WELCOME

Dear Montana VEBA HRA Participant:

Welcome to your State of Montana VEBA HRA Plan. Please carefully review this brochure regarding your Montana VEBA HRA account.

You may now begin withdrawing benefits. The Montana VEBA HRA third-party administrator (TPA) is REHN & ASSOCIATES. You will receive semi-annual statements detailing your account activity. If you have questions, you may contact the TPA at the toll-free number on the front of this brochure. The Montana VEBA HRA third-party administrator maintains plan records and accounts.

In the event of a discrepancy between this Plan Summary and the actual Plan and Trust documents, the Plan and Trust documents control. This Plan Summary supersedes any previously published Plan descriptive materials.

MONTANAVEBA
HEALTH REIMBURSEMENT ACCOUNT

Plan Summary

September 2015

Montana VEBA HRA
Third-party Administrator (TPA)
REHN & ASSOCIATES
P.O. Box 5433
Spokane, WA 99205-0433
1-800-VEBA101 (832-2101)
Fax: (509) 535-7883
montana@rehnonline.com

Plan Consultant
Corkery & Jones Benefits Inc.
818 West Riverside, Suite 800
Spokane, WA 99201-0913
(509)353-9546
Fax: (509)444-2786

Trustee
Washington Trust Bank
Spokane, WA

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PART I

Questions & Answers

What is the State of Montana VEBA Health Reimbursement Account ("Montana VEBA HRA")?
This is the State of Montana's VEBA Health Reimbursement Account or "Montana VEBA HRA." The Montana VEBA HRA is a pre-retirement and post-retirement health reimbursement plan. Your employer may make tax-free contributions to the Montana VEBA HRA plan on your behalf. The funds are held in a non-profit, tax-exempt voluntary employees' beneficiary association (VEBA) trust authorized under Internal Revenue Code (IRC) § 501(c)(9). You can use these tax-free funds to reimburse eligible out-of-pocket healthcare costs and premiums for yourself, your spouse, and your qualified children and dependents.

What is a VEBA?
VEBA stands for "voluntary employees' beneficiary association" and is a tax-exempt trust authorized by Internal Revenue Code Section 501(c)(9). The tax objectives of the plan are:

1. To enable your employer to make tax-free deposits on your behalf to the Plan;
2. To credit your account with tax-free investment earnings; and
3. To enable you to obtain tax-free reimbursements for your qualified medical expenses and insurance premiums.

VEBA contributions are not reportable on your Form W-2. You do not report VEBA contributions, earnings, or benefit payments on your individual 1040 federal income tax form.

Do VEBA contributions reduce my State of Montana pension benefits?
PERS members – potentially. If you have a sick or annual/vacation leave balance at termination/separation, MPERA may enhance your monthly retirement benefit by using it to increase the calculation of your final average salary (FAS). For State of Montana members, the PERS calculation of your FAS compensation will NOT include the 25% balance in your sick leave account or the 100% balance in your annual/vacation leave account if you are participating in the VEBA. You will only receive 100% of your annual leave toward the PERS FAS calculation if it is not considered part of your VEBA.

TRS members – potentially. TRS members who elect to contribute sick leave at termination/separation to the enhancement of their TRS benefit will likely see a greater retirement benefit than by contributing to the Montana VEBA HRA.

In either case, please consult with your financial advisor to determine the amount of the impact.

How do I file a claim for benefits?
When you or a qualified child or dependent incur a qualified expense you may complete and submit a Montana VEBA HRA Claim Form. You will need to include proper substantiation of your expense such as a detailed receipt or an EOB (Explanation of Benefits) from your insurance provider.

Some participating employers provide contributions for active employees. If so, and if you are an active employee, your total account claims reimbursement is limited to $500 per calendar year. A provision will be made for distributions of greater than $500 because of hardship. Upon separation from service, reimbursements for benefits will be limited to the amount of your account balance. Claims are paid weekly and direct deposit is available.

What expenses are eligible for reimbursement?
Eligible expenses include qualified medical, dental, and vision expenses not covered by your insurance plans, or medical, dental, vision, Medicare Part B and Part D, Medicare supplement, and tax-qualified long-term care insurance premiums. Purchases made prior to January 1, 2011 of certain over-the-counter drugs, if properly substantiated, qualify for reimbursement. After January 1, 2011, the law permits expenses for over-the-counter drugs (other than insulin) to be reimbursed only if documentation is provided that the drug was prescribed. Eligible expenses are defined in Internal Revenue Code § 213(d). A list of qualified expenses is available at **www.montana.rehnonline.com.**

Insurance premiums paid by an employer, or premiums that are or could be deducted pre-tax through your or your spouse's section 125 cafeteria plan, are not eligible for reimbursement.

Whose expenses are eligible?
Expenses incurred by the participant, their spouse, or any qualified children and dependents are eligible for reimbursement. Qualified dependents are defined in IRC § 105(b) and described in IRS Publication 502, available at www.irs.gov.

Can my Montana VEBA HRA automatically reimburse me for my insurance premiums?
Yes. If you join the Montana Retiree Medical Plan, you can authorize the MPERA to deduct your medical premium from your monthly defined benefit pension check. You can then arrange with the TPA to directly reimburse you from your Montana VEBA HRA account using the Systematic Premium Reimbursement Form. Direct deposit is available. You may also complete the Montana VEBA HRA Systematic Premium Reimbursement Form and the TPA will mail a check/direct deposit each month to you to reimburse the cost of qualified insurance premiums not deducted from your pension.

What is a health savings account (HSA) and can I contribute to an HSA?
HSAs are a type of tax-favored medical reimbursement account (your Montana VEBA HRA is not an HSA). If you want to make contributions to an HSA, you must meet the contribution eligibility requirements. HSA eligibility requirements are contained in the U.S. Treasury Department's HSA Basics brochure at www.ustreas.gov.

Current IRS rules require that you limit your Montana VEBA HRA coverage to permit the reimbursement of only certain types of expenses and insurance premiums as one of the eligibility requirements necessary to make contributions to an HSA. To limit withdrawals from your Montana VEBA HRA account, simply submit a completed and signed Election of Limited VEBA HRA Plan Coverage form. If you have any questions, please contact the TPA.

What is the death benefit?
If the participant dies with a positive participant account balance, his/her surviving spouse, if any, may file claims for eligible medical benefits incurred by the participant, the surviving spouse, and any other qualified dependents. If a participant dies without a surviving spouse and with dependent(s), the guardian(s) of the dependent(s), may file claims for eligible medical benefits on behalf of the dependent(s). Upon the death of the last to die of the participant, surviving spouse or qualified dependents, the executor or administrator of the estate may file claims for any eligible expenses incurred with respect to such person, after which any remaining account balance shall be reallocated on a per capita basis to all Participant Accounts.

Will I receive a statement of my account?
Yes. You will receive semi-annual statements (in January and July) detailing all activity in your account. You may also call or e-mail the TPA with a request for additional statements at any time. Contact the TPA if you have questions about your account, pending claim, or need claim forms.

Can I view my account information online?
Yes. Login to your account at www.montana.rehnonline.com to view your personal account information including account balance; detailed account activity; investment fund allocation; change your fund allocations; and change your address. Login information is provided in your Welcome letter and on your semi-annual Participant Activity Statement.

What are the Plan expenses and how are they paid?
Plan expenses include costs and fees such as: claims administration, preparing and issuing statements, legal, consulting, trustee, printing, postage, investment management, auditing, mail service, custodial and banking services. Plan expenses are paid by plan participants. Participant accounts will be charged 1.50% of assets calculated on an annualized basis and deducted monthly. Investment fund management expenses depend on the fund(s) selected and are listed on the

Investment Fund Overview. As the Trust assets grow and the Plan becomes more popular, the fees

could be reduced. The Department of Administration retains the right to change the fees. The State of Montana does not financially profit in any way by offering this plan.

Who is responsible for developing and managing this Plan?
The State of Montana, Department of Administration, Health Care & Benefits Division is responsible for on- going management of the Plan. The Department of Administration has contracted with various service providers to assist with operating the Plan.

Who is the Third-party Administrator (TPA)?
REHN & ASSOCIATES in Spokane, Washington is the TPA. Founded in 1961, REHN & Associates is an experienced employee benefits administrator with highly trained staff specializing in the administration of health reimbursement plans. The TPA provides all correspondence, accounting, and benefit payment services. Please immediately notify REHN of any address, name, or systematic premium reimbursement changes.

Who is the Trustee of the Plan?
Washington Trust Bank in Spokane, Washington is the Trustee of the Plan. The Trustee safeguards the plan assets and assists the Department of Administration with selection of the investment funds to be made available to plan participants.

Where do I get more information?
Check with the State of Montana Department of Administration for Plan information, or call the TPA.

State of Montana Department of Administration
Melanie Denning, VEBA Officer
Health Care & Benefits Division
P.O. Box 200130
Helena, MT 59620-0130
(406) 444-3745
(406) 444-0080 (fax)
mdenning@mt.gov

Montana VEBA HRA Third-party Administration (TPA)

REHN & ASSOCIATES
P.O. Box 5433
Spokane, WA 99205-0433
1-800-VEBA101 (832-2101)
(509) 535-7883 (fax)
montana@rehnonline.com

PART II

Other Plan Information

The name of the Plan is the State of Montana Health Benefit Plan and Trust, also known as the "Montana Health Reimbursement Account" or "Montana VEBA HRA."

The assets of the Plan are held in a trust. Washington Trust Bank has been named trustee.

Washington Trust Bank
Attn: Private Banking
717 W. Sprague Avenue
P.O. Box 2127
Spokane, WA 99210-2127

This Trust is a voluntary employees' beneficiary association under Internal Revenue Code 501(c)(9).

The Montana VEBA HRA plan administration is conducted by a third party, REHN & ASSOCIATES, P.O. Box 5433, Spokane, WA 99205-0433, 1-800-VEBA101 (832-2101)or (509) 534-0600.

The Plan consultant is Corkery & Jones Benefits Inc., 818 West Riverside, Suite 800, Spokane, WA 99201, Attn: Jeff Gilson.

The Plan's agent for service of legal process is the State of Montana Department of Administration, Employee Benefit Bureau. Notice of legal process may also be delivered to the Trustee or the Plan TPA.

This Plan is provided under collective bargaining agreements or employer policy.

Because the benefits for a participant in the Plan depend solely on the value of the employer's contribution to the Plan on the participant's behalf,

the law does not require this Plan to be insured by the Pension Benefit Guaranty Corporation.

All accounts are 100% vested and the Plan does not discriminate regarding eligibility to participate. In the event any Participant Account shall have been unclaimed for a period of at least three (3) years since the whereabouts or continued existence of the person entitled thereto was last known to the TPA, the Participant Account shall be turned over to whichever State office or department may be entitled to such property under applicable state unclaimed property law.

The Plan year is the calendar year.

Requests for benefits under the Plan must be made in writing to the TPA in accordance with the claims procedure. Requests for benefits that are denied may be appealed in writing to the TPA.

PART III

Procedure for Disputed Claims

If your claim is denied in whole or in part, the Montana VEBA HRA third-party administrator (TPA) shall notify you of the denial. Such notice will include the specific reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable). The notice will also include the specific Plan provisions or IRS rules or regulations upon which the denial is based; a description of any material necessary for your claim to be processed; a description of available internal appeals processes, including information regarding how to initiate an appeal; and the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman. A statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes will also be included.

If your claim is denied, you or your authorized representative may appeal the denial in writing to the TPA. You have 180 days from the date you receive the written notification of your denial to make your appeal. You will have the right to review pertinent documents and submit written issues and comments concerning your claim to the TPA.

After the TPA receives an appeal of a denied claim from you or your authorized representative, the TPA shall deliver the complete file to the State of Montana Department of Administration, who shall consider your appeal within 30 days from the time that your appeal was received by the TPA.

In special circumstances, the State of Montana Department of Administration may request a 15-day extension to review the decision prior to the expiration of the initial 30-day period. The State's decision shall be furnished to you and shall include specific reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, and claim amount (if applicable). The notice will also include the specific Plan provisions or IRS rules or regulations upon which the denial is based; a description of any material necessary for your claim to be processed; a description of available internal appeals processes, including information regarding how to initiate an appeal; and the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman. A statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes will also be included.

The State of Montana Department of Administration may determine that a hearing is required to properly consider a claim that has been appealed. In that event, such determination shall constitute special circumstances permitting an extension of time in which to consider the claim that is appealed. After exhausting the above claims procedure in full, if your request for benefits is denied in whole or in part, you or your authorized representative may request an external review of your denied claim. Any such request for review

must be delivered to the TPA no later than four months from the date you received written notification of the State's final denial of your request for benefits or from the date the claim was deemed denied. Within five (5) business days of receiving the external review request, the TPA will complete a preliminary review to confirm that you are covered under the Plan, you provided all the information and forms necessary to process the external review, and have exhausted the internal appeals process.

Once the review above is complete, the TPA will notify you in writing of the outcome of its review. If you are not eligible for external review, the notice will inform you of this and include contact information for Employee Benefits Security Administration of the Department of Labor. If your request for external review was incomplete, the notice will describe materials needed to complete the request and you will have the later of 48 hours or the four month filing period to provide the materials needed to complete your filing.

Upon satisfaction of the above requirements, the TPA will assign an independent review organization (IRO) using a method of assignment that assures the independence and impartiality of the assignment process. You may submit to the IRO in writing additional information to consider when conducting the external review, and the IRO must forward any additional information submitted by you to the TPA within one (1) business day of receipt. The decision by the IRO is binding on the Plan, as well as on you, except to the extent other remedies are available under State or Federal law. For standard external review, the IRO must provide written notice to the TPA and to you of its decision to uphold or reverse the benefit denial within no more than forty-five (45) days. An expedited external review in certain circumstances is available and the IRO must provide notice as soon as possible but not later than 72 hours after receipt of the request. Claims proceedings set forth in the Plan Summary and in more detail in the Plan Document must be strictly adhered by each claimant under this Plan and no judicial or arbitration proceedings with respect to any claim for Plan benefits shall be commenced by any such claimant until the appeal has been exhausted in full.

PART IV

Investment Fund Information

You may choose from among nine investment funds listed on the Enrollment Form. You may have your Montana VEBA HRA funds invested in any combination of the listed investment funds, and you may change your investment allocations as often as monthly. An Investment Fund Overview with investment results history and fund objectives is available. In addition, you may view up-to-date fund fact sheets and prospectuses on each fund's website. Website addresses are listed on the Investment Fund Overview.

Investment Risk
Stock, bond, and asset allocation funds are not guaranteed and will fluctuate in value on a monthly basis. Benefit withdrawals from these types of funds may be worth more or less than your original deposit.

Periodically review your selected investment fund choice(s). Should your objectives change, you should reevaluate your fund selection(s) and notify the TPA of any changes. Remember, there have been numerous loss periods in the past in these types of funds and there will be others in the future. Please remember that investment returns, particularly over shorter time horizons, are highly dependent on trends in various investment markets. Thus, stock, bond, or asset allocation investments are suitable primarily as longer-term investments and should not be for short-term use.

Using Multiple Funds
You may have your Montana VEBA HRA allocated to any combination of the available funds.

Transfers
You may transfer among funds monthly. Transfers are effective the first business day of each month. The TPA must receive transfer requests by the 25th of each month in order to be effective on the first business day of the following month.

Withdrawals
If you have multiple funds, benefit withdrawals (claims) made from your account will be prorated based on your fund allocation percentage on file with the TPA, unless you request otherwise in writing.

Investment Advice
Participants are encouraged to seek advice regarding the investment funds from their personal financial advisor. The Plan Consultant, Trustee, and TPA do not give investment advice.

Investment Expenses
Expenses are calculated as a percent of assets on an annualized basis and are deducted monthly from investment earnings, or if there are no earnings, from participant account balances.

PART V

COBRA Notice, USERRA Rights, and FMLA Notice

COBRA NOTICE

Important information regarding COBRA continuation coverage rights for all participating employees, spouses and covered children.

Introduction
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides participants and those covered by this Plan the right to continue to make contributions and/or file claims for a specified time period if such rights are lost due to certain qualifying events.

You, your spouse, and covered children should carefully read this notice. It is intended to generally explain your COBRA continuation coverage rights and the responsibilities of you and your employer as described by the law. This notice is a summary only. It is not an exhaustive description.

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to the TPA, REHN & ASSOCIATES.

General Information
A "qualifying event" is an event resulting in the loss of continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan.

Individuals losing coverage due to a qualifying event are known as "qualified beneficiaries." Qualified beneficiaries have a right to elect COBRA continuation coverage; however, either the employer or participant is required to notify the TPA within certain time limits for COBRA continuation coverage rights to apply.

COBRA continuation coverage must begin on the day coverage would otherwise end; no lapse in coverage is permitted. Qualified beneficiaries electing COBRA continuation coverage must pay a monthly premium for such coverage. In addition, an administrative fee of 2% is added as permitted by COBRA law.

Qualifying events
***Participating employee*.** If you are a participating employee, you will become a qualified beneficiary if continued employer contributions to the Plan are lost due to any of the following qualifying events: (1) you are voluntarily or involuntarily terminated (other than for gross misconduct); or (2) you experience a reduction in hours.

Spouse. If you are the spouse of a participating employee, you will become a qualified beneficiary if continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours; (3) you become divorced or legally separated from employee; or (4) employee passes away.

Children. Children of a participating employee will become qualified beneficiaries if continued employer contributions and/or access to benefits to which they would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours; (3) employee and spouse become

divorced or legally separated; (4) child reaches age limitation or no longer meets definition of qualifying child; or (5) employee passes away.

Qualifying event notification
The TPA will offer COBRA continuation coverage to qualified beneficiaries after being notified of a qualifying event within allowable time limits. When the qualifying event is due to an active participating employee's (1) voluntary or involuntary termination (other than for gross misconduct); (2) reduction of hours of employment; or (3) death, the employer must notify the TPA within 30 days of the occurrence of such event.

All other qualifying events (divorce or legal separation, or child reaches age limitation (no longer meets the definition of qualifying child) require that the participating employee or qualified beneficiary notify the TPA within 60 days of the occurrence of such event, using the Notice of COBRA Qualifying Event form. The completed Notice must be mailed or hand delivered to the TPA. A divorce decree or decree of legal separation is required if the COBRA qualifying event is due to divorce or legal separation; additional documentation may be required. If the Notice is received late, incomplete, or is not submitted as outlined under Notification of Procedures provided on the reverse side of the aforementioned form, no qualified beneficiary will be offered the opportunity to elect COBRA coverage.

COBRA continuation period
The "COBRA continuation period" is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA. COBRA continuation coverage can last for up to 18 months when the qualifying event is due to a participating employee's: (1) voluntary or involuntary termination (other than for gross misconduct); or (2) reduction of hours of employment.

A maximum of up to 36 months is allowed when the qualifying event is due to the participating employee's: (1) legal separation or divorce; (2) death; or (3) when a child reaches age limitation or no longer meets the definition of qualifying child.

18-month COBRA continuation period extension
If you or any other family member covered under the Plan is determined by the Social Security Administration to be disabled within the first 60 days of an 18-month COBRA continuation period, an 11-month extension, for a total of up to 29 months, is allowable for all covered individuals. To receive the extension, you or the qualified beneficiary(ies) must notify the TPA within 60 days of the disability determination and before the end of the original 18-month COBRA continuation period.

Also, if a second qualifying event occurs during an 18-month COBRA continuation period involving the participating employee's legal separation or divorce, or child reaches age limitation (no longer meets the definition of qualifying child), or death, the covered spouse and/or covered children may continue coverage for up to the number of months totaling a maximum 36-month COBRA continuation period. To be eligible for the extension, the qualified beneficiary(ies) must notify the TPA within 60 days of the occurrence of the second qualifying event.

Information resources
Questions concerning your COBRA continuation coverage under this Plan (including the cost of such coverage and when payments are due) should be directed to the TPA, and you may visit www.dol.gov/ebsa to view more information or locate a U.S. Department of Labor Employee Benefits Security Administration (EBSA) office near you.

USERRA RIGHTS

If you are on military leave that is governed by the Uniformed Services Employment and Re-employment Rights Act (USERRA), you may continue to file claims for qualified expenses for you and your qualified dependents.

If you were entitled to receive a future contribution, but will not receive the contribution due to the military leave, you or your covered qualified dependents may elect to continue contributions to the Plan for the lesser of 24 months or the period ending on the date in which you could, but fail to

apply for or return a position of employment with your participating employer. If you make this election, you will generally be required to pay 102% of the contributions to which you were entitled.

Should you have any questions regarding USERRA rights, please contact the TPA.

FMLA NOTICE

The State of Montana VEBA HRA plan qualifies as a group health plan under the Family and Medical Leave Act (FMLA). If you are receiving monthly or other recurring contributions to your VEBA HRA account, you may be entitled to continued contributions paid by your employer should you go out on FMLA leave.

For additional information regarding FMLA, contact your benefits/payroll office or the Wage and Hour Division of the U.S. Department of Labor at 1-866-4US-WAGE (1-866-487-9243) or visit www.wagehour.dol.gov.

PART VI

Privacy Notice

Introduction
This notice informs you of the ways the Montana VEBA HRA Plan may use and disclose medical information about you, and describes our obligations and your rights regarding the use and disclosure of medical information.

This notice also describes how you can access such information. Please review carefully. Questions should be directed to the Plan's TPA, REHN & ASSOCIATES at 1-800-VEBA101 (832-2101) or montana@rehnonline.com.

Who will follow this notice
The Plan is structured so that your medical information is administered and maintained solely by the Plan's TPA, and neither the Plan, the Plan Sponsor, nor your Employer will create or receive medical information except for summary health information for limited purposes and enrollment/disenrollment information. The TPA and any other third party that assists in the administration of Plan claims are required by law and by contract with the Plan to follow this notice.

Privacy pledge
Medical information about you and your health is personal, and we are committed to protecting it. A record of your health care claims reimbursed under the Plan is kept for administration purposes only. This notice applies to all medical records we maintain.

We are required by law to: (1) make sure medical information identifying you is kept private; (2) make sure that information stored or transmitted in electronic form is secure; (3) provide this notice of our legal duties and privacy/security practices concerning medical information about you; and (4) follow the terms of the notice currently in effect.

How we may use and disclose medical information about you
The following categories describe various ways we use and disclose medical information. Explanations and examples are provided for each category of uses or disclosures. Not every use or disclosure is listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

For payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is medically necessary, or to determine whether the Plan will cover the treatment. We may also share medical information with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments.

For health care operations (as described in applicable regulations). We may use and disclose medical information about you for other Plan operations necessary to run the Plan. For example,

we may use medical information in connection with conducting quality assessment and improvement activities; other activities relating to Plan coverage; conducting or arranging for legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As required by law. We will disclose medical information about you when required to do so by federal, state, or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To avert a serious threat to health or safety. We may use and disclose medical information about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person, but only to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

Special situations: Military and veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' compensation. We may release medical information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.

Public health risks. We may disclose medical information about you for public health activities such as to: (1) prevent or control disease, injury, or disability; (2) report births and deaths; (3) report child abuse or neglect; (4) report reactions to medications or problems with products; (5) notify people of recalls of products they might be using; (6) notify a person who might have been exposed to a disease or might be at risk for contracting or spreading a disease or condition; or (7) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law).

Health oversight activities. We may disclose medical information to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections, and licensure necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested.

Law enforcement. We may release medical information if asked to do so by a law enforcement official: (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct at a hospital; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National security and intelligence activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your rights regarding medical information about you. You have the following rights regarding medical information we maintain about you.

Right to inspect and copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such information, you must submit a written request to the TPA. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, in which case you may request that the denial be reviewed.

Right to amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit a written request to the TPA including a reason that supports your request. Your request may be denied if it is not in writing or does not include a reason to support the request, or if you ask us to amend information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

Right to an accounting of disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations. This includes any unauthorized access, use, disclosure, modification, or destruction of electronic medical information or any interference with an information system handling such information. To request an accounting of disclosures, you must submit a written request to the TPA stating a specific time period, which may not be longer than six years, and may not include dates before your Plan participation began. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free; you may be charged for additional lists. We will notify you of any charge and you may choose to withdraw or modify your request before any costs are incurred.

Right to request restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, health care operations, or to someone who is involved in your care, or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. To request restrictions, you must submit a written request to the TPA detailing: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (i.e., your spouse).

Right to request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to the TPA specifying how or where you wish to be contacted. We will not ask the reason and will accommodate all reasonable requests.

Right to a paper copy of this notice. You have the right to a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. To obtain a paper copy of this notice, contact the TPA.

Changes to this notice

We reserve the right to change this notice and make the revised notice effective for medical information we already have about you as well as any information we receive in the future.

Future revised notices will be delivered and made available to members via one or more of the following methods: e-mail, regular mail, and by request to the TPA.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact

the third-party administrator's compliance officer at 1-800-832-2101. You will not be penalized for filing a complaint.

Other uses of medical information
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. Such permission may be revoked, in writing, at any time and we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the service we provided you.

PART VII

Medicare Part D Notice of Noncreditable Coverage

To participants, spouses, children and dependents eligible or becoming eligible for Medicare. Important notice regarding your prescription drug coverage under this Plan and Medicare Part D.

Introduction
Please read this notice carefully and keep it where you can find it. This notice contains information about prescription drug coverage provided by this Plan and Medicare Part D prescription drug coverage available for everyone with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Medicare Part D prescription drug coverage became available in 2006.
You may have heard about Medicare's prescription drug coverage and wondered how it will affect you. Medicare prescription drug coverage became available to everyone with Medicare in 2006. All Medicare Part D prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

You might want to consider enrolling in Medicare prescription drug coverage.
Prescription drug coverage provided by this Plan is limited to your available account balance and is considered "non-creditable." In other words, coverage provided by this Plan is, on average for all Plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. Therefore, you might want to consider enrolling in a Medicare prescription drug plan.

If you don't enroll when first eligible, you may pay more and have to wait to enroll.
Generally, individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. If, after becoming eligible for Medicare, you go 63 days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's prescription drug coverage), your premium will go up at least 1% per month for every month that you did not have creditable coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than what many other people pay.

If you or your spouse, children, or dependents are currently Medicare eligible, you need to make a decision.
The terms of this Plan will not change if you choose to enroll in a Medicare prescription drug plan. This Plan will continue to reimburse all qualified premiums and expenses, including prescription drug costs not payable under the Medicare prescription drug plan, subject to the terms of the Plan and limited to your available account balance.

When making your decision whether to enroll, you should compare your current coverage, including which drugs are covered, with the coverage offered by the Medicare prescription drug plans in your area.

Information resources
More detailed information about Medicare plans that offer prescription drug coverage is contained in the Medicare & You handbook from Medicare available online at www.medicare.gov. You may also be contacted directly by Medicare-approved prescription drug plans. Obtain additional information by (1) visiting www.medicare.gov for personalized help; (2) calling your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for telephone numbers); or (3) calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Find out more by visiting the Social Security Administration online at www.socialsecurity.gov, or by calling 1-800-772-1213 (TTY 1-800-325-0778).

NOTE: You might receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage and when necessitated by coverage changes. You may also request a copy at any time from the third-party administrator.

PART VIII
Coordination of Benefits with Medicare

Coordination of Benefits with Medicare.
If you are entitled to Medicare and are claims eligible under your HRA account, federal law governs whether your HRA account or Medicare pays or reimburses your medical expenses first. The following summarizes the priority of claims payment as between your HRA account and Medicare. To comply with federal law you should file your claims in accordance with these primary and secondary payer rules.

- If you or your spouse are entitled to Medicare benefits due to your age, and you are currently employed and have an active, claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare.
- If you, your spouse, or dependents are entitled to Medicare benefits due to a disability, and you are currently employed and have an active, claims eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare.
- If you, your spouse, or dependents are entitled to Medicare benefits due to end-stage renal disease (ESRD), and you have an active HRA account (regardless of your employment or retirement status), your account is primary to Medicare for the first 30 months of your Medicare eligibility. During the first 30 months of your Medicare eligibility you should file claims against your HRA account prior to submitting expenses or claims to Medicare.

MMSEA Section 111 Reporting.
Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective for HRA plans for plan years beginning on or after October 1, 2010, requires the TPA for your Montana VEBA HRA account to report specific information about Medicare beneficiaries who have other group coverage (such as your VEBA HRA coverage). To comply with this federal law, the policies and procedures of the TPA will now require you to provide information necessary to comply with the MMSEA Section 111 reporting requirements in order to file claims in your VEBA HRA account. In addition, in submitting claims for reimbursement for coverage under your HRA account and Medicare, you should follow the priority of payment rules summarized above. If you have any questions about MMSEA Section 111 reporting or about who should pay first, you should contact the TPA or you can call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.