc.) shall become void as of the date of termination of eligibility as an employee and/or dependent under this group Agreement.

ARTICLE III WAITING PERIODS

A. New employees shall have a six (6) month waiting period for preexisting conditions. The waiting period for preexisting conditions will not apply to employees enrolling during the initial enrollment period for a September 1, 1979, effective date.

B. Plan benefits for preexisting conditions is available only after the Member has been continuously enrolled for a period of at least six (6) consecutive months. "Preexisting condition" means any condition for which a Member received medical treatment, diagnosis, consultations, or prescribed drugs during the ninety (90) day period preceding the effective date of coverage, or for which any prudent individual would have sought medical care.

ARTICLE IV EXCLUSIONS AND LIMITATIONS

A. The Plan will not be required to furnish any items of hospital care or services other than those set forth in this Agreement or to furnish services for:

1. Hospitalization furnished in any hospital owned or operated by any State Governmental Agency or any U. S. Governmental Agency for which the Member is not required to make payment.

2. Hospitalization primarily for diagnostic tests, observation, or examinations when treatment of illness of injury does not require bed patient care.

3. Any period of inpatient hospitalization which is not required for the therapeutic treatment of any injury or disease, or is custodial.

4. The charges occurring to a Member for medical services provided during a hospital stay for which the Member was admitted prior to become a Member of The Plan. Provided charges occurring to a Member after the effective date of membership in The Plan shall be eligible to be paid as benefits, except as provided in Article III B.

5. Treatment of bodily injury, sickness, or disease if the benefits therefor are either payable or required to be provided under any Worker's Compensation Law or any other Governmental Law or agency.

6. Rest cures.

7. Inpatient hospitalization including board and room primarily for physical therapy or inhalation therapy when such hospitalization is deemed not medically necessary.

8. Conditions caused by or arising out of an act of war, declared or undeclared, armed invasion or agression.

9. Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the Member enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act of 1965, including amendments thereto, applies to retirees only.

10. Any services furnished by an institution which is primarily a place for rest, a place for the aged, a nursing home, a convalescent home, or any institution of like character.

11. Mental, psychoneurotic and personality disorders, drug addiction, alcoholism, unless hospitalizaed and then only those services rendered during such hospital period, except as specified under covered services for outpatient psychiatric visits.

12. Charges for eye examinations and refractions for glasses or examinations for hearing aids.

13. Charges for hospitalization, services and supplies to the extent that they are not reasonably necessary for treatment of an injury or disease, or charges to the extent they exceed reasonable and customary levels.

14. Routine physical examinations and immunization, including routine postnatal exams of any infant and premarital examinations.

15. Treatment for obesity, including surgery and complications.

16. Marriage, family, sexual counseling services or supplies for sex changes, dysfunction or inadequacies.

17. Charges for services or procedures which are not generall accepted by the medical profession and services or procedures which are experimental or for research.

18. Expenses for dental care or cosmetic surgery except those which result from injuries sustained in an accident.

19. Speech therapy except as provided in Article IV, Covered Services.

20. Charges that are made only because the Member has benefits under the plan.

ARTICLE V CONDITIONS OF HOSPITALIZATION

A. The Member agrees that any and all medical and hospital records relating to the diagnosis, treatment or services provided to the Member shall be made available to The Plan.

B. Hospital service benefits shall be provided only when deemed medically necessary by a physician, and only during the time the Member is under the care and treatment of a physician. The Member shall be responsible to the hospital for payment of its regular charges if he remains in the hospital when bed patient care is not medically indicated.

C. The Plan will be required to furnish hospital service or benefits provided hereunder only if admission to the hospital occurred on or after the Member's effective date of coverage hereunder.

ARTICLE VI CHANGES IN MEMBERSHIP DUES OR PROVISIONS AND TERMINATION

A. Provisions of this Agreement or membership dues may be changed by the Board of Trustees or the President of The Plan by ninety (90) days written notice prior to the anniversary date, or at any other time by written agreement between the State of Montana and Blue Cross of Montana.

B. Benefits of this Agreement are terminated immediately upon nonpayment of dues. In such event, reinstatement of benefits of this Agreement shall be at the sole discretion of and under such conditions as may be specified by The Plan.

C. This Agreement may be terminated by The State by giving The Plan at least thirty-one (31) days prior written notice. Dues, if any, paid by the Members beyond the date of termination will be refunded by The Plan.

D. A Member who has been covered under [illegible] upon termination of eligibility and while this Agreement is in effect, to apply for a group conversion contract subject to the rules and regulations in effect at such time. Application for the group conversion contract must be submitted within thirty-one (31) days of termination of group coverage.

E. Upon termination of Membership, all benefits provided under this Agreement shall automatically cease without notice as of midnight of the date of termination except as specified below in Article VI, Paragraph F.

F. Should a Member be totally and continuously disabled and employment is terminated as a result of such disability resulting in termination of coverage hereunder, the Member will be entitled to all benefits of this Agreement for a period not to exceed twelve (12) consecutive months after termination of coverage or until the maximum amount of benefits has been paid, whichever occurs first. Such benefits shall be furnished solely in connection with the condition causing such total disability. Proof of such disability and the continuation thereof shall be furnished within ninety (90) days after the date of termination of coverage hereunder. In the event the Master Agreement shall terminate, benefits shall continue hereunder until the maximum amount of benefits has been paid or the twelve (12) month period has elapsed, whichever occurs first.

ARTICLE VII SUBROGATION

A. The Plan will not be required to furnish any services or benefits under this Agreement or any Endorsement thereto for any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible, provided that if the Member is unable to recover from the responsible third party after exercising all reasonable legal rights so to do the Member shall be entitled to the benefits of this Agreement and any Endorsement thereto as if no third party liability were involved.

B. It is further agreed that in the event of any payment under this Agreement or any Endorsement thereto, Blue Cross of Montana will be subrogated to all rights of recovery therefor which the Member or any person receiving such payment may have against any person or organization and such person shall execute and deliver instruments and papers and do nothing after loss to prejudice such rights.

Blue Cross

ARTICLE VIII RIGHT OF RECOVERY

Whenever payments have been made by Blue Cross of Montana 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 provision, Blue Cross of Montana shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as Blue Cross of Montana shall determine any person to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

ARTICLE IX FACILITY OF PAYMENT

Whenever payments which should have been made under this Agreement in accordance with this provision have been made under any other insurance plan, Blue Cross of Montana shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts determined to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Agreement and, to the extent of such payments, Blue Cross of Montana shall be fully discharged from liability under this Agreement.

ARTICLE X GENERAL PROVISIONS

A. The Plan is not obligated to furnish care if hospital facilities are not available or in case of epidemic, public disaster or other causes beyond its control.

B. No agent or representative of The Plan other than the Board of Trustees or the President is authorized to change this Agreement or waive any of its provisions.

C. This Agreement replaces any and all Agreements which may have been issued previously by The Plan.

D. The Plan will not be liable for any act of commission or omission of any hospital.

E. This Agreement shall constitute the entire Agreement between the parties and all statements made by The State or any Member shall, in the absence of fraud, be deemed representations and not warranties and no such statements shall be used in defense of a claim under this Agreement unless it is contained in a written application.

F. If this Agreement shall be terminated by The State, rights of all Members covered hereunder shall be terminated and no Member shall be entitled to continue hereunder or transfer to a group conversion contract of The Plan, except as specified in Article VI, Paragraph F, contained herein.

G. None of the terms or provisions of the charter, constitution or bylaws of The Plan shall form a part of this Agreement or be used in the defense of any suit hereunder unless the same is set forth in full herein.

H. No person other than the Member is entitled to receive hospital care and benefits or professional medical or surgical benefits furnished by The Plan under this Agreement. Such rights to services and benefits are not transferable.

I. The member hospitals furnishing hospital care to the Member do so as independent contractors with The Plan, and The Plan will not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by the Member while receiving care in such hospital.

J. No clerical error on the part of the State shall operate to defeat any of the rights, privileges or benefits of any Member covered hereunder

K. Benefits hereunder shall be allowed only if notice of claim is made within one year from the date on which covered expenses were first incurred, unless it shall be shown not to have been reasonably possible to give notice within such time limit and that such notice was furnished as soon as was reasonably possible, but in no event shall benefits be allowed if notice of claim is made beyond December 31 of the calendar year following the calendar year in which the expenses are incurred.

ARTICLE XI VENUE

The venue of any suit brought by any of the parties hereto to enforce any obligation hereunder shall be laid in the County of Cascade, State of Montana, and each party waives in favor of any other party any provisions of law establishing or permitting venue in any other location.

ARTICLE XII ASSIGNMENTS

Payments due under this Agreement shall not be assignable except to hospitals or licensed physicians.

ARTICLE XIII COORDINATION OF BENEFITS

The benefits payable under the Benefit Provisions of the Agreement shall be reduced if the benefits payable under all other Plans in the absence of this and similar provisions exceed the total allowable charges.

1. If the Coordination of Benefits provision applies, the benefits payable under this Agreement shall be reduced so that the total payments to the Member under all Plans, as defined below, do not exceed one hundred percent (100%) of all allowable charges.

2. The term "Allowable Charges" includes any necessary, reasonable and customary charges for services and supplies covered in full or in part by any Plan.

3. The term "Plan" as used in this provision includes the benefits payable under this Agreement and any other group or franchise policy, any group service or prepayment plan, or any benefits received by reason of eligibility for Medicare.

4. Failure to invoke this provision on any claim shall not waive The Plan's right to invoke it on subsequent claims.

ARTICLE XIV BENEFITS WHEN ELIGIBLE FOR MEDICARE

If a retiree or dependent is eligible for Medicare, but does not enroll for Medicare coverage, the benefits provided under this Agreement will be reduced by the benefits that would have been received under Medicare had the retiree or dependent been enrolled. Active employees who are eligible for Medicare but who elect not to enroll shall receive the same benefits as all other employees until age 70 or termination of employment, whichever occurs first.

SECTION II
COMPREHENSIVE MAJOR MEDICAL BENEFITS

ARTICLE I COINSURANCE DEDUCTIBLE

A. The Plan will pay ninety percent (90%) of eligible covered services incurred in each contract year by each Member.

B. If the expense incurred for eligible covered services for a Member exceeds two thousand five hundred dollars ($2,500) and payment has been made in accordance with Paragraph A above, The Plan will make payment of one hundred percent (100%) of any additional eligible covered services incurred during that same contract year up to the lifetime maximum specified herein. When the family reaches five thousand dollars ($5,000) in incurred covered services during the same contract year, one hundred percent (100%) payment will begin for all family members incurring covered services during the rest of the contract year.

C. Any expense for covered services incurred in connection with an illness, disease or injury originating in the last contract quarter of the year and applied against the first two thousand five hundred dollars ($2,500) as outlined by Paragraph B above, shall be carried forward to apply against the coinsurance deductible for the ensuing year.

ARTICLE II LIFETIME MAXIMUM

A. The Plan will provide benefits in accordance with Article I above up to a maximum lifetime payment of one million dollars ($1,000,000) per Member.

B. Up to two thousand dollars ($2,000) of benefits shall automatically be restored for each Member per contract year until the maximum lifetime benefit available has been restored.

ARTICLE III PAYMENT OF BENEFITS

A. The Plan will provide payment for services rendered in any accredited general hospital which is registered with the American Medical Association or listed by the American Hospital Association. Outside the continental U.S., hospitals licensed in the country in which expenses are incurred will be considered as covered expenses as approved by Blue Cross of Montana.

B. Expenses must be incurred on or after the Member's effective date of coverage hereunder, or in the event such person is hospitalized on such effective date, such expense must be incurred subsequent to the date of discharge from the hospital. An expense will be considered to have been incurred on the date that the individual receives the services for which the charge is made.

C. Payment for covered services shall be based upon charges not exceeding the usual, reasonable and customary charges for such services in the area in which such services were incurred as determined by The Plan.

D. Benefits hereunder shall be allowed only if notice of claim is made within one (1) year from date on which covered expenses were first incurred, unless it shall be shown to have not been reasonably possible, but in no event shall benefits be allowed if notice of claim is made beyond December 31 of the calendar year following the calendar year in which the expenses are incurred.

E. In the event that covered services are furnished by a member hospital, The Plan reserves the right to make payment direct to the hospital for that portion of the charges, if any, for which The Plan is responsible under this Agreement.

ARTICLE IV COVERED SERVICES

"Covered Services" as used in this Agreement means only those services and supplies listed below or those determined to be medically necessary for the treatment of illness or accidental injury:

A. Inpatient hospital services as follows when a Member is confined to the hospital for necessary treatment of an illness or injury requiring bed patient care, and not primarily for diagnostic tests or examination purposes:

1. Bed, board and general nursing service in semiprivate (two (2) or more beds) accommodations. The Plan will allow the hospital's average semiprivate room charge as the allowance toward the private room.

2. Bed, board and general nursing service in Intensive Care and Cardiac Care Units (two (2) or more bed accommodations) if deemed medically necessary by the attending physician.

3. The charges of an approved surgical center, a State approved alcoholism treatment center which has also been approved by the Department of Administration, and a Christian Science sanitorium which is operated or listed and certified by the First Church of Christ Scientists, Boston, Massachusetts.

4. All hospital services as described below are available to the Member:

a. Use of operating room, recovery room and delivery room.

b. Surgical and anesthetic supplies.

c. Anesthesia services when rendered by a hospital employee.

d. Splints, plaster casts and dressings.

e. All accepted drugs, including all medicines, sera and biologicals listed in the U.S. Pharmacopoeia, National Formulary and the New and Non-Official Remedies.

f. Oxygen and use of equipment for its administration.

g. Intravenous injections; set-ups for intravenous solutions including the solution if included in (e) above.

h. Physical therapy if administered by or under the supervision of a registered physical therapist in the employ of the hospital, excluding occupational therapy.

i. Heat therapy, including infra-red and diathermy.

j. Inhalation therapy if administered by or under the supervision of a registered inhalation therapist in the employ of the hospital.

k. Administration of blood; excluded is blood donor's fee.

l. Laboratory services.

m. X-ray examinations.

n. Electrocardiograms.

B. Outpatient hospital services if a Member is treated at the hospital, but not admitted for bed patient care, and when such services are incurred as the result of an injury or illness.

C. Surgical services (cutting procedures for the treatment of diseases and injuries) and services for the treatment of fractures and dislocations rendered by a licensed surgeon-physician to the Member.

D. In-hospital medical services when such Member is confined to a licensed hospital as a registered bed patient under the care of a licensed physician or surgeon and entitled to hospital care under this Agreement. This benefit shall not apply to routine care of newborn infant during the hospital confinement of the mother.

E. Physician-anesthesiologist services rendered and billed by a physician-anesthesiologist. Payment of physician-anesthesiologist services shall be made only if the Member is eligible for surgical benefits for the same procedure.

F. X-ray and laboratory examinations made for diagnostic purposes due to accident or illness for which hospital confinement is not required or for which benefits are not provided elsewhere in this Agreement.

Exclusions: No benefits shall be provided for the following:

1. Dental examinations or treatments, except for dental x-rays resulting from injuries sustained in an accident.

2. Eye examinations.

3. Premarital examinations and routine physical check-ups, including examinations made as a requirement of employment or governmental authority.

4. Nervous and mental disorders and alcoholism.

G. Miscellaneous professional services rendered by a physician and surgeon for treatment of an accidental injury or illness.

H. Professional services rendered by a physician and surgeon or doctor or dental surgery for treatment of a fractured jaw or other accidental injury to natural teeth provided that the injury occurs while the patient is covered hereunder. Such services shall be covered only during the twelve (12) month period immediately following date of injury.

I. Professional nursing service of a registered graduate nurse, other than one who ordinarily resides in the Member's home or who is related to the Member by blood or marriage.

J. X-ray, radium and radioactive isotope therapy.

K. Services of a licensed physician and surgeon, or a registered physical therapist, in connection with physical therapy treatment, other than one who ordinarily resides in the Member's home or who is related to the Member by blood or marriage.

L. Local licensed ambulance service, including air ambulance. Payment shall be made for local licensed air ambulance when certified by an M.D. that necessary treatment for an illness or injury requiring bed patient care cannot be provided in the current facility and further that it is medically necessary to transfer the patient to another facility. Payment shall be made only to the nearest facility equipped to provide the required treatment, but in no event shall payment exceed services in excess of five hundred (500) miles.

M. Drugs and medicines directly related to the treatment of an illness or injury and requiring a written prescription and dispensed by a licensed pharmacist or licensed physician and surgeon.

N. Artificial limbs or eyes, casts, splints, trusses, braces, crutches, and other similar appliances, and also the rental of a wheelchair, hospital-type bed, iron lung or other similar mechanical equipment required for treatment. These supplies shall be limited to those reasonably required by standard treatment practices as a result of illness, disease or injury occurring while the Member is covered hereunder. Replacement of such supplies shall be made only if the existing appliance cannot be made satisfactory by standard repair practices.

O. Blood transfusions, including cost of blood and blood plasma.

P. Mental or nervous conditions, drug addiction or alcoholism shall be covered only while hospitalized up to a maximum of ten thousand dollars ($10,000) per contract year for each member.

Covered charges while not confined in a hospital shall include professional fees for psychiatric treatment with payment based on fifty/fifty (50/50) coinsurance but not to exceed a fifteen hundred dollar ($1,500) maximum per contract year. Covered charges shall only include such professional fees if they are those of a physician legally licensed to practice medicine and surgery; a psychologist listed in the National Register of Health Service Providers in Psychology or an approved alcoholism treatment center.

Q. Payment of hospital and doctor services for maternity services shall be made on the same basis as any other condition for the Member. The newborn child of the employee or spouse shall be covered at instant of birth. Routine nursery charges for the newborn of the Member are covered if the mother is eligible for maternity benefits.

1. If change of rate category is necessary, newborn must be added within thirty-one (31) days of birth.

2. If newborn is child of other than employee or spouse, such child will not have instant of birth coverage.

R. Bone and eye bank charges for covered conditions and the initial covered medical expense of a human organ donor chargeable to a Member of the plan for an organ transplant to the extent such charges are not covered by donors' health plan.

S. Charges for one way transportation by a regularly scheduled passenger aircraft or railroad inside the United States and Canada from the place where a Member requires treatment to the nearest medical facility equipped to provide the special necessary treatment not available in a local facility are considered covered expense subject to the following:

1. A life endangering situation must exist that requires immediate transfer to a hospital that has special facilities for treatment of the condition.

2. Surgery is needed that cannot be performed locally.

3. If a condition exists which cannot be treated locally, transportation benefits in any one contract year shall be limited to:

   a. One visit and one follow-up visit which is preauthorized as a disabling condition which cannot be treated locally, or;

   b. One pre- or post-surgical visit and one visit for the actual surgical procedure which cannot be treated locally, or;

   c. One visit for each allergic condition which cannot be treated locally.

If the patient is a child under 12 years of age, the transportation charges of a parent or legal guardian may be allowed if the attending physician certifies the need for such attendance. Transportation charges for a physician or a registered nurse may be covered to accompany the Member only when determined necessary by Blue Cross of Montana.

Necessity for air transportion must be certified in advance of travel by Blue Cross of Montana (except for emergency accident or life endangering situation) by completing an Air Travel Preauthorization Application Form.

T. The following services and supplies furnished in subscriber's home in accordance with a home health care plan will be considered covered expenses:

1. Part time or intermittent nursing care by an R.N.

2. Part time or intermittent home health aid services which consist primarily for treatment of the individual.

3. Physical, occupational and speech therapy.

4. Medical supplies, drugs and medicines and laboratory services provided by a hospital but only to the extent they would have been covered under the plan if the Member were in a hospital.

The number of home health care visits covered during any one (1) contract year is seventy (70). All visits received by an individual in any one (1) day shall be considered a one (1) visit, except that home health aide services in excess of four (4) hours in any one (1) day shall be considered as an additional visit.

1. Services or supplies not included in the home health care plan.

2. Services of a person ordinarily residing in the patient's home or is a member of patient's family by blood or marriage.

3. Services of a social worker.

4. Transportation services.

Care must be approved in writing by your attending physician, commence within seven (7) days following termination of confinement as an inpatient in a hospital or skilled nursing facility and be for the same or related condition causing confinement.

U. Services of an approved Skilled Nursing Facility are covered up to seventy (70) days during a convalescent period during any one contract year. To be a covered medical expense, the convalescent confinement must be within fourteen (14) days of a hospital confinement of at least three (3) consecutive days and caused by the same condition requiring Skilled Nursing Facility care. Custodial care is not covered, nor are confinements for mental and nervous disorders, alcoholism or drug addiction. Confinements must be recommended by the attending physician.

V. Care that is considered primarily rehabilitation shall be considered a covered expense. The Plan shall pay sixty (60) days of inpatient care and forty-five (45) days (at twenty dollars ($20.00) per day) of care outside of the hospital per contract year. Out-of-hospital care must be prescribed by a physician and must begin within twelve (12) months of the onset of the condition for which you are being treated. Inpatient care must be rendered in a rehabilitation care facility approved by Blue Cross of Montana and such care must not be custodial in nature.

W. Services of a licensed doctor of chiropractic practicing within the scope of his license shall be considered a covered expense such to the following:

1. Therapeutic Care – any treatment considered necessary to return the member to a pre-clinical status or establish a stationary status shall be considered a covered expense.

2. Pallatative Care – any treatment affording relief but no cure will be considered a covered expense as determined by Blue Cross of Montana.

3. Rehabilitative Care – procedure for reeducation or functional restoration of a disabled body system or part will be considered a covered expense as determined by Blue Cross of Montana.

Exclusions: No benefits shall be provided for the following:

1. Maintenance – a regime designed to provide the optimum status of health while minimizing recurrence of the clinical status.

2. Preventative Treatment – procedures necessary to prevent the development of clinical status.

X. Services of a qualified speech therapist or physiotherapist when ordered by the licensed attending physician.

SECTION III
SUPPLEMENTAL BENEFITS FOR ACCIDENTS

Services provided hereunder are separate and distinct from coverage under the Comprehensive Major Medical Benefits Plan, but subject to all provisions of Articles III, IV, V, VI, VII, VIII, IX, X, XI, XII and XIII of the General Section.

ARTICLE I BENEFIT PROVISIONS

A. When a Member sustains a bodily injury effected through accidental means, which does not arise out of or in the course of employment, as a direct result of which expenses are incurred for professional medical services, as herein defined, rendered within ninety (90) days after the date of sustaining such injury, then, subject to the limitations and exclusions hereinafter set forth, The Plan will make payment to the Member for coinsurance deductibles as outlined by Article I of the Comprehensive Major Medical Benefits Plan, but not to exceed a maximum additional payment of five hundred dollars ($500) for all expenses incurred as the result of any one (1) accident.

B. "Professional medical services", for the purposes hereon, shall mean only:

1. Medical or surgical treatment by a legally qualified physician or surgeon.

2. Confinement and necessary care in a legally constituted and operated hospital, excluding, however, such confinement and care obtained in Marine or Veteran Hospitals or in other hospitals where such care is available without cost to the Member.

3. Services of a registered nurse, provided such nurse is not related to the Member by blood or marriage.

4. Laboratory and x-ray examinations.

5. Professional ambulance services to and/or from the nearest hospital facility.

C. Exclusions: No benefits shall be provided for the following:

1. Any professional medical services provided as a benefit under any other terms or conditions of this Agreement.

2. Ptomaine poisoning, disease or infection (except pyogenic infection occurring through an accidental cut or wound).

3. Dentistry (except if services are performed as a result of an accidental injury to sound natural teeth), eye refractions or the fitting of eye glasses.

4. An intentionally self-inflicted injury.

5. Any professional medical service for which the Member is not legally required to pay.

6. Any professional medical service incurred as a result of an accidental injury sustained prior to the effective date of coverage.

D. Payment for such services shall not exceed the reasonable and customary charges for such services as determined by The Plan.

GROUP LIFE AND ACCIDENT AND HEALTH INSURANCE POLICY

a contract between

Ætna Life Insurance Company

(A Stock Company herein called Ætna)

and

STATE OF MONTANA

(Policyholder)

Policy Number: GP-390000

Date of issue: September 21, 1979

To take effect: September 1, 1979

Policy delivered in: Montana

This policy will be construed in accordance with the law of the jurisdiction in which it is delivered.

In consideration of premium payments by the Policyholder in the amounts and at the times provided, Ætna agrees with the Policyholder, to pay benefits in accordance with the policy terms.

The obligations and the rights of all persons will be determined solely in accordance with the policy terms. This policy is non-participating.

Signed at Ætna's Home Office in Hartford, Connecticut on the date of issue.

William O. Bailey

President

Lewis R. Morris

Secretary

Jo Ann Auter

Registrar

INDEX

PLAN SUMMARIES

PART I

EMPLOYEE PARTICIPATION -- CHANGES

PART II

DESCRIPTION OF COVERAGE
3010

PART III

TERMINATION OF COVERAGE --
EXTENSION OF BENEFITS --
CONVERSION PRIVILEGE

PART IV

GENERAL PROVISIONS

PART V

POLICYHOLDER AND INSURANCE
COMPANY MATTERS

PLAN SUMMARY 1

Effective Date of Coverage: September 1, 1979

Eligible Class:

Employees of the State of Montana, other than employees of the Montana University System, as follows:

(1) Permanent part-time employees scheduled to work more than six months in any twelve month period.

(2) Part-time permanent employees who are scheduled to work a regular schedule of 20 hours or more per week.

(3) Seasonal employees who are scheduled to work six months or more a year.

(4) Elected officials.

(5) Officers and employees of the legislative branch.

(6) Judges and employees of the judicial branch.

(7) Temporary employees:

(a) non-professional employees in the Maintenance and Construction Divisions of the Department of Highways represented by any labor union;

(b) employees who are scheduled to work more than six months a year or who work for a continuous period of more than six months.

(8) Members of the legislature.

Eligibility Date: With respect to non-professional employees in the Maintenance and Construction Division of the Department of Highways represented by any labor union, September 1, 1979 or, if later, on the date the employee completes six months of continuous service.

With respect to all other employees, September 1, 1979 or, if later, on the first of the month provided that premiums have been paid.

Basis of Coverage: Contributory as to Dependent Coverage, Special Accidental Death and Dismemberment Coverage and Supplemental Life Insurance.

Non-contributory as to all other coverage.

Eligible Retired Employees: An employee under age 65 who retires under his Participant Employer's IRS Qualified Retirement Plan and will receive pension consideration (except a deferred vested pension) under that plan.

SCHEDULE OF LIFE INSURANCE

For Employees Only

Classification	Amount of Insurance Plan A Basic Insurance
All Employees	$10,000

Classification	Amount of Insurance Supplemental Insurance	
	Plan C	Plan D
All employees	An amount equal to 100% of the employee's Annual Rate of Basic Earnings, the resulting amount, if not a whole multiple of $1,000 to be taken to the next higher whole multiple of $1,000.	$100,000, or any lesser amount elected by the employee which is a whole multiple of $5,000.

An employee may elect to be insured under Plan D if he is insured under Plan C.

In no event will the total amount of Basic and Supplemental Life Insurance exceed $110,000 plus an amount equal to 100% of the employee's Annual Rate of Basic Earnings.

If an employee's Life Insurance is being continued under the Extended Life Insurance Benefit, such insurance will cease on the date he attains age 65.

Any Basic Life Insurance in force for an Eligible Retired Employee retiring while insured under this policy may be continued during his retirement, such coverage will cease on the date he attains age 65.

For Dependents Only

Plan B

Classification	Amount of Insurance
Wife or husband	$2,000
Unmarried child, age 14 days but less than 23 years	1,000

SCHEDULE OF ACCIDENT & HEALTH COVERAGE

For Employees and Dependents

Special Accidental Death and Dismemberment Benefits:

Schedule of Insurance
(Initial Amounts)

Classification	Amount of Insurance (Principal Sum)
Employee Coverage	$200,000, or any lesser amount elected by the employee which is an whole multiple of $25,000, but in no event shall the amount of insurance (Principal Sum) (1) exceed ten times the employee's Annual Rate of Basic Earnings, calculated to the next higher whole multiple of $25,000, or (2) be less than $25,000.
Dependent Coverage:	
Wife or husband	
Without dependent child	50% of amount of employee's insurance
With dependent child or children	40% of amount of employee's insurance
Each dependent child	5% of amount of employee's insurance
Each dependent child if no wife or husband covered	10% of the employee's Principal Sum

Medical Expense Benefits--Regular Plan

For Employees and Dependents

Comprehensive Dental Expense Benefits
Coinsurance Percentage
Type A Expenses..... 100%
Type B Expenses..... 50%

PART I

EMPLOYEE PARTICIPATION--CHANGES

EMPLOYEE PARTICIPATION

ELIGIBLE CLASSES

All classes of employees of a Participant Employer are eligible except (a) temporary employees, (b) substitute employees, (c) employees in any class for which a Plan Summary is not included in this policy.

An employee is eligible only for the coverages shown on the Plan Summary applicable to his class.

If a Participant Employer is a partnership or proprietorship, each of its natural-person partners, or the proprietor, will be considered an employee, for policy purposes, but only if the person is actively engaged in and devoting his time on a substantially full-time basis to the conduct of the Employer's business.

EMPLOYEE COVERAGE

An employee becomes eligible for Employee Coverage on his Eligibility Date, or on the date he enters an Eligible Class, or on the effective date of the policy, whichever is latest.

Effective Date--Any Employee Coverage which is non-contributory (i.e., the employee is not required to request the coverage nor contribute for it) becomes effective on the date the employee becomes eligible.

Any Employee Coverage which is contributory becomes effective on the date the employee becomes eligible if by then he has made written request for the coverage and agreed to make the required contributions to his Participant Employer, otherwise, on such later date that he makes the request. If the request is made after 31 days following the date the employee becomes eligible, the coverage will become effective only if and when Aetna gives its written consent. Consent will be granted for Special Accidental Death and Dismemberment Coverage on the October 1 following the date request is made but only if such request is made during the 31 day period immediately preceding such date.

MULTIPLE COVERAGE

If an individual is connected with more than one Participant Employer, he will not be eligible for multiple coverage. He will be treated as though he were connected with a single Participant Employer. However, for policy purposes, his remuneration from all Participant Employers will be considered as being paid by the single Participant Employer.

DEPENDENT COVERAGE

An employee's "dependent" is any person in the eligible dependent classes, but, with respect to dental coverage, a person who is insured (or eligible for benefits because of prior insurance) as an employee is not a dependent.

The eligible dependent classes are

The employee's wife or husband

The employee's unmarried child under 23 years of age (14 days to 23 years with respect to Life Insurance)

A "child" is, in addition to the employee's own or lawfully adopted child, any other child who depends upon the employee for support and lives with the employee in a regular parent-child relationship.

Eligibility--An employee in an eligible class becomes eligible for Dependent Coverage on the date the employee becomes eligible for Employee Coverage, if he then has a dependent, otherwise on the date he acquires a dependent.

Effective Date--Any Dependent Coverage which is non-contributory becomes effective on the date the employee becomes eligible for Dependent Coverage.

As to any Dependent Coverage which is contributory, the requirements for making contributory Employee Coverage effective also apply to Dependent Coverage.

In no event will Dependent Coverage become effective at a time the employee is not insured for the corresponding Employee Coverage.

NON-CONFINEMENT RULE

If an individual has recently been confined on the date any applicable medical expense benefits coverage would otherwise become effective, that coverage will be deferred until he has either been free of all confinement (at home, in a hospital or elsewhere) for 31 days, or the Ætna has received evidence satisfactory to it that the individual no longer has any disease or injury.

A "recent confinement" for the purposes of this section means either that

The individual is confined anywhere on the date coverage would otherwise become effective, or

The individual has been confined in a hospital during the 31 days prior to that date.

Application of Non-Confinement Rule--The Non-confinement Rule applies to the following:

Any Comprehensive Dental Expense Benefit coverages included in the Regular Plan for a dependent, except a child who becomes covered within 31 days after he becomes eligible.

SPECIAL PROVISIONS FOR RETIRED EMPLOYEES

If the applicable Plan Summary indicates a class of Eligible Retired Employees, each such employee and his eligible dependents, if any, will be eligible for coverage under this policy only as specifically provided below.

Life Insurance--Any Basic Life Insurance in force for an Eligible Retired Employee retiring while insured under this policy will be continued during his retirement until terminated under the Termination of Coverage section.

Any reduction in the amount of Life Insurance that may be continued for any retired employee is shown in the Plan Summary. If any retired employee is required to make contributions for his Employee Life Insurance Coverage, the rate per $1,000 of such contribution may not be increased above the level such employee was required to pay before his retirement.

CHANGE IN AMOUNTS

EMPLOYEE COVERAGE

Classification or Schedule Change --If, for any reason and at any time, the level of any benefit (other than Comprehensive Dental Expense Benefits if included in the regular plan) is changed to an amount different from that for which the employee is then covered, the amount of his coverage will be changed as follows:

> Any reduction will become effective on the first day of the calendar month next following the date the employee requests the Participant Employer to make the reduction.
>
> Any increase will become effective automatically, subject to the Active Service Requirement. However, the employee may, within 31 days of the date the increase would become effective, refuse the increase. If an employee refuses an increase, then no increase will become effective in the employee's coverage until Ætna gives its written consent.

A retroactive change in an employee's rate of earnings will be considered to become effective on the date the change is determined.

This section will not apply to any reductions due to attainment of a specified age or due to retirement. Any rules for reduction of insurance under these circumstances are shown in the applicable Plan Summary. However, once the first reduction is made because of either age or retirement, no further changes in the amount of the employee's insurance because of a change in the classification or Schedule will be made under this section. When any Employee Life Insurance Coverage is reduced due to age, the rate of contribution per $1,000 for these coverages will not thereafter be increased. The same rule will apply to any reduction of Employee Life Insurance Coverage due to retirement.

DEPENDENT COVERAGE

Classification or Schedule Change--If, for any reason and at any time, the level of any benefit (other than Comprehensive Dental Expense Benefits if included in the regular plan) is changed to an amount of coverage for a dependent different from that then in force, the amount of such coverage will be adjusted accordingly.

LIMITATIONS ON CERTAIN AMOUNTS

EMPLOYEE COVERAGE

No employee whose classification provides an amount of Employee Life Insurance Coverage in excess of the Maximum Benefit may become insured unless he furnishes evidence of insurability satisfactory to Ætna. If the evidence is not entirely satisfactory to Ætna, Ætna may limit the amount of Life Insurance to the Maximum Benefit.

No employee's Employee Life Insurance Coverage may be increased to an amount in excess of the Maximum Benefit or his existing amount of insurance, if greater, unless he furnishes evidence of insurability satisfactory to Ætna.

If satisfactory evidence is submitted and accepted by Ætna, the amount of insurance for which evidence was submitted will be effective on the first of the month following the date that the State is notified that the evidence has been accepted.

EMPLOYEE COVERAGE

Change in Eligibility Date--An increase in any required period of service will apply only to an employee entering service on or after the effective date of the increase. Any decrease in any required period of service will permit an employee to become eligible on the effective date of the decrease if he has then completed the new required period of service, otherwise on the date he completes it.

EMPLOYEE AND DEPENDENT COVERAGE

Addition or Deletion of a Benefit--If any benefit becomes applicable to an employee or a dependent already covered under the policy, that individual will be covered for that benefit immediately. Employee Coverage or Dependent Coverage, whichever applies, for that benefit will become effective in accordance with the Effective Date provisions including the Active Work Requirement and any applicable Non-confinement Rule. However, if the effective date of any employee Medical Expense Benefit if being postponed, the corresponding dependent's coverage will be postponed until the employee becomes covered for the benefit.

If any benefit ceases to apply to an employee or a dependent, coverage for that benefit will cease immediately for that individual but without prejudice to any rights under the benefit established by the individual while the coverage was in force.

PART II

DESCRIPTION OF COVERAGE

LIFE INSURANCE DESCRIPTION

LIFE INSURANCE BENEFIT

Employee Coverage--If an employee dies while Employee Life Insurance Coverage is in force for him under this Part II, Ætna will pay, on receipt of due proof of the death at its Home Office, in Hartford, Connecticut, the amount of Life Insurance in force for him at date of death. The benefit will be payable to the employee's beneficiary in accordance with the Beneficiary section under General Provisions.

Dependent Coverage--If an employee's dependent dies while Life Insurance is in force under this Part II for the dependent, Ætna will pay, upon receipt of due proof of the death at its Home Office, in Hartford, Connecticut, the amount of Life Insurance in force for the dependent at date of death. The benefit will be payable to the employee, if living at the time of payment, otherwise to the employee's executors or administrators or, at Ætna's option, to the employee's surviving wife or husband.

The following dependents are not eligible for coverage:

Dependents in full-time active military service.
Children 14 days of age or younger.

LIFE INSURANCE DESCRIPTION

EXTENDED LIFE INSURANCE BENEFIT

Extended Insurance Benefit--Ætna will extend the Employee Life Insurance and Dependent Life Insurance Coverage of a totally and permanently disabled employee, without payment of further premiums, if all the following conditions are met:

The employee became totally and permanently disabled while Employee Life Insurance Coverage is in force for him, before age 60, and before termination of employment with his Participant Employer. An employee is considered to be "totally and permanently disabled" only if illness or injury prevents him from engaging in his own or any other gainful occupation and will continue to prevent him from engaging in any reasonable occupation. A "reasonable occupation" is any gainful occupation for which the employee is, or may reasonably become, fitted by education, training, or experience.

The total and permanent disability has lasted for at least 9 months.

Ætna has received at its Home Office in Hartford, Connecticut written notice of claim within 12 months from the date the employee ceased active work, and proof of the total and permanent disability no later than 12 months after discontinuance of premium payments for the employee's life insurance.

Ætna has had the opportunity to examine, at its own expense, the person of the employee as often as reasonably required before approving the proof.

LIFE INSURANCE DESCRIPTION

EXTENDED LIFE INSURANCE BENEFIT (Continued)

The amount of Employee Life Insurance Coverage which may be extended will be the amount of the employee's life insurance to which this section applies and for which he was insured under this policy on the date from which he has been continuously and totally disabled.

The extension period for Employee Life Insurance Coverage will terminate on the earliest of the following dates:

The date Aetna sends a request for examination of the person of the employee or for due proof of continuance of total and permanent disability to the employee at his last known address as shown on Aetna's records, if the employee does not submit to the examination or furnish the proof within 31 days of that date.

The date the employee recovers sufficiently so as to be able to engage in any reasonable occupation.

The date the employee starts to work in any gainful occupation.

The date the employee attains age 65.

After the life insurance of the employee has been extended under this section continuously for 2 years, Aetna will not request examination or proof more often than once in a 12 month period.

When the extension period terminates, the employee will be eligible for the Life Insurance Conversion Privilege. If the individual concerned does not [redacted] policy within 31 days of the [redacted] the Life Insurance Conversion Privilege will be [redacted] being extended under this section for the individual concerned on the date the extension period terminated.

LIFE INSURANCE DESCRIPTION

EXTENDED LIFE INSURANCE BENEFIT (Continued)

Extended Death Benefit--On receipt by Ætna at its Home Office in Hartford, Connecticut of due proof that all of the following apply to an employee, Ætna will pay the employee's beneficiary, as a total and permanent disability benefit, the amount of Employee Life Insurance Coverage which may be extended under this section:

Premium payments for the employee's Life Insurance are discontinued while he is totally disabled by illness or injury which prevents him from engaging in any reasonable occupation.

The employee dies during the uninterrupted continuance of the total disability and no later than 12 months after discontinuance of premium payments for his Life Insurance.

The employee would have qualified for extended insurance under this section except for the fact that (a) the disability had not continued for at least 9 months, or (b) the required proof has not yet been received or approved by Ætna.

Written notice of the death of the employee must be given Ætna at its Home Office in Hartford, Connecticut within 12 months of death. Otherwise, Ætna will not be liable for payment of the Extended Death Benefit.

General--When Ætna approves a claim for any benefit under this section, the benefit will be in full settlement and satisfaction of Ætna's obligations.

If an individual policy has been issued to an employee under the Life Insurance Conversion Privilege, the employee's rights under this section may be subject to restoration. However, in order to restore those rights, the employee's individual Life Insurance policy--or all the employee's individual Life Insurance policies, if more than one was issued--must be surrendered without claim, except for return of the individual policy premiums.

ACCIDENT AND HEALTH COVERAGE DESCRIPTION

INTRODUCTION

Unless otherwise specified, the accident and health coverage provided under this policy is non-occupational and any reference to "disease" or "injury" in the following benefit sections means only a non-occupational disease or non-occupational injury.

Non-occupational Disease--A disease is considered non-occupational only if it does not arise out of (or in the course of) any work for pay or profit nor, in any way, results from a disease which does. However, if proof is furnished to the Ætna that an individual covered under a Workmen's Compensation Law (or other law of similar purpose), is not covered for a particular disease under such law, that disease shall be considered "non-occupational" regardless of its cause.

Non-occupational Injury--An injury is considered non-occupational only if it is an accidental bodily injury and does not arise out of (or in the course of) any work for pay or profit nor, in any way, results from an injury which does.

DESCRIPTION OF COVERAGE--SPECIAL PROVISIONS (Continued)

ACCIDENT AND HEALTH COVERAGE DESCRIPTION

SPECIAL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If an employee or an employee's dependent has a covered loss, Aetna will pay a benefit as determined below.

Covered Loss--The loss of life, a hand, a foot, or an eye which meets all the following tests:

It results directly (and independently of all other causes) from a bodily injury (including a bodily injury arising out of or in the course of employment) of the employee or the dependent caused by an accident, occurring while insurance is in force for the individual under this section, and evidenced by a visible wound or contusion on the outside of the body (except in case of drowning or internal injury).

It occurs no later than 365 days after the date of the accident.

As to a hand or foot, there is actual severance at or above the wrist or ankle joint. As to an eye, there is entire and irrecoverable loss of sight in the eye.

It is not excluded under the Limitations section.

The benefit for covered loss of life is the Principal Sum, and for any other covered loss is one-half the Principal Sum, but not more than the Principal Sum is payable for all covered losses of an individual through one accident.

Benefits for covered losses will be payable in accordance with the Payment of Claims section of General Provisions, except that any benefit for a dependent's loss of life will be payable to the employee, if living at the time of payment, otherwise to the employee's executors or administrators.

DESCRIPTION OF COVERAGE--SPECIAL PROVISIONS (Continued)

ACCIDENT AND HEALTH COVERAGE DESCRIPTION

SPECIAL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (Continued)

Limitations--Any loss resulting from an injury caused, to any extent, by any of the following is not a covered loss even though the proximate or precipitating cause of loss is accidental bodily injury:

Bodily or mental infirmity.

Disease, ptomaines or bacterial infections, except a pus-forming infection resulting directly from an injury not excluded under this section.

Medical or surgical treatment, except a loss resulting directly from a surgical procedure required for treatment of an injury not excluded under this section and performed within ninety days after the date of the injury.

Suicide or a suicide attempt, sane or insane, or intentionally self-inflicted injury.

War or any act of war, declared or undeclared.

Traveling in or by, including descending from, any air or space navigation vehicle or device except as a passenger, with no duties whatever, on an aircraft being used only for transportation of passengers or of passengers and cargo.

ACCIDENT AND HEALTH COVERAGE DESCRIPTION

MEDICAL EXPENSE BENEFITS

FOREWORD

Certain words and phrases, used in the following benefit sections, are defined below.

Family Member--An employee or his dependent. Under any benefit section, a "covered family member", as of any given time, is a family member for whom insurance is then in force under the section.

Incurred Charge--The charge for a service or supply is considered to be incurred on the date it is furnished. In the absence of due proof to the contrary when a single charge is made for a series of services, each service will be considered to bear a pro rata share of the charge.

Reasonable Charge--The reasonable charge for a service or supply is the smaller of:

The charge usually made for it by the provider who furnishes it.

The prevailing charge made for it, in the geographic area, by those of similar professional standing.

If the usual and prevailing charges for a service or supply cannot be easily determined, because of the unusual nature of the service or supply, Aetna will determine to what extent the charge is reasonable, taking into account

The complexity involved.
The degree of professional skill required.
Other pertinent factors.

Necessary Service or Supply--A service or supply is considered necessary only if it is broadly accepted professionally as essential to the treatment of the disease or injury.

Dentist--A legally qualified dentist or a legally qualified physician authorized by his license to perform, at the time and place involved, the particular dental procedure rendered by him.

COMPREHENSIVE DENTAL EXPENSE BENEFITS

Dental Claim Requirements--As part of proof of any claim:

Ætna has the right to have an oral examination made of any family member at its own expense.

The employee is responsible for furnishing to Ætna all material which Ætna may require to establish its liability, such as x-rays, models, charts and written reports. If he does not, the benefits payable may be less than would otherwise be the case, to the extent Ætna cannot verify Covered Dental Expenses.

ACCIDENT AND HEALTH COVERAGE DESCRIPTION

MEDICAL EXPENSE BENEFITS--REGULAR PLAN (Continued)

COMPREHENSIVE DENTAL EXPENSE BENEFITS (Continued)

Dental Expense Benefits

If Covered Dental Expenses are incurred during a calendar year as to a covered family member, for treatment of a disease or injury, Aetna will pay a benefit equal to the applicable Coinsurance Percentage of Type A Dental Expenses and Type B Dental Expenses.

Covered Dental Expenses--Dentists' charges for services and supplies listed below, but only to the extent that the services and supplies meet all of the following tests:

They are necessary and customarily employed nationwide for the treatment of the dental condition.

They are appropriate and meet professional standards of quality.

COMPREHENSIVE DENTAL EXPENSE BENEFITS (Continued)

Covered Dental Expenses (Continued)

Type A Expenses

Oral examination (including prophylaxis--scaling and cleaning of teeth), but not more than one in any period of 6 consecutive months.

Topical application of sodium fluoride or stannous fluoride, but only for covered family members under 19 years of age, but not more than one application in any period of 6 consecutive months.

Emergency palliative treatment.

Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment. Also other dental x-rays, but not more than one full mouth x-ray or series in any period of 36 consecutive months.

Type B Expenses

Space maintainers.

Extractions.

Oral surgery, including fracture and dislocation treatment, diagnosis and treatment of cysts and absesses and apicoectomy.

Fillings consisting of silver, amalgam, silicate and plastic restorations. For other types of fillings including crowns, inlays and onlays required to restore diseased or accidentally broken teeth, the allowance is limited to what would be otherwise allowed for amalgam restoration.

Treatment of periodontal and other diseases of the gums and tissues of the mouth.

Endodontic treatment, including pulpotomy, pulp capping and root canal therapy.

Mucogingivoplastic surgery, management of an acute infection and oral lesions.

COMPREHENSIVE DENTAL EXPENSE BENEFITS (Continued)

Limitations

No benefits are payable for:

Charges for any dental services or supplies included as covered expenses under any other benefit section included in this policy, or any other plan of group benefits carried or sponsored by the Participant Employer, whether or not benefits are payable under such section or plan as to such charges.

Charges made by other than a dentist, or charges for treatment by other than a dentist, except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is rendered under the supervision or the direction of the dentist.

Charges for services or supplies for congenital malformation, primarily of cosmetic or asthetic purposes or for dental implants.

Charges for any services or supplies which are for orthodontic treatment, except for extractions incidental thereto.

Charges for dentures, crowns, inlays, onlays, bridgework or other appliance or service to increase vertical dimension or to restore occlusion including periodontal splinting.

Charges for precision or other elaborate attachments for any appliance.

COMPREHENSIVE DENTAL EXPENSE BENEFITS (Continued)

Benefits After Termination of Coverage--This section applies only if an individual's coverage terminates while the individual is not "totally disabled", as defined in the Extension of Benefits section.

Expenses incurred as to an individual, after termination of the individual's coverage under this benefit section, for any of the following items:

Dentures;

Fixed bridgework;

Crowns;

will be considered to be expenses incurred when ordered, but only if item is finally installed or delivered no later than 30 days after termination of coverage.

"Ordered" means

As to a denture, that impressions have been taken for its preparation.

As to any other item listed above, that the teeth which will serve as retainers or support, or which are being restored, have been fully prepared to receive the item, and impressions have been taken for its preparation.

ACCIDENT AND HEALTH COVERAGE DESCRIPTION

SPECIAL PROVISIONS APPLICABLE TO INDIVIDUALS ELIGIBLE FOR MEDICARE

Medicare--The "Health Insurance For The Aged and Disabled" part of the U.S. Social Security Act, as now constituted or later amended.

Eligibility for Medicare--A family member is "eligible for Medicare" during any period he either has coverage under Medicare or, while otherwise qualifying for coverage under Medicare, does not have such coverage solely because he has refused, discontinued, or failed to make any necessary application for, Medicare Coverage.

Effect of Eligibility for Medicare--"Medical Expense Benefits--Regular Plan" does not cover any service or supply furnished a covered family member while he is eligible for Medicare.

Thereafter, in determining any medical expense benefits premiums as to any coverage for him, the family member will not be considered to be covered under "Medical Expense Benefits--Regular Plan".

However, any extension of benefits provided by this policy at termination of insurance will apply but only as to any category of expense for which Medicare provides no coverage.

Any insurance as to a dependent of the employee will not, unless the policy otherwise specifies, continue after the employee's death, nor after the date it would otherwise have terminated under the policy terms.

If a family member's medical expense coverage ceases because of the above provisions, any conversion privilege provided under this policy will be available immediately, if the family member is not eligible for coverage under the "Medical Expense Benefits For Individuals Eligible For Medicare".

OK

ACCIDENT AND HEALTH COVERAGE DESCRIPTION

MEDICAL EXPENSE BENEFITS FOR ALL INDIVIDUALS

GENERAL EXCLUSIONS

This policy does not provide insurance for any of the following:

Charges that are made only because the insurance exists.

Charges incurred as to a person while he is not a covered family member.

Charges that no person, to whom the insurance relates, is legally obliged to pay.

Charges for services or supplies furnished, paid for, or as to which benefits are provided or required, under any law (national or otherwise) because of service in the armed forces of any government.

Charges for services or supplies furnished, paid for, or as to which benefits are provided or required under any law (national or otherwise), other than because of armed forces service and other than through a plan for civilian employees of a government.

Charges for care, treatment, services or supplies not recommended and approved by the family member's attending physician.

Charges for care, treatment, services or supplies not necessary for treatment of the disease or injury involved.

Charges for custodial care.

Charges for services and supplies to the extent that they are not reasonable.

Charges for the services of an intern or resident physician, but not as to any Accident Expense Benefits, Comprehensive Medical Expense Benefits and Major Medical Expense Benefits.

Before determining benefits under any benefit section, the amount of the above charges will be deducted from the family member's expenses which are covered under the benefit section and, if this policy contains a Coordination of Benefits With Other Plans, the amount of the above charges will not be included as Allowable Expenses (definition follows).

GENERAL EXCLUSIONS (Continued)

If the law of the jurisdiction in which this policy is issued prohibits or restricts the application of the fourth or fifth excluded items on the preceding page as to a facility owned or operated by the jurisdiction or one of its political subdivisions, those items will be applicable only to the extent permitted by law.

No benefits are payable under this policy to the extent that the provision of benefits is prohibited by any law of the jurisdiction in which the individual resides at the time claim is incurred.

ACCIDENT AND HEALTH COVERAGE DESCRIPTION

MEDICAL EXPENSE BENEFITS FOR ALL INDIVIDUALS (Continued)

COORDINATION OF BENEFITS WITH OTHER PLANS

Benefits Subject to This Provision--All benefits provided under this policy (except those provided under any Life Insurance, Temporary Disability or Accidental Death and Dismemberment Benefit Section) are subject to this provision.

Plan--Any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by one of the following:

Group insurance or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis.

Automobile reparations (no-fault) insurance required under any law of a government and provided on other than a group basis, but only to the extent of the benefits required under such no-fault law.

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

This Plan--The parts of this policy which provide benefits subject to this provision.

Allowable Expense--Any necessary and reasonable item of medical or dental expense at least partly covered under at least one of the Plans covering the person for whom claim is made.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

Claim Determination Period--A calendar year. However, if a person is not eligible for benefits under this Plan during all of a calendar year, then the Claim Determination Period for the person as to that year will be the total period thereof during which he was eligible for benefits.

COORDINATION OF BENEFITS WITH OTHER PLANS (Continued)

Effect on Benefits--This provision will apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to the person during such Claim Determination Period, the sum of the following would exceed the Allowable Expenses:

Benefits that would be payable under this Plan in the absence of this provision.

Benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision.

As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period will be reduced to the extent necessary so that the sum of the reduced benefits and all the benefits payable for the Allowable Expenses under all other Plans, except as provided in the next following paragraph of this section, will not exceed the total of the Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made for them.

If both of the following apply to another Plan involved in the next preceding paragraph, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan:

The other Plan contains a provision coordinating its benefits with those of this Plan which would, according to its rules, determine its benefits after the benefits of this Plan have been determined.

The rules set forth in the next following paragraph would require this Plan to determine its benefits before such other Plan.

COORDINATION OF BENEFITS WITH OTHER PLANS (Continued)

Order of Benefit Determination--
The rules establishing the order of benefit determination referred to above are:

The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent will be determined before the benefits of a Plan which covers the person as a dependent.

The benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a male person will be determined before the benefits of a Plan which covers the person as a dependent of a female person.

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 will be determined before the benefits of a Plan which has covered the person the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision will be reduced proportionately, and the reduced amount will be charged against any applicable benefit limit of this Plan.

Right to Receive and Release Necessary Information--For the purposes of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, Ætna may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which Ætna deems to be necessary for such purposes. Any person claiming benefits under this Plan must furnish Ætna such information as may be necessary to implement this provision.

Facility of Payment--Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, Ætna will have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it determines to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and, to the extent of the payments, Ætna will be fully discharged from liability under this Plan.

Right of Recovery--Whenever payments have been made by Ætna with respect to Allowable Expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, Ætna will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as Ætna determines: any persons to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.

SPECIAL PROVISIONS

EFFECT OF PRIOR COVERAGE

If the coverage of any family member under one or more benefit sections of this policy replaces any prior coverage in effect for the member, the rules below will apply to the benefit sections.

"Prior Coverage" is any plan of group life insurance carried or sponsored by a Participant Employer (or its predecessor) which has been replaced entirely or in part, with respect to the class of employees of which the employee is a member, by coverage under one or more benefit sections of this policy. Any such plan shall be considered "prior coverage" whether provided under another group policy or any benefit section of this policy.

An employee's insurance under this policy replaces and supersedes any prior coverage and will be in exchange for all privileges and benefits under the prior coverage. However, if an employee or his beneficiary becomes entitled to claim under the prior coverage, his insurance under this policy will be cancelled, as of its effective date, and any premiums paid for his insurance under this policy will be refunded to the Policyholder.

If the prior coverage was underwritten by Aetna, the employee's latest optional method of settlement election and latest designation of beneficiary under any prior life insurance coverage will be effective under this policy until a change is made in accordance with the terms of this policy.

PART III

TERMINATION OF COVERAGE--
EXTENSION OF BENEFITS--
CONVERSION PRIVILEGE

TERMINATION OF COVERAGE

TERMINATION OF COVERAGE--Coverage of an employee will terminate on the last day of the month for which the employee has made a full month's contribution when any of the following occurs

Discontinuance of this policy as to such coverage.

The date the employee's employment terminates.

The date of the employee's death, unless otherwise provided.

Except as provided below:

If absent from work because of disease, injury or an approved leave of absence, his employment may be considered to continue, until terminated by his Participant Employer, but for no longer than 12 months from the start of the absence.

If absent from work because of temporary layoff, his employment may be considered to continue, until terminated by his Participant Employer, but for no longer than the end of the policy month after the policy month in which the absence started.

If absent from work because of retirement in a class of Eligible Retired Employees shown on the Plan Summary, his employment may be considered to continue for any coverage specifically continued under Part I, until terminated by his Participant Employer. If the applicable Plan Summary does not designate a class of Eligible Retired Employees, no coverage is available for retired employees.

As to an exception, a Participant Employer may signify an employee's termination of employment either by notifying Ætna or ceasing premium payments for his coverage. Any maximum period of continuation may be extended by written mutual agreement between the Participant Employer and Ætna.

No contributory coverage may be continued beyond the end of the period for which the employee has made the required contributions to his Participant Employer.

TERMINATION OF COVERAGE--
EXTENSION OF BENEFITS--
CONVERSION PRIVILEGE (Continued)

TERMINATION OF COVERAGE (Continued)

Termination of Dependent Coverage--Any Dependent Coverage of an employee will terminate, regardless of continuation of his Employee Coverage, upon discontinuance of such Dependent Coverage under this policy or, if earlier, when the employee ceases to be in a class of employees eligible for such Dependent Coverage.

Termination of Coverage For Individual Dependents--Dependent Coverage of an employee as to an individual dependent will cease, regardless of continuation of other Dependent Coverage, when the individual ceases to be a dependent or, if earlier, when the individual becomes insured for Employee Coverage.

TERMINATION OF COVERAGE--
EXTENSION OF BENEFITS--
CONVERSION PRIVILEGE (Continued)

TERMINATION OF COVERAGE (Continued)

Coverage For Certain Incapacitated Children--Any Dependent Dental Coverage and any Special Accidental Death and Dismemberment Coverage under this policy as to an unmarried dependent child may be continued, beyond the date the child attains the limiting age for dependent children, if all the following tests are met:

The child, on the date he attains the limiting age, is incapable of self-sustaining employment because of mental retardation or physical handicap and became so incapacitated prior to such date.

The child, on that date, is chiefly dependent on the employee for support.

The child has not been issued an individual medical expense insurance policy under the Conversion Privilege section.

Ætna is furnished due proof of the incapacity at its Home Office in Hartford, Connecticut not later than 31 days after the date the child attains the limiting age.

However, Dependent Coverage as to the child may not be continued beyond the earliest of the following occurrences:

Cessation of the incapacity.

Failure to furnish any required proof of continuing incapacity or to submit to any required examination.

Termination of Dependent Coverage as to the child for any reason other than attaining the limiting age.

Ætna will have the right to require due proof of the continuation of the incapacity and the right and opportunity, at its own expense, to examine the person of the child whenever it may reasonably require during the continuation of the incapacity. However, an examination will not be required more often than once each year after 2 years have elapsed from the date the child attained the limiting age.

TERMINATION OF COVERAGE--
EXTENSION OF BENEFITS--
CONVERSION PRIVILEGE (Continued)

EXTENSION OF BENEFITS

LIFE INSURANCE

If a person dies during the [redacted] period during which he is entitled to apply for an individual life [redacted] conversion privilege, the amount of group life insurance [redacted] converted for the deceased person will be payable as a death benefit under this policy.

TERMINATION OF COVERAGE--
EXTENSION OF BENEFITS--
CONVERSION PRIVILEGE (Continued)

EXTENSION OF BENEFITS (Continued)

ACCIDENT AND HEALTH BENEFITS

This section applies to all accident and health benefit sections except any section providing Special Accidental Death and Dismemberment, Temporary Disability, Poliomyelitis or Accident Expense Benefits.

As used in this section, "totally disabled" means:

That the family member, if an employee, is prevented, because of non-occupational injury or non-occupational disease, from performing his occupational duties and is not engaged in employment or any other gainful activity.

That the family member, if a dependent, is prevented, because of non-occupational injury or non-occupational disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Benefit Extension

As to any Comprehensive Dental Expense Benefit section

If coverage for a family member under a benefit section terminates while he is totally disabled, any benefit provided by the section for that family member only will continue to be available for expenses incurred while he continues to be totally disabled, but not beyond 12 months from the termination date.

However, these benefits will cease immediately on the date a family member becomes covered for similar benefits under any other group policy, regardless of the insurer, except when coverage has terminated because of discontinuance of the benefit section as to the Eligible Class of which the employee is a member.

EXTENSION OF BENEFITS (Continued)

ACCIDENT AND HEALTH BENEFITS (Continued)

Limitation Applicable to any Dental Expense Benefits

Dental Expense Benefits and Comprehensive Dental Expense Benefits will be available as described in this section only for expenses incurred for covered services and supplies rendered and received, including delivered and installed, if applicable, before the end of the applicable benefit extension period.

CONVERSION PRIVILEGE

Life Insurance

Employee Coverage--If any of an employee's life insurance under this policy ceases because of termination of employment, termination of membership in the class of employees eligible, age, pension or retirement, the amount of life insurance which ceases (or a lesser amount, if desired) may be converted to an individual life insurance policy.

If any of an employee's life insurance ceases because this policy discontinues with respect to such coverage as to the employee's class, and if his life insurance under this policy has then been in force for at least five continuous years, the amount that ceases, less the amount of any group life insurance for which the employee becomes eligible within 31 days of discontinuance, may be converted to an individual life insurance policy. However, the maximum amount that may be converted in the event of discontinuance is $2,000.

The individual policy may be any kind of individual life insurance policy without disability or other supplementary benefits then customarily being issued by Aetna at the age and amount being converted, other than term insurance. The premiums for the individual policy will be at Aetna's customary rate for its form and amount, and the employee's class of risk and attained age (nearest birthday) on the policy effective date.

TERMINATION OF COVERAGE--
EXTENSION OF BENEFITS--
CONVERSION PRIVILEGE (Continued)

CONVERSION PRIVILEGE (Continued)

LIFE INSURANCE (Continued)

Dependent Coverage--If any of an employee's life insurance as to a dependent under this policy ceases because of termination of employment or termination of membership in the class of employees eligible, the amount of life insurance for the dependent which ceases (or a lesser amount, if desired) may be converted to an individual life insurance policy.

If any of an employee's life insurance as to a dependent ceases because Dependent Life Insurance Coverage discontinues as to the employee's class, and if his life insurance as to the dependent under this policy has then been in force for at least 5 years, the amount that ceases, less the amount of any group life insurance for which the employee becomes eligible as to the dependent within 31 days of discontinuance, may be converted to an individual life insurance policy. However, the maximum amount that can be converted as to a dependent in the event of discontinuance is $2,000.

The individual policy may be one of the level premium whole life or endowment policy forms, providing a level amount of insurance, then customarily being issued by Ætna at the age and amount being converted. The premiums for the individual policy will be at Ætna's customary rate for the policy's form and amount, the dependent's class of risk, and the dependent's attained age (nearest birthday) on the policy effective date.

CONVERSION PRIVILEGE (Continued)

LIFE INSURANCE (Continued)

General--To convert the [redacted] over the employee or dependent as to Dependent Coverage) must make written application for the individual policy, and pay the first premium due to Aetna, within 31 days after cessation of the particular insurance under this policy. Any individual policy issued under this section will take effect at the end of the 31 day period during which application may be made.

No evidence of insurability is required for conversion.

When insurance becomes effective for a person under an individual policy issued under this section, it will be in exchange for all privileges and benefits under this policy as to the insurance which was converted.

PART IV

GENERAL PROVISIONS

ASSIGNMENT

By Policyholder or Participant Employer--No assignment of any present or future right or interest under this policy by the Policyholder or any Participant Employer will bind Aetna without its written consent.

By Others

Life Insurance--The employees and their beneficiaries may not assign the insurance or other benefits provided under any Life Insurance benefit section of this policy.

Accident and Health Coverage--No assignment of any accident and health benefits by an employee or his beneficiary will bind Aetna without its written consent.

CLAIMS OF CREDITORS

Insofar as possible under any applicable law, the Life Insurance and any Accidental Death and Dismemberment Coverage and benefits under this policy are exempt from any legal or equitable process for the debts of employees or beneficiaries.

BENEFICIARY

An employee, whether or not employment has terminated, may designate a beneficiary, and at any time change his designation, by written request filed at the headquarters of the Policyholder or at Ætna's Home Office in Hartford, Connecticut. The designation or change will take effect as of the date the employee executes the request, whether or not he is living at the time of filing, but without prejudice to Ætna on account of any payments made by it before receipt of the request at its Home Office in Hartford, Connecticut.

Any amount payable to a beneficiary will be paid to the beneficiary or beneficiaries designated by the employee, subject to the conditions in the following paragraphs.

If more than one beneficiary is designated, the designated beneficiaries will share equally, unless otherwise specifically provided by the employee.

If any designated beneficiary predeceases the employee, the share which such beneficiary would have received if surviving the employee will, unless otherwise specifically provided by the employee, be payable equally to the remaining designated beneficiary or beneficiaries, if any, who survive the employee.

If no designated beneficiary survives the employee or if no beneficiary has been designated, payment will be made to:

The employee's surviving spouse, if any.

If there is no surviving spouse, in equal shares to the employee's surviving children.

If there is no surviving spouse or child, to the employee's parents, equally, or to the survivor.

If there is no surviving spouse, child or parent, in equal shares to the employee's brothers and sisters who survive the employee.

If there is none of the above surviving, to the employee's executors or administrators.

LIFE INSURANCE ONLY

Mode Of Settlement--All or part of any amount of Life Insurance payable will be paid in one sum unless another method of settlement has been elected by the employee and agreed to by Ætna. An employee may revoke any election before payments commence by written notice filed at Ætna's Home Office in Hartford, Connecticut. An employee may change any election made but only with Ætna's consent.

If any amount of Life Insurance death benefit is payable in one sum, the beneficiary may, after the employee's death but before payment is made, elect that all or part of it be payable in accordance with another method of settlement elected by the beneficiary and agreed to by Ætna. A beneficiary may change or revoke any election but only with Ætna's consent.

The methods of settlement available will be those being offered by Ætna, on the date of the election, under individual life insurance policies Ætna is then issuing.

Facility Of Payment--If any payee for any Life Insurance benefit payment under this policy is a minor or is, in Ætna's opinion, legally incapable of giving a valid receipt and discharge for payment, Ætna may elect to pay as follows, unless claim has been made by the payee's legal guardian or committee:

> Payment of the benefit in monthly installments of not over $100 the first month and $50 a month thereafter to the person or persons who, in Ætna's opinion, are caring for and supporting the payee.

Any such payment will fully discharge Ætna's obligation to that extent. Ætna will have no responsibility as to how the payment is applied.

GENERAL PROVISIONS (Continued)

ACCIDENT AND HEALTH BENEFITS ONLY

Time Limit on Certain Defenses--Claim under any given coverage of an individual, for a loss incurred or commencing more than two years after the coverage becomes effective for the individual, will not be reduced or denied because there existed, prior to the effective date, a disease or physical condition not expressly excluded from the coverage on the date of the loss.

Proof of Loss--Written proof of loss must be given to Ætna within 90 days after the loss.

Proof of loss must cover the occurrence, character, and extent of the loss.

Late proof may be accepted only if, under the particular circumstances, it was furnished as soon as was reasonably possible, and, in any event except in the absence of the employee's legal capacity, within one year after the time it was otherwise required.

No action at law or in equity may be brought to recover on this policy after three years from the time written proof is required to be furnished.

Payment of Claims--Benefits payable for any loss will be paid immediately upon receipt of due written proof of loss. Any benefit payment for loss of life will be payable in accordance with the beneficiary designation and the provisions as to such payment. All other benefits will be payable to the employee. However, unless the employee requests otherwise in writing not later than the time proof of loss is filed, Ætna may pay any part or all of any benefits provided on account of hospital, convalescent facility, nursing, medical, surgical or dental service directly to the institution or person providing the services.

If any benefit is payable to the employee, and the employee is a minor or otherwise not competent to give a valid release, or if any benefit is payable to the employee's estate, Ætna may deduct up to $1,000 from the benefit payable and pay it to any of the employee's relatives (by blood or marriage) whom it believes is fairly entitled to it.

Ætna will have the right and opportunity to examine, at its own expense, the person of any individual whose injury or disease is the basis of a claim when and as often as it may reasonably require while a claim is pending and, if a benefit for loss of life is provided, to make an autopsy in case of death where it is not forbidden by law.

PART V

POLICYHOLDER AND INSURANCE COMPANY MATTERS

DECLARATIONS

The first "policy month" begins on	September 1, 1979
and thereafter a policy month begins on the	first day
of a calendar month	
The first "policy year" begins on	September 1, 1979
and ends on	July 31, 1980
and, thereafter, a policy year begins on a	August 1
, the policy anniversary, and ends on a	July 31

PARTICIPANT EMPLOYERS

The Participant Employers shall, as of any given time, consist of those employers which have been included under this policy, by written mutual agreement between the Policyholder and Ætna, and which have not been removed in accordance with any of the policy terms.

An Employer may be included as a Participant Employer if not contrary to the law of the jurisdiction in which this policy is delivered.

The Policyholder may act for all Participant Employers in all policy matters, and every such act, or agreement made between Ætna and the Policyholder, or notice given Ætna or the Policyholder by the other, will be binding on all the Employers.

DATA REQUIRED

The Policyholder and each Participant Employer must furnish Ætna all information Ætna reasonably requires as to matters pertaining to this policy. All material which may have a bearing on insurance or premiums will be open for inspection by Ætna at all reasonable times during the continuance of this policy and until the final determination of all rights and obligations under this policy.

CLERICAL ERROR

Any clerical error (by the Policyholder, a Participant Employer, or Ætna) in keeping pertinent records, or a delay in making any entry, will not invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. An equitable adjustment of premiums will be made when the error or delay is discovered.

MISSTATEMENTS

If any relevant fact as to an individual to whom the insurance relates is found to have been misstated, an equitable adjustment of premiums will be made. If the misstatement affects the existence or amount of insurance, the true facts will be used in determining whether insurance is in force under this policy and its amount.

POLICYHOLDER AND INSURANCE COMPANY MATTERS (Continued)

NON-DISCRIMINATION--In the administration of this policy, the Policyholder and the Participant Employers will act so as not to discriminate unfairly between individuals in similar situations at the time of the action. Ætna will be entitled to rely on any such action, without being obliged to inquire into the circumstances.

CERTIFICATES--Ætna will issue to the Policyholder, for delivery to each insured employee, an individual certificate. The certificate will summarize the features of his insurance coverage, and contain statements as to whom benefits are payable, and of the Conversion Privilege.

POLICY CHANGES--This policy may be changed at any time by written agreement between Ætna and the Policyholder and, in the case of any Special Accidental Death and Dismemberment Benefits, on the policy anniversary which first occurs after the end of a 90 day period following written notification to the Policyholder by Ætna, without the consent of any employee or other person. All agreements made by Ætna are signed by one of its executive officers. No other person can change or waive any of the policy terms or make any agreement binding Ætna.

POLICYHOLDER AND INSURANCE COMPANY MATTERS (Continued)

CONTRACT

This policy and application of the Policyholder, a copy of which is attached to this policy, constitute the entire contract. All statements made by the Policyholder or insured employees shall be deemed representations and not warranties. No written statement made by an insured employee shall be used by Ætna in a contest unless a copy of the instrument containing the statement is or has been furnished to the employee or his beneficiary, or the person making the claim.

LIFE INSURANCE--INCONTESTABILITY

With respect to Life Insurance

The validity of this policy shall not be contested, except for non-payment of premiums, after it has been in force for 2 years from its effective date. No statement made by any insured employee relating to his insurability shall be used by Ætna in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for 2 years during the employee's lifetime nor unless such statement is contained in a written instrument signed by him.

ACCIDENT AND HEALTH COVERAGE--STATEMENTS

With respect to Accident and Health Coverage

Except as to a fraudulent misstatement:

No statement made by the Policyholder or any employee shall avoid any coverage or reduce any benefits or be used in defense of a claim unless it is in writing.

No statement made by the Policyholder shall be used to void this policy after it has been in force for 2 years from its effective date.

No statement made by any employee eligible for coverage under this policy shall be used in defense to a claim for loss incurred or commencing after coverage with respect to which claim is made has been in effect for 2 years.

PREMIUM RATES

Employee Life Insurance Coverage

TABLE OF PREMIUM RATES

Age on Birthday Nearest Beginning of the Policy Year	Monthly Premium Per $1,000 of Insurance	Age on Birthday Nearest Beginning of the Policy Year	Monthly Premium Per $1,000 of Insurance	Age on Birthday Nearest Beginning of the Policy Year	Monthly Premium Per $1,000 of Insurance	Age on Birthday Nearest Beginning of the Policy Year	Monthly Premium Per $1,000 of Insurance
15	$.19	35	$ .32	55	$1.65	75	$ 8.56
16	.20	36	.34	56	1.80	76	9.24
17	.21	37	.36	57	1.97	77	10.00
18	.22	38	.38	58	2.14	78	10.86
19	.23	39	.41	59	2.32	79	11.81
20	.23	40	.45	60	2.51	80	12.83
21	.24	41	.49	61	2.72	81	13.93
22	.24	42	.53	62	2.96	82	15.07
23	.25	43	.58	63	3.21	83	16.26
24	.25	44	.63	64	3.48	84	17.50
25	.25	45	.68	65	3.78	85	18.80
26	.25	46	.74	66	4.11	86	20.16
27	.26	47	.81	67	4.48	87	21.60
28	.26	48	.89	68	4.89	88	23.13
29	.26	49	.97	69	5.34	89	24.79
30	.27	50	1.06	70	5.81	90	26.62
31	.27	51	1.16	71	6.32	91	28.68
32	.28	52	1.26	72	6.84	92	31.03
33	.29	53	1.38	73	7.38	93	33.75
34	.30	54	1.51	74	7.95	94	36.95
						95	40.98

The above monthly premiums are applicable to male employees only. For female employee premiums, multiply the above monthly premiums by .60.
For annual, semi-annual, or quarterly premiums multiply the monthly premiums determined from the above table by 11.83, 5.96 or 2.99 respectively.

Policy Charge

The premium calculated as above shall be increased by a policy charge of $.20 for each $1,000 of insurance in force hereunder at the beginning of the then current policy year for each policy month which occurs during the premium paying period, provided that the policy charge shall not exceed $8.00 in respect of any month.

PREMIUM RATES (Continued)

Employee Life Insurance Coverage (Continued)

Advance Expense Adjustment

For the first policy year the total premium for Employee Life Insurance Coverage, including the policy charge, shall be reduced by the applicable advance expense adjustment indicated below (for annual, semi-annual or quarterly premiums, divide the total premium for Employee Life Insurance Coverage, including the policy charge, by 12, 6, or 3, respectively, before entering this table):

Total Monthly Premium for Employee Life Insurance Coverage Before Advance Expense Adjustment	Advance Expense Adjustment	Total Monthly Premium for Employee Life Insurance Coverage Before Advance Expense Adjustment	Advance Expense Adjustment
Under $125	0 %	$ 700 - 899	26%
$125 - 149	10	900 - 1,399	27
150 - 174	11	1,400 - 2,499	28
175 - 199	13	2,500 - 3,999	29
200 - 224	14	4,000 - 7,499	30
225 - 249	16	7,500 - 11,999	31
250 - 299	17	12,000 - 26,999	32
300 - 349	19	27,000 - 59,999	33
350 - 399	20	60,000 - 79,999	34
400 - 449	21	80,000 and over	35
450 - 499	22		
500 - 549	23		
550 - 599	24		
600 - 699	25		

POLICYHOLDER AND INSURANCE COMPANY MATTERS (Continued)

CONTRACT--This policy and application of the Policyholder, a copy of which is attached to this policy, and the individual applications of the employees, if any, constitute the entire contract. All statements made by the Policyholder or insured employees shall be deemed representations and not warranties. No statement made by the Policyholder or by an insured employee shall be used in defense to a claim under this policy unless contained in a written application.

STATEMENTS--Except as to a fraudulent misstatement -

No statement made by the Policyholder or any employee shall avoid any coverage or reduce any benefits or be used in defense of a claim unless it is contained in a written application.

No statement made by the Policyholder shall be used to void this policy after it has been in force for two years from its effective date.

No statement made by any employee eligible for coverage under this policy shall be used in defense to a claim for loss incurred or commencing after coverage with respect to which claim is made has been in effect for two years.

POLICYHOLDER AND INSURANCE COMPANY MATTERS (Continued)

PREMIUM RATES (Continued)

Employee Life Insurance Coverage (Continued)

At the beginning of each policy year, Ætna will compute an aggregate annual, semi-annual, quarterly, or monthly premium based upon the frequency of premium payments then agreed upon between the Policyholder and Ætna. The aggregate premium will be the sum of the individual premiums for the employees then insured, calculated according to the table of premium rates then in effect and on the basis of the ages (nearest birthday) then attained by employees insured for Employee Coverage and their amounts of insurance. From such computation an average premium rate will be determined by dividing the aggregate premium by the aggregate amount of insurance then in force.

The average premium rate may be redetermined as of any premium-due date in either of the following circumstances:

When requested by Ætna, by reason of a change in factors bearing on the risk assumed.

Once during any continuous 12 month period, when requested by the Policyholder, subject to 60 days advance notice to Ætna.

Such redetermination will be made on the basis of the attained ages (nearest birthday) of the employees insured, the individual premiums for the employees insured, the table of premiums in effect, and the amounts of Employee Coverage for the employees insured, all taken as of the date of the redetermination.

The average premium rate will remain in effect and be used in calculating premiums under this policy until a new one is determined. Each premium due during the policy year will be calculated by multiplying the amount of insurance in force at the beginning of the premium-paying period by the average premium rate then in effect.

Dependent Life Insurance Coverage--It is Ætna's intent to compute premium charges for Dependent Coverage on the basis of the table of premium rates effective under this policy. However, because of practical difficulties in securing ages of dependents, Ætna will use premium rates, based on the premium rate per $1,000 of Employee Coverage, which, in its opinion, and according to appropriate actuarial assumptions, would produce approximately the same premium amount that would be obtained by using the dependents' actual ages.

PREMIUM RATES (Continued)

Accident and Health Benefits--The premium rates for the accident and health coverage provided under this policy are as follows, but are subject to change as provided below. The premium rates are for a period of one month.

Special Accidental Death and Dismemberment Benefits--
premium per $1,000 of Principal Sum: $.045

	Premium Per Employee			
	Employee Coverage	Dependent Coverage		
		One Dependent		More Than One Dependent
		Spouse	Spouse and Child or Children	Child or Children
Medical Expense Benefits--Regular Plan				
Comprehensive Dental Expense Benefits	$3.11	$2.68	$9.16	$6.48

PREMIUMS DUE--EXPERIENCE RATING (Continued)

At the end of a policy year, Ætna may declare an experience credit in the amount it determines. The amount of each credit Ætna declares will be refunded to the Policyholder, or upon request by the Policyholder, part or all of it will be applied against the payment of premiums.

If at any time the sum of employee contributions which have been made for group insurance exceeds the sum of premiums which have been paid for group insurance (after giving effect to any experience credits allowed the Policyholder), the excess will be applied by the Policyholder for the sole benefit of employees. Ætna will not be obliged to see to the application of any such excess.

Instead of the method of calculation of premiums described above, premiums may be calculated by any method approved by Ætna that produces approximately the same amount of premiums.

Ætna will not be required to refund any premium, whether paid in error or otherwise, for any period prior to the first day of the policy year in which Ætna receives the evidence that the refund should be made, or prior to the date 3 months before Ætna's receipt of the evidence if it produces a larger refund.

Payment of Premiums--The Policyholder will pay premiums in advance at Ætna's Home Office in Hartford, Connecticut or to its authorized agent.

A premium under this policy will be due and payable on the first day of each policy month.

With Ætna's written consent, the Policyholder may change the frequency of premium payments as of any premium-due date.

Grace Period--A grace period of 31 days following the due-date will be allowed the Policyholder for the payment of each premium.

POLICYHOLDER AND INSURANCE COMPANY MATTERS (Continued)

DISCONTINUANCE OF POLICY

The Policyholder may discontinue this policy with respect to any or all coverage of all employees of any one or more Participant Employers, and any Participant Employer may discontinue this policy with respect to any or all coverage of all employees of such Employer by giving to the Insurance Company written notice stating when, after the date of such notice, such discontinuance shall become effective; but no such discontinuance shall become effective with respect to any coverage of the employees of any Participant Employer during any period for which a premium has been paid to Ætna with respect to such coverage.

Ætna reserves the right to discontinue this policy as to all employees of a Participant Employer, at any time after the end of the grace period allowed for payment of a premium as to the employees which has not been paid, by giving the Policyholder written notice of the discontinuance date. This right is subject to the terms of any applicable law or regulation.

Ætna may also discontinue this policy in its entirety or as to any or all coverage of all employees of a Participant Employer, at any time, by giving the Policyholder advance written notice of the discontinuance date, but the date shall not be earlier than 31 days after the date of the notice unless mutually satisfactory to the Policyholder and Ætna.

If this policy discontinues as to any coverage of the employees of a Participant Employer, the Policyholder and the Employer will be jointly and severally liable to Ætna for all unpaid premiums for the period such coverage under this policy was in force as to any of the employees of the Employer.

POLICYHOLDER AND INSURANCE COMPANY MATTERS (Continued)

PREMIUMS DUE--EXPERIENCE RATING

The premium due under this policy on any premium-due date will be the sum of the premium charges for the coverages then provided under this policy. On any premium-due date for a period in which Special Accidental Death and Dismemberment coverage is provided under this policy, the premium due will include a premium charge of not less than $100.00 per month for such coverage.

If premiums are payable monthly, any insurance becoming effective will be charged for from the first day of the policy month coinciding with or next following the date the insurance takes effect, and premium charges for any insurance terminated will cease as of the first day of the policy month coinciding with or next following the date the insurance terminates. If premiums are payable less frequently than monthly, premium charges or credits for a fraction of a premium-paying period required by the foregoing terms will be made on a pro rata basis for the number of policy months between the date premium charges commence or cease and the end of the premium-paying period. If this policy is amended to provide additional or increased coverage to be effective on a date other than the first day of a premium-paying period, a pro rata premium for the coverage will become due and payable on that date to cover the period then beginning and ending immediately prior to the commencement of the next premium-paying period.

The premium charges for any coverage provided under this policy will be calculated at the premium rates specified above, subject to any reductions or increases that Ætna determines are warranted by experience or because of any change in factors bearing on the risk assumed. Each reduction or increase in a premium rate shall be made by written notification to the Policyholder by Ætna.

No experience reduction or increase in premium rates shall become effective less than 23 months after the effective date of this policy.

The Employee Life Insurance Coverage section of this Part V describes the manner in which the premium rate for such coverage will be determined and redetermined. The premium charges for any other coverage under this policy may be recalculated, as of any premium due date, under either of the following circumstances:

When requested by Ætna, by reason of a change in factors bearing on the risk assumed.

Once during any continuous 12 month period, when requested by the Policyholder, subject to 60 days advance notice to Ætna.

Any such recalculation will be made upon the basis of the attained ages of the employees insured, the amounts of insurance in force, the applicable premium rates, and any other pertinent factors, all taken as of the date of the recalculation.