AMENDMENT #1
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION
for the

KANE FURNITURE CORPORATION
HEALTH PLAN - GROUP #2003015

Effective August 1, 2018, the Kane Furniture Corporation Health Plan is amended as follows:

The **"SCHEDULE OF MEDICAL BENEFITS - OAP LOW OPTION"** is replaced as follows:

SCHEDULE OF MEDICAL BENEFITS - OAP LOW OPTION
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND MAXIMUM ELIGIBLE EXPENSE (MEE)

THE BENEFIT PERIOD IS A TWELVE MONTH PERIOD COMMENCING ON AUGUST 1ST AND ENDING ON JULY 31ST OF EACH YEAR

COST SHARING PROVISIONS	NETWORK
DEDUCTIBLE Per Covered Person per Benefit Period Per Family per Benefit Period	 $7,000 $14,000
The Deductible applies to all benefits unless specifically indicated as waived.	
BENEFIT PERCENTAGE	100%
The Benefit Percentage applies after the Deductible is satisfied and applies to all benefits unless specifically stated otherwise	
COPAYMENTS	
Certain services are subject to a Copayment as stated in this Schedule of Medical Benefits. Copayments do not apply towards the Deductible but do apply towards the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.	
OUT-OF-POCKET MAXIMUM Per Covered Person per Benefit Period Per Family per Benefit Period	 $7,000 $14,000
The Out-of-Pocket Maximum is combined for Medical Benefits and Pharmacy Benefits and includes the Deductible, Medical Benefit Copayments, Pharmacy Copayments and Eligible Expenses in excess of the Benefit Percentage.	
MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES	None
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	None

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
ACUPUNCTURE TREATMENT	
	No Benefit
ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)	
	100% after Deductible
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY	
Inpatient Facility Services	100% after Deductible
Inpatient Professional Provider Services	100% after Deductible
Outpatient Facility Services	100% after Deductible
Outpatient Professional Provider Services	100% after Deductible
Office Visit Services	100% after $50 Copayment, Deductible Waived
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.	
ALLERGY TREATMENT (testing, serum/vials and injections)	
	100%, Deductible Waived
AMBULANCE SERVICE	
Air Ambulance	100% after Deductible
Ground Ambulance	100% after Deductible
AMBULATORY SURGICAL CENTER	
Outpatient Facility Services	100% after Deductible
Outpatient Professional Provider Services	100% after Deductible
X-ray and Advanced Radiology Imaging	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for certain surgeries. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
BARIATRIC SURGERY	
	No Benefit
BIRTHING CENTER	
Facility Services	100% after Deductible
Professional Provider Services	100% after Deductible
CARDIAC REHABILITATION THERAPY - OUTPATIENT	
	100% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
CHEMOTHERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
CHIROPRACTIC CARE	
Examinations, manipulations and therapy	100% after $50 Copayment, Deductible Waived
Laboratory and X-ray	100% after $100 Copayment, Deductible Waived
Benefit Limits: 12 Visits per Benefit Period. Physical Therapy when provided by a Chiropractor will deplete the Chiropractic Care limit. "Visit" includes all services provided during a day, except for x-rays. If multiple chiropractic services are provided on the same day, only one Copayment applies.	
COGNITIVE THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Benefit Limits: Combined maximum of 60 visits per Benefit Period for Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy and Audiology Therapy. Chiropractic services track toward the Chiropractic Care limit.	
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
COLONOSCOPY	
Routine Colonoscopy	100%, Deductible Waived
Diagnostic Colonoscopy	100% after $100 Copayment, Deductible Waived
CONTRACEPTIVES (Including Contraceptive Management)	
Administered during Office Visit	100%, Deductible Waived
See Pharmacy Benefit for details if obtained from a Pharmacy.	
DENTAL SERVICES (Covered under Medical Benefits)	
	Payable the same as any other Illness depending on place of service and type of provider.
DIABETIC NUTRITIONAL COUNSELING (Diabetes Self-Management Training)	
	Payable the same as any other Illness depending on place of service and type of provider.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
DIAGNOSTIC TESTS - OUTPATIENT	
Laboratory and Miscellaneous tests at a Clinic	100% after $100 Copayment, Deductible Waived
X-ray at a Clinic (other than Advanced Radiology Imaging)	100% after $100 Copayment, Deductible Waived
Independent Laboratory	100% after $100 Copayment, Deductible Waived
Professional Provider Services	100% after $100 Copayment, Deductible Waived
Advanced Radiology Imaging at a Hospital or Ambulatory Surgical Center	100% after Deductible
DIALYSIS TREATMENTS - OUTPATIENT	
	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
EMERGENCY ROOM SERVICES	
Emergency as defined Facility and Ancillary services for Emergency as defined	100% after Deductible
Emergency as defined Professional Provider Services (includes Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary services by an Emergency Room Physician)	100% after Deductible
Non-emergency Facility and Ancillary services	100% after Deductible
Non-emergency Professional Provider Services (includes Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary services by an Emergency Room Physician)	100% after Deductible
HEARING AIDS	
	No Benefit
HOME HEALTH CARE	
	100% after Deductible
Benefit Limits: 60 Visits per Benefit Period If therapies and home health visits are provided on the same day, the services will track as one visit per day. **Pre-treatment Review by the Plan is strongly recommended. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.**	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
HOSPICE CARE (Includes Bereavement Counseling)	
	100% after Deductible
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.	
HOSPITAL SERVICES	
Inpatient Facility Services Inpatient Room and Board limited to average semi-private room	100% after Deductible
Inpatient Professional Provider Services	100% after Deductible
Outpatient Facility Services (Surgical) Services	100% after Deductible
Outpatient Facility (Non-Surgical) Services	100% after Deductible
Outpatient Professional Provider Services	100% after Deductible
Laboratory and Miscellaneous Tests	100% after Deductible
X-ray	100% after $100 Copayment and Deductible
Advanced Radiology Imaging	100% after Deductible
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted. **Pre-treatment Review by the Plan is strongly recommended for certain surgeries. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.**	
INFERTILITY	
Infertility Counseling and Treatment	Payable the same as any other Illness depending on place of service and type of provider.
Artificial Means of Achieving Pregnancy	No Benefit
Pre-treatment Review by the Plan is strongly recommended. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
INFUSION SERVICES - OUTPATIENT	
	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
INJECTIONS AT A CLINIC (other than routine immunizations, flu or pneumonia immunizations, contraceptive injections for birth control reasons and allergy injections)	
Injections at a Clinic	100%% after $5 Copayment, Deductible Waived
Copayments for injections are applied per injection (multiple Copayments will apply including a Copayment for an office visit, when applicable).	
MAMMOGRAMS	
Routine Mammograms	100%, Deductible Waived
Diagnostic Mammograms	100% after $100 Copayment, Deductible Waived
MASSAGE THERAPY	
	No Benefit
MEDICAL EQUIPMENT/SUPPLIES	
Durable Medical Equipment	100% after Deductible
Prosthetic Appliances	100% after Deductible
Orthopedic Devices	100% after Deductible
Other Medical Supplies	100% after Deductible
Foot orthotics, arch supports and orthopedic shoes if Medically Necessary because of diabetes or hammertoe	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for any item for charges exceeding $5,000. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
MENTAL ILLNESS	
Inpatient Facility Services	100% after Deductible
Inpatient Professional Provider Services	100% after Deductible
Outpatient Facility Services	100% after Deductible
Outpatient Professional Provider Services	100% after Deductible
Office Visit Services	100% after $50 Copayment, Deductible Waived
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.	
NATUROPATHY/HOMEOPATHIC	
	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
NON-AMBULANCE TRAVEL BENEFIT	
	100%, Deductible Waived
Benefits are payable up to $10,000 Maximum Benefit per transplant, limited to the following: Coach airfare. If driving, IRS standard mileage rate reimbursement. Meals limited to $40 per day per person. Lodging not to exceed $125 per day. **This benefit is available to the patient and one companion, limited to travel to a contracted Center of Excellence, if treatment at a contracted Center of Excellence is more cost effective than the same treatment if received from other providers.**	
OCCUPATIONAL THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Benefit Limits: Combined maximum of 60 visits per Benefit Period for Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy and Audiology Therapy. Chiropractic services track toward the Chiropractic Care limit.	
OFFICE VISIT	
Primary Care Physician	100% after $50 Copayment, Deductible Waived
Specialty Care Physician	100% after $75 Copayment, Deductible Waived
Copayments for the office visit are applied to the charge billed for the provider's office visit services for evaluation and management (the consultation and examination in an office, clinic or other Outpatient setting). Additional charges for services that are performed at the time or incurred in conjunction with the office visit, are payable based on specific benefits for diagnostic lab, x-ray, office surgery, miscellaneous testing, allergy injections. Office Visit includes Telemedicine services. See Medical Benefits for details.	
ORGAN AND TISSUE TRANSPLANT SERVICES **Network is limited to a Center of Excellence**	
Inpatient Facility Services Inpatient Room and Board limited to average semi-private room	100% after Deductible
Inpatient Professional Provider Services	100% after Deductible
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted. **Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.**	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
PHYSICAL THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Benefit Limits: Combined maximum of 60 visits per Benefit Period for Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy and Audiology Therapy. Chiropractic services track toward the Chiropractic Care limit.	
PREGNANCY/MATERNITY SERVICES **See Preventive Care Benefit for well-women prenatal visits.**	
Office Visit (if not part of a global fee)	100% after $50 Copayment, Deductible Waived
Outpatient Facility Services	100% after Deductible
Professional Provider Services (if billed as global fee)	100% after Deductible
Inpatient Facility Services	100% after Deductible
Inpatient Professional Provider Services	100% after Deductible
PRESCRIPTION DRUGS - SEE PHARMACY BENEFIT FOR DETAILS	
PREVENTIVE CARE	
	100%, Deductible Waived
Covered Services: ♦ Well-Child Care ♦ Physical examinations ♦ Pelvic examination and pap smear ♦ Laboratory and testing ♦ Hearing and vision screening, up to age 18 ♦ Mammogram ♦ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ♦ Cardiovascular screening blood tests ♦ Colorectal cancer screening tests ♦ Vaccinations and Immunizations recommended by Physician ♦ BRCA1 and BRCA2 when medically indicated ♦ Nutritional counseling ♦ Well Women Preventive Care subject to Plan limitations on sterilization procedures Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/ If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.	
PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY	
	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
RADIATION THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
RESIDENTIAL TREATMENT FACILITY	
	100% after Deductible
Benefit Limits: 60 days per Benefit Period **Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.**	
RESPIRATORY OR PULMONARY THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE **(Applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.)**	
Facility Services	100%, Deductible Waived
Professional Provider Services	100% after Deductible
SKILLED NURSING FACILITY	
	100% after Deductible
Benefit Limits: 60 days per Benefit Period **Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.**	
SPEECH THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Benefit Limits: Combined maximum of 60 visits per Benefit Period for Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy and Audiology Therapy. Chiropractic services track toward the Chiropractic Care limit.	
STERILIZATION PROCEDURES	
Female Sterilization Procedures	100%, Deductible Waived
Vasectomy	100% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
SURGERY - OUTPATIENT	
Hospital Facility Services	100% after Deductible
Professional Provider Services	100% after Deductible
Surgery at a Clinic (including professional provider services, Assistant Surgeon, Physician Assistant and Anaesthesiologist)	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for certain surgeries. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
TMJ/JAW DISORDERS	
	No Benefit
URGENT CARE FACILITY	
	100% after $100 Copayment, Deductible Waived
WEIGHT LOSS PROGRAMS	
	No Benefit
WELL-CHILD CARE - SEE PREVENTIVE CARE	
	100%, Deductible Waived
WIG	
	No Benefit

The **"SCHEDULE OF MEDICAL BENEFITS - OAP HIGH OPTION"** is replaced as follows:

SCHEDULE OF MEDICAL BENEFITS - OAP HIGH OPTION
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND MAXIMUM ELIGIBLE EXPENSE (MEE)

THE BENEFIT PERIOD IS A TWELVE MONTH PERIOD COMMENCING ON AUGUST 1ST AND ENDING ON JULY 31ST OF EACH YEAR

COST SHARING PROVISIONS	NETWORK
DEDUCTIBLE Per Covered Person per Benefit Period Per Family per Benefit Period	 $5,000 $10,000
The Deductible applies to all benefits unless specifically indicated as waived.	
BENEFIT PERCENTAGE	100%
The Benefit Percentage applies after the Deductible is satisfied and applies to all benefits unless specifically stated otherwise	
COPAYMENTS	
Certain services are subject to a Copayment as stated in this Schedule of Medical Benefits. Copayments do not apply towards the Deductible but do apply towards the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.	
OUT-OF-POCKET MAXIMUM Per Covered Person per Benefit Period Per Family per Benefit Period	 $5,000 $10,000
The Out-of-Pocket Maximum is combined for Medical Benefits and Pharmacy Benefits and includes the Deductible, Medical Benefit Copayments, Pharmacy Copayments and Eligible Expenses in excess of the Benefit Percentage.	
MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES	None
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	None

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
ACUPUNCTURE TREATMENT	
	No Benefit
ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)	
	100% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY	
Inpatient Facility Services	100% after $200 Copayment per day for the first 5 days of admission. Inpatient admissions beyond 5 days are payable at 100% after Deductible.
Inpatient Professional Provider Services	100% after Deductible
Outpatient Facility Services	100% after Deductible
Outpatient Professional Provider Services	100% after Deductible
Office Visit Services	100% after $25 Copayment, Deductible Waived
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.	
ALLERGY TREATMENT (testing, serum/vials and injections)	
	100%, Deductible Waived
AMBULANCE SERVICE	
Air Ambulance	100% after Deductible
Ground Ambulance	100% after Deductible
AMBULATORY SURGICAL CENTER	
Outpatient Facility Services	100% after $300 Copayment, Deductible Waived
Outpatient Professional Provider Services	100% after Deductible
X-ray and Advanced Radiology Imaging	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for certain surgeries. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
BARIATRIC SURGERY	
	No Benefit
BIRTHING CENTER	
Facility Services	100% after Deductible
Professional Provider Services	100% after Deductible
CARDIAC REHABILITATION THERAPY - OUTPATIENT	
	100% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
CHEMOTHERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
CHIROPRACTIC CARE	
Examinations, manipulations and therapy	100% after$35 Copayment, Deductible Waived
Laboratory and X-ray	100% after $100 Copayment, Deductible Waived
Benefit Limits: 25 Visits per Benefit Period. Physical Therapy when provided by a Chiropractor will deplete the Chiropractic Care limit. "Visit" includes all services provided during a day, except for x-rays. If multiple chiropractic services are provided on the same day, only one Copayment applies.	
COGNITIVE THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Benefit Limits: Combined maximum of 60 visits per Benefit Period for Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy and Audiology Therapy. Chiropractic services track toward the Chiropractic Care limit.	
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
COLONOSCOPY	
Routine Colonoscopy	100%, Deductible Waived
Diagnostic Colonoscopy	100% after $100 Copayment, Deductible Waived
CONTRACEPTIVES (Including Contraceptive Management)	
Administered during Office Visit	100%, Deductible Waived
See Pharmacy Benefit for details if obtained from a Pharmacy.	
DENTAL SERVICES (Covered under Medical Benefits)	
	Payable the same as any other Illness depending on place of service and type of provider.
DIABETIC NUTRITIONAL COUNSELING (Diabetes Self-Management Training)	
	Payable the same as any other Illness depending on place of service and type of provider.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
DIAGNOSTIC TESTS - OUTPATIENT	
Laboratory and Miscellaneous tests at a Clinic	100% after $100 Copayment, Deductible Waived
X-ray at a Clinic (other than Advanced Radiology Imaging)	100% after $100 Copayment, Deductible Waived
Independent Laboratory	100% after $100 Copayment, Deductible Waived
Professional Provider Services	100% after $100 Copayment, Deductible Waived
Advanced Radiology Imaging at a Hospital or Ambulatory Surgical Center	100% after Deductible
DIALYSIS TREATMENTS - OUTPATIENT	
	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
EMERGENCY ROOM SERVICES	
Emergency as defined Facility and Ancillary services for Emergency as defined	100% after Deductible
Emergency as defined Professional Provider Services (includes Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary services by an Emergency Room Physician)	100% after Deductible
Non-emergency Facility and Ancillary services	100% after Deductible
Non-emergency Professional Provider Services (includes Emergency Room Physician, Radiologist, Pathologist, Anesthesiologist and ancillary services by an Emergency Room Physician)	100% after Deductible
HEARING AIDS	
	No Benefit

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
HOME HEALTH CARE	
	100% after Deductible
Benefit Limits: 100 Visits per Benefit Period If therapies and home health visits are provided on the same day, the services will track as one visit per day. **Pre-treatment Review by the Plan is strongly recommended. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.**	
HOSPICE CARE (Includes Bereavement Counseling)	
	100% after Deductible
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.	
HOSPITAL SERVICES	
Inpatient Facility Services Inpatient Room and Board limited to average semi-private room	100% after $300 Copayment per day for the first 5 days of admission. Inpatient admissions beyond 5 days are payable at 100% after Deductible.
Inpatient Professional Provider Services	100% after Deductible
Outpatient Facility (Non-Surgical) Services	100%, Deductible Waived
Outpatient Professional Provider Services	100% after Deductible
Laboratory and Miscellaneous Tests	100% after Deductible
X-ray	100% after $100 Copayment and Deductible
Advanced Radiology Imaging	100% after Deductible
Outpatient Facility (Surgical) Services	100% after $600 Copayment, Deductible Waived
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted. **Pre-treatment Review by the Plan is strongly recommended for certain surgeries. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.**	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
INFERTILITY	
Infertility Counseling and Treatment	Payable the same as any other Illness depending on place of service and type of provider.
Artificial Means of Achieving Pregnancy	No Benefit
Pre-treatment Review by the Plan is strongly recommended. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
INFUSION SERVICES - OUTPATIENT	
	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
INJECTIONS AT A CLINIC (other than routine immunizations, flu or pneumonia immunizations, contraceptive injections for birth control reasons and allergy injections)	
Injections at a Clinic	100%% after $5 Copayment, Deductible Waived
Copayments for injections are applied per injection (multiple Copayments will apply including a Copayment for an office visit, when applicable).	
MAMMOGRAMS	
Routine Mammograms	100%, Deductible Waived
Diagnostic Mammograms	100% after $100 Copayment, Deductible Waived
MASSAGE THERAPY	
	No Benefit
MEDICAL EQUIPMENT/SUPPLIES	
Durable Medical Equipment	100% after Deductible
Prosthetic Appliances	100% after Deductible
Orthopedic Devices	100% after Deductible
Other Medical Supplies	100%, Deductible Waived
Foot orthotics, arch supports and orthopedic shoes if Medically Necessary because of diabetes or hammertoe	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for any item for charges exceeding $5,000. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
MENTAL ILLNESS	
Inpatient Facility Services	100% after $200 Copayment per day for the first 5 days of admission. Inpatient admissions beyond 5 days are payable at 100% after Deductible.
Inpatient Professional Provider Services	100% after Deductible
Outpatient Facility Services	100% after Deductible
Outpatient Professional Provider Services	100% after Deductible
Office Visit Services	100% after $25 Copayment, Deductible Waived
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.	
NATUROPATHY/HOMEOPATHIC	
	No Benefit
NON-AMBULANCE TRAVEL BENEFIT	
	100%, Deductible Waived
Benefits are payable up to $10,000 Maximum Benefit per transplant, limited to the following: Coach airfare. If driving, IRS standard mileage rate reimbursement. Meals limited to $40 per day per person. Lodging not to exceed $125 per day. **This benefit is available to the patient and one companion, limited to travel to a contracted Center of Excellence, if treatment at a contracted Center of Excellence is more cost effective than the same treatment if received from other providers.**	
OCCUPATIONAL THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Benefit Limits: Combined maximum of 60 visits per Benefit Period for Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy and Audiology Therapy. Chiropractic services track toward the Chiropractic Care limit.	
OFFICE VISIT	
Primary Care Physician	100% after $35 Copayment, Deductible Waived
Specialty Care Physician	100% after $55 Copayment, Deductible Waived
Copayments for the office visit are applied to the charge billed for the provider's office visit services for evaluation and management (the consultation and examination in an office, clinic or other Outpatient setting). Additional charges for services that are performed at the time or incurred in conjunction with the office visit, are payable based on specific benefits for diagnostic lab, x-ray, office surgery, miscellaneous testing, allergy injections. Office Visit includes Telemedicine services. See Medical Benefits for details.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
ORGAN AND TISSUE TRANSPLANT SERVICES **Network is limited to a Center of Excellence**	
Inpatient Facility Services Inpatient Room and Board limited to average semi-private room	100% after $300 Copayment per day for the first 5 days of admission. Inpatient admissions beyond 5 days are payable at 100% after Deductible.
Inpatient Professional Provider Services	100% after Deductible
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted. **Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.**	
PHYSICAL THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Benefit Limits: Combined maximum of 60 visits per Benefit Period for Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy and Audiology Therapy. Chiropractic services track toward the Chiropractic Care limit.	
PREGNANCY/MATERNITY SERVICES **See Preventive Care Benefit for well-women prenatal visits.**	
Office Visit (if not part of a global fee)	100% after $35 Copayment, Deductible Waived
Outpatient Facility Services	100% after Deductible
Professional Provider Services (if billed as global fee)	100% after Deductible
Inpatient Facility Services Inpatient Room and Board limited to average semi-private room	100% after $300 Copayment per day for the first 5 days of admission. Inpatient admissions beyond 5 days are payable at 100% after Deductible.
Inpatient Professional Provider Services	100% after Deductible
PRESCRIPTION DRUGS - SEE PHARMACY BENEFIT FOR DETAILS	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
PREVENTIVE CARE	
	100%, Deductible Waived
Covered Services: ♦ Well-Child Care ♦ Physical examinations ♦ Pelvic examination and pap smear ♦ Laboratory and testing ♦ Hearing and vision screening, up to age 18 ♦ Mammogram ♦ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ♦ Cardiovascular screening blood tests ♦ Colorectal cancer screening tests ♦ Vaccinations and Immunizations recommended by Physician ♦ BRCA1 and BRCA2 when medically indicated ♦ Nutritional counseling ♦ Well Women Preventive Care subject to Plan limitations on sterilization procedures Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/ If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.	
PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY	
	No Benefit
RADIATION THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
RESIDENTIAL TREATMENT FACILITY	
	100% after Deductible
Benefit Limits: 60 days per Benefit Period **Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.**	
RESPIRATORY OR PULMONARY THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE **(Applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.)**	
Facility Services	100% , Deductible Waived
Professional Provider Services	100% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT NETWORK
SKILLED NURSING FACILITY	
	100% after Deductible
Benefit Limits: 60 days per Benefit Period **Pre-certification by the Plan is strongly recommended for all Inpatient Services. If Pre-certification is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary when the claim is submitted.**	
SPEECH THERAPY - OUTPATIENT	
Clinic and Outpatient Facility	100% after Deductible
Benefit Limits: Combined maximum of 60 visits per Benefit Period for Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy and Audiology Therapy. Chiropractic services track toward the Chiropractic Care limit.	
STERILIZATION PROCEDURES	
Female Sterilization Procedures	100%, Deductible Waived
Vasectomy	100% after Deductible
SURGERY - OUTPATIENT	
Hospital Facility Services	100% after $600 Copayment, Deductible Waived
Professional Provider Services	100% after Deductible
Surgery at a Clinic (including professional provider services, Assistant Surgeon, Physician Assistant and Anesthesiologist)	100% after Deductible
Pre-treatment Review by the Plan is strongly recommended for certain surgeries. If Pre-treatment Review is not obtained, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.	
TMJ/JAW DISORDERS	
	No Benefit
URGENT CARE FACILITY	
	100% after $65 Copayment, Deductible Waived
WEIGHT LOSS PROGRAMS	
	No Benefit
WELL-CHILD CARE - SEE PREVENTIVE CARE	
	100%, Deductible Waived
WIG	
	No Benefit

Within the **"PHARMACY BENEFIT"** section, the "COST SHARING PROVISIONS - OAP LOW OPTION" subsection is replaced as follows:

COST SHARING PROVISIONS - OAP LOW OPTION

Deductible per Benefit Period . . . . . None

Out-of-Pocket Maximum per Benefit Period
Per Covered Person $7,000*
Per Family $14,000*

The Out-of-Pocket Maximum is combined for Medical Benefits and Pharmacy Benefits. Pharmacy Copayments do not serve to satisfy the Medical Deductible but do serve to satisfy the Out-of-Pocket Maximum combined for Medical Benefits and Pharmacy Benefits. Pharmacy Benefits are payable at 100% after satisfaction of the Out-of-Pocket Maximum for the remainder of the Benefit Period.

Copayment per Prescription				
Drug Type	**Retail PBM Network**	**Member Submit Retail PBM Network***	**Mail Order**	**Specialty Drug**
Generic	$25	$25	$50	25%
Preferred Brand	$75	$75	$150	25%
Non-Preferred Brand	$100	$100	$200	25%

*For Member Submit prescriptions obtained from Retail PBM Network, the PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription. Prescriptions obtained from a non-network pharmacy are not covered.

The following are payable at 100% and are not subject to any Deductible or Copayment:

1. Prescribed generic contraceptives or brand if generic is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and
3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/

Within the **"PHARMACY BENEFIT"** section, the "COST SHARING PROVISIONS - OAP HIGH OPTION" subsection is replaced as follows:

COST SHARING PROVISIONS - OAP HIGH OPTION

Deductible per Benefit Period . . . . . None

Out-of-Pocket Maximum per Benefit Period
Per Covered Person $5,000*
Per Family $10,000*

The Out-of-Pocket Maximum is combined for Medical Benefits and Pharmacy Benefits. Pharmacy Copayments do not serve to satisfy the Medical Deductible but do serve to satisfy the Out-of-Pocket Maximum combined for Medical Benefits and Pharmacy Benefits. Pharmacy Benefits are payable at 100% after satisfaction of the Out-of-Pocket Maximum for the remainder of the Benefit Period.

Copayment per Prescription				
Drug Type	**Retail PBM Network**	**Member Submit Retail PBM Network***	**Mail Order**	**Specialty Drug**
Generic	$25	$25	$50	25%
Preferred Brand	$75	$75	$150	25%
Non-Preferred Brand	$100	$100	$200	25%

*For Member Submit prescriptions obtained from Retail PBM Network, the PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription. Prescriptions obtained from a non-network pharmacy are not covered.

The following are payable at 100% and are not subject to any Deductible or Copayment:

1. Prescribed generic contraceptives or brand if generic is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and
3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/

Within the **"MEDICAL BENEFITS"** section, the "MENTAL ILLNESS" subsection is replaced as follows:

MENTAL ILLNESS

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment including, but not limited to, group therapy.

2. Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.

3. Charges for Inpatient or Partial Hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.

4. Charges for Medically Necessary treatment at a Psychiatric Facility.

"Partial Hospitalization" means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

Within the **"MEDICAL BENEFIT EXCLUSIONS"** section, the following item #15 (group therapy) is deleted and items #16 through #46, as amended, are renumbered accordingly:

15. Charges for group therapy, except for the treatment of Alcoholism and/or Chemical Dependency.

Within the **"PROCEDURES FOR CLAIMING BENEFITS"** section, the "APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM" subsection is replaced as follows:

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

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

1. The reason the claim was denied;

2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;

3. Any additional information needed to perfect the claim and why such information is needed; and

4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on appeal.

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

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action under Section 502(a) of ERISA. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. **First Level of Benefit Determination Review**

   The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within fifteen (15) days following the date the Plan Supervisor receives the request for reconsideration.

   If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Plan Supervisor, not later than sixty (60) days after receipt of the Plan Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. **Second Level of Benefit Determination Review**

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

   After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action under Section 502(a) of ERISA. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

Within the **"PROCEDURES FOR CLAIMING BENEFITS"** section, the "APPEALING AN UN-REIMBURSED POST SERVICE CLAIM" subsection is replaced as follows:

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

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

1. The reason the claim was denied;

2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;

3. Any additional information needed to perfect the claim and why such information is needed; and

4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on appeal.

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

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action under Section 502(a) of ERISA. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. **First Level of Benefit Determination Review**

   The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within thirty (30) days following the date the Plan Supervisor receives the request for reconsideration.

   If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Plan Supervisor, not later than sixty (60) days after receipt of the Plan Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. **Second Level of Benefit Determination Review**

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

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan at each level of review.

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

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action under Section 502(a) of ERISA. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

Within **"TERMINATION OF COVERAGE"** section, the "RESCISSION OF COVERAGE" subsection is replaced as follows:

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

Within the **"FRAUD AND ABUSE"** section, the "RESCISSION OF COVERAGE" subsection is replaced as follows:

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

Within the **"GENERAL DEFINITIONS"** section, the "ADVERSE BENEFIT DETERMINATION" definition is replaced as follows:

ADVERSE BENEFIT DETERMINATION

"Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate, or a rescission of coverage if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

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

KANE FURNITURE CORPORATION

BY: _____

TITLE: _____