MMIA Employee Benefits Administration Handbook

This document is kept up to date online at www.mmiaeb.net. Please use the online resource for the most current information.

MONTANA MUNICIPAL INTERLOCAL AUTHORITY

Questions?

Call MMIA at 1-800-635-3089 and select option 4 or visit us online www.mmiaeb.net.

MMIA is a member-owned organization. We are here for you and value your input and involvement.

This handbook is intended to provide an easy-to-use reference in the administration of employee benefits to members of the MMIA program. Complete information can be found in the Summary Plan Document. This handbook is not a replacement of that information.

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General Information

Montana Municipal Interlocal Authority (MMIA) is a member owned risk retention pool. Cities and towns join the Employee Benefits program to cover each other's expenses and reap the benefits of the stability of being a pool member. The Employee Benefits (EB) program provides self-funded medical, dental, and vision coverages to employees via their employer city or town. We also make available access to affordable life insurance coverage.

The EB program is the newest program to the MMIA, added in 2004. It has grown rapidly from the 43 groups in the original purchasing pool to 86 groups today. The program provides benefits to over 2,900 employees and their dependents.

MMIA does use the services of Third-Party Administrators (TPAs), such as Allegiance, to process claims; however, the ultimate plan design and implementation comes from MMIA. We comply with state and federal requirements and use the advisement of our EB committee, made up of members, to stay responsible and innovative.

The majority of MMIA EB plan costs are actual claim dollars. If you think of MMIA as a piggy bank, the concept may be a bit clearer. We all contribute to this piggy bank and withdraw from it as claims arise. The only way to manage the rising costs of claims is to manage the reasons the claims are occurring. MMIA does this by promoting an annual wellness program that includes a health screening, blood draw, encouraging utilization of cost containment initiatives through case/disease management, offering resources such as the Employee Assistance Program (EAP), MMIA Scripts, Teladoc, Healthcare Bluebook, and providing education to our participants.

This handbook is designed to give our members a quick reference for common questions and issues that occur while administering employee benefits. It does not replace, nor supersede, the program agreement or other plan documents provided to your member city or town.

Important Health Privacy Information:

Finally, it's imperative to note that plan administrators, such as city clerks or managers, can find themselves in a position of assisting employees with health questions. Privacy laws under the Health Insurance Portability and Accountability Act (HIPAA) are fairly clear in their interpretation. **Employers should not be handling private health information for their employees.** This means that if an employee comes in with questions about claims, they should be directed to the customer service of our vendors. Although it may seem like good service to do the footwork or even listen to the details that an employee freely provides, it is actually putting both you and your city/town in a dangerous position. HIPAA does enforce violations of private health information breeches and will fully investigate complaints.

ELIGIBILITY GUIDELINES

Employee eligibility is based upon the eligibility criteria of each city or town. This includes classification of eligible employees and the number of work hours required to be eligible. These requirements are critical to coverage under your plan, and we recommend that you review the individuals who are listed as eligible from time to time to be sure they are within an eligible class and working enough hours to be covered under your health benefits.

Dependent children are eligible for the medical, dental, and vision plans through age 26, regardless of student or marriage status.

Domestic partnerships as noted in the Summary Plan Document (SPD), coverage is up to the city or town and must be written into your personnel policy.

Changing coverage mid-year is only allowed within 31 days of a qualifying event. Qualifying events include marriage, birth, or loss of other coverage. For full details regarding qualifying events, please refer to your SPD. If such an event occurs, an employee may add someone to their plan or change their choice of plans. If a loss of other coverage occurs, a certificate of coverage will be required for verification purposes. Other documentation may be required to prove eligibility. Enrollment changes must be completed and submitted to MMIA within 31 days of the qualifying event.

Having a baby is considered a qualifying event, but newborns are not automatically enrolled on the plan. If such an event does occur, it is important that the city or town be formally notified by the employee to make the necessary change within the 31 days. Failure to notify and enroll a newborn on the plan within 31 days from the date of birth will result in no coverage until either open enrollment or another qualifying event occurs.

Annual Group Enrollment

Each year, both individual participants and groups get the opportunity to make changes to their coverage. The first step in the annual enrollment process is for the group (city or town) to complete the Group Election Form.

MMIA members are given the option to offer one or multiple medical plans to their employees. MMIA strongly recommends allowing the menu selection to employees, as it provides them with the most options to fit their individual needs. Offering only the highest benefit plan can be an unnecessary expense. If you are currently offering only one plan, consider opening up the options to the entire menu. Other group benefit selections to choose for the group include dental, vision and life options. This is also the time to review your required eligibility hours and probationary periods. This must be indicated on the Group Election Form and can only be altered during annual enrollment period.

Employees can waive out of the medical coverage if they have other eligible group coverage. It is recommended each employee waiving coverage complete the open enrollment form each year and indicate their choice to waive the available coverage. .

Participant Open Enrollment

Once the Group Enrollment process ends, Open Enrollment for individual participants is from May 15 - June 15 each year. This is the time for participants to individually assess their coverage and make any pertinent changes or additions. The changes made during Open Enrollment become effective July 1st.

This is the only time eligible employees can make changes to their coverage throughout the year other than a qualifying event. Changes may include adding an eligible spouse or dependent or switching plan options if offered. The enrollment changes must be received by June 15th.

New Employee Enrollment

A new employee is eligible according to your city's probationary policy and has 31 days from their date of hire to enroll. New employees may become eligible for benefits outside of the annual open enrollment period.

Elected Official Enrollment

Elected Officials may become eligible for benefits according to your city or town policy. Your city or town must have in place or pass a resolution allowing elected officials to enroll and a copy must be provided the MMIA Employee Benefits Program. A newly elected official is eligible for benefits on the first day of the term and has 31 days to enroll.

Notifying MMIA of changes

Changes to an employee's name, address and marital status should be reported to MMIA as soon as possible.

Identification Cards

Identification cards display the Group Name, Group ID number, name of covered person, dependents and types of coverage. To protect individuals' privacy, Social Security Numbers are not displayed.

Terminations and Leaves of Absence

MMIA does not require an employee's signature for a termination. Just submit the termination to MMIA within 31 days of the employee's termination. The rest is handled by MMIA and Allegiance.

- Timeline - Termination of benefits must be handled in a timely manner. This is for a number of reasons, including complying with federal COBRA requirements. COBRA is the extension of benefits once someone leaves employment and must be offered by the employer. A terminating employee must be notified of their COBRA rights within 30 days and dependents within 60 days. If the timeframe for notifying someone of their COBRA rights is missed, the employer may be responsible for any medical costs during that time period.

- Reduced Hours - If an employee's hours of work have dropped below the hours of work required to be eligible, this creates a COBRA event. For employees, federal law requires you notify MMIA of this COBRA event within 30 days after it occurs. If we do not receive the notice within 30 days, we may not be able to provide COBRA coverage for your employee and there may be issues within our plan coverage concerning eligibility for stop loss claims as well. Changes in coverage for dependents have their own timeframe requirements of 60 days. **Timely notice is vital.**

- Retro-Termination - In compliance with federal healthcare reform regulations, MMIA is not able to retroactively terminate coverage. That means that if you do not notify MMIA of a termination of benefits within 30 days, the city must still pay through the end of the month in which notification was given. The only exception to the retroactive rescission rule is if there is a non-payment of premiums or mis-representation by

the participant. For example, if a participant fails to notify you of a divorce then retro adjustment may be made.

- Leave of Absence - Your plan provides that employees and their families may stay on the policy and remain covered as active employees without having to elect COBRA in certain situations, including family medical leave, and other approved leaves of absence. However, for family and medical leave or any other approved leave of absence, in order to qualify you must have written policies regarding these leaves and must be able to provide copies of those written policies to MMIA if this situation arises. Note that you or your employee must continue to pay the premium for coverage during the periods covered by these leaves of absence. A convenient decision tree concerning leaves of absence is included in this document as Appendix A.

- Workers Compensation Leave - This chart will also help you if an employee gets injured on the job and is out on Workers' Compensation disability. Since the worker may not be receiving a paycheck while out on disability, this can be a very confusing situation. The basic rule to follow is to have a written policy and to follow it consistently.

- Seasonal and temporary layoff workers –Seasonal or temporary workers must be terminated from benefits when they are laid off. Their coverage will go through the end of the month in which they terminate. If they are re-hired within 63 days, the terms of their coverage remain intact. If more than 63 days lapse, then they are treated as a new employee and all probationary periods apply.

<u>Retirement</u>

Retirees are eligible to stay on MMIA plans indefinitely, as long as they continue to pay the monthly premiums. Once they terminate coverage they can never come back on the plan. Spouses of retirees are also eligible to participate in the plan, if they were covered at the time of retirement. If a retiree deceases while covering a spouse, the spouse can maintain coverage as a surviving spouse, again as long as premiums are paid. These premiums should be paid directly to the city/town.

Once retired, and if over the age of 65, Medicare is a retiree's primary coverage. If not retired but over the age of 65, MMIA remains primary until

the participant retires. If you have an employee contemplating retirement and the complex world of supplement plans, be sure to encourage them to fully consider options. They can choose to just remain on the dental or vision coverage, for example, but if they do choose to leave the MMIA coverage to opt for a supplemental plan, they are not eligible to come back on our plan. MMIA sponsors a group Medicare Advantage Plan for retirees over the age of 65. For more detailed information visit our website at www.mmiaeb.net/retirees/, or contact the EB Department.

Please note that MMIA is required to also send COBRA notices to retirees; however, in almost all cases, this is not going to be the best financial choice since a retiree can stay on the plan at rates less than COBRA and for a longer period of time than COBRA allows. COBRA administers your current plan with an additional 2% administration fee. When an employee leaves employment, consider if it is a retirement or a termination. If an employee retires, you would notify us that it is a change in status, rather than a termination.

Billing

MMIA generates a monthly invoice of all charges due. The cutoff for additions, changes and terminations for the following month is on the 14th of the month. This means all enrollments, terminations, and changes must be submitted to MMIA by noon on the 14th in order for the billing to be accurate.

The bill you receive after the 15th of the month is for next month's premiums and is due by the end of the month you receive the bill. For example, the bill generated September 16th is for October premiums and payment is due September 30th.

MMIA does not prorate monthly premiums. If an employee terminates at any time during the month, coverage always extends to the end of the month. If benefit coverage starts on or prior to the 15th, you will be billed for the entire month. If coverage starts after the 15th, you will not be billed until the first of the following month. Newborns are not automatically enrolled in the MMIA program, however, if the participant does choose to enroll them they will not be billed for the first thirty days.

The invoice is in two parts. The first page gives an overview of the content of the bill with the total amount due. The remainder of the bill is a detailed report listing individual, participant ID along with the exact coverage and its

premium amount. Any credits or charges for previous changes, such as terminations, that are not received by MMIA by the 15th will be reflected on the top of the detail report identified by month. MMIA should be paid as billed. If a different amount is remitted, the differences must be noted on the reconciliation sheet and returned with the payment. If your payment does not equal the amount billed, the discrepancy form must be completed to explain the difference.

LIFE PRODUCTS

Basic Life

Some cities and towns offer the Basic Life product to their employees. This is a fully insured employer paid product. The cities and towns decide the amount they want to offer employees and whether or not they will offer dependent coverage and the amount. If a city/town decides to offer Basic Life, all eligible employees are required to participate. Active employees must work at least 20 hours a week, unless your city requires more. Each employee within the group or bargaining unit must have the same benefit level. Coverage is reduced by 50% at age 70. The rates are very competitive but are evaluated annually. Eligible children must be less than 26 years of age. Retirees are not able to remain on the basic life coverage once they are no longer an active employee. However, they have the option to convert their basic life policy within 30 days of retirement.

Voluntary Group Life and Accidental Death & Dismemberment (AD&D)

MMIA has available competitively priced voluntary group life (term and whole) and AD&D programs. The city or town must decide if they are going to offer this to employees. Each employee can select an amount of life benefit that fits their needs. Rates are based on the age of the covered person. The premiums are paid 100% by the employee. The guarantee issue amount on this product is $200,000 for the employee, $25,000 for spouse and a dependent child benefit of up to $10,000 in $2,000 increments. Guarantee issue means that no health statement is required.

The maximum amount an employee can apply for is 5 times their salary in increments of $5,000, up to $500,000. Spouses are eligible for 100% of the employee amount in increments of $5,000 and not to exceed $500,000. Amounts in excess of the guarantee issue will require a health statement. If an employee chooses not to enroll when they are hired, and waits until a later open enrollment, they will be subject to standard underwriting procedures by completing the health statement with no guarantee issue. Eligible children must be less than 26 years of age.

Claims

In the event of a life claim, please contact MMIA Employee Benefits at 1-800-635-3089, option 4.

Coordination of Benefits

Your plan contains provisions that state how it coordinates with other coverage your employees or their dependents may have. It also states how it coordinates with Medicare for employees who are eligible.

For actively employed (non-retiree) plan participants, MMIA will be primary for your employee and dependents or secondary if your employee's dependents have other coverage. For retirees, MMIA may become secondary to Medicare if they are over 65.

MMIA coordinates benefits with Medicare as mandated by federal law. MMIA is not allowed to deviate from those rules. Further, the plan will coordinate with Medicare in instances where the policy should be secondary to Medicare, even if your employee has not enrolled in or purchased Medicare. This means that the plan will only pay the amount Medicare would not have paid, even if your employee does not have Medicare.

WELLNESS PROGRAM

The MMIA Employee Benefits Program has made it a priority to promote wellness with all member cities and towns. As a member of the MMIA EB Program, your city or town has access to a comprehensive Wellness Program designed to provide the tools necessary to manage your well-being and healthcare costs.

All eligible employees, spouses and retirees on a MMIA medical plan are eligible to participate in the Wellness Program and receive incentives. Dependent children are not eligible to participate. Wellness Program activities can be found at www.mmiaeb.net/wellness.

The Wellness Program includes four incentive activities, each worth $50, for a total possible incentive of $200:

- **Health Screenings:** On-site screenings will be provided by ISWM. Helena-area participants will complete the screening process at the Montana Health Center locations.
- **80% Employee Participation:** If at least 80% of eligible employees complete a health screening, all eligible employees, spouses and retirees who got a screening will receive the incentive.
- **Health Screening Review:** Review screening results and resources with a designated health coach. Referrals to a program called Take Control may be necessary for some participants with specific health factors.
- **Education Incentive:** Watch a short video on the website, then take a quiz about the content of the video and submit your answers online.

Health screenings, 80% Employee Participation and Education activities must be completed between July 1 and September 30. The Health Screening Review with a Take Control health coach must be completed by November 5.

New employees enrolled on a medical plan will be informed of the Wellness Program upon enrollment and will be allowed to participate in the program if they are active between July 1 and September 30 to complete their Health Screening.

In order to receive incentives, you must be eligible on the medical plan at the time gift cards are distributed. MMIA will distribute incentives upon completion of the wellness program cycle.

For more information visit www.mmiaeb.net/wellness or contact MMIA Employee Benefits at 1-800-635-3089 option 4.

This program was developed in compliance with the EEOC wellness rules and does not violate anti-discrimination laws as determined by the Americans with Disabilities Act and Genetic Information Nondiscrimination Act. Participation in this program is voluntary. MMIA maintains the privacy and security of personally identifiable health information.

The MMIA Wellness Program will be evaluated and updated on an annual basis and MMIA reserves the right to alter the Wellness Program at any time.

APPEALS

Although employers should not be involved with individual claims issues in order to comply with HIPAA, from time to time a participant may seek advice on how to formally dispute claim results. Every Explanation of Benefits (EOB) has appeal information on the backside and our Summary Plan Document (SPD) also provides details about the appeals procedure. In general, there are two types of appeals.

Pre-service appeals are for times when someone is trying to pre-authorize a service, such as surgery, and it has been denied. Post-service appeals are for when someone is trying to appeal an already processed claim and its outcome. For instance, if they disagree with a service being denied as non-emergency when it truly was an emergency, they might file a post-service appeal. In both cases, the covered person must submit in writing an appeal within 180 days of the denial. **If they do not submit it within 180 days, they have no further steps that can be taken.** There are different levels of reviews so that there are multiple opportunities for the denial to be reconsidered.

Again, as the employer, the city and town should not become involved with individual claims issues. If a participant is not getting the results or information that they are seeking, direct them to either the appropriate vendor or MMIA. HIPAA does not provide leeway for trying to help out a neighbor or co-worker.

HEALTH CARE REFORM

With the passage of the Patient Protection and Affordable Care Act (PPACA), or the health care reform law, there are several requirements of plans, individuals and employers. MMIA Employee Benefits is working to stay informed about all PPACA requirements and be here as a resource to assist you.

PPACA Required Changes

- No lifetime maximum
- Dependents may remain on plan until age 26
- Preventive services paid at 100% including cancer screenings
- No pre-existing condition exclusion
- Eligibility waiting period may be no more than 90 days
- Re-insurance & research fees
- Employers must report premium amounts
- "Pay or Play" penalty

MMIA's Response

- All MMIA plans comply with required actuarial value.
- Benefit structure changes were implemented immediately upon passage of bill.
- Immediate structure changes provided two years of data to report no impact on rates.
- MMIA has and will continue to pay the re-insurance and research fees.
    - These additional costs will not be the responsibility of the employees or employers to collect, report or pay. Both fees have and will continue to be taken from a reserve fund so they will not impact rates.
- PPACA does not impact MMIA plans to the point that we aren't able to offer the same coverage or better

NOTICES

All notices distributed by MMIA are a federally mandated requirement and can be found on our website at www.mmiaeb.net/forms/notices/.

Medicare Part D Credible Coverage
Notifies Medicare eligible policy holders whether their drug coverage is creditable coverage or not. Their coverage is expected to pay on average as much as the standard Medicare drug coverage.

Notice of Privacy Practices (NPP)
Notifies individuals of how medical information about you may be used and disclosed and how you can get access to this information.

Children's Health Insurance Program Re-Authorization Act of 2009 (CHIPRA)
Notifies employees of their rights to enroll their children under your health plan if they lose coverage under Medicaid or a state-sponsored child health insurance program. This notice must be distributed by the employer.

Women's Health and Cancer
Notifies individuals of their mandated rights to breast reconstruction after a mastectomy.

RESOURCES AND FORMS

The forms, documents, and internet resources mentioned in this Benefit Administration Handbook are listed below.

Forms:
Current and up-to-date forms, such as those listed below, are available on the Employee Benefits section of our website at https://www.mmiaeb.net/forms/. You may also call the EB department at 1-800-635-3089, option 4 to request copies.

- Authorization for Release of Information
- Prescription Drug Claim
- Vision Out-of-Network Claim Reimbursement
- Basic and Voluntary Life and AD&D
- Medical claim forms can be provided but almost all providers should give this to patients or submit claims directly. If there does arise an occasion to submit a claim, the form is available for use.

*** Forms are updated annually. When new forms are provided to the Member Group be sure to discard all old forms.**

Documents:
Summary Plan Descriptions (SPD) for medical, dental and vision plans, along with a plan index for easy reference is available on the Employee Benefits section of our website at www.mmiaeb.net/medical/.

The SPD contains the most comprehensive information concerning the plan, including reimbursement levels, exclusions and eligibility criteria. Claims are processed according to the SPD, so it is a good idea to be familiar with the layout of the SPD and the summary of benefits that is included within each one.

Internet Resources:
- U.S. Treasury Department website for Health Savings Accounts: http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx
- Medicare Information: http://www.medicare.gov/

Who to contact or direct participants to:

- Medical coverage questions - **Allegiance Benefit Plan Management**
  www.askallegiance.com 1-866-339-4308
  They process medical claims and verify eligibility. They can help explain benefits, how a claim processed and also assist in finding network providers.

- Dental coverage questions - **Delta Dental**
  www.deltadentalins.com 1-800-521-2651
  They process dental claims and verify eligibility. They will explain benefits and also have a network of providers that should be utilized in order to get the best level of reimbursement.

- Vision coverage questions - **Vision Service Plan**
  www.vsp.com 1-800-877-7195
  They process vision claims and verify eligibility. They will explain benefits and assist in finding a network provider.

- Pharmacy Benefit Management - **ProAct**
  www.proactrx.com 1-888-869-4600
  They assist with all prescription issues including anything purchased at a pharmacy or via one of their mail order options. This includes benefit verification, drug pricing and claims questions. They can help provide formulary information, as well as assist with clinical questions and prior authorization (PA) requirements.

- Case Management - **Allegiance**
  www.askallegiance.com/Resources/CareManagement 1-800-877-1122
  Contact Allegiance Care Management to get approval of inpatient hospital services prior to the claim. This is a service to assist participants with navigating through a recent high dollar case or with coordinating care for diseases. They do provide outreach based upon claim information but are available for self-referral.

- Disease Management – **Take Control**
  www.takecontrol.com 1-800-746-2970
  A nurse coach can provide guidance and health tips to assist with several health conditions such as: congestive heart failure, coronary artery disease, diabetes, high blood pressure, high cholesterol and more.

- Maternity Management - **Take Control**
  www.takecontrol.com 1-800-746-2970
  Take Control's maternal health and wellness coaching provides support and guidance through 7 prenatal and postnatal phone coaching sessions. Benefits of enrolling include access to free prenatal vitamins and a $50 incentive for completing the program.

- Employee Assistance Program – **IBH Solutions – Formerly RBH**
  www.ibhsolutions.com 1-866-750-1327 Access Code MMIA
  EAP is available for 6 sessions per issue each year per household member. Contact the EAP to get a referral to a local professional for free counseling services.

- Telemedicine – **Teladoc**
  www.Teladoc.com 1-800-TELADOC (1-800-835-2362)
  This is a no charge 24/7 service to provide brief medical guidance with licensed Medical Doctors.

- Healthcare Bluebook
  www.askallegiance.com
  Find the best prices for healthcare services. Shop for care to get the most affordable prices for quality services in your area.

- MMIA Scripts
  www.mmiascripts.com 1-866-488-7874
  Obtain brand name medications at no cost, mailed direct to your home. For a complete list of qualifying medications visit the website or call an MMIA Scripts representative.

Remember any interaction with each of our vendors is confidential.

FAQs & Definitions

Deductible: A deductible is a set amount that either an individual or a family must meet per benefit period before the plan will reimburse anything.

Benefit Percentage: This is the applicable percentage that the plan and the patient shares, normally after the deductible has been met. For example, the plan pays 80% of allowable and the participant pays the remaining 20%.

Annual Out-of-Pocket Maximum: This is the most that the patient will be responsible before the plan pays 100% of the Maximum Eligible Expense (MEE).

Formulary Listing: This is similar to a provider network but the savings are realized in the discounts provided. It is important that the Formulary drug listing is utilized, especially for cities and towns on the drug card plan.

What is the difference between Professional and Facility services?

Think of professional services as those that an individual doctor provides. Facility services are linked to a clinic or hospital. This is important to know, because otherwise it may be confusing why there is more than one bill for the same service. For example:

If you were to have a surgery at a hospital, typical costs associated with these services may be submitted as:

Surgeon Charges –Professional Services
Anesthesiologist Charges –Professional Services
Hospital Charges –Facility Services
Lab Work Charges –Facility Services

What is the difference between Participating Provider and Non-Participating Provider for my medical coverage?

Essentially, providers are contracted with by Allegiance and Cigna to agree upon pricing on charges. Services rendered with a Participating Provider will receive benefit payment with no balance bill. This means the provider cannot balance bill the patient any amount beyond the Procedure Based Maximum Expense (PBME) that is agreed to by the Participating Provider contract. This is an amount paid by both the plan benefit and any cost sharing with the participant (deductible, copay, etc.), that the provider accepts in full so there

are no unexpected costs. Services rendered with a Non-Participating provider will receive up to the Procedure Based Maximum Expense (PBME) for the service. However, the patient may receive a balance bill for the remainder of the charges. This balance bill is entirely the patients' responsibility.

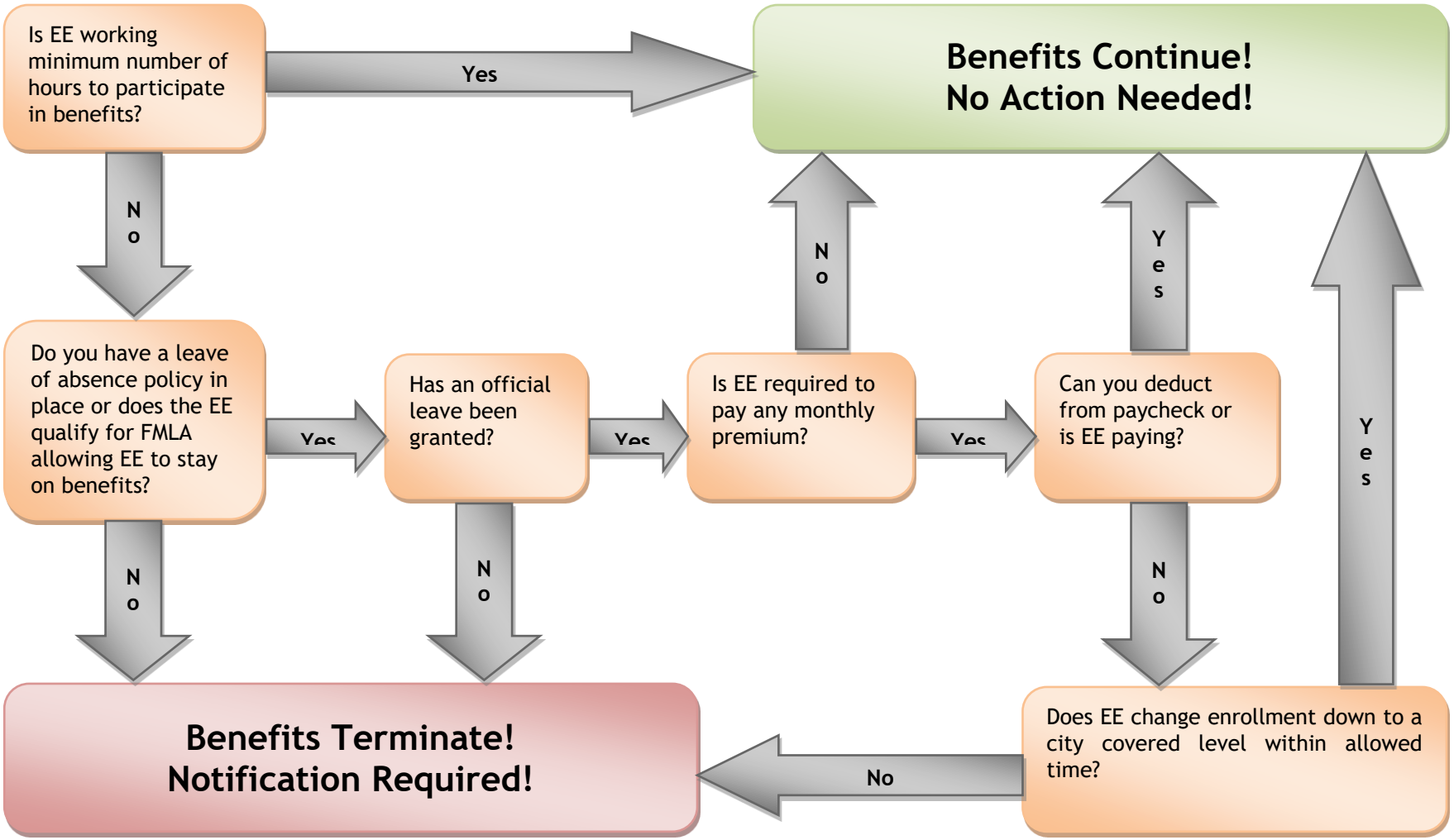
What is the difference between Flex and Health Savings Accounts?

A flexible spending account (FSA) is when you elect for your employer to deduct a tax-free portion from your pay to fund an account each year. Once this is done you generally cannot change it until the next annual Open Enrollment period. Your funds from this account must be spent within the tax year. FSA funds can be spent on qualified medical expenses.

A health savings account (HSA) is offered only in conjunction with a high deductible health insurance (HDHP) policy. A tax-free contribution is deposited into an account for you to use to meet you deductible and further expenses. Your funds are portable and allow you to keep your account even if you terminate coverage. HSA funds can be spent on qualified medical expenses.

Be aware that neither of these products is offered through MMIA. Contact your HR Department for more information on whether these products are offered through your city or town.

Leaves of Absence and Employee Benefits
APPENDIX A



MMIA Employee Benefits Program Members

Alberton
Anaconda
Baker
Belgrade
Belt
Big Sandy
Boulder
Bozeman
Bridger
Broadus
Cascade
Chester
Chinook
Choteau
Circle
Clyde Park
Colstrip
Columbia Falls
Columbus
Conrad
Culbertson
Cut Bank
Deer Lodge
Denton
Dillon
Drummond
Dutton
East Helena
Ekalaka
Ennis
Eureka
Fairfield
Forsyth
Fort Benton
Fort Peck
Fromberg
Glasgow
Glendive
Harlem
Harlowton
Havre
Hot Springs
Helena
Joliet
Kalispell
Kevin
Lewistown
Libby
Lima
Livingston
Manhattan
Malta
Medicine Lake
Miles City
MLCT
MMIA
Moore
Nashua
Philipsburg
Plains
Plentywood
Poplar
Red Lodge
Richey
Ronan
Roundup
Saco
Scobey
Shelby
Sheridan
Sidney
Stanford
Stevensville
Sunburst
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Whitefish
Whitehall
Wibaux
Wolf Point

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