WRAP PLAN DOCUMENT
FOR MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF STATE OF MONTANA

This booklet describes the Medical, Prescription Drug,
Dental and Vision Plan Benefits
in effect as of January 1, 2017

The Wrap Plan Document has been published
for the benefit of
eligible Employees, Retirees and their Dependents of:

STATE OF MONTANA

The Flex Plan Document and the Flex Summary Plan Description for the State of Montana are included as part of the Wrap Plan Document.

The terms of the Wrap Plan Document are not applicable to the Flex Plan Document or Flex Summary Plan Description.

If any conflict arises between the Wrap Plan Document and the Flex Plan Document or Flex Summary Plan Description, the terms of the Flex Plan Document or Flex Summary Plan Description will control first, followed by the Wrap Plan Document.

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INTRODUCTION

Effective January 1, 2017, State of Montana, hereinafter referred to as the "State" or "Employer", published its Wrap Plan Document for the medical, prescription drug, dental and vision benefits, rights and privileges which will pertain to participating Employees, referred to as "Participants," and the eligible Dependents of such Participants, and Retirees and their eligible Dependents, as defined, and which medical, prescription drug, dental and vision benefits are provided through a fund established by the State and referred to as the "Plan" or "Wrap Plan Document". This booklet describes the Plan in effect as of January 1, 2017.

Coverage provided under this Wrap Plan Document together with the Summary Plan Descriptions for Employees, Retirees and their Dependents will be in accordance with the Eligibility, Effective Date, Qualified Medical Child Support Order, Termination, Family and Medical Leave Act and other applicable provisions as stated in this Plan.

State of Montana (the Plan Sponsor) has retained the services of independent Plan Supervisors, experienced in claims processing, to handle health, prescription drug, dental and vision claims. The Plan Supervisors for the Plan are:

For Medical Benefits:
Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Dental Benefits:
Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA, 30023

For Pharmacy Benefits:
Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999

For Vision Benefits:
Cigna Vision
P.O. Box 997561
Sacramento, CA 95899-7561

We recommend that you read this booklet carefully before incurring any medical expenses. If you have specific questions regarding coverage or benefits, you are urged to refer to the Wrap Plan Document or Summary Plan Descriptions which are available for your review in the Personnel Office or at the office of the applicable Plan Supervisor. If you wish, you may call or write to the applicable Plan Supervisor listed above regarding any detailed questions you may have concerning the Plan.

These benefits are not intended to, and cannot be used as workers' compensation coverage for any Employee or any covered Dependent of an Employee. Therefore, this Plan generally excludes claims related to any activity engaged in for wage or profit including, but not limited to, farming, ranching, part-time and seasonal activities. See Plan Exclusions for specific information.

The information contained in this Wrap Plan Document is only a general statement regarding FMLA, COBRA, USERRA, and QMCSO's. It is not intended to be and should not be relied upon as complete legal information about those subjects. Covered Persons and Employers should consult their own legal counsel regarding these matters.

Pre-certification or Pre-treatment Review by the Plan is strongly recommended for certain services. If you choose not to pre-certify or obtain Pre-treatment Review, 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.

SEE THE APPENDICES FOR MEDICAL PLAN BENEFITS, PRESCRIPTION DRUG PLAN BENEFITS, DENTAL PLAN BENEFITS AND VISION PLAN BENEFITS IMMEDIATELY FOLLOWING THE WRAP PLAN DOCUMENT.

ELIGIBILITY PROVISIONS

EMPLOYEE ELIGIBILITY

Eligible Employees include the following:

1. Employees of a department or agency of the judicial, legislative and executive branches of the State;
2. Elected Officials;
3. Officers of the legislative branch;
4. Judges;
5. Employees of Montana State Fund; and
6. Members of the legislature.

An Employee becomes eligible under this Plan for each employment status and schedule as follows:

STATUS	SCHEDULE	INSURANCE
Seasonal < 6 months	Full-Time Part-Time Variable	No. Audit for employment > 6 months.
Short-Term Worker	Full-Time Part-Time	Yes.
Short-Term Worker	Variable	No. Audit for 90 days in a year.
Short-Term Recurring	Full-Time Part-Time Variable	No. Audit for 90 days in a year.
Regular Temporary Seasonal	Variable	No. Audit for average hours > 20 hours per week.
Regular Temporary Seasonal	Full-Time Part-Time	Yes.

WAIVER OF COVERAGE AND RE-ENROLLMENT

If an eligible Employee waives coverage under this Plan, the foregone State Employer contribution accrues to the benefit plan to be used for the group benefit cost (§ 2-18-703, MCA).

An eligible Employee may enroll for coverage under this Plan at anytime.

STATUS DEFINITIONS

1. "Temporary" means an Employee who is hired on a temporary basis, and will not work in that position more than twelve (12) months. If the Employee is in a Temporary position and meets the requirements of "Seasonal < 6 Months", the Employee is moved into the "Seasonal < 6 Months" status.

2. "Seasonal < 6 Months" means an Employee hired in a position that is both filled for a particular season roughly the same time every AND for a period of less than six (6) months. If the Employee is temporary, employment must be terminated at the end of the six (6) months. If the Employee is permanent, the Employee should be put on a leave of absence without pay at the end of the six (6) month period.

3. "Seasonal" means an Employee who performs duties interrupted by seasons and who may be recalled. Seasonal status is used when the Employee is expected to work six (6) months or more in a "Regular" position that is re-hired roughly the same time every year.

4. "Short-Term Worker" means an Employee who is hired to work ninety (90) days or less in a twelve (12) month period and is in a position that does not recur each year.

5. "Short-Term Recurring" means an Employee who is hired to work ninety (90) days or less in a twelve (12) month period and the position is filled on a recurring basis, roughly the same time of year and within six (6) months.

6. "Regular" means an Employee who is permanent or eligible to become permanent.

SCHEDULE DEFINITIONS

1. "Variable" means an Employee is expected to work an average of less than twenty (20) hours per week, or the number of hours vary, or the days worked are intermittent or unknown. Employee is not offered benefits until the Employee completes a Measurement Period of twelve (12) consecutive months, during which the Variable Employee averages twenty (20) hours per week of actual work and/or paid leave, FMLA leave or jury duty whether paid or not for twelve (12) consecutive months.

2. "Full-Time" means an Employee is expected to work forty (40) hours per week. Employee is offered benefits when employment begins.

3. "Part-time" means and Employee is expected to work an average of twenty (20) hours or more, but less than forty (40) hours per week. Employee is offered benefits when employment begins.

"Measurement Period" is the period of time adopted by the Plan for during which Employees' work hours and applicable leave are measured to determine whether such Employees are eligible for coverage during a Stability Period.

"Stability Period" is the maximum period of time Employees may be offered benefits under the Plan as active Employees after completion of a Measurement Period.

An Employee is eligible while on active military duty or in a leave of absence status.

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien or is otherwise legally present in the United States or in any other jurisdiction that the related Participant or Retiree has been assigned by the Employer, who submits the Dependent Verification described in the next section, and who is either:

1. The Participant's or Retiree's legal spouse, according to the marriage laws of the state where the marriage was first solemnized or established

   An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant or a Retiree and has a court order or decree stating such from a court of competent jurisdiction, and regardless of a court order requirement to carry or pay for a legally separated or divorced spouse's coverage.

2. The Participant's or Retiree's domestic partner provided all of the following "Required Eligibility Conditions" are met:

   A. The Participant or Retiree and domestic partner are both eighteen (18) years of age or older;

   B. The Participant or Retiree and domestic partner share a common residence;

   C. Neither the Participant or Retiree nor the domestic partner is married to any other person;

   D. The Participant or Retiree and domestic partner are not legally related to each other as a parent, brother or sister, half-brother or half-sister, niece, nephew, aunt, uncle, grandparent or grandchild;

   E. The Participant or Retiree and domestic partner have a financially-interdependent relationship as evidenced by at least one (1) of the following:

      1) Mutually granted powers of attorney or mutually granted health care powers of attorney; or

      2) Designation of each other as primary beneficiary in wills, life insurance policies, or retirement plans;

      and

   F. The Participant or Retiree and domestic partner share a residence.

3. The Participant's or Retiree's Dependent child who meets all of the following "Required Eligibility Conditions":

   A. Is a natural child; step-child; legally adopted child; a child who has been Placed For Adoption (must provide pre-adoption placement agreement) with the Participant or Retiree or spouse/domestic partner and for whom as part of such placement the Participant or Retiree or spouse/domestic partner has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant or Retiree or spouse/domestic partner has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining eighteen (18) years of age; and

B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant's or Retiree's child was mentally handicapped/challenged or physically handicapped/challenged provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant or Retiree for support and maintenance.

An eligible Dependent does not include a spouse of the Dependent child or a child of the Dependent child.

If both spouses are employed by the Employer, and both are eligible for Dependent Coverage, either spouse, but not both, may elect Dependent Coverage for their eligible Dependents. No one can be covered under this Plan as both an Employee and a Dependent. No one can be covered under this Plan as a Dependent by more than one Participant.

VERIFICATION OF DEPENDENT ELIGIBILITY REQUIREMENTS

For each applicable Dependent enrolled, the Participant shall submit the following information:

For a spouse:

1. A copy of the marriage certificate, or

2. A copy of the front page of the most recent tax-return showing the tax filing status as "married". Any financial information may be blacked out.

For a domestic partner:

1. A Declaration of Domestic Partner Relationship form available at: www.benefits.mt.gov/forms;

2. Proof of a shared residence; and

3. A copy of mutually-granted powers of attorney or health care powers of attorney; or

4. A copy of mutual designations of primary beneficiary in will, life insurance policies or retirement plans.

For Dependent children:

1. A copy of the Dependent child's birth certificate, adoption order or pre-adoption papers, or

2. A copy of a court-ordered parenting plan, custody agreement or legal guardianship.

For stepchildren:

1. Required documentation listed above for domestic partner or spouse, if individual is not enrolled; and

2. A copy of the stepchild's birth certificate, adoption order or pre-adoption papers; or

3. A copy of a court-ordered parenting plan, custody agreement or legal guardianship.

For incapacitated children, proof of incapacity must be furnished to the Plan Supervisor as follows:

1. The incapacity commenced before the date the child's Plan coverage would otherwise terminate.

2. The child is dependent upon the eligible Participant or Retiree for support and maintenance within the current meaning of the COBRA disability continuation criteria. In other words, the Social Security Administration must have determined that the child is disabled and qualifies for disability benefits through either Old Age, Survivors and Disability Insurance (OASDI) or Supplemental Security Insurance (SSI) (documentation must be provided).

3. Notification and proof of such incapacity must be submitted to the Plan Supervisor within thirty-one (31) days of the date the child's coverage would otherwise terminate.

4. Must submit the most recent tax return which indicates the disabled child is a qualified tax dependent of the Participant or Retiree.

5. Re-certification of the disability may be required annually by the Plan.

For grandchildren:

1. A copy of the grandchild's adoption order or pre-adoption papers; or

2. A copy of a court-ordered custody agreement or legal guardianship.

SURVIVING DEPENDENT ELIGIBILITY

Pursuant to § 2-18-704, MCA, surviving spouses and Dependent children may remain covered as follows:

1. The surviving spouse of a Participant or Retiree may remain a Covered Person of the Plan as long as the spouse is eligible for retirement benefits accrued by the deceased Participant or Retiree as provided by law unless the spouse is eligible for Medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

2. The surviving children of a Participant may remain Covered Persons of the Plan as long as they are eligible for retirement benefits accrued by the deceased Participant as provided by law unless they have equivalent coverage with substantially the same or greater benefits at an equivalent cost or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

RETIREE ELIGIBILITY

A Retiree is considered eligible for coverage under this Plan only if the Retiree was covered under this Plan as a Participant on their last day of Active Service for the Employer prior to retirement, and coverage is subject to the terms of § 2-18-704, MCA. A Retiree's Dependents and surviving Dependents upon the death of the Retiree are also eligible if the Retiree was eligible for coverage and covered under this Plan, subject to the terms of § 2-18-704, MCA.

The Retiree must notify the Employer within sixty (60) days of the date Active Service ends to continue post-retirement coverage. The Retiree may continue coverage on the Plan on a self pay basis, retroactive to the date Active Service ended.

A Retiree may transfer coverage and become a Dependent of an actively employed or retired spouse/domestic partner on the Plan while still retaining the right to return to coverage under their own name in the case of an event resulting in loss of eligibility for spouse coverage (divorce, death of the spouse/domestic partner, etc.).

Only Retirees who left the Plan between September 1, 2014 and December 31, 2016 to enroll in another health plan offering "minimum essential coverage" as defined by federal law will have a one-time opportunity to return to the Plan.

1. A Retiree wishing to re-enroll in the Plan shall notify the Plan within two (2) years of the date the Retiree waived coverage.

2. Re-enrollment is not allowed if there is any lapse in coverage.

3. Re-enrollment is not allowed if the loss of Plan coverage was due to the Retiree's failure to pay monthly Retiree contribution payment.

4. Re-enrollment requests must include proof of other coverage along with a Retiree re-enrollment form found at www.benefits.mt.gov.

If the Retiree voluntarily terminates other coverage within the two (2) year time period:

1. The Retiree may only re-enroll during the Open Enrollment period following request for re-enrollment;

2. Plan coverage is effective January 1 of the following Plan Year.

3. The Retiree shall ensure there is not a lapse in coverage when cancelling other coverage; and

4. Only Dependents that were covered at the time the Retiree terminated the Plan are eligible to re-enroll, unless otherwise allowed by Open Enrollment rules.

If the Retiree experiences an involuntary loss of other coverage within the two (2) year time period:

1. The Retiree shall re-enroll on the Plan within sixty (60) days of losing other coverage to avoid a lapse in coverage;

2. Coverage is retroactively effective to the date other coverage ends following receipt of re-enrollment forms and payment; and

3. Only Dependents that were covered at the time the Retiree terminated the Plan are eligible to re-enroll and those Dependents also experienced an involuntary loss of coverage, unless otherwise allowed by Open Enrollment rules.

A Retiree's coverage and cost options for the Plan after exercising their Retreat Right are subject to the available plans and eligibility rules of the Plan Year in which the Retiree is eligible to re-enroll.

NOTICE: If a Retiree terminates coverage after December 31, 2016, the Retiree is not eligible to re-enroll in the Plan.

CONTINUATION COVERAGE FOR LEGISLATORS (§ 2-18-704, MCA)

1. A legislator may continue coverage under this Plan until the legislator becomes eligible for Medicare under the federal Health Insurance for the Aged Act if the legislator:

    A. Terminates service in the legislature and is a vested member of a state retirement system provided by law; and

    B. Notifies the Plan in writing within ninety (90) days of the end of the legislator's legislative term.

2. A former legislator may not remain covered under the Plan under the provisions of subsection (1) if the person:

    A. Is a member of a plan with substantially the same or greater benefits at an equivalent cost; or

B. Is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

3. A legislator who remains covered under the Plan under the provisions of subsection (1) and subsequently terminates coverage may not rejoin the Plan unless the person again serves as a legislator or is eligible under another provision of the Plan.

4. Subsequent monthly benefit payments must be received by the Plan by the first (1st) of each month.

5. A legislator who is involuntarily terminated from performing service in either house of the legislature because of term limits is entitled to remain covered by the Plan and to the continuation of the Employer contributions to the Plan for up to six (6) months from the last day of the legislator's final term of office in that house. The provisions of this section are in addition to the rights and benefits provided under § 2-18-704, MCA and do not affect the right of a legislator to remain on the Plan after six (6) months if the legislator is otherwise eligible under § 2-18-704, MCA to remain covered.

CONTINUATION COVERAGE FOR JUDGES (§ 2-18-704, MCA)

1. A member of the judges' retirement system who leaves judicial office but continues to be an inactive vested member of the judges' retirement system as provided by § 19-5-301, MCA, may continue coverage under the Plan if the judge notifies the Plan in writing within ninety (90) days of the end of the judges's judicial service of the judge's choice to continue coverage under the Plan.

2. A former judge may not remain covered under the Plan under the provisions of subsection (1) if the person:

   A. Is a member of a plan with substantially the same or greater benefits at an equivalent cost;

   B. Is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost; or

   C. Becomes eligible for Medicare under the federal Health Insurance for the Aged Act.

3. A judge who remains covered under the Plan under the provisions of this subsection (1) and subsequently terminates membership may not rejoin the Plan unless the person again serves in a position that is eligible under the Plan.

DOMESTIC PARTNER TAX STATUS

For a domestic partner, the Employee must declare the tax status as required by the Internal Revenue Service to apply the proper tax treatment (pre-tax or after-tax) to benefits. The qualification of these individuals as a dependent for tax purposes does not affect their eligibility but impacts the tax treatment of that coverage and any required monthly contributions.

If the tax status is not indicated, the domestic partner will default to non-qualified tax dependent status. The Declaration of Tax Status form is available at: www.benefits.mt.gov.

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan commences at 12:01 A.M. in the time zone in which the Covered Person permanently resides on the date such coverage becomes effective.

PARTICIPANT COVERAGE (Initial Enrollment Period)

Participant coverage under the Plan is retroactively effective to the Enrollment Date and the first day of eligibility for newly-eligible Employees, provided application for enrollment is received within the thirty-one (31) day initial enrollment period. If these requirements are met, the Employee may be offered coverage or an opportunity to waive coverage even if the offer is after the date coverage becomes effective, regardless of the time that has elapsed, provided that the reason coverage was not offered was as a result of an administrative error on the part of the Employer, Plan Administrator or Plan Supervisor.

Elected Officials become eligible to enroll on the first day they take the oath of office or the day the term begins, whichever is earlier.

A Variable Employee remains eligible for a period of time not to exceed twelve (12) months from the effective date of coverage (the Stability Period) regardless of the number of hours worked and applicable leave, as long as the individual remains employed by the Employer. At the end of the Stability Period, if the individual remains employed as a Variable Employee and averages at least twenty (20) hours per week during the subsequent standard Measurement Period, the individual may remain eligible for a period of time not to exceed an additional twelve (12) months as long as the individual remains employed by the Employer.

DEPENDENT COVERAGE (Initial Enrollment Period)

Each Participant who applies for Dependent Coverage on the Plan may become covered for Dependent Coverage as follows:

1. On the Participant's effective date of coverage, if application for Dependent Coverage is made during the same enrollment period. This subsection applies only to Dependents who are eligible on the Participant's initial effective date of coverage.

2. In the event a Dependent is acquired after the Participant's effective date of coverage as a result of a legal guardianship or in the event that a Participant is required to provide coverage as a result of a valid court order, or if the Dependent is acquired as a result of operation of law, Dependent Coverage may begin on the first day of the pay period following the Plan's receipt of an Mid-Year Change form and copy of said court order, if applicable.

3. In the event a Dependent is acquired as a result of establishment of a domestic partnership, Dependent coverage begins on the first day of the pay period following the Plan's receipt of a Mid-Year Change form and signed Declaration of Domestic Partner Relationship.

4. Automatic coverage of an infant born to a Plan Participant or a Plan Participant's covered spouse begins at birth for a thirty-one (31) day period. Automatic coverage for a thirty-one (31) day period does not apply to the newborn grandchild of a Plan Participant or a Plan Participant's covered spouse.

5. In the event Dependent coverage is waived during the initial enrollment period, refer to Open Enrollment or Special Enrollment Period.

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

Each Employee becomes eligible for Dependent Coverage on the latest of:

1. The date the Employee becomes eligible for Participant coverage; or

2. The date on which the Employee first acquires a Dependent.

OPEN ENROLLMENT PERIOD

The Open Enrollment Period is a two (2) week period in the last quarter of each year, during which an Employee may request Participant coverage changes or Dependent coverage.

Coverage requested during any Open Enrollment Period begins on the first day of the subsequent Plan Year following the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

"Special Enrollment Period" means a period of time allowed under this Plan, other than the eligible person's Initial Enrollment Period or an Open Enrollment Period, during which an eligible person may request coverage under this Plan as a result of certain events that create special enrollment rights.

In addition to other enrollment times allowed by this Plan, certain persons may enroll during the Special Enrollment Periods below described. Dependent verification is required. See "Dependent Verification of Eligibility Requirements" within ELIGIBILITY PROVISIONS for required documentation.

Coverage becomes effective as stated below for the following events if the Employee makes a special enrollment request, orally or in writing, within thirty (31) days of any special enrollment event and application for such coverage is made on the Plan's Mid-Year Change form within sixty (60) days of the event.

1. An eligible Employee, Participant or Retiree, and all eligible Dependents acquired as a result of the event who are not enrolled may enroll and become covered on the first day of the first pay period under the following specific event:

   A. Marriage to the Employee.

2. An eligible Employee, Participant or Retiree may enroll eligible Dependents who are acquired under the following specific events may enroll and become covered on the date of the event under the following specific events:

   A. Birth of the Participant's child; or

   B. Adoption of a child by the Participant, provided the child is under the age of 18; or

   C. Placement for Adoption with the Employee (must provide pre-adoption placement agreement), provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 18.

3. The following individuals may enroll and become covered when coverage under another health care plan or health insurance is terminated due to loss of eligibility or if employer contributions to the other coverage have been terminated (Loss of Coverage), subject to the following:

   A. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee who also lost coverage may enroll and become covered.

B. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

C. If an eligible Dependent of a covered Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.

Loss of Coverage means only one of the following:

A. COBRA Continuation Coverage under another plan that has been terminated or the maximum period of COBRA Continuation Coverage under the other plan has been exhausted; or

B. Group or insurance health coverage that has been terminated as a result of termination of employer contributions* towards the other coverage; or

C. Group or insurance health coverage (includes other coverage that is Medicare) that has been terminated only as a result of a loss of eligibility for coverage for any of the following reasons:

1) Legal separation or divorce of the eligible Employee;
2) Cessation of Dependent status;
3) Death of the eligible Employee;
4) Termination of employment of the eligible Dependent;
5) Reduction in the number of hours of employment of the eligible Dependent;
6) Termination of the eligible Dependent's employer's plan;
7) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or
8) Any loss of eligibility for individual or group coverage because the eligible Employee or Dependent no longer resides, lives or works in the service area of a HMO or other such plan.

*Employer contributions include contributions by any current or former employer that was contributing to the other non-COBRA coverage.

A Loss of Coverage does not occur if coverage was terminated due to a failure of the Employee or Dependent to pay premiums on a timely basis or coverage was terminated for cause.

4. Individuals may enroll and become covered under this Plan when coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 is terminated due to loss of eligibility, subject to the following:

A. A request for enrollment must be made either orally or in writing within sixty (60) days after this special enrollment event, and written application for such coverage must be made within ninety (90) days after such event.

B. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.

C. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

D. If an eligible Dependent of a covered Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.

5. Individuals who are eligible for coverage under this Plan may enroll and become covered on the date they become entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement is the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (CHIP or Medicaid). A request for enrollment, either orally or in writing, must be made within sixty (60) days after this special enrollment event, and written application for such coverage must be made in writing within ninety (90) days after such event.

MID-YEAR OPEN ENROLLMENT

An Employee who waives coverage may enroll other than during an Open Enrollment Period or Special Enrollment Period. An Employee who enrolls outside of the Open Enrollment Period or Special Enrollment Period is effective the first day following the receipt of the Employee Enrollment form. The Mid-Year Open Enrollment is available for eligible Employees only.

CHANGE IN STATUS

If a Covered Dependent under this Plan becomes an eligible Employee of the State, the Covered Dependent may continue their coverage as a Dependent or elect to be covered as a Participant, but may not be covered as both a Dependent and a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of the State, but is eligible to be covered as a Dependent under another Participant, the former Employee may elect to continue their coverage as a Dependent of such Participant.

Application for coverage due to a Change in Status must be made on the Plan's Mid-Year Change form within sixty (60) days following the date the Employee becomes or ceases to be an eligible Employee.

JOINT CORE COVERAGE

Under Joint Core, the family is subject to only one Out-of-Pocket Maximum.

Joint Core enrollment is available when two (2) Employees are:

A. Married;

B. Both spouses are covered under the Plan; and

C. Cover at least one (1) Dependent under the Plan.

Contact the Health Care & Benefits Division (HCBD) at (800) 287-8266 or benefitsquestions@mt.gov for additional information regarding Joint Core eligibility.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

Pursuant to Section 609(a) of ERISA, the Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified in accordance with ERISA's requirements, to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. Employer adopts ERISA standards to comply with child support enforcement obligation of Part D of Title IV of the Social Security Act of 1975 as amended.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.

2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:

   A. Provides for child support for a child of a Participant under this Plan;

   B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and

   C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

3. "Plan" means this self-funded Employee Health Benefit Plan, including all supplements and amendments in effect.

4. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Plan Administrator to meet the qualification requirements as outlined under "Procedures" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

To be qualified, a Medical Child Support Order must clearly:

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and

2. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and

3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

In the case of any Medical Child Support Order received by this Plan:

1. The Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the plan's procedures for determining whether Medical Child Support Orders are qualified orders; and

2. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination.

NATIONAL MEDICAL SUPPORT NOTICE

If the plan administrator of a group health plan which is maintained by the employer of a non-custodial parent of a child, or to which such an employer contributes, receives an appropriately completed National Medical Support Notice as described in Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the criteria shown above for a qualified order, the Notice will be deemed to be a Qualified Medical Child Support Order in the case of such child.

FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act (FMLA) requires Employers who are subject to FMLA to allow their "eligible" Employees to take unpaid, job-protected leave. The Employer may also require or allow the Employee to substitute appropriate paid leave including, but not limited to, vacation and sick leave, if the Employee has earned or accrued it. The maximum leave required by FMLA is twelve (12) workweeks in any twelve (12) month period for certain family and medical reasons and a maximum combined total of twenty-six (26) workweeks during any twelve (12) month period for certain family and medical reasons and for a serious Injury or Illness of a member of the Armed Forces to allow the Employee, who is the spouse, son, daughter, parent, or next of kin to the member of the Armed Forces, to care for that member of the Armed Forces. In certain cases, this leave may be taken on an intermittent basis rather than all at once, or the Employee may work a part-time schedule.

DEFINITIONS

For these Family and Medical Leave Act of 1993 provisions only, the following definitions apply:

1. "Member of the Armed Forces" includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation or therapy.

2. "Next of Kin" means the nearest blood relative to the service member.

3. "Parent" means Employee's biological parent or someone who has acted as Employee's parent in place of Employee's biological parent when Employee was a son or daughter.

4. "Serious health condition" means an Illness, Injury impairment, or physical or mental condition that involves:

   A. Inpatient care in a hospital, hospice, or residential medical facility; or

   B. Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services).

5. "Serious Injury or Illness" means an Injury or Illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform his or her military duties.

6. "Son or daughter" means Employee's biological child, adopted child, stepchild, legal foster child, a child placed in Employee's legal custody, or a child for which Employee is acting as the parent in place of the child's natural blood related parent. The child must be:

   A. Under the age of eighteen (18); or

   B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.

7. "Spouse" means a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides, including "common law" marriage and same-sex marriage.

EMPLOYERS SUBJECT TO FMLA

In general, FMLA applies to any employer engaged in interstate commerce or in any industry or activity affecting interstate commerce who employs 50 or more Employees for each working day during each of 20 or more calendar work weeks in the current or preceding Calendar Year. FMLA also applies to those persons described in Section 3(d) of the Fair Labor Standards Act, 29 U.S.C. 203(d). The FMLA applies to government entities, including branches of the United States government, state governments and political subdivisions thereof.

ELIGIBLE EMPLOYEES

Generally, an Employee is eligible for FMLA leave only if the Employee satisfies all of the following requirements as of the date on which any requested FMLA leave is to commence: (1) has been employed by the Employer for a total of at least twelve months (whether consecutive or not); (2) the Employee has worked (as defined under the Fair Labor Standards Act) at least 1,250 hours during the twelve-(12) month period immediately preceding the date the requested leave is to commence; (3) the Employee is employed in any state of the United States, the District of Columbia or any Territories or possession of the United States; and (4) at the time the leave is requested, the Employee is employed at a work site where 50 or more Employees are employed by the Employer within 75 surface miles of the work site.

REASONS FOR TAKING LEAVE

FMLA leave must be granted (1) to care for the Employee's newborn child; (2) to care for a child placed with the Employee for adoption or foster care; (3) to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; (4) because the Employee's own serious health condition prevents the Employee from performing his or her job; or (5) because of a qualifying exigency, as determined by the Secretary of Labor, arising out of the fact that a spouse, son, daughter or parent of the Employee is on active duty or has been called to active duty in the Armed Forces in support of a contingency operation (e.g., a war or national emergency declared by the President or Congress).

ADVANCE NOTICE AND MEDICAL CERTIFICATION

Ordinarily, an Employee must provide thirty (30) days advance notice when the requested leave is "foreseeable." If the leave is not foreseeable, the Employee must notify the Employer as soon as is practicable, generally within one to two working days. An employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee's serious health condition, the Employer may require second or third opinions, at the Employer's expense, and a certification of fitness to return to work prior to allowing the Employee to return to work.

PROTECTION OF JOB BENEFITS

For the duration of FMLA leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same conditions as coverage would have been provided if the Employee had been in Active Service during FMLA leave period. Taking FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave, unless the loss would have occurred even if the Employee had been in Active Service.

UNLAWFUL ACTS BY EMPLOYERS

Employers cannot interfere with, restrain or deny the exercise of any right provided under the FMLA or to manipulate circumstances to avoid responsibilities under the FMLA. Employers may not discharge, or discriminate against any person who opposes any practice made unlawful by the FMLA or who may be involved in a proceeding under or relating to the FMLA.

ENFORCEMENT

The U.S. Department of Labor is authorized to investigate and resolve complaints of FMLA violations. An eligible Employee may also bring a civil action against an employer for FMLA violations. The FMLA does not supersede any federal or state law prohibiting discrimination, and does not supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. For additional information, contact the nearest office of Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month of the pay period in which the Employee is employed;

2. On the last day of the month in which the waiver form is received;

3. On the last day of the month in which the Participant ceases to be eligible for coverage;

4. The first day of the pay period for which the Participant fails to make any required contribution for coverage;

5. On the last day of the month the Plan is terminated;

6. The date the State terminates the Participant's coverage;

7. The date the Participant dies; or

8. For Variable Employees on the last day of the Stability Period, unless at the expiration of the Stability Period, the Participant is otherwise eligible as the result of a subsequent Measurement Period or as a result of status change to a Full-Time or Part-Time Employee.

A Participant whose Active Service ceases because of Illness or Injury or as a result of any other approved leave of absence may remain covered as an Employee in Active Service for a period of twelve (12) weeks, or such other length of time that is consistent with and stated in the State's current Employee Personnel Policy Manual or pursuant to the Family and Medical Leave Act. Coverage under this provision is subject to all the provisions of FMLA if the leave is classified as FMLA leave.

Under the State Employee Protection Act (§§ 2-18-1201 through 2-18-1206, MCA), a Participant whose Active Service ceases due to temporary layoff is considered employed by the State for the purposes of his/her coverage under this Plan, and such coverage may continue for six (6) months from the effective date of the layoff, or until the Participant becomes employed in a job that provides comparable benefits and must only self-pay the employee benefit payments.

If a Participant's coverage is to be continued during disability, approved leave of absence or temporary layoff, the amount of his or her coverage is the same as the Plan benefits in force for an active Employee, subject to the Plan’s right to amend coverage and benefits.

A Participant who has been continuously covered under the Plan since August 1, 1998 whose Active Service ceases is entitled to an additional month of State share and Participant and Dependent coverage provided any required Employee contributions are paid. This is referred to as the “grandfathered” month.

RETIREE TERMINATION

Retiree coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which final benefits payments are made;

2. The date the Plan is terminated;

3. The date the State terminates the Retiree's coverage; or

4. The day following the date the Retiree dies.

REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of termination of employment and who again becomes eligible for coverage under the Plan within a thirteen (13) week period immediately following the date of such termination of employment will become eligible for reinstatement of coverage on the date of renewed eligibility. Coverage is reinstated for the Employee and eligible Dependents on the date of renewed eligibility. Reinstatement of Coverage is subject to the following:

1. Credit may be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.

2. All prior accumulations toward annual or lifetime benefit maximums apply.

If renewed eligibility occurs under any circumstances other than as stated in this sub-section, enrollment for coverage for the Employee and their Dependents is treated as if initially hired for purposes of eligibility and coverage under this Plan.

Employees terminated and rehired within thirty-one (31) days are automatically reinstated in the same benefit options elected prior to termination. Employees terminated and rehired after thirty-one (31) days shall complete the new hire enrollment process.

The Reinstatement of Coverage provision is not applicable to a Variable Employee except for any period of time that the Variable Employee is actually enrolled and covered during the Stability Period.

DEPENDENT TERMINATION

Each Covered Person, whether Participant or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of Dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage After Termination.

Coverage for a Dependent automatically terminates upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan;

2. On the last day of the month of the pay period in which the Participant's coverage terminates under the Plan;

3. On the last day of the month in which the Participant ceases to be eligible for Dependent Coverage;

4. The first day of the pay period for which the Participant fails to make any required contribution for Dependent Coverage;

5. The date the Plan is terminated;

6. The date the State terminates the Dependent's coverage;

7. The pay period following the date the Participant dies, or the date following the date the Retiree or other self-pay Participant dies;

8. The date following the date the Dependent dies;

9. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Dependent whose coverage is to be terminated; or

10. In the event notice of Dependent ineligibility is not received within sixty (60) days, on the first day of the month of the pay period in which notification of the Dependent's ineligibility is received by the Plan.

RESPONSIBILITY TO REMOVE INELIGIBLE DEPENDENTS

It is the member's responsibility (Employee, Retiree, COBRA enrollee, or surviving spouse/domestic partner) to remove any Dependents that cease to be eligible from coverage within sixty (60) days of the date eligibility is lost. The Employee, Retiree, COBRA enrollee, or surviving spouse/domestic partner is responsible for repayment of any claim dollars paid out for an ineligible Dependent. Any excess benefit contributions paid for the ineligible Dependent are refunded if the notification is received by the Plan within sixty (60) days of the date eligibility is lost. Refunds will not be issued if notification was made after sixty (60) days of the date eligibility is lost. In the event of automatic coverage termination due to death or State Children's Health Insurance Program (SCHIP) eligibility, contributions subsequently collected are returned as pre-tax or after-tax depending on which method was used to pay the contributions.

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 in order to obtain coverage and/or benefits under the Plan. In such case, the Participant shall receive written notice at least thirty (30) days before the coverage is rescinded.

CONTINUATION COVERAGE AFTER TERMINATION

Under the Public Health Service Act, as amended, Employees, spouses or domestic partners and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more employees.

The Plan Administrator is State of Montana, 100 N. Park St. Suite 320, P.O. Box 200130, Helena, MT, 59620 (406) 444-7462, (800)287-8266, TTY: (406) 444-1421, (406) 444-0080 (Fax), benefitsquestions@mt.gov (Email). COBRA Continuation Coverage for the Plan is administered by: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222, (406) 523-3131 (Fax), COBRAinquire@askallegiance.com (Email).

COBRA Continuation Coverage is available to any Qualified Beneficiary whose coverage would otherwise terminate due to any Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day immediately following the date coverage terminates.

1. Qualifying Events for Participants, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:

   A. The termination (other than by reason of gross misconduct) of the Participant's employment.

   B. The reduction in hours of the Participant's employment.

2. Qualifying Events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:

   A. Death of the Participant or Retiree.

   B. Termination of the Participant's employment.

   C. Reduction in hours of the Participant's employment.

   D. The divorce or legal separation of the Participant or Retiree from his or her spouse.

   E. A covered Dependent child ceases to be a Dependent as defined by the Plan.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Employer of the following Qualifying Events within sixty (60) days after the date the event occurs. The Employer must notify the Plan Supervisor of any of the following:

1. Death of the Participant or Retiree.

2. The divorce or legal separation of the Participant or Retiree from his or her spouse.

3. A covered Dependent child ceases to be a Dependent as defined by the Plan.

The Employer must notify the Plan Supervisor of the following Qualifying Events within thirty (30) days after the date of the event occurs:

1. Termination (other than by reason of gross misconduct) of the Participant's employment.

2. Reduction in hours of the Participant's employment.

ELECTION OF COVERAGE

When the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than fourteen (14) days after the Plan Administrator is notified of the Qualifying Event.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notification from the Plan Administrator, whichever is later, to notify the Plan Administrator that he or she elects to continue coverage under the Plan. Failure to elect continuation within that period will cause coverage to end.

MONTHLY PREMIUM PAYMENTS

A Qualified Beneficiary is responsible for the full cost of continuation coverage. Monthly premium for continuation of coverage must be paid in advance to the Plan Administrator. The premium required under the provisions of COBRA is as follows:

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).

2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.

3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:

    A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce or legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.

    B. If the second Qualifying Event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Plan Administrator of the applicable monthly premium for such coverage. The monthly premium for continuation coverage under this provision is due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Employer.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222, (406) 523-3131 (Fax), COBRAinquire@askallegiance.com (Email).

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and Dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and Dependent children if the former employee dies or becomes divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. **In all of these cases, the Plan Supervisor must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222, (406) 523-3131 (Fax), COBRAinquire@askallegiance.com (Email). Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

The dependents of a former employee are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of the former employee's enrollment in Part A and Part B of Medicare, whichever occurs earlier.

When the former employee enrolls in Medicare before the Qualifying Event of termination, or reduction in hours, of employment occurs, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends on the later of:

1. Eighteen (18) months after the Qualifying Event of termination of employment or reduction in hours of employment; or

2. Thirty-six (36) months after the former employee's enrollment in Medicare.

When the former employee enrolls in Medicare after the Qualifying Event of termination, or reduction in hours, of employment, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends eighteen (18) months after the Qualifying Event, unless a second Qualifying Event, as described above occurs within that eighteen (18) month period.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage and any coverage under the Plan that has been elected with respect to any Qualified Beneficiary will cease on the earliest of the following:

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance.

2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A and Part B).

3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to the Plan Administrator.

4. On the date the Employer ceases to provide any group health plan coverage to any Employee.

5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.

6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:

   A. Eighteen (18) months for a former employee who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment;

   B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen-month period entitling that Dependent to an additional eighteen (18) months;

   C. For the Dependent who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment of the former employee if that former employee enrolled in Medicare before termination, or reduction in hours, of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.

   D. On the first day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.

   E. Twenty-nine (29) months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.

   F. Thirty-six (36) months for all other Qualified Beneficiaries.

7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222, (406) 523-3131 (Fax), COBRAinquire@askallegiance.com (Email), or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

In order to protect the Employee's family's rights, the Employee should keep the Plan Administrator informed of any changes in the addresses of family members. The Employee should also keep a copy, for his/her records, of any notices sent to the Plan Administrator.

REDUCTION IN FORCE CONTINUATION COVERAGE

During the period of unemployment as a result of privatization, reorganization of an agency, closure of or a reduction in force at an agency or other actions by the legislature, the employee is entitled to remain covered by the state's group health insurance plan and to the continuation of the employer's contribution to the employee's group health insurance for six (6) months from the effective date of layoff or until the employee becomes employed, whichever occurs first. (§ 2-18-1205, MCA)

A covered Employee may continue coverage under this Plan for a period of six (6) months following termination due to a reduction in force (RIF). A covered Employee will continue to receive State Share for the six-month period and all benefits will remain intact.

Reduction in force continuation coverage is subject to the following requirements:

1. The Employee's position must fall within the definition of RIF.

2. The Employee must remain in the current position until the RIF date.

3. The Employee is unable to take the State Plan retiree benefit.

4. The Employee must continue to pay the out-of-pocket contribution amount.

If the Employee obtains another position with the State of Montana and becomes eligible for benefits, the Employee's coverage will automatically continue as an active Employee under the new position.

In the event the Employee is eligible for retirement, the following conditions apply:

Retirement before age sixty-five (65):

1. The Employee may continue coverage under the Plan as a Retiree, will not receive Employer's contribution (State Share). The Employee may continue until age sixty-five (65), and will then be moved to Medicare Retiree; or

2. The Employee may terminate coverage and move to another health insurance product (Insurance Market plan, spouse plan, etc.)

Retirement after age sixty-five (65):

1. The Employee may enroll in Medicare and continue on the State Plan as a Medicare Retiree, will not receive Employer's contribution (State Share); or

2. The Employee may terminate coverage and move to Medicare Part A, Part B, or Part D, Medicare Supplement Plan or Medicare Advantage Plan.

The following rules apply immediately following the six (6) month period of time in which the Employee is entitled to continue on the State Plan and receive State Share:

1. A 1985 federal law (P.L. 99-272, Title X), the Consolidated Omnibus Budget Reconciliation Act (COBRA), modified by the 1996 Health Insurance Portability and Accountability Act (HIPAA), gives employees and all covered dependents who are losing edibility for employer group health care benefits the right to continue certain coverage by self-paying the entire monthly group benefits payment.

2. The Employee will receive a letter from the State of Montana containing a summary of rights under federal law to continue group health care benefits upon termination of existing benefits. The Employee and Dependents losing eligibility due to a Qualifying Event also receive this letter to ensure the Employee receives the information needed to choose whether or not to continue health care benefits under COBRA.

COVERAGE FOR A MILITARY RESERVIST

To the extent required by the Uniform Services Employment and Reemployment Rights Act (USERRA), the following provisions will apply:

1. If a Participant's employment is terminated with Employer by reason of service in the uniformed services, the Participant may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:

   A. The twenty-four (24) month period beginning on the date on which the Participant's absence begins; or

   B. The period beginning on the date on which the Participant's absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment, as required by USERRA.

2. A Participant who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.

3. In the case of a Participant whose coverage under the Plan is terminated by reason of service in the uniformed services, an exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who notifies the Employer of his or her intent to return to employment in a timely manner as defined by USERRA, and is reemployed and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee. **This provision will not apply to the coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.**

4. The requirements of this section shall not supersede any anti discrimination in coverage requirement promulgated by TriCare or Champus/VA related to eligibility for those coverages.

COVERAGE FOR A MONTANA NATIONAL GUARD MEMBER

To the extent required by the Montana Military Service Employment Rights Act (MMSERA), the following provisions will apply:

"State Active Duty" means duty performed by a Montana National Guard member when a disaster is declared by the proper State authority and shall include the time period as certified by a licensed physician to recover from an Illness or Injury incurred while performing the state active duty.

1. In any case in which a Covered Person has coverage under this Plan, and such Covered Person is absent from employment with Employer by reason of State Active Duty, the Covered Person may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election shall be the period beginning on the thirty-first consecutive day of State Active Duty and ending on the day immediately before the day the Covered Person returns to a position of employment with the Employer, provided the Covered Person returns to employment in a timely manner, or ending on the day immediately after the day the Covered Person fails to return to a position of employment in a timely manner.

   For purposes of this subsection, a timely manner means the following:

   A. For State Active Duty of thirty (30) days but not more than one hundred eighty (180) days, the next regularly scheduled day of Active Service following fourteen (14) days after the termination of State Active Duty.

   B. For State Active Duty of more than one hundred eighty (180) days, the next regularly scheduled day of Active Service following ninety (90) days after the termination of State Active Duty.

2. An eligible Covered Person who elects to continue Plan coverage under this Section may be required to pay:

   A. Not more than one hundred percent (100%) of the contribution required from a similarly situated active Employee until such Covered Person becomes eligible for coverage under the State of Montana Health Benefit Plan as an employee of the Department of Military Affairs.

   B. Not more than one hundred two percent (102%) of the contribution required from a similarly situated active Employee for any period of time that the Covered Person is also eligible for coverage under the State of Montana Health Benefit Plan as an employee of the Department of Military Affairs.

3. In the case of a person whose coverage under the Plan is terminated by reason of State Active Duty, a Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if such an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who is reemployed in a timely manner as defined by MMSERA and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee.

4. **In no event will this Plan cover any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State Active Duty.**

5. The requirements of this section shall not supersede any anti discrimination in coverage requirement promulgated by TriCare or Champus/VA related to eligibility for those coverages.

COORDINATION OF BENEFITS

The Coordination of Benefits provision prevents the payment of benefits which exceed the Allowable Expense. It applies when the Participant or Dependent who is covered by this Plan is or may also be covered by any other plan(s). This Plan pays either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan(s), may not exceed 100% of the Allowable Expense. Only the amount paid by this Plan may be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization is hereby given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Wrap Plan Document are subject to this provision.

DEFINITIONS

"Allowable Expense" as used herein means:

1. If the claim as applied to the primary plan is subject to a contracted or negotiated rate, Allowable Expense is equal to that contracted or negotiated amount.

2. If the claim as applied to the primary plan is not subject to a contracted or negotiated rate, but the claim as applied to the secondary plan is subject to a contracted or negotiated rate, the Allowable Expense is equal to that contracted or negotiated amount of the secondary plan.

3. If the claim as applied to the primary plan and the secondary plan is not subject to a contracted or negotiated rate, then the Allowable Expense is equal to the secondary plan's chosen limits for non-contracted providers.

"Plan" as used in this Coordination of Benefits section means any plan providing benefits or services for or by reason of medical, prescription drug, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis including, but not limited to:

   A. Hospital indemnity benefits; and

   B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims;

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;

4. A licensed Health Maintenance Organization (HMO);

5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or

6. Any coverage under a Governmental program and any coverage required or provided by any statute.

"Plan" in this Coordination of Benefits section is construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION

1. **Non-Dependent/Dependent**

   The plan that covers the person other than as a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. **Child Covered Under More Than One Plan**

   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

      1) The parents are married;
      2) The parents are not separated (whether or not they have ever been married), or
      3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

   B. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

   C. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph may not apply with respect to any claim determination period, Benefit Period or Plan Year during which benefits are paid or provided before the entity has actual knowledge.

   D. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and no court decree allocates responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

      1) The plan of the custodial parent.
      2) The plan of the spouse of the custodial parent.
      3) The plan of the non-custodial parent.
      4) The plan of the spouse of the non-custodial parent.

3. **Active or Inactive Employee**

   The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule may not be followed.

4. **Longer or Shorter Length of Coverage**

If the preceding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.

A. To determine the length of time a person has been covered under a plan, two plans may be treated as one if the Covered Person was eligible under the second within 24 hours after the first ended.

B. The start of a new plan does not include:

1) A change in the amount or scope of a plan's benefits;
2) A change in the entity that pays, provides, or administers the plan's benefits; or
3) A change from one type of plan to another (such as from a single employer plan to that of a multiple-employer plan).

C. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group is used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

5. **No Rules Apply**

If none of these preceding rules determines the primary plan, the Allowable Expense may be determined equally between the plans.

COORDINATION WITH MEDICARE

Medicare Part A and Part B will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits.

1. **For Working Aged**

A covered Employee who is eligible for Medicare Part A and Part B as a result of age may be covered under this Plan and be covered under Medicare in which case this Plan will pay primary. A covered Employee, eligible for Medicare Part A and Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan terminates.

A covered Dependent, eligible for Medicare Part A and Part B as a result of age, of a covered Employee may also be covered under this Plan and be covered under Medicare in which case this Plan again will pay primary. A covered Dependent, eligible for Medicare Part A and Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan terminates.

2. **For Retired Persons**

Medicare is primary and this Plan is secondary for the covered Retiree if the Retiree is an individual who is enrolled in Medicare Part A as a result of age.

Medicare is primary and this Plan is secondary for the covered Retiree's Dependent who is enrolled in Medicare Part A if both the covered Retiree and the covered Dependent are enrolled in Medicare Part A as a result of age and retired.

Medicare is primary for the Retiree's Dependent when the Retiree is not enrolled for Medicare Part A as a result of age and the Retiree's Dependent is enrolled in Medicare Part A as a result of age.

3. **For Covered Persons who are Disabled**

This Plan is primary and Medicare is secondary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability, if the Employee is actively employed by the Employer.

This Plan is secondary and Medicare is primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

4. **For Covered Persons with End Stage Renal Disease**

Except as below stated*, for Employees or Retirees and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan is primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan is secondary with respect to Medicare coverage, unless after the thirty-month period described, the Covered Person has no dialysis for a period of twelve (12) consecutive months and:

A. Resumes dialysis, at which time this Plan becomes primary for a period of thirty (30) months; or

B. Undergoes a kidney transplant, at which time this Plan becomes primary for a period of thirty (30) months.

*If a Covered Person is covered by Medicare as a result of disability and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare continues to be primary and this Plan is secondary.

Federal law requires that group health plans report certain information about individuals covered under its group health plan for the purpose of coordinating benefits with Medicare under the Medicare Secondary Payer Rules. Information required to be reported includes the Social Security Numbers (SSNs) for all Participant's and all Dependents over the age of forty-four (44).

COORDINATION WITH MEDICAID

If a Covered Person is covered by Medicaid, this Plan is primary and Medicaid is secondary.

COORDINATION WITH TRICARE/CHAMPVA

If a Covered Person is covered under TRICARE/CHAMPVA, this Plan is primary and TRICARE/CHAMPVA is secondary. TRICARE coverage includes programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

If the Covered Person is eligible for Medicare and entitled to veterans benefits through the Department of Veterans Affairs (VA), this Plan is primary and the VA is secondary for non-service connected medical claims. For these claims, this Plan makes payment to the VA as though this Plan was making payment secondary to Medicare.

PROCEDURES FOR CLAIMING MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION BENEFITS

Medical, prescription drug, dental and vision claims must be submitted to the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan within twelve (12) months after the date services or treatments are received or completed. Non-electronic claims may be submitted on any approved medical, prescription drug, dental or vision claim form, available from the provider. The claim must be completed in full with all the requested information. A complete claim must include the following information:

- Date of service;
- Name of the Participant;
- Name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- Diagnosis [code] of the condition being treated;
- Treatment or service [code] performed;
- Amount charged by the provider for the treatment or service; and
- Sufficient documentation, in the sole determination of the Plan Administrator, to support the Medical or Dental Necessity of the treatment or service being provided and sufficient to enable the Medical, Prescription Drug, Dental or Vision Plan Supervisor to adjudicate the claim pursuant to the terms and conditions of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan.

Medical, prescription drug, dental and vision claims are processed separately. See the "CLAIMS PROCESSING" section for where to send medical, prescription drug, dental and visions claims.

A claim will not, under any circumstances, be considered for payment of benefits if initially submitted to the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan more than twelve (12) months from the date that services were incurred.

Upon termination of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan, final claims must be received within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

CLAIMS ARE NOT DEEMED SUBMITTED UNTIL RECEIVED BY THE APPROPRIATE PLAN SUPERVISOR.

The Plan Administrator has the right, in its sole discretion and at its own expense, to require a claimant to undergo a medical, prescription drug, dental or vision care examination, when and as often as may be reasonable, and to require the claimant to submit, or cause to be submitted, any and all medical, prescription drug, dental or vision care and other relevant records it deems necessary to properly adjudicate the claim.

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims are considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines and administrative practices not inconsistent with the terms of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan. The Plan Administrator may, when appropriate or when required by law, consult with relevant health care, prescription drug care, dental care or vision care professionals and access professional industry resources in making decisions about claims that involve specialized medical, prescription drug, dental or vision knowledge or judgment. Initial eligibility and claims decisions are made within the time periods below stated. For purposes of this section, "Covered Person" will include the claimant and the claimant's Authorized Representative;

"Covered Person" does not include a health care, prescription drug care, dental care or vision care provider or other assignee, and said health care provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

"Authorized Representative" means a representative authorized by the claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The claimant must authorize the representative in writing, and this written authorization must be provided to the Plan Administrator. The Plan Administrator may recognize this Authorized Representative only after the Plan Administrator receives the written authorization.

INFORMATION REGARDING URGENT CARE CLAIMS IS PROVIDED TO YOU UNDER THE DISCLOSURE REQUIREMENTS OF APPLICABLE LAW; THE PLAN DOES NOT MAKE TREATMENT DECISIONS. ANY DECISION TO RECEIVE TREATMENT MUST BE MADE BETWEEN THE PATIENT AND THE PATIENT'S HEALTHCARE PROVIDER, PRESCRIPTION DRUG CARE PROVIDER, DENTAL CARE PROVIDER OR VISION CARE PROVIDER. HOWEVER, THE MEDICAL PLAN, PRESCRIPTION DRUG PLAN, DENTAL PLAN OR VISION PLAN ONLY PAYS BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN, PRESCRIPTION DRUG PLAN, DENTAL PLAN OR VISION PLAN. SOME SERVICES ARE EXCLUDED UNDER THIS PLAN REGARDLESS OF MEDICAL NECESSITY.

1. **Urgent Care Claims** - An Urgent Care Claim is any claim for medical care or treatment with respect to which:

   A. In the judgment of a prudent layperson possessing an average knowledge of health and medicine may seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

   B. In the opinion of a Physician with knowledge of the claimant's medical condition, may subject the claimant to severe pain that may not be adequately managed without the care or treatment that is the subject of the claim.

   There are no Pre-Service Urgent Care requirements under this Plan, and therefore, there are no rights to appeal a pre-service Urgent Care claim denial.

2. **Pre-Service Claims** - Pre-Service Claims must be submitted to the appropriate Plan before the Covered Person receives medical treatment, prescription drug, dental or vision care services. A Pre-Service Claim is any claim for a medical, prescription drug, dental or vision care benefit which the appropriate Plan terms condition the Covered Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are procedures stated in the Summary Plan Descriptions which the Plan Administrator recommends be utilized before a Covered Person obtains medical, prescription drug, dental or vision care.

3. **Post-Service Claims** - A Post-Service Claim is any claim for a medical, prescription drug, dental or vision benefit under the applicable Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, prescription drug care, dental care or vision care, and for which medical, prescription drug, dental or vision treatment has been obtained prior to submission of the claim(s).

   In most cases, initial claims decisions on Post-Service Claims are made within thirty (30) days of the appropriate Plan's receipt of the claim. The appropriate Plan shall provide timely notice of the initial determination once sufficient information is received to make an initial determination, no later than thirty (30) days after receiving the claim.

4. **Concurrent Care Review** - For patients who face early termination or reduction of benefits for a course of treatment previously certified by the appropriate Plan, a decision by the appropriate Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the appropriate Plan's benefit maximums is not an Adverse Benefit Determination.) The appropriate Plan shall notify the Covered Person sufficiently in advance to allow an appeal for uninterrupted continuing care before the benefit is reduced or terminated. Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time must be decided within twenty-four (24) hours of the appropriate Plan's receipt of the request. The appeal for ongoing care or treatment must be made to the appropriate Plan at least twenty-four (24) hours prior to the expiration of the initially-prescribed period.

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

If a medical, prescription, dental or vision claim is denied in whole or in part, the Covered Person shall receive written notification of the Adverse Benefit Determination. A claim denial is provided by the appropriate Plan showing:

1. The reason the claim was denied;

2. Reference(s) to the specific Medical Plan, Prescription Drug Plan, Dental Plan or Vision 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 following an Adverse Benefit Determination on appeal.

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

The Covered Person shall appeal the Adverse Benefit Determination before the Covered Person may exercise the Covered Person's right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person shall exercise both levels of review before bringing a civil action.

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

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the appropriate Plan Supervisor in writing. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail):

For Medical Benefits:
Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Dental Benefits:
Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA, 30023

For Pharmacy Benefits:
Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Vision Benefits:
Cigna Vision
P.O. Box 997561
Sacramento, CA 95899-7561

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

The first level of benefit determination review is completed by the Medical, Prescription Drug, Dental or Vision Plan Supervisor. The appropriate Plan Supervisor researches the information initially received and determines if the initial determination was appropriate based on the terms and conditions of the appropriate Plan and other relevant information. Notice of the decision on the first level of review must be sent to the Covered Person within fifteen (15) days following the date the appropriate 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 may initiate the second level of benefit review. The Covered Person shall request the second review in writing and send it to the appropriate 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 renders the determination final.

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

The Plan Administrator reviews the claim in question along with the additional information submitted by the Covered Person. The Plan Administrator, who is neither the original decision maker nor the decision maker's subordinate, conducts a full and fair review of the claim. The Plan Administrator may not give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care, prescription drug care, dental care or vision care professionals in making decisions about appeals that involve specialized medical, dental or vision care judgment. Where the appeal involves issues of Medical or Dental Necessity or experimental treatment, the Plan Administrator shall consult with a health care, prescription drug care, dental care or vision care professional with appropriate training who was neither the medical nor dental care 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 Administrator shall provide a written or electronic notice of the final benefit determination containing the same information as notices for the initial determination within fifteen (15) days.

INDEPENDENT EXTERNAL REVIEW FOR A PRE-SERVICE CLAIM

Does not apply to dental or vision claims.

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person shall request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Plan Administrator through the Medical Plan Supervisor shall forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO shall notify the Covered Person of its procedures to submit further information.

The IRO shall issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO is final and binding except that the Covered Person has the right to appeal the matter to a court with jurisdiction.

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

If a medical, prescription, dental or vision claim is denied in whole or in part, the Covered Person shall receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) is provided by the Plan Administrator through the approrpriate Plan Supervisor showing:

1. The reason the claim was denied;

2. Reference(s) to the specific Medical Plan, Prescription Drug Plan, Dental Plan or Vision 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 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 appropriate 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. 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 appropriate Plan Supervisor 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 Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan which was not initially provided and forward it to the appropriate 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 appropriate Plan Supervisor in writing. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail):

For Medical Benefits:
Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Dental Benefits:
Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA, 30023

For Pharmacy Benefits:
Allegiance Benefit Plan Mgt, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

For Vision Benefits:
Cigna Vision
P.O. Box 997561
Sacramento, CA 95899-7561

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

The first level of benefit determination review is completed by the Medical, Prescription Drug, Dental or Vision Plan Supervisor. The appropriate Plan Supervisor researches the information initially received and determines if the initial determination was appropriate based on the terms and conditions of the appropriate Plan and other relevant information. Notice of the decision on the first level of review is sent to the Covered Person within thirty (30) days following the date the appropriate 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 appropriate 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 Plan Administrator reviews the claim in question along with the additional information submitted by the Covered Person. The Plan Administrator, who is neither the original decision maker nor the decision maker's subordinate, conducts a full and fair review of the claim. The Plan Administrator may not give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care, prescription drug care, dental care or vision care professionals in making decisions about appeals that involve specialized medical, dental or vision care judgment. Where the appeal involves issues of Medical or Dental Necessity or experimental treatment, the Plan Administrator shall consult with a health care, prescription drug care, dental care or vision care professional with appropriate training who was neither the medical nor dental care 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 Administrator shall 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 Administrator at each level of review.

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

INDEPENDENT EXTERNAL REVIEW FOR A POST-SERVICE CLAIM

Does not apply to dental or vision claims.

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person shall request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Plan Administrator through the Medical Plan Supervisor shall forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO notifies the Covered Person of its procedures to submit further information.

The IRO issues a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO is final and binding except that the Covered Person has an additional right to appeal the matter to a court with jurisdiction.

CLAIMS PROCESSING

Medical, prescription drug, dental and vision claims are processed separately. Completed medical, prescription drug, dental and vision claims must be sent accordingly for processing to the following:

MEDICAL BENEFIT CLAIMS:

Name:	Allegiance Benefit Plan Management, Inc.
Address:	P.O. Box 3018 Missoula, MT 59806-3018
Phone:	(855) 999-1057 or (406) 523-3199
Fax:	(406) 721-2252
Web:	www.askallegiance.com/som

Medical claims may also be submitted through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

PRESCRIPTION DRUG CLAIMS:

Name:	Navitus Health Solutions
Address:	P.O. Box 999 Appleton, WI 54912-0999
Phone:	(866) 333-2757
Web:	www.navitus.com

DENTAL BENEFIT CLAIMS:

Name:	Delta Dental Insurance Company
Address:	P.O. Box 1809 Alpharetta, Georgia 30023-1809
Phone:	(866) 496-2370
Web:	www.deltadentalins.com/stateofmontana

Claims for dental benefits must be filed on a standard claim form which may be obtained from Delta Dental Insurance Company.

VISION BENEFIT CLAIMS:

Name:	Cigna Vision, Claims Department
Address:	P.O. Box 385018 Birmingham, AL 35238-5018
Phone:	(877) 478-7557
Web:	www.mycigna.com

PAYMENT OF CLAIMS

All Plan benefits are payable to a Participant, Qualified Beneficiary or Alternate Recipient, whichever is applicable. All or a portion of any benefits payable by the Plan may, at the Covered Person's option and unless the Covered Person requests otherwise in writing not later than the time of filing the claim, be paid directly to the health care provider rendering the service, if proper written assignment is provided to the Plan and the health care provider is a Participating Provider. No payments may be made to any provider of services unless the Covered Person is liable for such expenses and such expenses are eligible for payment by the Plan.

The Plan may not recognize assignments of payment of benefits from non-Participating Providers. The Plan, at the discretion of the Plan Administrator, pays the Procedure Based Maximum Expense (PBME) amount to the Covered Person or to the Covered Person and the provider jointly who incurred the claim (or the Participant, Qualified Beneficiary or Alternate Recipient if the Covered Person is a minor), and notifies the provider that the Plan does not recognize or accept assignments for payment of claims from non-Participating Providers.

If any benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor, or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate. The Plan, in its sole option, may require that an estate, guardianship or conservatorship be established by a court of competent jurisdiction prior to payment of any benefit. Any payment made under this subsection constitutes a complete discharge of the Plan's obligation to the extent of such payment and the Plan may not be required to oversee the application of the money so paid.

FRAUD AND ABUSE

THIS PLAN IS SUBJECT TO FEDERAL LAW WHICH PERMITS CRIMINAL PENALTIES FOR FRAUDULENT ACTS COMMITTED AGAINST THE PLAN. STATE LAW MAY ALSO APPLY.

Anyone who knowingly defrauds or tries to defraud the Plan or obtains Plan funds through false statements or fraudulent schemes, may be subject to criminal prosecution and penalties. The following may be considered fraudulent:

1. Falsifying eligibility criteria for a Dependent to get or continue coverage for that Dependent when not otherwise eligible for coverage;

2. Falsifying or withholding medical history or information required to calculate benefits;

3. Falsifying or altering documents to get coverage or benefits;

4. Permitting a person not otherwise eligible for coverage to use a Plan ID card to get Plan benefits; or

5. Submitting a fraudulent claim or making untruthful statements to the Plan to get reimbursement from the Plan for services that may or may not have been provided to a Covered Person.

The Plan Administrator, in its sole discretion, may take additional action against the Participant or Covered Person including, but not limited to, terminating the Participant or Covered Person's coverage under the Plan.

MISSTATEMENT OF AGE

If the Covered Person's age was misstated on an enrollment form or claim, the Covered Person's eligibility or amount of benefits, or both, must be adjusted to reflect the Covered Person's true age. If the Covered Person was not eligible for coverage under the Plan or for the amount of benefits received, the Plan has a right to recover any benefits paid by the Plan. A misstatement of age may not continue coverage that was otherwise properly terminated or terminate coverage that is otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If a Participant misrepresents a Dependent's marital status, domestic partnership status, age, Dependent child relationship or other eligibility criteria to get coverage for that Dependent, when he or she would not otherwise be eligible, coverage for that Dependent terminates as though never effective.

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not otherwise eligible as a Covered Person to use an ID card, the Plan Sponsor may, at the Plan Sponsor's sole discretion, terminate the Covered Person's coverage.

REIMBURSEMENT TO PLAN

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan but for whom benefits were paid based upon fraud as defined in this section must be reimbursed to the Plan by the Participant. Failure to reimburse the Plan upon request may result in an interruption or a loss of benefits by the Participant and Dependents.

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 in order to obtain coverage and/or benefits under the Plan. In such case, the Participant shall receive written notice at least thirty (30) days before the coverage is rescinded.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefitted from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits, or from the benefits for any covered Family member even if the erroneous payment was not made on that Family member's behalf.

Payment of benefits by the Plan for Participants' spouses, ex-spouses, or children, who are not eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate, false information provided by, or information omitted by, the Employee is reimbursed to the Plan by the Employee. The Employee's failure to reimburse the Plan after demand is made, may result in an interruption in or loss of benefits to the Employee, and could be reported to the appropriate governmental authorities for investigation of criminal fraud.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine.

The provisions of this section apply to any Physician or Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Physician or Licensed Health Care Provider fails to refund a payment of benefits, the Plan may refuse to recognize future assignments of benefits to that provider.

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was responsible or liable for payment of those medical expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid, but the Plan may seek reimbursement only if the Covered Person has been made whole.

Accordingly, if a Covered Person, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any accident, Injury, condition or Illness for which benefits were provided by the Plan and the Covered Person has been made whole, in that event, the Covered Person agrees to hold the money received for the benefit of the Plan. The Covered Person agrees to reimburse the Plan, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that is paid as a result of the accident, Injury, condition or Illness.

Provided that the Covered Person has been made whole, reimbursement to the Plan is paid first, in its entirety, regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages.

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from any third party who is liable to the Covered Person for a loss or benefits paid by the Plan, provided the Covered Person has been made whole. The Plan may proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover benefits paid under the Plan.

Provided that he/she has been made whole, the Covered Person agrees to subrogate to the Plan any and all claims, causes of action or rights that he or she has or that may arise against any entity who has or may have caused, contributed to or aggravated the accident, Injury, condition or Illness for which the Plan has paid benefits, and to subrogate any claims, causes of action or rights the Covered Person may have against any other coverage including, but not limited to, liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

If a Covered Person has been made whole and decides not to pursue a claim against any third party or insurer, the Covered Person will notify the Plan, and specifically authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Covered Person's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

1. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any liable third party, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment, provided that the Covered Person has been made whole.

2. If the Covered Person has been made whole, he/she will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any benefits paid by the Plan from any liable third party. This cooperation includes, but is not limited to, make full and complete disclosure in a timely manner of all material facts regarding the accident, Injury, condition or Illness to the Plan Administrator; report all efforts by any person to recover any such money; provide the Plan Administrator with any and all requested documents, reports and other information in a timely manner, regarding any demand, litigation or settlement involving the recovery of benefits paid by the Plan; and notify the Plan Administrator of the amount and source of funds received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.

3. Covered Persons will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers including, but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.

4. The Covered Person will not act, fail to act, or engage in any conduct directly, indirectly, personally or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Covered Person will not conceal or attempt to conceal the fact that recovery has occurred or will occur.

5. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage including, but not limited to, attorney fees or costs of litigation. The Plan recognizes the Covered Person has a right to be made whole, as set forth in §§ 2-18-901 and 902, MCA.

PLAN ADMINISTRATION

PURPOSE

The purpose of the Wrap Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of the claim. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees, Retirees and their covered Dependents.

EFFECTIVE DATE

The effective date of the Plan is January 1, 1979; and restated January 1, 2017.

PLAN YEAR

The Plan Year commences January 1 and ends on December 31 of each year.

PLAN SPONSOR

The Plan Sponsor is State of Montana.

PLAN SUPERVISOR

The Plan Supervisor for the Medical Plan is: Allegiance Benefit Plan Management, Inc.

The Plan Supervisor for the Prescription Drug Plan is: Navitus Health Solutions.

The Plan Supervisor for the Dental Plan is: Delta Dental Insurance Company.

The Plan Supervisor for the Vision Plan is: Cigna Vision.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is State of Montana, a Montana governmental entity, who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator has the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

PLAN INTERPRETATION

The Named Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Except as provided in the Health Plan Administrator and Provider Network Services Contract DOA2016-0011P between the State and Allegiance Benefit Plan Management, Inc., final authority to interpret and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator made in good faith are final and binding.

CONTRIBUTIONS TO THE PLAN

The amount of contributions to the Plan are to be made on the following basis:

> State Agencies shall contribute the amount established in § 2-18-703, MCA to the Plan fund for group benefit costs on a per eligible Employee per month basis regardless of whether the eligible Employee elects health benefit coverage. The State may from time to time evaluate the costs of the Plan and determine the amount to be contributed by the State, if any, and the amount to be contributed, if any, by each Participant.

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Wrap Plan Document contains all the terms of the Plan and may be amended at any time by the Plan Administrator. Any changes are binding on each Participant and on any other Covered Persons referred to in this Wrap Plan Document. The authority to amend the Plan is delegated by the Plan Administrator to the Director of Department of Administration or their equivalent, whichever is applicable, of the State. Any such amendment, modification, revocation or termination of the Plan is authorized and signed by the Director of Department of Administration or their equivalent, whichever is applicable, of the State, pursuant to a governmental policy, granting that individual the authority to amend, modify, revoke or terminate this Plan. A copy of the executed policy shall be supplied to the appropriate Plan Supervisor. Written notification of any amendments, modifications, revocations or terminations shall be given to Plan Participants at least sixty (60) days prior to the effective date, except for amendments effective on the first day of a new Plan Year, for which thirty (30) days advance notice is required.

TERMINATION OF PLAN

The State reserves the right at any time to terminate the Plan by a written notice. All previous contributions by the State will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or may be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

WRAP PLAN DOCUMENT

Each Participant covered under this Plan shall be issued a Wrap Plan Document (WPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits and the limitations and exclusions of the Plan.

GENERAL PROVISIONS

EXAMINATION

The Plan has the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim when and so often as it may reasonably require to adjudicate the claim. The Plan may also have the right to have an autopsy performed in case of death to the extent permitted by law.

LEGAL PROCEEDINGS

No action at law or equity may be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor may such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

CHOICE OF LAW, VENUE AND ATTORNEY FEES

This Plan is interpreted pursuant to the laws of the state of Montana except as preempted by federal law (e.g., PPACA and COBRA). As a condition precedent to receiving benefits under this Plan, all Covered Persons under this Plan agree that any litigation related to the terms, benefits, limitations or exclusions of the Plan must be brought in the First Judicial District in and for the County of Lewis and Clark, State of Montana, and each party shall pay their own costs and attorney fees.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan may be waived, and there is no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver may be deemed a continuing waiver unless specifically stated therein, and each such waiver may operate only as to the specific term or condition waived and may not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

ORAL STATEMENTS

Oral statements or representations of the Plan Administrator, its agents and Employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and Employees, or Covered Persons may be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection may not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF PHYSICIAN

The Covered Person has free choice of any licensed Physician, Licensed Health Care Provider or surgeon and the patient-provider relationship is maintained.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the applicable law. Only that provision which is contrary to applicable law is amended to conform; all other parts of the Plan remain in full force and effect.

MISCELLANEOUS

Section titles are for convenience of reference only and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan may affect the right thereafter to enforce such provision, nor may such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan may have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of this provision. Amounts so paid are deemed to be benefits paid under this Plan and to the extent of such payments, the Plan must be fully discharged from liability under this Plan.

The benefits that are payable may be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan is subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same is void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which becomes due to any Participant, the Plan Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application is a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Wrap Plan Document constitutes the primary authority for Plan administration. The establishment, administration and maintenance of this Plan may not be deemed to constitute a contract of employment, give any Participant of the State the right to be retained in the service of the State, or to interfere with the right of the State to discharge or otherwise terminate the employment of any Participant.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following general exclusions and limitations apply to all Expenses Incurred under this Plan:

1. Charges for services rendered or started or supplies furnished prior to the effective date of coverage under the Plan or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions.

2. Charges which are caused by or arising out of war or act of war, (whether declared or undeclared), civil unrest, armed invasion or aggression, or caused during service in the armed forces of any country.

3. Charges to the extent that the Covered Person may have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid.

4. Charges by the Covered Person for all services and supplies resulting from any Illness or Injury which occurs in the course of employment for wage or profit, or in the course of any volunteer work when the organization, for whom the Covered Person is volunteering, has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including Employees' compensation or liability laws of the United States (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though:

   A. Coverage for the Covered Person under Workers' Compensation provides benefits for only a portion of the services Incurred;

   B. The Covered Person's employer/volunteer organization has failed to obtain such coverage required by law;

   C. The Covered Person waived his/her rights to such coverage or benefits;

   D. The Covered Person fails to file a claim within the filing period allowed by law for such benefits;

   E. The Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits;

   F. The Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective; or

   G. The Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

   This exclusion will not apply to household and domestic employment, employment not in the usual course of the trade, business, profession or occupation of the Covered Person or Employee, or employment of a Dependent member of an Employee's family for whom an exemption may be claimed by the Employee under the Internal Revenue Code, or in cases in which it is legally impossible to obtain Workers' Compensation coverage for a specific Illness or Injury.

5. Charges for which the Covered Person is not, in the absence of this coverage, legally obligated to pay or for which a charge would not ordinarily be made in the absence of this coverage.

6. Charges for non-prescription vitamins or nutritional supplements, except as specifically covered under the Preventive Care Benefit.

7. Charges for services or supplies used primarily for cosmetic, personal comfort, convenience, beautification items, television or telephone use that are not related to treatment of a medical condition.

8. Charges for non-medical expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician, except as specifically covered.

9. Expenses Incurred by persons other than the Covered Person receiving treatment.

10. Charges in excess of the Eligible Expense.

11. Charges for services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person, or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services.

12. Charges for professional services on an Outpatient basis in connection with disorders of any type or cause, that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis.

13. Charges for services, treatment or supplies not considered legal in the United States.

14. Travel Expenses Incurred by any person for any reason, except as specifically covered under the Non-Ambulance Travel Benefit.

15. Charges for services, treatments or supplies that may be useful to persons in the absence of Illness or Injury such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, dehumidifiers, exercise equipment, health club memberships, etc., whether or not they have been prescribed or recommended by a Physician.

16. Charges for preparation of reports or itemized bills in connection with claims, unless specifically requested and approved by the Plan.

17. Charges for services or supplies that are not specifically listed as a Covered Benefit of this Plan.

18. Charges for any services or supplies to the extent that benefits are otherwise provided under this Plan or under any other plan of group benefits that the Participant's Employer contributes to or sponsors.

19. Charges for incidental supplies or common first-aid supplies such as, but not limited to; adhesive tape, bandages, antiseptics, analgesics, etc.

20. Charges for dental braces or corrective shoes, except for orthotics for diabetes as specifically listed as a covered service.

21. Charges for the following treatments, services or supplies:

    A. Charges related to or connected with treatments, services or supplies that are excluded under this Plan.

    B. Charges that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan.

22. Charges for treatment, services or supplies not actually rendered to or received and used by the Covered Person.

23. Charges for care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

24. Charges arising out of or relating to any violation of a health care-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below. If the defined term is not used in this document, the term does not apply to this Plan.

Masculine pronouns used in this Plan Document will include either the masculine or feminine gender unless the context indicates otherwise.

Any words used herein in the singular or plural will include the alternative as applicable.

ABORTION (Elective or Therapeutic)

“Elective Abortion” means the interruption of a Pregnancy at the woman’s request for other than maternal health or fetal disease.

“Therapeutic Abortion” means the interruption of a Pregnancy to protect the life of the mother.

ACCIDENTAL INJURY

“Accidental Injury” means an Injury sustained as a result of an external force or forces that is/are sudden, direct and unforeseen and is/are exact as to time and place. A hernia of any kind will only be considered as an Illness.

ACTIVE SERVICE

“Active Service” means that an Employee is in service with the State on a day which is one of the State's regularly scheduled work days and that the Employee is performing all of the regular duties of his/her employment with the State on a regular basis, either at one of the State's business establishments or at some location to which the State's business requires him/her to travel.

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 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.

ALCOHOLISM

“Alcoholism” means a morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health, social or economic functioning.

ALCOHOLISM AND/OR CHEMICAL DEPENDENCY TREATMENT FACILITY

"Alcoholism and/or Chemical Dependency Treatment Facility" means a licensed institution which provides a program for diagnosis, evaluation, and effective treatment of Alcoholism and/or Chemical Dependency; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services or arranges with a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards.

AMBULANCE SERVICE

"Ambulance Service" means an entity, its personnel and equipment including, but not limited to, automobiles, airplanes, boats or helicopters, which are licensed to provide Emergency medical and Ambulance services in the state in which the services are rendered.

AMBULATORY SURGICAL CENTER

"Ambulatory Surgical Center" (also called same-day surgery center or Outpatient surgery center) means a licensed establishment with an organized staff of Physicians and permanent facilities, either freestanding or as a part of a Hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous Physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for ambulatory surgery centers in the state in which the facility is located.

"Ambulatory Surgical Center" does not include an office or clinic maintained by a Dentist or Physician for the practice of dentistry or medicine, a Hospital emergency room or trauma center.

AUTISM SPECTRUM DISORDER

"Autism Spectrum Disorder" means neurological disorders, usually appearing in the first three (3) years of life, that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

BENEFIT PERCENTAGE

"Benefit Percentage" means that portion of Eligible Expenses payable by the Plan, which is stated as a percentage in the Schedule of Benefits.

BENEFIT PERIOD

"Benefit Period" refers to a time period of one year, which is either a Calendar Year or other annual period, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or

2. The date the Plan terminates.

BIRTHING CENTER

A "Birthing Center" means a freestanding or hospital based licensed facility which provides obstetrical delivery services under the supervision of a Physician, and through an arrangement or an agreement with a Hospital.

CALENDAR YEAR

"Calendar Year" means a period of time commencing on January 1 and ending on December 31 of the same year.

CENTER OF EXCELLENCE

"Center of Excellence" is any facility that provides transplant services which the Plan Administrator has determined to be a Center of Excellence and for which the Plan Administrator is able to obtain a discount for services.

CHEMICAL DEPENDENCY

"Chemical Dependency" means the physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine, caffeine or eating disorders are not included in this definition.

CLOSE RELATIVE

"Close Relative" means the spouse, parent, brother, sister, child, or in-laws of the Covered Person.

COBRA

"COBRA" means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. § 300bb-1 through § 300bb-8], which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

"COBRA Continuation Coverage" means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of "COBRA".

CONVALESCENT NURSING FACILITY

See "Skilled Nursing Facility".

COSMETIC

"Cosmetic" means services or treatment ordered or performed solely to change a Covered Person's appearance rather than for the restoration of bodily function.

COVERED PERSON

"Covered Person" means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

CUSTODIAL CARE

"Custodial Care" means the type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEDUCTIBLE

"Deductible" means a specified dollar amount that must be incurred before the Plan will pay any amount for any benefit during each Benefit Period.

DENTAL HYGIENIST

"Dental Hygienist" means a person who is licensed to practice dental hygiene and who works under the supervision and direction of a Dentist.

DENTALLY NECESSARY OR DENTAL NECESSITY

"Dentally Necessary" or "Dental Necessity" means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose a Dental condition or dental disease; and

2. Are ordered by a Dentist or Licensed Health Care Provider and consistent with the symptoms or diagnosis and treatment of the dental condition or dental disease; and

3. Are not primarily for the convenience of the Covered Person, Dentist or other Licensed Health Care Provider; and

4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person; and

5. Are not of an Experimental/Investigational or solely educational nature; and

6. Are not provided primarily for dental, medical or other research; and

7. Do not involve excessive, unnecessary or repeated tests; and

8. Are commonly and customarily recognized by the dental profession as appropriate in the treatment or diagnosis of the diagnosed condition; and

9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration, Centers for Medicare/Medicaid Services (CMS), or American Dental Association, pursuant to that entity's program oversight authority based upon the dental treatment circumstances.

DENTIST

"Dentist" means a person holding one of the following degrees–Doctor of Dental Science, Doctor of Medical Dentistry, Master of Dental Surgery or Doctor of Medicine (oral surgeon) -- who is legally licensed as such to practice dentistry in the jurisdiction where services are rendered, and the services rendered are within the scope of his or her license.

A "Dentist" will not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

DENTURIST

"Denturist" means a dental technician, duly licensed, specializing in the making and fitting of dentures.

DEPENDENT

"Dependent" means a person who is eligible for coverage under the Dependent Eligibility subsection of this Plan.

DEPENDENT COVERAGE

"Dependent Coverage" means eligibility for coverage under the terms of the Plan for benefits payable as a consequence of Eligible Incurred Expenses for an Illness or Injury of a Dependent.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment which is:

1. Able to withstand repeated use, e.g., could normally be rented, and used by successive patients; and

2. Primarily and customarily used to serve a medical purpose; and

3. Not generally useful to a person in the absence of Illness or Injury.

ELIGIBLE EXPENSES

"Eligible Expenses" means the maximum amount of any charge for a covered service, treatment or supply that may be considered for payment by the Plan, including any portion of that charge that may be applied to the Deductible or used to satisfy the Out-of-Pocket Maximum. Eligible Expenses are equal to the Procedure Based Maximum Expense (PBME) as defined by this Plan.

EMERGENCY

"Emergency" means a medical condition manifesting itself by acute symptoms which occur suddenly and unexpectedly and for which the Covered Person receives medical care no later than 48 hours after the onset of the condition. Emergency is any medical condition for which a reasonable and prudent layperson, possessing average knowledge of health and medicine, would expect that failure to seek immediate medical attention would result in death, more severe or disabling medical condition(s), or continued severe pain without cessation in the absence of medical treatment. Emergency may include, but is not limited to, severe Injury, hemorrhaging, poisoning, loss of consciousness or respiration, fractures, convulsions, injuries reasonably likely to require sutures, severe acute pain, severe burns, prolonged high fever and symptoms normally associated with heart attack or stroke.

"Emergency" will specifically exclude usual out-patient treatment of childhood diseases, flu, common cold, pre-natal examinations, physical examinations and minor sprains, lacerations, abrasions and minor burns, and other medical conditions usually capable of treatment at a clinic or doctor's office during regular working hours.

EMERGENCY SERVICES

"Emergency Services" shall include all services provided which are related to an Emergency as defined by the Plan. Those services include, but are not limited to, Ambulance services, services of Physicians and other Licensed Health Care Providers and services for emergency rooms and other Hospital facilities.

EMPLOYEE

"Employee" means a person employed by the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer's W-2 payroll, except for Montana University System, Office of the Commissioner of Higher Education employees.

Employee does not include any employee leased from another employer including, but not limited to, those individuals defined in Internal Revenue Code Section 414(n), or an individual classified by the Employer as a contract worker or independent contractor if such persons are not on the Employer's W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as Express Services, Westaff, and A2Z Staffing Solutions, etc.

EMPLOYER

"Employer" means the State of Montana or any affiliated entity that has adopted this Plan for its Employees and which is a "controlled group" as defined by applicable state and federal law, as amended.

ENROLLEE

"Enrollee" means an Employee of the State who is eligible and enrolled for coverage under this Plan.

ENROLLMENT DATE

"Enrollment Date" means the date a person becomes eligible for coverage under this Plan or the eligible person's effective date of coverage under this Plan, whichever occurs first.

ERISA

"ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended.

EXPERIMENTAL/INVESTIGATIONAL

"Experimental/Investigational" means:

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

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

3. That the drug, device or medical treatment or procedure is under study, prior to or in the absence of any clinical trial, to determine its maximum tolerated dose, its toxicity, or its safety; or

4. That based upon Reliable Evidence, the drug, device, medical treatment or procedure is the subject of an on-going Phase I or Phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not considered Experimental or Investigational.) For chemotherapy regimens, a Phase II clinical trial is not considered Experimental or Investigational when both of these criteria are met:

    A. The regimen or protocol has been the subject of a completed and published Phase II clinical trial which demonstrates benefits equal to or greater than existing accepted treatment protocols; and

B. The regimen or protocol listed by the National Comprehensive Cancer Network is supported by level of evidence Category 2B or higher; or

5. Based upon Reliable Evidence, any drug, device, medical treatment or procedure that the prevailing opinion among experts is that further studies or clinical trial are necessary to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or

6. Any drug, device, medical treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, Centers for Medicare and Medicaid Services (CMS), American Dental Association, American Medical Association).

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

FAMILY

"Family" means a Participant and his or her eligible Dependents as defined herein.

FMLA

"FMLA" means Family and Medical Leave Act.

GENDER IDENTITY DISORDER/ GENDER DYSPHORIA

DSM-V diagnosis in children:

1. A definite difference between experienced/expressed gender and the one assigned at birth of at least six (6) months duration. At least six (6) of the following must be present:

   A. Persistent and strong desire to be of the other sex or insistence that they belong to the other sex.

   B. In male children, a strong preference for cross-dressing and in female children, a strong preference for wearing typical masculine clothing and dislike or refusal to wear typical feminine clothing.

   C. Fantasizing about playing opposite gender roles in make-belief play or activities.

   D. Preference for toys, games or activities typical of the opposite sex.

   E. Rejection of toys, games and activities conforming to one's own sex. In male children, avoidance of rough-and-tumble play, and in female children, rejection of typically feminine toys, games and activities.

   F. Preference for playmates of the other sex.

   G. Dislike for sexual anatomy. Male children may hate their penis and testes, and female children may dislike urinating sitting.

   H. Desire to acquire the primary and/or secondary sex characteristics of the opposite sex.

2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The subtypes may be ones with or without defects or defects in sexual development.

DSM-V diagnosis in adolescents and adults:

1. A definite mismatch between the assigned gender and experienced/expressed gender for at least six (6) months duration as characterized by at least two (2) or more of the following features:

    A. Mismatch between experienced or expressed gender and gender manifested by primary and/or secondary sex characteristics at puberty.

    B. Persistent desire to rid oneself of the primary or secondary sexual characteristics of the biological sex at puberty.

    C. Strong desire to possess the primary and/or secondary sex characteristics of the other gender.

    D. Desire to belong to the other gender.

    E. Desire to be treated as the other gender.

    F. Strong feeling or conviction that he or she is reacting or feeling in accordance with the identified gender.

2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The subtypes may be ones with or without defects or defects in sexual development.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

HOSPICE

"Hospice" means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse (R.N.), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE BENEFIT PERIOD

"Hospice Benefit Period" means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal Illness, and the Covered Person is accepted into a Hospice program. The period will end the earliest of six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof will be required by the Plan Administrator before a new Hospice Benefit Period can begin.

HOSPITAL

"Hospital" means an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an emergent or Inpatient basis at the patient's expense; and

2. It is licensed as a hospital or a critical access hospital under the laws of the jurisdiction in which the facility is located; and

3. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an Illness or an Injury or provides for the facilities through arrangement or agreement with another hospital; and

4. It provides treatment by or under the supervision of a physician or osteopathic physician with nursing services by registered nurses as required under the laws of the jurisdiction in which the facility is licensed; and

5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and

6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

"Hospital Miscellaneous Expenses" mean the actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services, regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS

"Illness" means a bodily disorder, Pregnancy, disease, physical sickness, Mental Illness, or functional nervous disorder of a Covered Person.

INCURRED EXPENSES OR EXPENSES INCURRED

"Incurred Expenses" or "Expenses Incurred" means those services and supplies rendered to a Covered Person. Such expenses will be considered to have occurred at the time or date the treatment, service or supply is actually provided.

INITIAL ENROLLMENT PERIOD

"Initial Enrollment Period" means the time allowed by this Plan for enrollment when a person first becomes eligible for coverage.

INJURY

"Injury" means physical damage to the Covered Person's body which is not caused by disease or bodily infirmity.

INPATIENT

"Inpatient" means the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT

"Intensive Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

2. It has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

3. It provides constant observation and treatment by Registered Nurses (R.N.'s) or other highly-trained Hospital personnel.

LICENSED HEALTH CARE PROVIDER

"Licensed Health Care Provider" means any provider of health care services who is licensed or certified by any applicable governmental regulatory authority to the extent that services are within the scope of the license or certification and are not specifically excluded by this Plan.

LICENSED PRACTICAL NURSE

"Licensed Practical Nurse" means an individual who has received specialized nursing training and practical nursing experience, and is licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LICENSED PROFESSIONAL COUNSELOR

"Licensed Professional Counselor" means a person currently licensed in the state in which services are rendered to perform mental health counseling in a clinical setting, for Mental Illnesses.

LICENSED SOCIAL WORKER

"Licensed Social Worker" means a person holding a Masters Degree (M.S.W.) in social work and who is currently licensed as a social worker in the state in which services are rendered, and who provides counseling and treatment in a clinical setting for Mental Illnesses.

MAXIMUM LIFETIME BENEFIT

"Maximum Lifetime Benefit" means the maximum benefit payable while a person is covered under this Plan. The Maximum Lifetime Benefit will not be construed as providing lifetime coverage, or benefits for a person's Illness or Injury after coverage terminates under this Plan.

MEDICAID

"Medicaid" means that program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.

MEDICAL POLICY AND DENTAL POLICY

"Medical Policy and Dental Policy" means the policy applied by the Plan Administrator to determine if medical or dental services, including procedures, medication, equipment, processes, and technology meet nationally accepted criteria such as the following:

A. Final approval from the appropriate governmental regulatory agency or agencies.

B. Conclusive scientific evidence of improved health outcome.

C. Compliance with established standards of good medical and dental practice and established coding procedures for insurance reimbursement.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

"Medically Necessary" or "Medical Necessity" means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose an Illness or Injury; and

2. Are ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and

3. Are not primarily for the convenience of the Covered Person, Physician or other Licensed Health Care Provider; and

4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person and are in accordance with the Plan's Medical Policy and Dental Policy; and

5. Are not of an Experimental/Investigational or solely educational nature; and

6. Are not provided primarily for medical or other research; and

7. Do not involve excessive, unnecessary or repeated tests; and

8. Are commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and

9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration (FDA) or Centers For Medicare/Medicaid Services (CMS), pursuant to that entity's program oversight authority based upon the medical treatment circumstances.

MEDICARE

"Medicare" means the programs established under the "Health Insurance for the Aged Act," Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those who are eligible for Medicare Part A, Part B or Part D as a result of age, those with end-stage renal disease, or with disabilities.

MENTAL ILLNESS

"Mental Illness" means a medically recognized psychological, physiological, nervous or behavioral condition, affecting the brain, which can be diagnosed and treated by medically recognized and accepted methods, **but will not include Alcoholism, Chemical Dependency or other addictive behavior**. Conditions recognized by the Diagnostic Statistical Manual (the most current edition) will be included in this definition.

MMSERA

"MMSERA" means the Montana Military Service Employment Rights Act (MMSERA), as amended.

NAMED FIDUCIARY

"Named Fiduciary" means the Plan Administrator which has the authority to control and manage the operation and administration of the Plan.

NEWBORN

"Newborn" refers to an infant from the date of his/her birth until the initial Hospital discharge or until the infant is fourteen (14) days old, whichever occurs first.

OCCUPATIONAL THERAPY

"Occupational Therapy" means a program of care ordered by a Physician which is for the purpose of improving the physical, cognitive and perceptual disabilities that influence the Covered Person's ability to perform functional tasks related to normal life functions or occupations, and which is for the purpose of assisting the Covered Person in performing such functional tasks without assistance.

ORTHODONTIC TREATMENT

"Orthodontic Treatment" means an appliance or the surgical or functional/myofunctional treatment of dental irregularities which either result from abnormal growth and development of the teeth, gums or jaws, or from Injury which requires the positioning of the teeth to establish normal occlusion.

ORTHODONTIST

"Orthodontist" means a Dentist with special training who uses braces or corrective appliances to straighten teeth, correct jaw position and improve facial balance.

ORTHOPEDIC APPLIANCE

"Orthopedic Appliance" means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

OUT-OF-POCKET MAXIMUM

"Out-of-Pocket Maximum" means the maximum dollar amount, as stated in the Schedule of Medical Benefits or Pharmacy Benefit, that any Covered Person or Family will pay in any Benefit Period for covered services, treatments or supplies.

OUTPATIENT

"Outpatient" means a Covered Person who is receiving medical care, treatment, services or supplies at a clinic, a Physician's office, a Licensed Health Care Provider's office or at a Hospital if not a registered bedpatient at that Hospital, Psychiatric Facility or Alcoholism and/or Chemical Dependency Treatment Facility.

PARTIAL HOSPITALIZATION

"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.

PARTICIPANT

"Participant" means an Employee of the State who is eligible and enrolled for coverage under this Plan.

PHYSICAL THERAPY

"Physical Therapy" means a plan of care ordered by a Physician and provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

PHYSICIAN

"Physician" means a person holding the degree of Doctor of Medicine, Dentistry or Osteopathy, or Optometry who is legally licensed as such.

"Physician" does not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

PLACEMENT OR PLACED FOR ADOPTION

"Placement" or "Placed for Adoption" means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

PLAN

"Plan" means the Health Benefit Plan for Employees of the State, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

"Plan Administrator" means the State and/or its designee which is responsible for the day-to-day functions and management of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan. The Plan Administrator may employ persons or firms to process medical, prescription drug, dental or vision claims and perform other Plan-connected services. For the purposes of any applicable state legislation of a similar nature, the State will be deemed to be the Plan Administrator of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan unless the State designates an individual or committee to act as Plan Administrator of the Plan.

PLAN SUPERVISOR

"Plan Supervisor" means the person or firm employed by the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan to provide consulting services to the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan in connection with the operation of the Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan and any other functions, including the processing and payment of claims. The Plan Supervisor provides ministerial duties only, exercises no discretion over Medical Plan, Prescription Drug Plan, Dental Plan or Vision Plan assets and will not be considered a fiduciary as defined by State or Federal law or regulation.

The Plan Supervisor for the Medical Plan is: Allegiance Benefit Plan Management, Inc.

The Plan Supervisor for the Prescription Drug Plan is: Navitus Health Solutions.

The Plan Supervisor for the Dental Plan is: Delta Dental Insurance Company.

The Plan Supervisor for the Vision Plan is: Cigna Vision.

PREGNANCY

"Pregnancy" means a physical condition commencing with conception, and ending with miscarriage or birth.

PREVENTIVE CARE

"Preventive Care" means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, and which is not provided as a result of any Injury or Illness.

PROCEDURE BASED MAXIMUM EXPENSE or PBME

"Procedure Based Maximum Expense" or "PBME" means the maximum amount the Plan will pay under any circumstances for any treatment, service or supply or combination of any treatments, services, or supplies that comprise a procedure covered by this Plan. The PBME will apply to all charges from all providers. The PBME shall be based upon a publicly available payment schedule including Medicare allowable amounts when applicable and other similar schedules in circumstances in which Medicare allowable amounts are inapplicable or unavailable. The specific Procedure Based Maximum Expense for any treatment, service or supply shall be based upon a mathematical formula using a multiple or percentage of the payment schedules referred to above and adopted by the Plan Supervisor and the Plan. In addition, the PBME will be determined based upon the geographical location and other considerations related to each specific provider and based upon the adequacy and quality of specific services and supplies.

The PBME will apply whether a provider agrees to accept the PBME as full payment for the claim or not. Providers who agree, in writing, to accept the PBME as full payment are defined as Participating Providers. Providers who are not Participating Providers will be reimbursed based upon the lowest PBME for a geographic area as established by the Plan based upon the physical location where the Covered Person received services or supplies.

The PBME for Emergency Services will apply to both Participating Providers and non-Participating Providers, but only during the time that the medical Emergency exists and will cease to apply when the Covered Person's condition is stable and no longer emergent. When the PBME for Emergency Services ceases to apply, the PBME for the applicable additional services, if any, will apply.

PROSTHETIC APPLIANCE

"Prosthetic Appliance" means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of Covered Dental Benefit, means any device which replaces all or part of a missing tooth or teeth.

PSYCHIATRIC CARE

"Psychiatric Care," also known as psychoanalytic care, means treatment for a Mental Illness or disorder, a functional nervous disorder, Alcoholism or drug addiction by a licensed psychiatrist, psychologist, Licensed Social Worker or Licensed Professional Counselor acting within the scope and limitations of his/her respective license, provided that such treatment is Medically Necessary as defined by the Plan, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

"Psychiatric Facility" means a licensed institution that provides Mental Illness treatment and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

"Psychologist" means a person currently licensed in the state in which services are rendered as a psychologist and acting within the scope of his/her license.

QMCSO

"QMCSO" means Qualified Medical Child Support Order as defined by Section 609(a) of ERISA, as amended.

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means an Employee, former employee or Dependent of an Employee or former employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA or Section 609(a) of ERISA in relation to QMCSO's.

"Qualified Beneficiary" will also include a child born to, adopted by or Placed for Adoption with an Employee or former employee at any time during COBRA Continuation Coverage.

REGISTERED NURSE

"Registered Nurse" means an individual who has received specialized nursing training and is authorized to use the designation of "R.N." and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

RETIREE

"Retiree" means an Employee who retires under a retirement program authorized by law and eligible to continue coverage with the Employer pursuant to the terms of § 2-18-704, MCA as amended from time to time.

ROOM AND BOARD

"Room and Board" refers to all charges which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SEMI-PRIVATE

"Semi-Private" refers to the class of accommodations in a Hospital or Skilled Nursing Facility in which at least two patient beds are available per room.

SKILLED NURSING FACILITY

"Skilled Nursing Facility" means an institution, or distinct part thereof, which meets all of the following conditions:

1. It is currently licensed as a long-term care facility or skilled nursing facility in the state in which the facility is located;

2. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders; and

3. It is certified by Medicare.

This term also applies to Incurred Expenses in an institution known as a Convalescent Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

SPEECH THERAPY

"Speech Therapy" means a course of treatment, ordered by a Physician, to treat speech deficiencies or impediments.

TELEMEDICINE

"Telemedicine" means the practice of medicine by electronic means, only for the purposes of diagnosis, providing medical advice and treatment to the Covered Person (patient), requiring direct contact between the Covered Person's (patient's) Licensed Health Care Provider and other Licensed Health Care Providers or entities in a different location. The Covered Person's (patient's) direct participation or physical presence is not a prerequisite for coverage if there is documentation that the consultation was conducted on behalf of the Covered Person for the purpose of diagnosing, providing medical advice or treatment to the Covered Person (patient).

URGENT CARE FACILITY

"Urgent Care Facility" means a free-standing facility which is engaged primarily in diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention. A clinic or office located in or in conjunction with or in any way made a part of a Hospital will be excluded from the terms of this definition.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act, as amended.

NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT: Group health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable.

WOMEN'S HEALTH AND CANCER RIGHTS ACT: Did you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your Plan Administrator for more information.

HIPAA PRIVACY AND SECURITY STANDARDS

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

"Protected Health Information" (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to the physical or mental health of an individual, health care that individual has received, or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an Employer.

"Summary Health Information" means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the ZIP Code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or plan participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Documents have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law. Such uses or disclosures may be for the purposes of Plan administration including, but not limited to, the following:

    A. Operational activities such as quality assurance and utilization management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.

    B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for Medical Necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.

    C. For purposes of this certification, Plan administration does not include disclosing Summary Health Information to help the Plan Sponsor obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a Participant in; is an enrollee of or has disenrolled from the group health plan.

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

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;

6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;

7. Make available the PHI required to provide an accounting of disclosures as required by the regulations;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;

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

10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document or employees designated by the Plan Administrator(s) who need to know that information to perform Plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan Documents have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.

2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.

3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.

4. Report to the Plan Administrator or the Named Fiduciary of the Plan any attempted breach, or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

WRAP PLAN DOCUMENT
FOR MEDICAL, PRESCRIPTION DRUG,
DENTAL AND VISION BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF STATE OF MONTANA
PLAN SUMMARY

The following information, together with the information contained in this booklet, form the Wrap Plan Document.

1. PLAN

The name of the Plan is the WRAP PLAN DOCUMENT FOR MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION BENEFITS FOR EMPLOYEES, RETIREES AND DEPENDENTS OF STATE OF MONTANA, which Wrap Plan Document describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Employees, referred to as “Participants,” and the eligible Dependents of such Participants, and Retirees and their eligible Dependents.

2. PLAN BENEFITS

This Wrap Plan Document together with the Summary Plan Descriptions provide benefits for Eligible Expenses Incurred by eligible Participants for:

Hospital, Surgical, Medical, Maternity, Prescription Drug, Dental, Vision and other eligible medical or dental related necessary expenses.

3. PLAN EFFECTIVE DATE

This Wrap Plan Document was established effective January 1, 1979 and restated January 1, 2017.

4. PLAN SPONSOR

Name: State of Montana
Phone: (406) 444-7462 or (800) 287-8266
Address: 100 N. Park St. Suite 320
P.O. Box 200130
Helena, MT 59620

5. PLAN ADMINISTRATOR

The Plan Administrator is the Plan Sponsor.

6. NAMED FIDUCIARY

Name: State of Montana
Phone: (406) 444-7462 or (800) 287-8266
Address: 100 N. Park St. Suite 320
P.O. Box 200130
Helena, MT 59620

7. PLAN FISCAL YEAR

The Plan fiscal year ends December 31.

8. PLAN TERMINATION

The right is reserved by the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

9. IDENTIFICATION NUMBER

Group Number: 3000900
Employer Identification Number: 81-0302402

10. PLAN SUPERVISOR FOR MEDICAL BENEFITS

Name: Allegiance Benefit Plan Management, Inc.
Address: P.O. Box 3018
Missoula, MT 59806

11. PLAN SUPERVISOR FOR PRESCRIPTION DRUG BENEFITS

Name: Navitus Health Solutions
Address: P.O. Box 999
Appleton, WI 54912-0999

12. PLAN SUPERVISOR FOR DENTAL BENEFITS

Name: Delta Dental Insurance Company
Address: 1130 Sanctuary Parkway
Alpharetta, GA 30009

13. PLAN SUPERVISOR FOR VISION BENEFITS

Name: Cigna Vision
Address: P.O. Box 997561
Sacramento, CA 95899-7561

14. ELIGIBILITY

Employees and their eligible Dependents and Retirees and their eligible Dependents of the Plan Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

15. PLAN FUNDING

The Plan is funded by contributions from the Employer and Employees.

16. AGENT FOR SERVICE OF LEGAL PROCESS

The Plan Administrator is the agent for service of legal process.

****

APPENDIX A

SUMMARY PLAN DESCRIPTION
FOR MEDICAL PLAN BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF

STATE OF MONTANA

Appendix A

Summary Plan Description
describes the Medical Plan Benefits
in effect as of January 1, 2017

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SCHEDULE OF MEDICAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND PROCEDURE BASED MAXIMUM EXPENSE (PBME)

THE BENEFIT PERIOD IS A CALENDAR YEAR

COST SHARING PROVISIONS	
DEDUCTIBLE (Applies to all benefits unless specifically indicated as waived) Per Covered Person per Benefit Period	$1,000
BENEFIT PERCENTAGE (Applies to all benefits unless specifically stated otherwise) Before satisfaction of Out-of-Pocket Maximum After satisfaction of Out-of-Pocket Maximum	75% 100%

COPAYMENTS

Copayments apply as specifically stated in this Schedule of Medical Benefits and are payable by the Covered Person. 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 no longer apply for the remainder of the Benefit Period.

Copayments apply only to those charges billed for the provider's office visit services for evaluation and management (the consultation and examination in the physical presence of the provider in an office, clinic or other outpatient setting). Additional charges for services that are performed at the time of the visit, together with any additional charges that are incurred in conjunction with the office visit, e.g., diagnostic lab, office surgery, diagnostic miscellaneous testing, injections, are subject to the applicable Deductible and Benefit Percentage.

"Primary Care Physician" includes Family Practice, General Practice, Internal Medicine, OB/Gyn (obstetrics/gynecology), Pediatrician, Licensed Nurse Practitioner or Physician Assistant or Naturopath.

"Specialty Care Physician" includes any Physician who is practicing any branch of medicine or medical specialty other than Family Practice, General Practice, Internal Medicine, OB/Gyn (obstetrics/gynecology), Pediatrician, Licensed Nurse Practitioner or Physician Assistant or Naturopath.

OUT-OF-POCKET MAXIMUM Per Covered Person per Benefit Period Per Family per Benefit Period	$4,000 $8,000

Includes the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not apply to the Medical Benefits Annual Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments apply toward the applicable Pharmacy Benefit Out-of-Pocket Maximum, except for Tier 3 and Non-Preferred Specialty Copayments. Tier 3 and Non-Preferred Specialty Copayments do not accrue to the Out-of-Pocket Maximum and will never be payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum.

COST SHARING PROVISIONS	
NON-PARTICIPATING PROVIDERS OUTSIDE OF MONTANA	
Deductible	$1,500
Benefit Percentage before satisfaction of Out-of-Pocket Maximum	65%
Benefit Percentage after satisfaction of Out-of-Pocket Maximum	100%
Out-of Pocket Maximum per Covered Person	$4,950
Out-of Pocket Maximum per Family	$10,900
Applies to all benefits unless specifically stated otherwise and subject to all Plan provisions, limitations and exceptions based upon the Summary Plan Description.	
MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES	None
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	None

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
ACCIDENTAL INJURY BENEFIT	
	75% after Deductible
ACUPUNCTURE TREATMENT	
	100% after $25 Copayment
Benefit Limits: Twenty (20) days maximum combined with Acupuncture and Chiropractor Benefit per Benefit Period	
ADVANCED RADIOLOGY IMAGING (MRI, MRA, CT, PET imaging, etc.)	
	75% after Deductible
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY	
Inpatient Facility Services	75% after Deductible
Inpatient Professional Provider Services	75% after Deductible
Outpatient Facility Services	75% after Deductible
Office Visit Services	100% after $25 Copayment
Outpatient Professional Provider Services (except for office visit consultation and examination)	75% after Deductible
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If you choose not to obtain Pre-certification, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
ALLERGY TREATMENT	
Office Visit Services	100% after $25 Copayment
Allergy Injections without Office Visit	75% after Deductible
Diagnostic Testing and Injections	75% after Deductible
Outpatient Professional Provider Services (except for office visit consultation and examination)	75% after Deductible
AMBULANCE SERVICE	
Medical Emergency Only	
Air Ambulance	75% after Deductible
Ground Ambulance	75% after Deductible
AMBULATORY SURGICAL CENTER	
	75% after Deductible
Pre-treatment Review by the Plan is strongly recommended for certain surgeries. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
AUTISM SPECTRUM DISORDER (ASD) AND/OR DOWN SYNDROME	
Includes certain treatments associated with Autism Spectrum Disorder (ASD) and/or Down Syndrome for Dependent children eighteen (18) years of age or younger	75% after Deductible
BARIATRIC SURGERY	
	No Benefit
BIRTHING CENTER	
Licensed Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
CARDIAC REHABILITATION THERAPY - OUTPATIENT	
	100% after $25 Copayment
CHEMOTHERAPY - OUTPATIENT	
Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
CHIROPRACTIC CARE	
	100% after $25 Copayment
Benefit Limits: Twenty (20) days Maximum combined with Acupuncture and Chiropractor Benefit per Benefit Period. Chiropractic x-rays and any additional charges for services that are performed at the time of the visit or additional charges that are incurred in conjunction with the office visit are subject to the applicable Deductible and Benefit Percentage.	
COLONOSCOPY	
First Colonoscopy Regardless of Diagnosis Per Benefit Period	100%, Deductible Waived
Additional Colonoscopy per Benefit Period	75% after Deductible
COMPLEX CARE AND TRANSITIONAL CARE MANAGEMENT	
	100%, Deductible Waived
CONTRACEPTIVES (Including Contraceptive Management)	
Administered during office visit	100%, Deductible Waived
Self-Administered - See Pharmacy Benefit for details	
DENTAL SERVICES	
As a result of Accidental Injury	75% after Deductible
DIABETIC EDUCATION	
	100%, Deductible Waived
Benefit Limits: Three (3) visits Maximum combined with Diabetic Education and Nutritional Counseling per Benefit Period	
DIAGNOSTIC TESTS - OUTPATIENT	
Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
DIALYSIS TREATMENTS - OUTPATIENT	
	75% after Deductible
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
EMERGENCY ROOM SERVICES	
Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
HEARING AIDS	
	No Benefit
HEARING SCREENING (Non-PPACA)	
	No Benefit
HOME HEALTH CARE	
	75% after Deductible
Benefit Limits: Seventy (70) days Maximum Benefit per Benefit Period.	
Pre-treatment Review by the Plan is strongly recommended for all Home Health Care Services. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
HOSPICE CARE	
Includes Bereavement Counseling	75% after Deductible
Pre-certification by the Plan is strongly recommended for all Hospice Care Services. If you choose not to obtain Pre-certification, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
HOSPITAL SERVICES	
Inpatient Facility Services Inpatient Room and Board limited to average semi-private room	75% after Deductible
Inpatient Professional Provider Services	75% after Deductible
Outpatient Facility Services	75% after Deductible
Outpatient Professional Provider Services	75% after Deductible
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If you choose not to obtain Pre-certification, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted. **Pre-treatment Review by the Plan is strongly recommended for certain surgeries. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.**	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
INFERTILITY TREATMENT	
Diagnostic Services Only	75% after Deductible
Pre-treatment Review by the Plan is strongly recommended. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
INFUSION SERVICES - OUTPATIENT	
	75% after Deductible
Pre-treatment Review by the Plan is strongly recommended. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
MAMMOGRAMS	
Routine Mammograms	100%, Deductible Waived
Diagnostic Mammograms	100%, Deductible Waived
MASSAGE THERAPY	
	No Benefit
MEDICAL EQUIPMENT/SUPPLIES	
Durable Medical Equipment	75% after Deductible
Prosthetic Appliances	75% after Deductible
Orthopedic Devices	75% after Deductible
Other Medical Supplies	75% after Deductible
Pre-treatment Review by the Plan is strongly recommended for any item for charges exceeding $2,500. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
MENTAL ILLNESS	
Inpatient Facility Services	75% after Deductible
Inpatient Professional Provider Services	75% after Deductible
Outpatient Facility Services	75% after Deductible
Office Visit Services	100% after $25 Copayment
Outpatient Professional Provider Services	75% after Deductible
Pre-certification by the Plan is strongly recommended for all Inpatient Services. If you choose not to obtain Pre-certification, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
NATUROPATHY/HOMEOPATHIC	
Office Services	100% after $25 Copayment
Ancillary charges (diagnostic lab, office surgery, diagnostic miscellaneous testing, etc.)	75% after Deductible
Preventive Care Services performed by a Naturopathic / Homeopathic Provider	100%, Deductible Waived
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 are not covered as Preventive Care and are subject to the cost sharing that applies to those specific services.	
NON-AMBULANCE TRAVEL BENEFIT FOR ORGAN AND TISSUE TRANSPLANT SERVICES	
	75% after Deductible
Benefits are payable up to $10,000 Maximum Benefit per Transplant, limited to the following: If driving, IRS standard mileage rate reimbursement. Coach airfare. Lodging not to exceed $140 per day. Meals limited to $63 per day per person. **This benefit is available to the patient and one companion and is 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.**	
NUTRITIONAL COUNSELING	
	100%, Deductible Waived
Benefit Limits: Three (3) visits Maximum combined with Diabetic Education and Nutritional Counseling per Benefit Period.	
OBESITY	
Non-Surgical and Non-Pharmaceutical Treatment	
Office Visit Services	100% after $25 Copayment
Dietary and Nutritional Counseling	100%, Deductible Waived
Benefit Limits: Three (3) visits Maximum for Dietary and Nutritional Counseling when Medically Necessary (approved diagnosis code only) per Benefit Period.	
OCCUPATIONAL THERAPY - OUTPATIENT	
	100% after $25 Copayment

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
OFFICE VISIT	
Primary Care Physician	100% after $25 Copayment
Specialist Physician	100% after $35 Copayment
Ancillary charges (diagnostic lab, office surgery, diagnostic miscellaneous testing, etc.)	75% after Deductible
Office Visit includes Telemedicine services. See Medical Benefits for details.	
ORGAN AND TISSUE TRANSPLANT SERVICES	
Center of Excellence Only	75% after Deductible

Benefit Limits:

Maximum Benefit for each Procedure:

Allogenic Stem Cell (related)	$250,000
Allogenic Stem Cell (unrelated)	$340,000
Autologous Stem Cell	$140,000
Stem Cell Other	$230,000
Heart	$275,000
Heart Lung	$345,000
Intestine	$485,000
Kidney	$95,000
Kidney Pancreas	$160,000
Liver	$220,000
Lung	$275,000
Pancreas	$140,000
Solid Other	$440,000
Other Eligible Transplant or Replacement Procedure	$75,000

Benefit limits apply to all expenses in connection with any eligible organ or tissue transplant procedure as stated in Medical Benefits section under Organ and Tissue Transplant Services.

Services subject to the benefit limits include, but are not limited: evaluation; pre-transplant, transplant and post-transplant care (not including outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. Charges for services incurred after such 12-month period are eligible under the Medical Benefits of this Plan and do not accrue toward the Transplant benefit limits.

Amounts exceeding the maximum case rate at contracted Center of Excellence (also known as outliers) is eligible for reimbursement under Medical Benefits.

Pre-certification by the Plan is strongly recommended for all Inpatient Services. If you choose not to obtain Pre-certification, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
ORTHOTICS (Foot)	
	75% after Deductible
Coverage is limited to diagnosis of diabetes.	
PHYSICAL THERAPY - OUTPATIENT	
	100% after $25 Copayment
PREGNANCY/MATERNITY SERVICES	
See Preventive Care Benefit for well-women prenatal visits	
Office Visit (if not part of a global charge)	100% after $25 Copayment
Outpatient Facility Services (if billed as global fee)	75% after Deductible
Inpatient Facility Services	75% after Deductible
Inpatient Professional Provider Services	75% after Deductible
PRESCRIPTION DRUGS	
See Pharmacy Benefit for Details	
PREVENTIVE CARE	
	100%, Deductible Waived
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 are not covered as Preventive Care and are subject to the cost sharing that applies to those specific services.	
PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY	
	No Benefit
PROSTATE CANCER SCREENING, PROSTATE SPECIFIC ANTIGEN (PSA) TESTING	
	100%, Deductible Waived
RADIATION THERAPY - OUTPATIENT	
Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
Pre-treatment Review by the Plan is strongly recommended for Outpatient Services. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
RESIDENTIAL TREATMENT	
	75% after Deductible
Benefit Limits: Seventy (70) days Maximum Benefit per Benefit Period.	
Pre-certification by the Plan is strongly recommended for all Residential Treatment charges. If you choose not to obtain Pre-certification, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
RESPIRATORY THERAPY - OUTPATIENT	
	75% after Deductible
ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE	
	100%, Deductible Waived
Applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.	
SKILLED NURSING FACILITY	
	75% after Deductible
Benefit Limits: Seventy (70) days Maximum Benefit per Benefit Period.	
Pre-certification by the Plan is strongly recommended for all Skilled Nursing Facility charges. If you choose not to obtain Pre-certification, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
SPEECH THERAPY - OUTPATIENT	
	100% after $25 Copayment
STERILIZATION PROCEDURES	
Female Sterilization Procedures	100%, Deductible Waived
Vasectomy	75% after Deductible
SURGERY - OUTPATIENT	
Facility Services	75% after Deductible
Professional Provider Services	75% after Deductible
Pre-treatment Review by the Plan is strongly recommended for certain surgeries. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT (Applies for all in-state and out-of-state Participating Providers)
SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES	
	75% after Deductible
Benefit Limits: Maximum Benefit per Implant for the following: $40,000 for Orthopedic Implants $60,000 for Cardiac Implants (except for LVAD and RVAD) $85,000 for Cochlear Implants $200,000 for LVAD / RVAD Implants Benefit limits apply to any implantable device and all supplies associated with that implantable device.	
Pre-treatment Review by the Plan is strongly recommended for all implant procedures. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
TMJ/JAW DISORDERS	
Surgical Treatment and Procedure	75% after Deductible
Benefit Limits: $10,000 Maximum Lifetime Benefit	
Non-Surgical Treatment and Procedure	No Benefit
Pre-treatment Review by the Plan is strongly recommended. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.	
URGENT CARE FACILITY	
Office Visit Services	100% after $35 Copayment
Ancillary charges (diagnostic lab, office surgery, diagnostic miscellaneous testing, etc.)	75% after Deductible
VISION SERVICES	
Non-routine treatment as a result of an Accidental Injury or medical condition	75% after Deductible
VOLUNTARY SECOND AND THIRD SURGICAL OPINION BENEFIT	
	100%, Deductible Waived
WEIGHT LOSS PROGRAMS	
	No Benefit
WELL-CHILD CARE - SEE PREVENTIVE CARE	
	100%, Deductible Waived

MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

Services, treatments or supplies are eligible for coverage if they meet all of the following requirements:

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider;

2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary;

3. Charges do not exceed the Eligible Expense of the Plan; and

4. They are not excluded under any provision or section of this Plan.

Treatments, services or supplies excluded by this Plan may be reimbursable if such charges are approved by the Plan Administrator prior to beginning such treatment. Prior approval is limited to medically accepted, non-experimental or investigational treatments, services, or supplies, which, in the opinion of the Plan Administrator, at the Plan Administrator's discretion, are more cost effective than a covered treatment, service or supply for the same Illness or Injury, and which benefit the Covered Person.

DEDUCTIBLE

The Deductible applies to Eligible Expenses Incurred during each Benefit Period, unless specifically waived. The Deductible applies only once for each Covered Person within a Benefit Period. **An individual Covered Person may not receive credit toward the Family Deductible for more than the Individual Annual Deductible as stated in the Schedule of Medical Benefits.**

BENEFIT PERCENTAGE

The Benefit Percentage is stated in the Schedule of Medical Benefits. The Plan will pay the Benefit Percentage of the Eligible Expense indicated.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, is stated in the Schedule of Medical Benefits and includes amounts applied toward the Deductible, amounts in excess of the Benefit Percentage paid by the Plan and all applicable Copayments for Medical Benefits. Expenses Incurred in a single Benefit Period after satisfaction of the Out-of-Pocket Maximum per Covered Person or per Family, whichever is applicable, is paid at 100% of the Eligible Expense for the remainder of the Benefit Period. **An individual Covered Person may not receive credit toward the Family Out-of-Pocket Maximum for more than the Individual Out-of-Pocket Maximum as stated in the Schedule of Medical Benefits.**

COPAYMENT

Copayments are stated in the Schedule of Medical Benefits. Copayments are first-dollar amounts that are payable for certain covered services under the Plan which are usually paid at the time the service is performed (e.g., Physician office visits or urgent care visits). These Copayments do not apply towards the Medical Benefits Deductible but apply towards the Medical Benefits Out-of-Pocket Maximum, and after the Out-of-Pocket Maximum is satisfied, Copayments no longer apply for the remainder of the Benefit Period.

MAXIMUM BENEFIT

The amount payable by the Plan may not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Medical Benefits, for any reason.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

Deductibles are applied to Eligible Expenses Incurred in the chronological order in which they are adjudicated by the Plan. Eligible Expenses Incurred are paid by the Plan in the chronological order in which they are adjudicated by the Plan. The manner in which the Deductible is applied and Eligible Expenses are paid by the Plan is conclusive and binding on all Covered Persons and their assignees.

CHANGES IN COVERAGE CLASSIFICATION

A change in coverage that decreases a benefit of this Plan becomes effective on the stated effective date of such change with regard to all Covered Persons to whom it applies.

NEW YORK STATE EXPENSES

This Plan has voluntarily elected to make public goods payments directly to the Office of Pool Administration in conformance with HCRA provisions and New York State Department of Health (Department) requirements.

MEDICAL BENEFITS

The following Medical Benefits are payable as stated in the Schedule of Medical Benefits subject to any benefit maximums specifically stated in the Schedule of Medical Benefits and all terms and conditions of this SPD.

1. Charges for services and supplies furnished by a Birthing Center.

2. Charges for the services of a licensed Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.

   Charges are eligible for drugs intended for use in a physicians' office or settings other than home use that are billed during the course of an evaluation or management encounter.

3. Charges for Pregnancy or maternity, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy.

4. Charges for Registered Nurses (R.N.s) or Licensed Practical Nurses (L.P.N.s) for private duty nursing.

5. Charges for midwife services by a Certified Nurse Midwife (CNM) who is a registered nurse and enrolled in either the certification maintenance program or the continuing competency assessment program through the American College of Nurse Midwives (ACNM).

   "Certified Nurse Midwife" means an individual who has received advanced nursing training and is authorized to use the designation of "CNM" and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

6. Charges for Ambulance Service to the nearest facility where Emergency care or treatment may be rendered; or from one facility to another for care. **The Plan does not pay for Ambulance Service from the facility to the patient's home.**

7. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs not available through the Pharmacy Benefit regardless of Medical Necessity and FDA approved over-the-counter female contraceptives prescribed by a Physician or Licensed Health Care Provider.

   Conditions of coverage for outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Pharmacy Benefit section of the Plan.

8. Charges for x-rays and laboratory tests.

9. Charges for radiation therapy or treatment and chemotherapy.

   Pre-treatment Review by the Plan is strongly recommended for radiation therapy or treatment and chemotherapy services. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

10. Charges for blood transfusions, blood processing costs, blood transport charges, blood handling charges, administration charges, and the cost of blood, plasma and blood derivatives. Any credit allowable for replacement of blood plasma by donor or blood insurance is deducted from the total Eligible Expense.

11. Charges for oxygen and other gases and their administration.

12. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.

13. Charges for the cost and administration of an anesthetic.

14. Charges for voluntary vasectomy for Participant and Dependent spouse only. Charges for sterilization procedures for females are covered under the Preventive Care Benefit.

15. Reasonable charges for producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Charges that exceed limits for such charges imposed by applicable law may not be deemed to be reasonable.

16. Charges for Contraceptive Management, regardless of Medical Necessity.

    "Contraceptive Management" means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation or placement of any contraceptive device. Charges for removal of contraceptive devices are covered regardless of Medical Necessity and are payable under the Preventive Care Benefit.

17. Charges for acupuncture treatment provided by a legally qualified provider practicing within the scope of his or her license. **Benefit maximums apply as stated in the Schedule of Medical Benefits.**

18. Charges for naturopathy or homeopathic treatment provided by a legally qualified provider practicing within the scope of their license.

19. Charges for allergy treatment including; office visit, diagnostic testing and injections.

20. Charges for respiratory therapy.

21 Charges for Orthotics for Covered Persons diagnosed with diabetes when prescribed by a Physician.

22. Charges for "Routine Patient Costs" for a Phase I "Approved Clinical Trial" for "Qualified Individuals".

    "Routine Patient Costs" include but are limited to Medically Necessary services which a Covered Person with the identical diagnosis and current condition may receive even in the absence of participating in an Approved Clinical Trial.

    "Routine Patient Costs" do not include any investigational item, device or service that is part of the Approved Clinical Trial; an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or an item or service customarily provided and paid for by the sponsor of an Approved Clinical Trial.

    "Approved Clinical Trial" means a Phase I clinical trial that is conducted in relation to the prevention, detection, or treatment of an acutely life-threatening disease state and is not designed exclusively to test toxicity or disease pathophysiology. The Approved Clinical Trial must be:

    A. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;

    B. Exempt from obtaining an investigational new drug application; or

C. Approved or funded by:

1) The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services or a cooperative group or center of any of the entities described above;
2) A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
3) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
4) The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:

a) Be comparable to the system of peer review of studies and investigations used by the national institutes of health; and
b) Provide unbiased scientific review by individuals who have no interest in the outcome of the review.

A "Qualified Individual" is a Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of an acutely life-threatening disease state and either (i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

23. Charges for services for Complex Care Coordination and Transitional Care Management, based on specific CPT Codes for those services as approved by Medicare, and are not subject to the Medical Necessity requirements of the Plan.

24. Charges for services that are related to or as a result of Telemedicine, limited to the following methods:

A. An interactive patient encounter between the Physician or Licensed Health Care Provider being consulted and the patient. This method requires a "live" two way video and audio transmission between the patient and the Physician or Licensed Health Care Provider, and may include one additional provider who is presenting the patient to a specialist for an opinion regarding the patient's condition. **Expenses billed for the use of equipment or transmission charges to transmit the audiovisual information are not covered.**

B. Storing and forwarding medical documentation to a licensed Radiologist or Pathologist for the purpose of reviewing telecommunicated medical documentation at a time which is convenient to the Radiologist or Pathologist's schedule. This method does not require actual contact between the patient and the provider. **Expenses billed for the use of equipment or transmission charges to transmit the audiovisual information are not covered.**

Telemedicine does not include charges for teleconsultations, which involves a practitioner seeking advice from a consultant concerning a patient's condition or course of treatment.

25. Charges for the initial purchase of eyeglasses or contact lenses following cataract surgery or aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

ADVANCED RADIOLOGY IMAGING

Coverage includes charges for Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT) and Computed Tomography(CT) imaging or other similar advanced radiology imaging tests.

ALCOHOLISM AND/OR CHEMICAL DEPENDENCY

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary 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, including aftercare, at an Alcoholism and/or Chemical Dependency Treatment 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.

AMBULATORY SURGICAL CENTER

Coverage includes charges made by an Ambulatory Surgical Center when treatment has been rendered.

CARDIAC REHABILITATION THERAPY

Charges for cardiac rehabilitation are payable as specifically stated in the Schedule of Medical Benefits. Coverage includes charges for cardiac rehabilitation services rendered by a recognized cardiac rehabilitation program, subject to the following requirements:

1. The Covered Person must be recovering from a myocardial infarction or cardiac surgery or be suffering from angina pectoris;

2. The Covered Person must be accepted by, and have a written referral from their attending Physician to a cardiac rehabilitation program.

CHIROPRACTIC CARE

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Coverage under this benefit includes charges for Chiropractic Treatment by a legally qualified chiropractor practicing within the scope of his or her license. Services include office visits, spinal adjustments and radiology for diagnosis, evaluation and treatment planning for musculoskeletal conditions.

Services are excluded for Emergency care, Preventive Care, maintenance care of a stable condition without symptomatic complaints and radiology for therapeutic purposes.

COLONOSCOPY BENEFIT

Charges are payable as specifically stated in the Schedule of Benefits. Coverage under this benefit includes Physician, anesthesiologist, lab and facility charges related to a colonoscopy ordered for routine screening or diagnostic purposes, such as lab, tissue removal or follow-up care.

DENTAL SERVICES - ACCIDENTAL INJURY

Coverage includes charges for dental treatment required because of Accidental Injury to natural teeth. Such expenses must be Incurred within twelve (12) months of the date of accident except in the event that it is not medically feasible for service to be completed within that time frame because of the age of the Covered Person or because of the healing process of the Injury. Coverage may not in any event include charges for treatment for the repair or replacement of a denture.

DIABETIC EDUCATION BENEFIT

Benefit maximums apply as stated in the Schedule of Medical Benefits. Coverage under this benefit includes diabetic outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes. A family member who is the primary care giver may attend the training on behalf of the Covered Person with diabetes.

DIALYSIS TREATMENTS - OUTPATIENT

Coverage under this benefit includes charges for services and supplies related to renal dialysis done on an Outpatient basis.

In order to avoid or reduce liability for amounts not covered by the Plan, a Covered Person who is diagnosed with End Stage Renal Disease (ESRD) shall immediately follow these steps:

1. Notify Plan Supervisor when you are diagnosed with ESRD by your doctor.

2. Notify Plan Supervisor if or when you begin to receive dialysis treatments.

3. Enroll in Medicare Part A and Part B and use a provider that accepts Medicare patients to prevent the Covered Person from being billed for amounts in excess of the benefit amounts stated in the Schedule of Medical Benefits.

4. Failure to use a provider that accepts Medicare patients may result in significant costs to the Covered Person for fees that will not be covered by the Plan.

5. Medicare Part A or Part B is considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits. **The Plan shall only pay the amount that Medicare may not have covered, even if the Covered Person did not elect to be covered under Medicare.**

Pre-treatment Review is strongly recommended for Outpatient Renal Dialysis. Failure to obtain Pre-treatment Review may result in significant out-of-pocket expenses not covered by the Plan.

GENDER IDENTITY DISORDER/GENDER DYSPHORIA SERVICES

Coverage includes charges for Medically Necessary surgical and non-surgical treatment such as:

1. Psychotherapy;

2. Continuous hormone replacement therapy and corresponding testing to monitor the safety; or

3. Surgical treatment.

Expenses for treatment of Gender Identity Disorder are covered to the same extent as would be covered if the same covered service was rendered for another medical condition. Treatment is subject to all Plan provisions including applicable Deductibles, Copayments and Benefit Percentage.

Certain services are excluded from coverage under the Medical Benefits Exclusion section of the Plan. It is important to review those exclusions.

Pre-treatment Review is strongly recommended for treatment of Gender Identity/Gender Dysphoria. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

HOME HEALTH CARE BENEFIT

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Coverage under this benefit includes charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan for the following services:

1. Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

2. Home health aides; and

3. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

“Home Health Care Agency” means an organization that provides skilled nursing services and therapeutic services (home health aide services, physical therapy, occupational therapy, speech therapy) on a visiting basis, in a place of residence used as the Covered Person’s home. The organization must be Medicare certified and licensed within the state in which home health care services are provided.

“Home Health Care Plan” means a program for continued care and treatment administered by a Medicare certified and licensed Home Health Care Agency, for the Covered Person who may otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility or following termination of a Hospital confinement as an Inpatient and is the result of the same related condition for which the Covered Person was hospitalized and is approved in writing by the Covered Person's attending Physician.

Home Health Care specifically excludes the following:

1. Services and supplies not included in the approved Home Health Care Plan;

2. Services of a person who ordinarily resides in the home of the Covered Person, or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services;

3. Services of any social worker;

4. Transportation services;

5. Housekeeping services; and

6. Custodial Care.

Pre-treatment Review by the Plan is strongly recommended. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

HOSPICE CARE SERVICES

Coverage includes charges made by a Hospice within any one Hospice Benefit Period for:

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area;

2. Nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a public health nurse who is under the direct supervision of a Registered Nurse;

3. Physical Therapy and Speech Therapy, when rendered by a licensed therapist;

4. Medical supplies, including drugs and biologicals and the use of medical appliances;

5. Physician's services;

6. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician; and

7. Bereavement counseling.

HOSPITAL SERVICES

Coverage includes charges made by a Hospital for:

1. Daily Room and Board in a Semi-Private Room (or private room if no Semi-Private room is available or when confinement in a private room is Medically Necessary) and general nursing services, or confinement in an Intensive Care Unit, not to exceed the applicable limits shown in the Schedule of Medical Benefits;

2. Medically Necessary Hospital Miscellaneous Expenses other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use for an Emergency only, Physical Therapy treatments, hemodialysis, and x-ray;

3. Nursery neonatal units, general nursing services, including Hospital Miscellaneous Expenses for services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities or premature delivery incurred by a Newborn Dependent; and

4. Therapy which has been prescribed by a speech pathologist or Physician and includes a written treatment plan with estimated length of time for therapy.

   Treatment rendered for stuttering or for behavioral, developmental or learning disorders is excluded.

INBORN ERRORS OF METABOLISM

Coverage under this benefit includes charges for treatment under the supervision of Physician for inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism, and for which medically standard methods of diagnosis, treatment and monitoring exist. Benefits included expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment including, but not limited to, clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

"Medical Foods" means any nutritional substances in any form that are:

1. Formulated to be consumed or administered enterally under supervision of Physician;

2. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;

3. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

4. Essential to optimize growth, health, and metabolic homeostasis.

INFUSION SERVICES - OUTPATIENT

Coverage includes charges for home and Outpatient infusion services ordered by a Physician and provided by a Home and Outpatient Infusion Therapy Organization licensed and approved within the state in which the services are provided. A "Home and Outpatient Infusion Therapy Organization" is a health care facility that provides home and Outpatient infusion therapy services and skilled nursing services. Home and Outpatient infusion therapy services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a Home and Outpatient Infusion Therapy Organization. Services also include education for the Covered Person, the Covered Person's care giver, or a family member. Home and Outpatient infusion therapy services include pharmacy, supplies, equipment and skilled nursing services when billed by a Home and Outpatient Infusion Therapy Organization.

Skilled nursing services billed by a home health agency are covered under the Home Health Care Benefit.

Pre-treatment Review by the Plan is strongly recommended. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

MAMMOGRAM BENEFIT

Coverage under this benefit includes professional provider, radiology and facility charges related to a mammogram ordered for routine screening or diagnostic purposes.

MEDICAL EQUIPMENT/SUPPLIES

Coverage includes charges for Durable Medical Equipment, Orthopedic Appliances, Prosthetic Appliances and other medical equipment as follows:

1. Rental of, up to the purchase price of, a wheelchair, Hospital bed, respirator or other Durable Medical Equipment required for therapeutic use or the purchase of this equipment if economically justified, whichever is less. If the purchase is not medically feasible, rental charges are paid without limitation based upon purchase price;

2. Purchase of Orthopedic Appliances or Prosthetic Appliances including, but not limited to, artificial limbs, eyes, larynx;

3. Replacement or repair of Durable Medical Equipment, Orthopedic Appliances, Prosthetic Appliances;

4. Medical supplies such as dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies; and

5. Rental of oxygen (O2) concentrators. Purchase of O2 concentrators is not covered.

Diabetic supplies are eligible for coverage under the Pharmacy Benefit of this Plan, including calibration liquid, insulin, lancet devices, lancets, blood glucose meters, pen needles, syringes, blood glucose test strips and ketone test strips.

Pre-treatment Review of charges for Medical Equipment that may exceed $2,500 is strongly recommended. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

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;

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; and

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.

NON-AMBULANCE TRAVEL BENEFIT (For Other Than Organ and Tissue Transplant)

Prior authorization is required.

This benefit is available to the Participant only in situations for which the Plan Supervisor determines:

1. There is no contracted provider that provides services within fifty (50) miles of the Covered Person’s primary residence as determined by Google Maps; and

2. The nearest contracted provider that the Plan Supervisor, in its sole discretion, determines provides equivalent and medically required services; and

3. Only if the Plan Supervisor, in its sole discretion, determines that the Covered Person would not have traveled to that contracted provider in any event in the absence of this benefit.

   Travel expenses include, but are limited to:

   A. The current IRS medical travel reimbursement mileage rate for automobile travel;

   B. Coach airfare if air travel is determined to be necessary by the Plan Supervisor;

   C. Overnight accommodations as determined to be necessary by the Plan Supervisor limited to $140 per night; and

   D. Meals determined to be necessary by the Plan Supervisor limited to a maximum of $63 per day.

OBESITY / NUTRITIONAL COUNSELING

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Charges for treatment rendered by a registered dietician or other Licensed Healthcare Provider for individuals with medical conditions that require a special diet. Such conditions include, but may not be limited to; diabetes mellitus, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, hyperlipidemias and obesity (approved diagnosis code only) when Medically Necessary.

OCCUPATIONAL THERAPY - OUTPATIENT

Coverage includes charges for Occupational Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Occupational Therapy must be ordered by a Physician and rendered by a licensed occupational therapist.

Treatment rendered for stuttering or for behavioral, developmental or learning disorders is excluded.

ORGAN AND TISSUE TRANSPLANT SERVICES

Coverage includes charges in connection with non-Experimental or non-Investigational organ or tissue transplant procedures, subject to the following conditions:

1. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education or such similar criteria, and must not be affiliated in any way with the Physician who is performing the actual surgery;

2. If the donor is covered under this Plan, Eligible Expenses Incurred by the donor are considered for benefits to the extent that such expenses are not payable by the recipient’s plan;

3. If the recipient is covered under this Plan, Eligible Expenses Incurred by the recipient are considered for benefits. Eligible Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, are considered for payment to the extent that such expenses are not payable by the donor's plan. In no event are benefits payable in excess of the benefit maximums available to the recipient;

4. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person are treated separately for each person; and

5. The cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, are considered for payment.

Pre-treatment Review by the Plan is strongly recommended for Outpatient services. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

PHYSICAL THERAPY - OUTPATIENT

Coverage includes charges for Physical Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Physical Therapy must be ordered by a Physician and rendered by a licensed physical therapist.

Treatment rendered for stuttering or for behavioral, developmental or learning disorders is excluded.

PREVENTIVE CARE

"Preventive Care" means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, and which is not provided as a result of any Injury or Illness.

Coverage under this benefit includes the following routine services, subject to the following limitations:

1. Routine Wellness care for children and adults for the following:

   A. Routine physical examinations by a Physician or Licensed Health Care Provider, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician or Licensed Health Care Provider and associated routine testing provided or ordered at the time of the examination; and

   B. Routine immunizations according to the schedule of immunizations which is recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention.

2. Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

3. Women's Preventive Care for the following:

   A. Well-women annual visits for women 18 years of age and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits as medically appropriate.

   B. Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

C. Human papillomavirus (HPV) DNA testing beginning at thirty (30) years of age, limited to once every three (3) years.

D. Annual counseling on sexually transmitted infections (STI's) and human immune-deficiency virus (HIV) screening for all sexually active women.

E. All Food and Drug Administration approved prescription contraceptives and female over-the-counter contraceptives when prescribed by a Physician or Licensed Health Care Provider, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Self-administered contraceptives are available only through the Pharmacy Benefit as outlined in the Pharmacy Benefit section of this Plan.

F. Breast feeding support, supplies, and counseling, including comprehensive lactation support and counseling by a trained provider during Pregnancy and/or in the postpartum period, and costs for breast feeding equipment and related supplies.

G. Annual screening and counseling for interpersonal and domestic violence.

4. Office visit charges only if the primary purpose of the office visit is to obtain a recommended Preventive Care service identified above.

Expenses payable under this Preventive Care Benefit are not subject to the Medical Necessity provisions of this Plan. Charges for Preventive Care that involve excessive, unnecessary or duplicate tests are specifically excluded.

Charges for treatment of an active Illness or Injury are subject to the Plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

PROSTATE CANCER SCREENING, PROSTATE SPECIFIC ANTIGEN (PSA) TESTING

Charges are payable as specifically stated in the Schedule Medical of Benefits. Coverage under this benefit includes annual routine examination for the detection of prostate cancer, including a prostate-specific antigen (PSA) test.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

Coverage includes charges for reconstructive breast surgery subsequent to any Medically Necessary mastectomy, limited to charges for the following:

1. Reconstruction of the breast(s) upon which the mastectomy was performed, including implants;

2. Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants; and

3. Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry.

Specifically excluded from this benefit are expenses for the following:

1. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;

2. Breast augmentation procedures unrelated to producing a symmetrical appearance;

3. Implants for the non-affected breast unrelated to producing a symmetrical appearance; and

4. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

RESIDENTIAL TREATMENT

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Coverage includes charges made by a Residential Treatment Facility for treatment of Mental Illness or Alcoholism and/or Chemical Dependency. Residential care room and board charges are covered in lieu of Inpatient room and board charges provided the patient would meet criteria for an Inpatient admission.

"Residential Treatment Facility" means an institution which:

1. Is licensed as a 24-hour residential facility for mental health and substance abuse treatment, although not licensed as a hospital;

2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a Physician or a Ph.D. psychologist; and

3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

Pre-certification by the Plan is strongly recommended for all Residential Treatment charges. If you choose not to obtain Pre-certification, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE

Routine Newborn Inpatient Nursery/Physician Care including the following services:

1. Routine Nursery Care includes room, board and Hospital Miscellaneous Expenses for a Newborn Dependent child, including circumcision; and

2. Routine Physician Care includes charges for services of a Physician for a Newborn Dependent child while Inpatient as a result of the child's birth, including circumcision.

SKILLED NURSING FACILITY

Benefit maximums apply as stated in the Schedule of Medical Benefits.

Coverage includes charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility during the convalescent confinement. Only charges in connection with convalescence from the Illness or Injury for which the Covered Person was Hospital-confined may be eligible for benefits. These expenses include:

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area;

2. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees; and

3. Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent confinement, but no other supplies.

Pre-certification by the Plan is strongly recommended for all Skilled Nursing Facility charges. If you choose not to obtain Pre-certification, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

SPEECH THERAPY - OUTPATIENT

Coverage includes charges made by a licensed speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders. The Plan provides benefits for Speech Therapy when all of the following criteria are met:

1. There is a documented condition or delay in development that may be expected to improve with therapy within a reasonable time;

2. Improvement is not normally expected to occur without intervention;

3. Treatment is rendered for a condition that is the direct result of a diagnosed neurological, muscular, or structural abnormality affecting the organs of speech; and

4. Therapy has been prescribed by the speech language pathologist or Physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all above conditions are met.

Treatment rendered for stuttering or for behavioral, developmental or learning disorders is excluded.

SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES

Charges for surgical implants and/or devices and related supplies are payable as specifically outlined in the Schedule of Benefits, subject to all terms and conditions of this Plan. Coverage under this benefit includes charges for implants, devices and related supplies, including fastenings, screws and all other hardware related to the device or implant.

Pre-treatment Review by the Plan is strongly recommended for all implant procedures. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

SURGICAL PROCEDURES

Coverage includes charges for Surgical Procedures.

For non-Participating Providers, when two or more Surgical Procedures occur during the same operative session, charges are considered as follows:

1. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, 100% of the Eligible Expense are considered for the Major Procedure; and 50% of the Eligible Expense are considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services are reimbursed at the contracted or negotiated rate; and

2. When an incidental procedure is performed through the same incision, only the Eligible Expense for the Major Procedure may be considered. Examples of incidental procedures are: excision of a scar, appendectomy at the time of other abdominal surgery, lysis of adhesions, etc.

When an assisting Physician is required to render technical assistance during a Surgical Procedure, the charges for such services are limited to 25% of the primary surgeon's Eligible Expense for the Surgical Procedure. When an assisting non-physician is required to render technical assistance during an operation, charges for such services are limited to 10% of the surgeon's Eligible Expense for the Surgical Procedure.

TMJ/JAW DISORDERS

Benefit maximums apply as stated in the Schedule of Medical Benefits. Coverage includes charges in connection with any surgical treatment for temporomandibular joint (TMJ) dysfunction including, but not limited to: correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia. Coverage does not include Expenses Incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.

Pre-treatment Review by the Plan is strongly recommended. If you choose not to obtain Pre-treatment Review, the claim may be denied if the service, treatment or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

URGENT CARE FACILITY

Coverage includes charges made by an Urgent Care Facility when treatment has been rendered.

VISION SERVICES - ACCIDENTAL INJURY OR MEDICAL CONDITION

Coverage includes charges for vision treatment as a result of Accidental Injury or medical condition.

VOLUNTARY SECOND AND THIRD SURGICAL OPINION BENEFIT

Charges are covered as follows:

1. Legally qualified Physician for a second opinion consultation if non-emergency, elective surgery is recommended by the Covered Person's attending Physician. The Physician rendering the second opinion regarding the Medical Necessity of such surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who is performing the actual surgery; and

2. Legally qualified Physician for a third consultation, if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such opinion, and must not be affiliated in any way with the consulting Physician, or with the Physician who is performing the actual surgery.

Expenses Incurred under this benefit are not subject to any Copayment or Deductible. Physician charges are payable at 100% of the Eligible Expense. Ancillary charges are payable as stated in the Schedule of Medical Benefits. The claim must indicate that charges are for a Second or Third Surgical Opinion. Claims that do not indicate Second or Third Surgical Opinion are considered under the Medical Benefits Section of the Plan, subject to all Plan conditions, exclusions, and limitations.

HOSPITAL ADMISSION CERTIFICATION

The Plan strongly recommends, but does not require, for Inpatient hospital admissions that the Covered Person pre-certify the Inpatient stay or notify the Plan of an Emergency admission.

Pre-certification, Plan notification and case management are designed to:

1. Provide information regarding coverage before you receive treatment, services, or supplies;

2. Provide information about benefits regarding proposed procedures or alternate treatment plans;

3. Assist in determining out-of-pocket expenses and identify possible ways to reduce them;

4. Help avoid reductions in benefits which may occur if the services are not Medically Necessary or the setting is not appropriate; and

5. If appropriate, assign a case manager to work with the Covered Person and their providers to design a treatment plan.

A benefit determination on a claim may be rendered only after the claim has been submitted to adjudicate whether it is eligible for coverage under the terms and conditions of the Plan. If it is determined not to be eligible, the Covered Person is responsible to pay for all charges that are determined to be ineligible. Therefore, although not required, pre-certification and Plan notification of Emergency admissions is strongly recommended to obtain coverage information prior to incurring the charges.

PRE-ADMISSION CERTIFICATION REVIEW

The Plan recommends that prior to admission for any non-emergency Illness or Injury, and within seventy-two (72) hours after admission for any Emergency Illness or Injury, the Covered Person or the Covered Person's attending physician call the designated utilization management company retained by the Plan Sponsor in connection with this Plan for a pre-admission certification review.

To pre-certify, call StarPoint LLC (the utilization management company) at (800) 342-6510 for pre-admission certification review.

Most certifications occur over the phone. Once a final decision is made regarding the request for certification, a notice of pre-certification is sent to the physician, to the Covered Person, to the Plan Supervisor and to the hospital.

NOTE: PRE-CERTIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT OF THE CLAIM(S). ELIGIBILITY FOR CLAIM PAYMENTS IS DETERMINED AT THE TIME CLAIMS ARE ADJUDICATED SINCE THE AMOUNT OF BENEFIT COVERAGE, IF ANY, IS SUBJECT TO ALL PLAN PROVISIONS INCLUDING, BUT NOT LIMITED TO, MEDICAL NECESSITY, PATIENT ELIGIBILITY, DEDUCTIBLES, CO-PAYMENTS AND ANY PLAN LIMITATIONS OR MAXIMUMS IN EFFECT WHEN THE SERVICES ARE PROVIDED. PROVIDERS AND COVERED PERSONS ARE INFORMED AT THE TIME CLAIMS ARE PRE-CERTIFIED THAT PRE-CERTIFICATION OF A COURSE OF TREATMENT BY THE PLAN DOES NOT GUARANTEE PAYMENT OF CLAIMS FOR THE SAME.

CONTINUED STAY CERTIFICATION

Charges for Inpatient hospital services for days in excess of any days previously certified by StarPoint LLC (the utilization management company) are subject to all terms, conditions and exclusions of the Plan, and must be certified by StarPoint LLC.

Certification for additional days may be obtained in the same manner as the pre-admission certification.

EMERGENCY NOTIFICATION/CERTIFICATION

The Covered Person or their representative may notify StarPoint LLC (the utilization management company) regarding any Emergency Hospital Admission within seventy-two (72) hours immediately following admission.

To notify the Plan of an Emergency admission, call StarPoint LLC (the utilization management company) at (800) 342-6510 for Emergency admission certification.

MATERNITY NOTIFICATION

The Covered Person or her representative may notify StarPoint LLC (the utilization management company) at **(877) 792-7827** when Pregnancy is diagnosed or as soon after as possible, in order to participate in the Plan's Star Baby Maternity Program. Notification is encouraged within the first trimester. Access to the Plan's Star Baby Maternity Program is available to the Covered Person through the entire term of the Pregnancy. Only Covered Persons who notify the utilization management company and participate in the Star Baby Maternity Program during the first and/or second trimester are eligible for the related incentive.

PRE-TREATMENT REVIEW

Pre-treatment Review is the process of verifying the eligibility of services to determine if reimbursement is available under Plan provisions. Although benefits may not be available under this Plan, Pre-treatment Review is strongly recommended before incurring expenses for any Inpatient or outpatient service, medication, supply or ongoing treatment for:

1. Surgeries:

   A. Spinal fusions or any other back surgery involving implantable devices;
   B. Reduction Mammoplasty;
   C. Blepharoplasty;
   D. Uvulapalato-pharyngoplasty (UPPP).

2. Organ or Tissue Transplants.

3. Infertility. **(Not Covered under this Plan)**

4. Medical Equipment for costs exceeding $2,500.

5. Outpatient dialysis.

6. Infusion services.

7. Obesity treatment.

8. Bariatric Surgery benefits. **(Not Covered under this Plan)**

9. Cancer treatments.

10. Commercial or Private Automobile Transportation.

11. Outpatient Rehabilitative Care (Benefits in excess of $2,000 per Benefit Period).

12. Surgery that could be considered cosmetic under some circumstances.

13. Any procedure or service that could possibly be considered Experimental or Investigational.

14. Surgical treatment of TMJ.

15. Home Health Care services.

16. Residential Treatment Facility.

17. Preventive/Prophylactic Mastectomy/Oophorectomy. **(Not Covered under this Plan)**

18. Chronic pain program. **(Some restrictions apply)**

19. Hemophilia.

20. Advanced Imaging. Employee may request pre-treatment review for PET Scan for cancer.

21. Skilled Nursing Facility.

22. Speech Therapy.

23. Gender Identity Disorder/Gender Dysphoria Services.

To obtain Pre-treatment Review from the Plan, submit the following to the Plan Supervisor at P.O. Box 3018, Missoula, MT 59806-3018 or via facsimile at (866) 201-0522:

1. A complete description of the procedure(s) or treatment(s) for which review is requested;

2. A complete diagnosis and all medical records regarding the condition that supports the requested procedure(s) or treatment(s) including, but not limited to, informed consent form(s), all lab and/or x-rays, or diagnostic studies;

3. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding CPT or HCPCS codes;

4. The attending Physician's prescription, if applicable;

5. A Physician's referral letter, if applicable;

6. A letter of Medical Necessity;

7. A written treatment plan; and

8. Any other information deemed necessary to evaluate the request for Pre-treatment Review.

Upon receipt of all required information, the Plan provides a written response to the written request for Pre-treatment Review of services.

THE BENEFITS QUOTED ARE NOT A GUARANTEE OF PAYMENT. FINAL DETERMINATION AS TO BENEFITS PAID IS MADE AT THE TIME THE CLAIM IS SUBMITTED FOR PAYMENT WITH REVIEW OF NECESSARY MEDICAL RECORDS AND OTHER INFORMATION.

MEDICAL EXPENSE SELF AUDIT BONUS

The Plan offers an incentive to all Covered Persons to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the Covered Person. The Covered Person is asked to review all Medical Expenses and verify that each itemized service has been received and that the bill does not represent either an overcharge or a charge for services never received. Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Covered Person to avoid unnecessary payment of health care costs.

In the event a self-audit results in elimination or reduction of charges, an amount up to fifty (50%) percent of identified overcharge, up to one-thousand ($1,000) dollars on overcharge of fifty ($50) dollars or more of the amount eliminated or reduced, will be paid directly to the Employee as a bonus, provided the savings are accurately documented and satisfactory evidence of a reduction in charges is submitted to Allegiance Benefit Plan Management (e.g. a copy of the incorrect bill and a copy of the corrected billing). The bonus only applies to charges which have been submitted to and paid by the Plan and for which an erroneous charge was paid by the Plan. Erroneous charges corrected by the Plan during the claims adjudication process are not eligible for this bonus.

This self-audit is a bonus in addition to the benefits of this Plan. The Covered Person must indicate on the corrected billings “This is a claim for the Medical Expense Self Audit Bonus” in order to receive the bonus.

This bonus is not payable for charges in excess of the Eligible Expense, regardless of whether the charges are reduced.

MEDICAL BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Medical Benefits in addition to the following Medical Benefit Exclusions:

1. Charges for routine medical examinations, routine health check-ups or preventive immunizations not necessary for the treatment of an Injury or Illness, except as specifically listed under the Preventive Care Benefit.

2. Charges in connection with the care or treatment of, surgery performed for, or as the result of, a Cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury or an Illness, or when rendered to correct a congenital anomaly.**

3. Charges for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a Covered Benefit of this Plan.

4. Charges for Elective or Therapeutic Abortion.

5. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury.

6. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician, except as specifically covered under the Telemedicine Benefit.

7. Charges for Licensed Health Care Providers' fees for any treatment which is not rendered by or in the physical presence of a Licensed Health Care Provider, except as specifically covered under the Telemedicine Benefit.

8. Special duty nursing services are excluded:

   A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or

   B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.

9. Charges in connection with eye refractions, the purchase or fitting of eyeglasses or contact lenses. **This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery or aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.**

10. Charges in connection with hearing aids, or such similar aid devices, including, but not limited to: exams for the purpose of fitting a hearing aid; any device, service or treatment for hearing loss; or any device, service or treatment for the purpose of improving or assisting hearing by directing or amplifying sound in the ear canal whether the ears are absent or deformed from trauma, surgery, disease or congenital defect, or Illness or Injury, or any tinnitus masking device, and all bone assisted hearing devices of any type.

11. Charges for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes, except as specifically listed as a covered service.

12. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, or any other assisted reproductive technique.

13. Charges for marital counseling, family counseling, recreational counseling, religious counseling, milieu therapy, hypnotherapy, holistic medicine, homeopathy, stress management or self-help programs. Refer to EAP Benefit for counseling services. Contact (800) 750-0512 or eap@mt.gov for further information.

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

15. Charges resulting from or in connection with the reversal of a sterilization procedure.

16. Charges in connection with services or supplies provided for the surgical treatment of obesity and weight reduction, including bariatric surgery or any other weight reduction surgery or procedure and weight loss medications regardless of Medical Necessity, and regardless of other condition, diagnosis or co-morbidity, are specifically excluded.

17. Charges for chiropractic treatment which are not related to an actual Illness or Injury or which exceed the maximum benefit as stated in the Schedule of Medical Benefits.

18. Charges for orthotics or rolfing, except for orthotics for diabetes as specifically listed as a covered service.

19. Charges for hair transplant procedures, wigs and artificial hairpieces.

20. Charges for any surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism.

21. Charges related to Custodial Care.

22. Charges for artificial organ implant procedures.

23. Charges for non-prescription supplies or devices, except as covered under the Preventive Care Benefit.

24. Charges for services of a doula, direct-entry midwife or lay midwife, or the practice of direct-entry midwifery. A direct-entry midwife is one practicing midwifery and licensed pursuant to state in which services are being performed pursuant to § 37-27-101 et seq, MCA.

    "Direct-entry midwife" means a person who advises, attends, or assists a woman during Pregnancy, labor, natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.

25. Charges for complications that directly result from acting against medical advice, non-compliance with specific physician's orders or leaving an Inpatient facility against medical advice.

26. Charges for equipment including, but not limited to, motorized wheelchairs or beds, that exceed the patient's needs for everyday living activities as defined by the Americans with Disabilities Act as amended from time to time, unless Medically Necessary by independent review and not primarily for personal convenience.

27. Charges for specialized computer equipment including, but not limited to, Braille keyboards and voice recognition software, unless determined to be Medically Necessary by independent review, and not primarily for personal convenience.

28. Charges for detoxification services or outpatient therapy under court order or as condition of parole.

29. Charges for nutrition-based therapy for alcoholism or drug addiction.

30. Charges for health care services to treat alcohol or drug co-dependency.

31. Charges for immunizations, medications and other preventive treatments that are recommended because of increased risk due to your type of employer or travel including, but not limited to, immunizations, medications and/or other preventive treatments for malaria and yellow fever.

32. Charges for examinations for employment, licensing, insurance, school camp, sports or adoption purposes.

33. Charges for court-ordered examinations or treatment.

34. Charges for expenses for examinations and treatment conducted for the purpose of medical research.

35. Charges for FAA and DOT Physicals.

36. Charges for the following (known as a “Never Event”) when the condition is a result of patient confinement or surgery:

    A. Removal of an object left in the body during surgery;

    B. Catheter-associated urinary tract infection;

    C. Pressure ulcers;

    D. Vascular catheter-associated infection;

    E. Infection inside the chest after coronary artery bypass graft surgery;

    F. Hospital acquired injuries such as fractures, dislocations, intracranial injuries, crushing injuries and burns; and

    G. Treatment, amputation or removal of the wrong body part or organ.

37. Charges for residential treatment, except as specifically listed as a covered service.

38. Charges for services for massage or massage therapy, except as provided by a Chiropractor or Physical Therapist.

39. Charges for routine foot care, including the following:

    A. Removal or treatment of corns or callosities,

    B. Hypertrophy, hyperplasia of the skin, or subcutaneous tissues;

    C. Cutting or trimming of nails;

    D. Treatment of flat feet, fallen arches, or chronic foot strain;

E. Orthotic appliances and casting for orthotic appliances, except as specifically covered;

F. Padding and strapping; or

G. Fabrication, except as specifically covered.

40. Charges for health clubs, health spas, personal trainers and exercise programs, whether or not approved or prescribed by a licensed provider.

41. Charges for Autism Spectrum Disorder, as defined, related services provided in a public school setting and paid for by the public school are specifically excluded.

42. Charges for biofeedback or orthomolecular therapy, including nutrients, vitamins and food supplements, except as specifically covered.

43. Charges for vocational rehabilitation.

44. Charges for legally ordered services, including services which are required by a court order or as a condition of parole or probation, unless subsequently found to be Medically Necessary.

45. Charges related to any services, care or treatment for sexual dysfunction including; medications, surgery, medical, counseling or Psychiatric Care, or treatment.

46. Charges for voice modification; suction assisted lipoplasty of the waist; blepharoplasty; facial reconstruction or facial feminization surgery; hair removal or other non-Medically Necessary services, care or treatment of Gender Identity Disorder or Gender Dysphoria.

    Charges for treatment of Gender Identity Disorder/Gender Dysphoria when the services are for reversal of a prior gender reassignment surgery or reversal of a prior surgery to revise secondary sex characteristics.

APPENDIX B

SUMMARY PLAN DESCRIPTION
FOR PRESCRIPTION DRUG BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF

STATE OF MONTANA

Appendix B

Summary Plan Description
describes the Pharmacy Plan Benefits
in effect as of January 1, 2017

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PHARMACY BENEFIT

Prescription drug charges are payable only through the Plan's Pharmacy Benefit Manager (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. Pharmacy Copayments do not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments apply toward the applicable Pharmacy Benefit Out-of-Pocket Maximum. **The Pharmacy Benefit Manager (PBM) shall provide separate information for details regarding Network pharmacies, Preferred Brand prescriptions, formulary listings and Specialty Drugs upon enrollment for coverage under this Plan.**

Additional information regarding the Prescription Drug Benefits is available at: www.benefits.mt.gov/rx.

COST SHARING PROVISIONS

Pharmacy Deductible per Benefit Period

Per Covered Person . . . . . None
Per Family . . . . . None

Pharmacy Out-of-Pocket Maximum per Benefit Period*

Per Covered Person $1,800
Per Family $3,600

*Includes any applicable Pharmacy Copayments. Pharmacy Benefits are payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum for the remainder of the Benefit Period, except for Tier 3 and Non-Preferred Specialty Copayments . Tier 3 and Non-Preferred Specialty Copayments do not accrue to the Out-of-Pocket Maximum and will never be payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum.

Copayment per Prescription				
	Preferred Pharmacy Retail 1 to 34 days' supply	**Preferred Pharmacy Retail** 35 to 90 days' supply	**Non-Preferred Pharmacy Retail Member Submit** 1 to 10 days' supply	**Preferred Pharmacy Mail Order** up to 90 days' supply
$0 Tier*	No charge	No charge	No charge	No charge
Tier 1 Generic	$15 Copayment	$30 Copayment	$15 Copayment	$30 Copayment
Tier 2 Preferred	$50 Copayment	$100 Copayment	$50 Copayment	$100 Copayment
Tier 3 Non-Preferred**	50% Copayment	50% Copayment	50% Copayment	50% Copayment
Tier 4 Speciality	$200 Copayment	N/A	50% Copayment** (up to 34 days' supply may be available)	N/A
*$0 Tier applies to certain preventive medications (as defined by the Affordable Care Act (ACA)) and select medications. See the formulary for a listing of covered products.				
**Does not accrue towards the Out-of-Pocket Maximum.				

Preventive Services
The following are payable at 100% and are not subject to any Copayment: 1. Prescribed generic female 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 ACA which may be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. 4. Vaccines available through the PBM's Vaccine Program.
Mandatory Generic
If there is a generic alternative for the prescription drug, and the Covered Person chooses a brand name instead, regardless of how the prescription is written, the Covered Person shall pay the difference in cost between the generic and brand name medication plus the applicable brand Copayment amount.
When Primary Coverage exists Under Another Plan
If primary coverage exists under another plan, charges for prescription drugs must be submitted to the primary carrier first. Once the PBM receives a copy of the drug receipt or explanation of benefits showing the total charges and amounts paid for eligible prescription drugs from the primary carrier, if applicable, this Plan may reimburse the Participant for the remainder of Eligible Expenses, not subject to the applicable Copayments. **In order to receive reimbursement, the drug receipt must be submitted to the Pharmacy Benefit Manager (PBM).**

COVERAGE

Coverage for prescription drugs only includes those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. Contraceptives and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider.

   Contraceptive Management is covered under the Medical Benefits of this Plan.

2. Diabetic supplies, including calibration liquid, insulin, lancet devices, lancets, blood glucose meters, pen needles, syringes, and blood glucose and ketone test strips.

3. Smoking deterrents prescribed by a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider.

4. Select over-the-counter (OTC) medications that offer a lower cost alternative and OTC medications listed as an A or B recommendation as a Preventive Service covered under the ACA, only when prescribed by a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider. ACA medications may be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

5. Legend vitamins (oral only); Prenatal agents used in Pregnancy; therapeutic agents used for specific deficiencies and conditions; and hemopoetic agents used to treat anemia.

6. Legend fluoride products (oral only): Dental or pediatric.

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:

PBM Network Prescriptions: Available only through a retail pharmacy that is part of the PBM Network. The pharmacy bills the Plan directly for the part of the prescription cost that exceeds the Copayment (Copayment amount must be paid to pharmacy at time of purchase). **The prescription identification card is required for this option.**

Member Submit Prescriptions: Available only if the prescription identification card may not be used because a pharmacy is not part of the PBM Network, or the prescription identification card is not used at a Network pharmacy. **Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the Pharmacy Benefit Manager (PBM), along with a reimbursement form (Direct Reimbursement). The PBM shall 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 may not exceed what the PBM would have reimbursed for a Network Prescription.**

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. **The mail order pharmacy bills the Plan directly for prescription costs that exceed the Copayment.**

Specialty Drug(s): These medications are generic or non-generic drugs classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty drugs may be obtained from a preferred specialty pharmacy. **A list of specialty drugs and preferred specialty pharmacies may be obtained from the PBM or Plan Supervisor.**

DRUG OPTIONS

The drug options available are:

Formulary Generic: Those drugs and supplies listed in the most current edition of the Physicians' Desk Reference or by the PBM Program as generic drugs. Drugs that are new to the market are reviewed by the Pharmacy and Therapeutics Committee for possible addition to the formulary approximately six (6) months after entering the market.

Preferred Brand: Non-generic drugs and supplies listed as "Preferred Brand" by the PBM Program as stated in a written list provided to Covered Persons and updated from time to time.

Non-Preferred Brand: Copyrighted or patented brand name drugs (Non-Generic) which are not recognized or listed as Preferred Brand drugs or supplies by the PBM Program. On limited occasions a Generic may be included when specific regulatory or market place circumstances exist.

PRESCRIPTION COPAYMENT

"Copayment" means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of service. Copayments are specifically stated in this section. Copayments are not payable by the Plan and do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments apply towards the applicable Pharmacy Out-of-Pocket Maximum, and after satisfaction of the Out-of-Pocket Maximum, Copayments no longer apply for the remainder of the Benefit Period.

SUPPLY LIMITS

Supply is limited to 90 days for PBM Network and Mail Order Prescriptions. Specialty Prescriptions are limited to 34 days' supply. Non-Preferred Pharmacy Prescriptions are limited to a 10 days' supply.

Prescription drug refills are not allowed until 75% for Retail refills and 70% for Mail Order refills of the prescribed day supply is used.

The amount of certain medications is limited to promote safe, clinically appropriate drug usage. If you have exceeded a limit and your Physician believes you need an additional supply of a medication, a request must be submitted and reviewed for Medical Necessity. A current list of applicable quantity limits may be obtained by contacting the PBM at the number listed on your identification card.

STEP THERAPY PROGRAM

A protocol that requires the member to try a preferred formulary medication before approving a more expensive preferred product or non-formulary product.

PRIOR AUTHORIZATION

Approval is required by the PBM for a select drug before authorizing coverage for the medication. Unless otherwise indicated by the PBM, the prior authorization must be in writing from the provider. Determinations for prior authorizations are at the discretion of the PBM.

EXCLUSIONS

Prescription drugs or supplies in the following categories are specifically excluded:

1. Drugs prescribed for cosmetic only indications including, but not limited to, photo-aged skin products (e.g., Renova); hair growth agents (e.g., Propecia, Vaniqa); and injectable cosmetics (e.g., Botox cosmetic).

2. Drugs prescribed for dermatology: Agents used in the treatment of acne and/or for cosmetic purposes for Covered Persons thirty-five (35) years or older or depigmentation products used for skin conditions requiring a bleaching agent, unless Prior Authorization has been obtained.

3. Legend homeopathic drugs.

4. Fertility agents, oral, vaginal and injectable.

5. Drugs prescribed for erectile dysfunction.

6. Drugs prescribed for weight management.

7. Allergen injectable.

8. Serums, toxoids.
9. Legend vitamins and legend fluoride products, except as specifically covered.
10. Over-the-counter equivalents and non-legend medications (OTC), except as specifically covered.
11. Durable Medical Equipment*
12. Experimental or Investigational drugs.
13. Abortifacient drugs.

*Eligible for coverage under the Medical Benefits, subject to all requirements and exclusions of this Plan.

APPENDIX C

SUMMARY PLAN DESCRIPTION
FOR DENTAL BENEFITS PLAN
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF

STATE OF MONTANA

Appendix C

Summary Plan Description
describes the Dental Benefits
in effect as of January 1, 2017

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GROUP HIGHLIGHTS

PLAN:

The dental plan is a Calendar Year plan, and deductibles and maximums are based upon a Calendar Year, which is January 1st through December 31st.

BENEFITS:		
	In-Network	Out-of-Network
Diagnostic & Preventive Benefits:	100%	100%
Basic Benefits:	80%	80%
Major Benefits:	50%	50%
Implant Benefits:	50%	50%
DEDUCTIBLES:		
Per Enrollee per Calendar Year:	$50	
Per Family per Calendar Year:	$150	
Diagnostic and Preventive Benefits are not subject to the deductible.		
MAXIMUM AMOUNTS:		
Per Enrollee per Calendar Year:	$1,800	
Lifetime for Implant Benefits:	$1,500	

CHOICE OF DENTIST

Delta Dental offers a choice of dentists from the Delta Dental panel of PPO Dentists and Premier Dentists or Enrollees may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists may be obtained by accessing the Delta Dental National Dentist Directory at deltadentalins.com/stateofmontana. Enrollees are responsible for verifying whether the Dentist they select is a PPO Dentist or a Premier Dentist. Dentists are regularly added to the panel. Additionally, Enrollees are advised to confirm with the dentist's office that a listed Dentist is still a contracted PPO Dentist or a Premier Dentist.

PPO Dentist
The PPO program potentially allows Enrollees the greatest reduction in their out-of-pocket expenses, since this select group of Dentists provide dental Benefits at a charge which has been contractually agreed upon between Delta Dental and the PPO Dentist.

Premier Dentists
The Premier Dentists, which include specialists (endodontists, periodontists or oral surgeons), have not agreed to the features of the PPO program; however, Enrollees may still receive dental care at a lower cost than if they select a Non-Delta Dental Dentist.

Non-Delta Dental Dentist
If a Dentist is a Non-Delta Dental Dentist, the amount charged to Enrollees may be above that accepted by the PPO or Premier Dentists. Non-Delta Dental Dentists may balance bill for the difference between the Maximum Plan Allowance and the Non-Delta Dental Dentist's Approved Amount. For a Non-Delta Dental Dentist, the Approved Amount is the dentist's submitted charge.

Maximum Plan Allowance (MPA)
The maximum amount Delta Dental may reimburse for a covered procedure. Delta Dental establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPAs are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. The MPA may vary by the type of participating Dentist.

Additional advantages of using a PPO Dentist or Premier Dentist

- The PPO Dentist and Premier Dentist are required to accept assignment of Benefits, meaning PPO Dentists and Premier Dentists are paid directly by Delta Dental after satisfaction of the deductible and coinsurance, and the Enrollee is not required to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The PPO Dentist and Premier Dentist shall complete the dental claim form and submit it to Delta Dental for reimbursement.

DEDUCTIBLE

The dental plan features a deductible. This is an amount Enrollees shall pay out-of-pocket before Benefits are paid by the dental plan. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees Enrollees pay for covered Benefits count toward the deductible, but Enrollees do not pay a deductible for Diagnostic and Preventive Benefits.

MAXIMUM AMOUNT

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis or a lifetime basis.

BENEFITS, LIMITATIONS & EXCLUSIONS

Delta Dental pays the Benefits for the types of dental services as described below. Delta Dental pays Benefits only for covered services. These services must be provided by a Dentist and must be necessary and customary under generally accepted dental practice standards. Delta Dental may use dental consultants to review treatment plans, diagnostic materials or prescribed treatments to determine generally accepted dental practices. If you receive dental services from a Dentist outside of the State of Montana, the Dentist is reimbursed according to Delta Dental's network payment provisions for said state according to the terms of the Contract.

If a comprehensive dental procedure includes component or interim procedures that are performed at the same time as the comprehensive procedure, the component or interim procedures are considered to be part of the comprehensive procedure for purposes of determining the benefit payable under the Contract. If the Dentist bills separately for the comprehensive procedure and each of its component or interim parts, the total benefit payable for all related charges is limited to the maximum benefit payable for the comprehensive procedure.

Enrollee Coinsurance

Delta Dental's provision of Benefits is limited to the applicable percentage of Dentist's fees shown on the Group Highlights page. Enrollees are responsible for paying the remaining applicable percentage of any such fees, known as the "Enrollee Coinsurance". The State of Montana (State) has chosen to require Enrollee Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the State and Enrollees.

If the Dentist discounts, waives or rebates any portion of the Enrollee Coinsurance to the Enrollee, Delta Dental is only obligated to provide as Benefits the applicable percentages of the Dentist's fees reduced by the amount of such fees that is discounted, waived or rebated.

BENEFITS

On the State's behalf, Delta Dental shall pay or otherwise discharge the percentage of Contract Allowance shown on the Group Highlights page for the following covered services:

- Diagnostic: procedures to assist the Dentist in choosing required dental treatment.

- Preventive: prophylaxis (cleaning, periodontal cleaning in the presence of gingival inflammation is considered to be periodontal (a Basic Benefit) for payment purposes) and topical application of fluoride solutions.
- Sealants: topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
- Palliative: treatment to relieve pain.

Basic Benefits :

- Oral Surgery: extractions and other surgical procedures (including pre-and post-operative care).
- General Anesthesia or IV Sedation: when administered by a Dentist for covered oral surgery or selected endodontic and periodontal surgical procedures.
- Endodontics: treatment of the tooth pulp.
- Periodontics: treatment of gums and bones supporting teeth, periodontal maintenance.
- Restorative: posterior composite, synthetic porcelain, plastic restorations (fillings), amalgam fillings and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- Other Basic Service: space maintainers.

Major Benefits:

- Denture Repairs: repair to partial or complete dentures including rebase procedures and relining.
- Crowns, Inlays/Onlays and Cast Restorations: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, plastic restorations.
- Prosthodontics: procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges.

Implant Benefits:
Implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

Note on additional benefits during pregnancy - When an Enrollee is pregnant, on the State's behalf, Delta Dental pays for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under this Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

LIMITATIONS

Limitations on Diagnostic and Preventive Benefits:

- On the State's behalf, Delta Dental pays for routine oral examinations and cleanings (including periodontal cleanings) no more than twice in any Calendar Year while the person is an Enrollee under any Delta Dental program or dental care program provided by the State. Note that periodontal cleanings are

covered as a Basic Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional benefits during pregnancy.

- Full-mouth x-rays and panoramic x-rays are limited to once every five (5) years while the person is an Enrollee under any Delta Dental program.
- Topical application of fluoride solutions is limited to twice in a Calendar Year for Enrollees under age 19.
- Delta Dental may not pay to replace an amalgam within 24 months of treatment if the service is provided by the same Dentist.
- Sealants are limited to once per tooth in a lifetime for permanent molars through age 15 if they are without cavities or restorations on the occlusal surface.
- Bitewing x-rays are provided twice in a Calendar Year for each Enrollee.

Limitations on Basic Benefits (coinsurance applies).:

- On the State's behalf, Delta Dental pays for periodontal cleanings no more than four (4) times in any Calendar Year while the person is an Enrollee under any Delta Dental program or dental care program provided by the State. See note on additional benefits during pregnancy.
- Delta Dental may not pay to replace synthetic porcelain or plastic restorations (fillings) within 24 months of treatment if the service is provided by the same Dentist.
- Delta Dental may not pay to replace prefabricated stainless steel restorations within 60 months of treatment if the service is provided by the same Dentist.
- Delta Dental limits payment for stainless steel crowns under this section to services on baby teeth. However, after consultant's review, Delta Dental may allow stainless steel crowns on permanent teeth as a Major Benefit.
- Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional benefits during pregnancy.

Limitations on Major Benefits (coinsurance applies).:

- Delta Dental may not pay to replace any crowns, inlays/onlays or cast restorations which the Enrollee received in the previous five (5) years under any Delta Dental program or any program of the State.
- Prosthodontic appliances and/or implants that were provided under any Delta Dental program may be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture may not be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Delta Dental program may be made if Delta Dental determines it is unsatisfactory and may not be made satisfactory. Delta Dental may pay for the removal of an implant once for each tooth during the Enrollee's lifetime.
- Delta Dental limits payment for dentures to a standard partial or complete denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means. Dentures and replacement dentures that were provided under any Delta Dental program may be replaced only after five (5) years have passed

Limitations on Implant Benefits (coinsurance applies):

- The maximum amount payable for each Enrollee during the Enrollee's lifetime is shown on the Group Highlights page.
- Implants Benefits are subject to all terms and conditions in this Contract.
- Implants that were provided under any Delta Dental program may be replaced only after five (5) years have passed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture may not be made satisfactory. Replacement of an implant supported prosthesis not provided under a Delta Dental program may be made if Delta Dental determines it is unsatisfactory and may not be made satisfactory. Delta Dental may pay for the removal of an implant once for each tooth during the Enrollee's lifetime.

Limitations on All Benefits - Optional Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- a crown where a filling would restore the tooth;

- a precision denture/partial where a standard denture/partial could be used; or
- an inlay/onlay instead of an amalgam restoration.

If you receive Optional Services, Benefits are based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee is responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

EXCLUSIONS

Delta Dental does not pay Benefits for:

- Cosmetic surgery or dentistry for purely cosmetic reasons.

- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), unless the service is provided to a newborn or adopted dependent child for treatment of a medically diagnosed congenital defect.

- Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. For example: equilibration, periodontal splinting, occlusal adjustment.

- Any Single Procedure started prior to the date the person became covered for such services under this program.

- Prescribed drugs, medication, pain killers or experimental procedures, services, or supplies.

- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

- Charges for anesthesia, other than general anesthesia and IV sedation administered by a licensed Dentist in connection with covered oral surgery or selected endodontic and periodontal surgical procedures.

- Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

- Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.

- Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.

- Services or supplies covered by any other health plan of the State.

- Medical procedures, services or supplies.

- Services for orthodontic treatment (treatment of malocclusion of teeth and/or jaws).

- Services for any disturbances of the temporomandibular (jaw) joints.

- Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the plan, are the responsibility of the Enrollee and not a covered Benefit.

THIS BOOKLET CONSTITUTES ONLY A SUMMARY OF THE DENTAL SERVICE PLAN. THE COMPLETE PLAN MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

APPENDIX D

SUMMARY PLAN DESCRIPTION
FOR VISION PLAN BENEFITS
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF

STATE OF MONTANA

Appendix D

Summary Plan Description
describes the Vision Benefits
in effect as of January 1, 2017

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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY STATE OF MONTANA WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

Cigna Vision Schedule of Vision Benefits
Copayments Copayments are amounts to be paid by Covered Persons for covered services.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
	The plan pays 100% after any copayment, subject to any maximum shown below	The plan reimburses Covered Persons at 100%, subject to any maximum shown below
Examinations One Eye Exam every Calendar Year	$10 Copay	$45
Lenses & Frames	$20 Copay* ***Note:** Lenses & Frames Copay does not apply to Contact Lenses	
Lenses One pair per Calendar Year		
Single Vision Lenses	100%	$45
Bifocal Lenses	100%	$55
Trifocal Lenses	100%	$65
Lenticular Lenses	100%	$80
Progressive Lenses	100%	$55
Contact Lenses One pair per Calendar Year		
Elective	100% up to $130	$95
Therapeutic	100%	$210
Frames One pair in any 2 Calendar Years	100% up to $130	$52

Vision Benefits

Covered Expenses

Examinations – One vision and eye health evaluation including, but not limited to, eye health examination, dilation, refraction and prescription for glasses.

Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).

- Polycarbonate lenses for children under 18 years of age;
- Oversize lenses;
- Rose #1 and #2 solid tints;
- Progressive lenses covered up to bifocal lenses amount.

Frames – One frame – choice of frame covered up to retail plan allowance.

Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance may be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.

Coverage for Therapeutic contact lenses may be provided when visual acuity may not be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses may obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus or aphakis; as determined and documented by the Covered Person's Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction may be covered in accordance with the Elective contact lens benefit shown on the Schedule of Vision Benefits (Schedule).

Expenses Not Covered

Covered Expenses do not include and no payment will be made for:

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination or any corrective eyewear required by an employer as a condition of employment.
- Charges incurred after the plan terminates or the Covered Person's coverage under the plan ends, except as stated in the plan.
- Experimental or non-conventional treatment or device.
- Charges in excess of the usual and customary charge for the service or materials.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- VDT (video display terminal)/computer eyeglass benefit.
- Magnification or low vision aids.
- Spectacle lens treatments, "add ons", or lens coatings not shown as covered in the Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglasses.
- Any non-prescription eyeglasses, lenses or contact lenses.
- Safety glasses or lenses required for employment.

Other Limitations are shown in the Exclusions and General Limitations section.

Exclusions and General Limitations

Exclusions

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- Treatment of an Injury or Sickness which is due to war, declared or undeclared.
- Charges which the Covered Person is not obligated to pay or for which the Covered Person is not billed or for which the Covered Person may not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider has waived, reduced or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) that the Covered Person is required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that the Covered Person remains responsible for any amounts that the plan does not cover. In the exercise of that discretion, Cigna shall have the right to require the Covered Person to provide proof sufficient to Cigna that they have made the required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge or charged the Covered Person at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or relating to any violation of a health care related state or federal law or which themselves are a violation of a health care related state or federal law.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.

General Limitations

No payment may be made for expenses incurred for Covered Persons:

- For charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government if such charges are directly related to a military-service-connected Injury or Sickness.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges which may not have been made if the person had no coverage.
- Expenses for supplies, care, treatment or surgery that are not Medically Necessary.

APPENDIX E

FLEX PLAN DOCUMENT AND
FLEX SUMMARY PLAN DESCRIPTION
FOR THE FLEXIBLE BENEFITS PLAN
FOR EMPLOYEES, RETIREES AND DEPENDENTS OF

STATE OF MONTANA

The Flex Plan Document and the Flex Summary Plan Description for the State of Montana are included as part of the Wrap Plan Document.

The terms of the Wrap Plan Document are not applicable to the Flex Plan Document or Flex Summary Plan Description.

If any conflict arises between the Wrap Plan Document and the Flex Plan Document or Flex Summary Plan Description, the terms of the Flex Plan Document or Flex Summary Plan Description will control first, followed by the Wrap Plan Document.

Appendix E

Flex Plan Document and
Flex Summary Plan Description
describes the Flexible Benefits Plan
in effect as of January 1, 2017

PLAN DOCUMENT

for the

FLEXIBLE BENEFITS PLAN

For The Employees of

STATE OF MONTANA

PLAN EFFECTIVE DATE:
SEPTEMBER 1, 1997

PLAN DOCUMENT EFFECTIVE DATE:
JANUARY 1, 2017

GROUP NUMBER:
501143/3001000

EMPLOYER ID NUMBER:
81-0302402

PLAN NUMBER:
501

The Flex Plan Document and Flex Summary Plan Description for the State of Montana are included as an attachment to the Wrap Plan Document.

The terms of the Wrap Plan Document are not applicable to the Flex Plan Document or Flex Summary Plan Description.

If any conflict arises between the Wrap Plan Document and the Flex Plan Document or Flex Summary Plan Description, the terms of the Flex Plan Document or Flex Summary Plan Description will control first, followed by the Wrap Plan Document.

Allegiance℠
a Cigna Company

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STATE OF MONTANA
FLEXIBLE BENEFITS PLAN

INTRODUCTION

The Employer has restated this Plan effective January 1, 2017, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based upon their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on September 1, 1997. The Plan shall be known as State of Montana Flexible Benefits Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. The Employer has contracted with Allegiance Benefit Plan Management, Inc. to provide Flexible Spending Account Administration Services. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **“Benefit Contributions”** mean the Participant's cost for the self-funded Benefits described in Section 4.1.

1.5 **"Benefit Contributions or Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of the Participant’s Cafeteria Plan Benefit Dollars may be allocated and from which Benefit Contributions or Premiums of the Participant are paid or reimbursed. If more than one type of

self-funded or insured Benefit is elected, sub-accounts must be established for each type of self-funded or insured Benefit.

1.6 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan is converted into one Cafeteria Plan Benefit Dollar.

1.7 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.8 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.9 **"Dependent"** means any individual who qualifies as a dependent under the Self-Funded Benefit Plan or Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)).

The term Dependent includes any Child of a Participant who is covered under a self-funded benefit plan or Self-Funded Benefit Plan or Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

The term Dependent includes an Employee's domestic partner who is eligible under the Self-Funded Benefit Plan and qualifies as a tax dependent under the Code.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes the Participant's natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child is an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage ends at the end of the calendar year.

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

1.10 **"Effective Date"** means September 1, 1997.

1.11 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Employer or Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period is determined pursuant to Section 5.1.

1.12 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual may not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly

intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

Retirees and legislators are not eligible to participate in the Health and/or Dependent Care Flexible Spending Accounts. Legislators are eligible to participate in the Salary Redirection Agreement when they are receiving paychecks during the legislative session.

1.13 **"Employee"** means any person who is employed by the Employer. The term Employee includes leased employees within the meaning of Code Section 414(n)(2).

1.14 **"Employer"** means State of Montana and any successor which maintains this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer includes any Participating, Affiliated or Adopting Employer.

1.15 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.16 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan.

1.17 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.18 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 **"Plan"** means this instrument, including all amendments thereto.

1.20 **"Plan Year"** means the 12-month period beginning January 1 and ending December 31. The Plan Year is the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period is that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the insured Benefits described in Section 4.1.

1.22 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions are converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participant’s elections made under Article V.

1.23 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce the Participant’s Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement applies only to Compensation that has not been actually or constructively received

by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and subsequently does not become currently available to the Participant.

1.24 **"Self-Funded Benefit Plan"** means a plan offered by employers who directly assume the major cost of benefits for the employers' covered enrollees.

1.25 **"Spouse"** means spouse as determined under Federal law.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date the Employee satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment continues to be eligible to participate in the Plan. Eligibility under this Plan shall be the same as the Medical Plan regardless of whether the Eligible Employee is enrolled under the Medical Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee becomes a Participant effective on the following days:

1. For Salary Redirection, on date of hire;
2. For Health Flexible Spending Account and Dependent Care Flexible Spending Account, on the first of the month coincident with or following becoming eligible as described in 2.1 above.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election is irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change their Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also complete a Salary Redirection Agreement during the Election Period for the Plan Year during which the Eligible Employee wishes to participate in this Plan. Any such Salary Redirection Agreement is effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's self-funded or insured Benefits under this Plan shall automatically become a Participant to the extent of the Benefit Contributions or Premiums for such self-funded benefits or insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

2.4 TERMINATION OF PARTICIPATION

A Participant may no longer participate in this Plan upon the occurrence of any of the following events:

(a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.6;

(b) **Change in employment status.** The end of the Plan Year during which the Participant became a limited Participant because of a change in employment status pursuant to Section 2.5;

(c) **Death.** The Participant's death, subject to the provisions of Section 2.7; or

(d) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be eligible to participate because of a change in employment status or classification (other than through termination of employment), the Participant becomes a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made on behalf of the Participant, and, except as otherwise provided herein, all further Benefit elections must cease, subject to the limited Participant's right to continue coverage under any Self-Funded Benefit Plan or Insurance Contracts. However, any balances in the limited Participant's Dependent Care Flexible Spending Account may be used during such Plan Year to reimburse the limited Participant for any allowable Employment-Related Dependent Care incurred during the Plan Year. Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided the Employee otherwise satisfies the participation requirements set forth in this Article II as if they were a new Employee and made an election in accordance with Section 5.1.

2.6 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, the Participant’s participation in the Benefit Options provided under Section 4.1 is governed in accordance with the following:

(a) **Self-Funded or Insurance Benefit.** With regard to Benefits which are self-funded or insured, the Participant's participation in the Plan ceases, subject to the Participant's right to continue coverage under any Self-Funded Benefit Plan or Insurance Contract for which Benefit Contributions or Premiums have already been paid.

(b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan ceases and no further Salary Redirection contributions may be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred through the remainder of the Plan Year in which such termination occurs and submitted within 120 days after the end of the Plan Year, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year employed. Such Participant shall submit claims for services

incurred prior to their termination date within 120 days after their date of termination. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account are applied and administered consistent with such further rights a Participant and their Dependents may be entitled pursuant to Code Section 4980B and Section 11.14 of the Plan.

(d) **Retirement.** When retiring from employment, Participants are given the option to pre-pay the remainder of their annual Health Flexible Spending Account pre-tax contributions out of the Participants final paycheck.

2.7 DEATH

If a Participant dies, the Participant's participation in the Plan ceases. However, such Participant's Spouse or Dependents may submit claims for expenses or benefits incurred up to the Participant's date of death for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a Spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations apply for purposes of the Health Flexible Spending Account.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan are financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Benefit Contributions or Premium Expenses. The Employer shall advise the Employer's salary administration program to allow each Participant to agree to reduce their pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection must be specified in the Salary Redirection Agreement and must be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement is only applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions are converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection must be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and are irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts are contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account is credited to such fund or account. Amounts designated for the Participant's Benefit Contributions or Premium Expense Reimbursement Account are likewise credited to such account for the purpose of paying Benefit Contribution or Premium Expenses.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement above provided and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

(1) Health Flexible Spending Account

(2) Dependent Care Flexible Spending Account

In addition, each Participant may have a sufficient portion of the Participant’s Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

(3) Group Health Benefit

(4) Group Dental Benefit

(5) Group-Term Life Insurance Benefit

(6) Group Vision Benefit

(7) Accidental Death and Dismemberment Insurance Benefit

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 GROUP HEALTH BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under the health Self-Funded Benefit Plan for the Participant, their Spouse, and their Dependents.

(b) **Employer selects contracts.** The Employer may select a suitable Self-Funded Benefit Plan or Insurance Contracts for use in providing this Employer Group Health Benefit, which provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such Self-Funded Benefit Plan or Insurance Contract are determined therefrom, and such Self-Funded Benefit Plan or Insurance Contract is incorporated herein by reference.

4.5 GROUP DENTAL BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Self-Funded Benefit Plan for the Participant, their Spouse, and their Dependents.

(b) **Employer selects contracts.** The Employer may select a suitable dental Self-Funded Benefit Plan or Insurance Contracts for use in providing this Group Dental Benefit, which provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Self-Funded Benefit Plan or Insurance Contract are determined therefrom, and such dental Self-Funded Benefit Plan or Insurance Contract is incorporated herein by reference.

4.6 GROUP-TERM LIFE INSURANCE BENEFIT

(a) **Coverage for Participant only.** Each Participant may elect to be covered under the Employer's group-term life Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable group-term life Insurance Contracts for use in providing this group-term life insurance benefit, which provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such group-term life Insurance Contract are determined therefrom, and such group-term life Insurance Contract is incorporated herein by reference.

4.7 GROUP VISION BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Self-Funded Benefit Plan for the Participant, their Spouse, and their Dependents.

(b) **Employer selects contracts.** The Employer may select suitable vision Self-Funded Benefit Plan or Insurance Contracts for use in providing this Group Vision Benefit, which provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Self-Funded Benefit Plan or Insurance Contract are determined therefrom, and such vision Self-Funded Benefit Plan or Insurance Contract is incorporated herein by reference.

4.8 ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's accidental death and dismemberment Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable accidental death and dismemberment Insurance Contracts for use in providing this accidental death and dismemberment insurance benefit, which provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such accidental death and dismemberment Insurance Contract are determined therefrom, and such accidental death and dismemberment Insurance Contract is incorporated herein by reference.

4.9 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits do not include benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but is not required to, reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator must be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the

reduction is made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among self-funded or insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph are forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided the Participant elects to do so on or before the Participant's effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's self-funded or insured benefits under this Plan shall automatically become a Participant to the extent of the Benefit Contributions or Premiums for such self-funded benefits or insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant is given the opportunity to elect, on an election of benefits form to be provided by the Administrator or on-line enrollment system provided by the Employer, which spending account Benefit options the Participant wishes to select. Any such election is effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate their participation in the Plan by notifying the Administrator in writing during the Election Period that the Participant does not want to participate in the Plan for the next Plan Year;

(c) An Employee who elects not to participate for the Plan Year following the Election Period must wait until the next Election Period before electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

With regard to Benefits available under the Plan for which no Benefit Contribution or Premium Expenses apply, any Participant who fails to complete a new benefit election form or enroll online pursuant to Section 5.2 by the end of the applicable Election Period is deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections are authorized or made for the subsequent Plan Year for such Benefits.

With regard to Medical and Dental Benefits available under the Plan for which Benefit Contributions or Premium Expenses apply, any Participant who fails to complete a new benefit election form or enroll online pursuant to Section 5.2 by the end of the applicable Election Period is deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant is deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

5.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual is increased under the family member plan.

Regardless of the consistency requirement, if the individual's dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state or federal law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage for the remainder of the Plan year and must elect coverage for those premiums, if applicable, for the subsequent Plan Year or Years. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election is effective at such time as the Administrator prescribes, but not earlier than the first pay period beginning after the election form or online enrollment is completed and returned to the Administrator. For the purposes of this subsection, a change in status only includes the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that leads to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, qualifies as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant may be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan will automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) **Health FSA cannot change due to insurance change.** A Participant may not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any Group Health Benefits, including a Dependent child's enrollment in a plan authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP).

(l) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke coverage under the group health plan (that is not a health Flexible Spending Account) which provides minimum essential coverage (as defined in Code §5000A(f)(1)) provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

(1) The Participant has been reasonably expected to average at least 20 hours of service per week, and there is a change in that Participant's status so that the Participant is reasonably expected to average less than 20 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to average less than 20 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

(1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and is interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed are periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account may in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, their Spouse and their Dependents may be reimbursed.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining the Participant's tax liability under the Code. "Medical Expenses" may be incurred by the Participant, their Spouse and their Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as Benefit Contributions or Premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or the Participant's Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

6.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof, excluding any carryover) is forfeited and credited to the benefit plan surplus. In such event, the Participant may have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $2,550, as adjusted by law.

(b) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of

the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Flexible Spending Account.

(c) **Carryover.** A Participant in the Health Flexible Spending Account may roll over up to $500 of unused amounts in the Health Flexible Spending Account remaining at the end of one Plan Year to the immediately following Plan Year. However, if a Participant does not enroll in the new Plan Year, they shall have a balance of $120 in order to be eligible to carryover any balance they may have. These amounts may be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the one-hundred twenty (120) day period following the end of the Plan Year. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of $500 are forfeited. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but is not required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section must be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it must be completed in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year is reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process must continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph are forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan constitutes enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like are governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, their Spouse and their Dependents during the Plan Year are reimbursed during the Plan Year subject to Section 2.6, even though the submission of such a claim may occur after the Participant's participation hereunder ceases but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements may be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant is entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and their Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan are made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement must be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application must include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount may not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year are paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 120 days after the end of the Plan Year, those Medical Expense claims may not be considered for reimbursement by the Administrator.

6.8 QUALIFIED RESERVIST DISTRIBUTIONS

(a) **Qualified Reservist Distribution.** A Participant may request a Qualified Reservist Distribution, provided the following provisions are satisfied. "Qualified Reservist Distribution" means any distribution to a Participant of all or a portion of the balance in the Participant's Health Flexible Spending Account if:

(1) Such Participant was an individual who was (by reason of being a member of a reserve component (as defined in Section 101 of Title 37, United States Code)) ordered or called to active duty for a period of 180 days or more or for an indefinite period.

(2) A Participant may have been called prior to June 18, 2008, provided the individual's active duty continues after June 18, 2008 and the period of duty complies with subsection (a).

(3) The distribution is made during the period beginning on the date of the order or call that applies to the Participant and ending on the last day of the Plan Year which includes the date of such order or call.

(4) The Qualified Reservist Distribution option is offered to all Participants who qualify under this Article.

(5) Qualified Reservist Distributions may only be made if the Participant is ordered or called to active duty, not the Participant's spouse or dependents.

(6) Under Section 101 of the Title 37 of the United States Code, "reserve component" means: (1) the Army National Guard, (2) the Army Reserve, (3) the Navy Reserve, (4) the Marine Corps Reserve, (5) the Air National Guard, (6) the Air Force Reserve, (7) the Coast Guard Reserve, or (8) the Reserve Corps of the Public Health Service.

(b) **Conditions:** The following conditions apply:

(1) The Employer must receive a copy of the order or call to active duty and may rely on the order or call to determine the period that the Participant has been ordered or called to duty.

(2) Eligibility for a Qualified Reservist Distribution is not affected if the order or call is for 180 days or more or is indefinite but the actual period of active duty is less than 180 days or is changed otherwise from the order or call.

(3) If the original order is less than 180 days, then no Qualified Reservist Distribution is allowed. However, if subsequent calls or orders increase the total days of active duty to 180 or more, then a Qualified Reservist Distribution may be allowed.

(c) **Amount:** The amount a Participant may be reimbursed from the Health Flexible Spending Account is the amount actually contributed as of the date of the distribution request by the Participant for the Plan Year less any reimbursements received (or in process) as of the date of the distribution request.

(d) **Procedure.** The Employer shall specify a process for requesting the distribution. The Employer may limit the number of distributions processed for a Participant to one per Plan Year. The distribution request must be made on or after the call or order and before the last day of the Plan Year. The QRD may be paid within a reasonable time but in no event more than 60 days after the date of the request.

(e) **Claims.** Claims incurred prior to the date of the request of the distribution are paid as any other claim. Claims incurred after the date of the distribution may not be paid, and the Participant's right to submit a claim is terminated as of the date of the distribution request.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and is interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed are paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of the Participant's Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant are considered employment related expenses under Code Section 21(b)(2). Generally, they include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense is subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment or grant for more than 6 individuals who do not

regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant may not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account is increased each pay period by the portion of Cafeteria Plan Benefit Dollars that the Participant has elected to apply toward the Participant’s Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account is reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses is entitled to receive from the

Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which they are a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) is forfeited and credited to the benefit plan surplus. In such event, the Participant has no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant may not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year may be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but is not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section must be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it must be completed in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year is reduced until the nondiscrimination tests set forth in this Section are satisfied or until the amount designated for the account

equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process must continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph are forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan constitutes enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like are governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form must include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which the Participant wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if they are employed, or

(2) if the Participant's Spouse is not employed, that

(i) they are incapacitated, or

(ii) they are a full-time student attending an educational institution and the months during the year which they attended such institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 120 days after the end of the Plan Year, those claims may not be considered for reimbursement by the Administrator.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) **Self-funded or Insurance claims.** Any claim for Benefits underwritten by an Insurance Contract shall be made to the Insurer. Any claim for Benefits under a Self-Funded Benefit Plan shall be paid by the Employer or their designated self-funded benefit administrator. If a claim is denied, the Participant or beneficiary shall follow the Insurer's, Employer's or self-funded benefit administrator's claims review procedure.

(b) **Dependent Care Flexible Spending Account or Health Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account or Health Flexible Spending Account Benefits must be made to the Administrator. For the Health Flexible Spending Account, if a Participant fails to submit a claim within 120 days after the end of the Plan Year, those claims may not be considered for reimbursement by the Administrator. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 120 days after the end of the Plan Year, those claims may not be considered for reimbursement by the Administrator. If the Administrator denies a claim, the Administrator provides notice to the Participant or beneficiary, in writing, within 30 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim is written in a manner calculated to be understood by the claimant and sets forth below:

(1) specific references to the pertinent Plan provisions which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim appeal procedure.

(c) **Appeal.** Within 180 days after receipt of the above material, the claimant must appeal the claim denial to the Administrator for a full and fair review. The claimant or their duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(d) **Review of appeal.** A decision on the review by the Administrator must be made not later than 30 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision must be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator must be written and include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions which the decision is based.

(e) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account (excluding any carryover) or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year is forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim is held in the Participant’s account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year is forfeited and credited to the benefit plan surplus.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but may not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event may such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan (excepting any carryover); nor may amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus are used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. The Employer has contracted with Allegiance Benefit Plan Management, Inc. to provide Flexible Spending Account Administration Services. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal (in writing or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan is under the supervision of the Administrator. The principal duty of the Administrator is to see that the Plan is carried out in accordance with its terms and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator has full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as deemed necessary or advisable to carry out the purpose of the Plan. The Administrator has all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such claims may be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator must be done in a nondiscriminatory manner based upon uniform principles consistently applied and must be consistent with the intent that the Plan complies with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Administrative expenses are paid by the Participants under the Plan. The Administrator may impose reasonable conditions for payments, provided that such conditions do not discriminate in favor of highly compensated employees.

9.4 SELF-FUNDED BENEFIT AND INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of a Self-Funded Benefit Plan established by the Employer or Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Self-Funded Benefit Plan or Insurance Contract control as to those Participants receiving coverage under such Self-Funded Benefit Plan or Insurance Contract. For this purpose, the Self-Funded Benefit Plan or Insurance Contract controls in defining the persons eligible for self-funded benefits or insurance, the dates of their eligibility, the conditions which must be satisfied to become insured or eligible, if any, the benefits Participants are entitled to, and the circumstances under which self-funded benefits or insurance terminates.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment may have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions may be made. Benefits under any Self-Funded Benefit Plan or Insurance Contract are paid in accordance with the terms of the Self-Funded Benefit Plan or Insurance Contract.

No further additions may be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund must continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period are forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan are interpreted and applied in a uniform, nondiscriminatory manner. This Plan must be read in its entirety and not severed except as provided in Section 11.12.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they may be construed as though they were also used in another gender in all cases where they so apply, and whenever any words are used herein in the singular or plural form, they may be construed as though they were also used in the other form in all cases where they so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan is maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan may not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan may be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge has upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it must be done and performed by a person duly authorized by their legally constituted authority.

11.7 EMPLOYER'S PROTECTIVE CLAUSES

Insurance purchase. Upon the failure of either the Participant or the Employer to obtain the benefits contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits are limited to the benefit contributions, if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

11.8 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan may be excludable from the Participant's gross income for federal or state income tax purposes or that any other federal or state tax treatment may apply to or be available to any Participant. Each Participant is obligated to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan are legally enforceable.

11.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement may not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant may have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that may have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.10 FUNDING

Unless otherwise required by law, contributions to the Plan may not be placed in trust or dedicated to a specific Benefit but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein may be construed to require

the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person may have any claim against, right to or security or other interest in any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.11 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as amended from time to time). In no event does the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan are construed, enforced and administered according to the laws of the State of Montana.

11.12 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability does not affect any other provisions of the Plan, and the Plan must be construed and enforced as if such provision had not been included herein.

11.13 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way affect the Plan or the construction of any provision thereof.

11.14 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant is entitled to continuation coverage as prescribed in Code Section 4980B and related regulations.

11.15 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan must be operated in accordance with Regulation 1.125-3.

11.16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan is operated in accordance with HIPAA and regulations thereunder.

11.17 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service are provided in accordance with the Uniform Services Employment and Reemployment Rights Act (USERRA) and regulations thereunder.

11.18 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section applies.

(b) **Disclosure of PHI.** The Plan may not disclose Protected Health Information to any member of the Employer's workforce unless the conditions set out in this Section 11.18 are met. "Protected Health Information" has the same definition as set forth in the Privacy Standards but generally means individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce may be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions include all Plan payment functions and health care operations. The terms "payment" and "health care operations" have the same definitions as set out in the Privacy Standards, but the term "payment" generally means activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits or reimbursement for health care costs. Protected Health Information that consists of genetic information may not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan may disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information and only to the extent and in the minimum amount necessary for that person to perform their duties with respect to the Plan. "Members of the Employer's workforce" refers to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information and provide the list and any updates to the Plan.

(1) An authorized member of the Employer's workforce who receives Protected Health Information may use or disclose the Protected Health Information only to the extent necessary to perform their duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident must be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer shall provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

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

(10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.19 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" has the same definition as set out in the Security Standards but generally means Protected Health Information that is transmitted by or maintained in electronic media.

(b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information agrees, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.18.

11.20 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan complies with the Mental Health Parity and Addiction Equity Act.

11.21 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan complies with the Genetic Information Nondiscrimination Act.

11.22 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan l complies with the Women's Health and Cancer Rights Act of 1998.

11.23 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan complies with the Newborns' and Mothers' Health Protection Act.

SUMMARY PLAN DESCRIPTION
for the

FLEXIBLE BENEFITS PLAN

For The Employees of

STATE OF MONTANA

PLAN EFFECTIVE DATE:
SEPTEMBER 1, 1997

PLAN DOCUMENT EFFECTIVE DATE:
JANUARY 1, 2017

GROUP NUMBER:
501143/3001000

PLAN NUMBER:
501

Flex Claims Processed By:

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
2806 Garfield Street
P. O. Box 4346
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WEB SITE:
www.askallegiance.com

The Flex Plan Document and Flex Summary Plan Description for the State of Montana are included as an attachment to the Wrap Plan Document.

The terms of the Wrap Plan Document are not applicable to the Flex Plan Document or Flex Summary Plan Description.

If any conflict arises between the Wrap Plan Document and the Flex Plan Document or Flex Summary Plan Description, the terms of the Flex Plan Document or Flex Summary plan Description will control first, followed by the Wrap Plan Document.

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SUMMARY

STATE OF MONTANA
FLEXIBLE BENEFITS PLAN

INTRODUCTION

This "Flexible Benefits Plan" has been established for eligible employees. Under this Plan, the employee may be able to choose among certain benefits that we make available. The benefits that the employee may choose are outlined in this Summary Plan Description ("SPD"). This SPD also provides other important information concerning the Plan, such as the rules the employee must satisfy before the employee may join and the laws that protect their rights.

One of the most important features of the Plan is that the benefits being offered are generally ones for which the employee is already paying but normally with money that has been subject to income and Social Security taxes. Under the Plan, these same expenses are paid for with a portion of the employee's pay before income or Social Security taxes are withheld. This means that the employee pays less tax and will have more money to spend and save.

Read this SPD carefully to understand the provisions of the Plan and the benefits an employee may receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan Document, which governs the operation of the Plan. The Plan Document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan Document conflict, the Plan Document always governs. Also, if there is a conflict between a self-funded benefit or insurance contract and either the Plan Document or this SPD, the self-funded benefit or insurance contract controls. To receive a copy of the legal Plan Document, please contact the Employer.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect an employee's rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. The Plan may also be amended or terminated. If the provisions of the Plan that are described in this SPD change, employees shall be notified.

Please contact the Employer with any questions. The name and address of the Employer may be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When may an employee become a participant in the Plan?

To become a Plan member (referred to in this SPD as a "Participant"), certain requirements must be met. First, an active employee shall meet the eligibility requirements. Second, the employee shall join the Plan on the "entry date" that has been established for all employees. The "entry date" is defined in Question 3. The employee will be required to complete an on-line application to enroll in the Health Flexible Spending Account or Dependent Care Flexible Spending Account.

2. What are the eligibility requirements for the Plan?

An employee is eligible to join the Plan once the employee has enrolled for coverage under the group medical plan. If the employee was already a Participant before this amendment, the employee shall remain a participant.

3. When is my entry date?

Once the employee has met the eligibility requirements, the employee's participation in the Health and Dependent Care Flexible Spending Accounts begins on the first day of the month coinciding with or following the date the employee met the eligibility requirements.

4. Are there any members of the group medical plan who are not eligible?

Yes, there are certain members of the group medical plan who are not eligible to join the Plan. They are:

-- Retirees and legislators are not eligible to participate in the Health or Dependent Care Flexible Spending Accounts.

5. What must an employee do to enroll in the Plan?

Before an employee may join the Plan, the employee shall complete an on-line application to participate in the Plan. The on-line application includes the employee's personal choices for each of the benefits offered under the Plan. The employee must also authorize the Employer to set some of the employee's earnings aside in order to pay for the benefits the employee has elected.

However, if the employee is covered under any of the self-funded benefits or insurance contracts provided by the Employer, the employee may automatically participate in this Plan to the extent of the employee's contributions or premiums unless the employee elects not to participate in this Plan.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, the employee may elect to have some of the employee's upcoming pay contributed to the Plan. These amounts are used to pay for the benefits the employee has chosen. The portion of the employee's pay that is paid to the Plan is not subject to income or Social Security taxes. In other words, this allows the employee to use tax-free dollars to pay for certain kinds of benefits and expenses which the employee normally pays for with out-of-pocket, taxable dollars. However, if the employee receives a reimbursement for an expense under the Plan, the employee may not claim an income tax credit or deduction on the employee's income tax return. (See the Article entitled "General Information About the Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of the employee's pay may the Employer redirect?

Each year, the Employer shall automatically contribute on the employee's behalf enough of the employee's compensation to pay for the self-funded benefit or insurance contract coverage provided, unless the employee elects not to receive any or all of such coverage. The employee may also elect to have the Employer contribute on the employee's behalf enough of the employee's compensation to pay for any other benefits that the employee elects under the Plan. These amounts are deducted from the employee's pay over the course of the year.

2. What happens to contributions made to the Plan?

Before each Plan Year begins, the employee may select the benefits the employee wants and indicate how much of the contributions applies toward each benefit. It is very important that the employee make these choices carefully based upon what the employee expects to spend on each covered benefit or expense during the Plan Year as the contributions are used to pay for eligible expenses that arise during the Plan Year.

3. When is an employee required to decide which accounts the employee wants to use?

The employee is required by federal law to decide during the election period (below defined) before the Plan Year begins. The employee is required to decide which benefits the employee wants and how much applies toward each benefit.

If the employee is already covered by any of the self-funded benefits or insured contracts offered by this Plan, the employee automatically becomes a Participant to the extent of the contributions or premiums for such self-funded benefit or insurance contract unless the employee elects, during the election period (defined below), not to participate in the Plan.

4. When is the election period for the Plan?

The employee may make the employee's initial election on or before the employee's entry date (defined in Section 1). For the following Plan Year, the election period is established by the Employer and applied uniformly to all Participants. It is normally a period of time prior to the beginning of each Plan Year. The Employer shall inform the employee each year about the election period. (See the Article entitled "General Information About the Plan" for the definition of Plan Year.)

5. May an employee change their elections during the Plan Year?

Generally, the employee may not change the elections the employee made after the beginning of the Plan Year. However, there are certain limited situations when the employee may change the employee's elections. The employee is permitted to change elections if the employee has a "change in status," and the employee makes an election change that is consistent with the change in status. Currently, federal law considers the following events to be a change in status:

-- Marriage, divorce, death of a spouse, legal separation or annulment;

-- Change in the number of dependents, including birth, adoption, placement for adoption (must provide pre-adoption placement agreement) or death of a dependent;

-- Any of the following events for the employee, the employee's spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite or any other change in employment status that affects eligibility for benefits;

-- One of the employee's dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

-- A change in the place of residence of the employee, the employee's spouse or dependent that would lead to a change in status, such as moving out of a coverage area for self-funded benefits or insurance contracts.

In addition, if the employee is participating in the Dependent Care Flexible Spending Account, there is a change in status if the employee's dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give the employee rights to change health coverage for the employee, the employee's spouse or the employee's dependents. If the employee changes coverage due to rights the employee has under the law, the employee may make a corresponding change in the employee's elections under the Plan. If any of these conditions apply to the employee, the employee may contact the Employer.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then the Employer will automatically increase or decrease, as the case may be, the employee's salary redirection election. If the cost increases significantly, the employee may be permitted to either make corresponding changes in the employee's payments or revoke the employee's election and obtain coverage under another benefit package option with similar coverage or revoke the employee's election entirely.

If the coverage under a benefit is significantly curtailed or ceases during a Plan Year, the employee may revoke the employee's elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if the Employer adds a new coverage option or eliminates an existing option, the employee may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If the employee is not a Participant, the employee may elect to join the Plan. There are also certain situations when the employee may be able to change the employee's elections due to a change under the plan of the employee's spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and the employee may not change the employee's election to the Health Flexible Spending Account if the employee makes a change due to cost or coverage for self-funded benefits or insurance contracts.

The employee may not change the employee's election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is the employee's relative.

The employee may revoke the employee's coverage under the Employer group health plan outside of the Employer's open enrollment period if the employee's employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. The employee must show intent to enroll in another health plan.

The employee may also revoke the employee's coverage under the Employer sponsored group health plan if the employee is eligible to obtain coverage through the health exchanges.

6. May I make new elections in future Plan Years?

Yes, the employee may. For each new Plan Year, the employee may change the elections that the employee previously made. The employee may also choose not to participate in the Plan for the upcoming Plan Year. If the employee does not make new elections during the election period before a new Plan Year begins, the employee's elections for self-funded benefits or insured contracts only remains the same. The employee will not be considered a Participant for the flexible spending accounts and vision hardware coverage under the Plan for the upcoming Plan Year if the employee does not make new elections during the election period before a new Plan Year begins.

IV
BENEFITS

1. Health Flexible Spending Account

The Health Flexible Spending Account enables the employee to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by the group medical plan and pay less tax at the same time. The Health Flexible Spending Account allows the employee to be reimbursed for expenses incurred by the employee and the employee's dependents. If the employee actively contributes to a health savings account (HSA) or if the employee's spouse actively contributes to an HSA, the employee may not continue those eligible contributions to an HSA if the employee participates in a general purpose health flexible spending account (FSA).

Drug costs, including insulin, may be reimbursed. However, the employee may be reimbursed for "over the counter" drugs only if those drugs are prescribed for the employee. The employee may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan or for long-term care expenses. A list of covered expenses is available from the Plan Administrator.

The most that the employee may contribute to the employee's Health Flexible Spending Account each Plan Year is $2,550, as adjusted by law. In addition, the employee may be eligible to carryover amounts left in the employee's Health Flexible Spending Account, up to $500. This means that amounts the employee does not use during a Plan Year may be carried over to the next Plan Year and used for expenses incurred in the next Plan Year. However, if the employee does not enroll in the Plan in the new Plan Year, the employee must have a balance of at least $120 in order to be eligible to carryover any balance.

In order to be reimbursed for a health care expense, the employee is required to submit to the Plan Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on the employee's personal income tax return.

Expenses under this Plan are treated as being "incurred" when the employee is provided with the care that gives rise to the expenses, not when the employee is formally billed or charged or when the employee pays for the medical care.

The employee may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child or a child placed with the employee for adoption (must provide pre-adoption placement agreement). If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, shall reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact the group medical plan administrator for more information.

2. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables the employee to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If the employee is married, the employee may use the account if the employee and their spouse both work or, in some situations, if the employee's spouse goes to school full-time. Single employees may also use the account.

An eligible dependent is someone for whom the employee may claim expenses on federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center. If care is provided by the facility for more than six individuals, the facility must comply with applicable state and local laws;

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and

(c) An "Individual" who provides care inside or outside the employee's home: The "Individual" may not be a child of the employee's under age 19 or anyone the employee claims as a dependent for federal tax purposes.

Make sure that the dependent care expenses for which the employee is currently paying qualify under the Plan before making an election to contribute.

The law places limits on the amount of money that may be paid to the employee in a calendar year from the employee's Dependent Care Flexible Spending Account. Generally, the employee's reimbursements may not exceed the lesser of: (a) $5,000 (if the employee is married filing a joint return or the employee is head of a household) or $2,500 (if the employee is married filing separate returns); (b) the employee's taxable compensation; (c) the employee's spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to the employee from this account be excludable from the employee's income, the employee must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on the employee's tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, federal tax laws permit a tax credit for certain dependent care expenses the employee may be paying for even if the employee is not a Participant in this Plan. The employee may save more money if the employee takes advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under the Plan. Consult a tax adviser to determine which is better for the employee.

3. Premium Expense Account

A Premium Expense Account allows the employee to use tax-free dollars to pay for certain premium expenses under various self-funded benefit or insurance programs that the Employer offers the employee. These premium expenses include:

-- Health care contributions under the self-funded group medical plan.

-- Some group term life insurance premiums.

-- Dental care contributions under the self-funded group dental plan.

-- Vision care contributions under the self-funded group vision plan.

-- Some accidental death and dismemberment insurance premiums.

Under the Plan, sub-accounts for the employee are established for each different type of self-funded benefit or insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Employer may terminate or modify Plan benefits at any time, subject to the provisions of any self-funded benefits or insurance contract providing benefits described. The Employer may not be liable to the employee if an insurance company fails to provide any of the benefits described. Also, the employee's self-funded benefit or insurance ends when the employee leaves employment, is no longer eligible under the terms of any self-funded benefit or insurance policies or when self-funded benefit or insurance terminates.

Any benefits to be provided by self-funded benefit or insurance company may be provided only after (1) the employee has provided the Employer the necessary information to apply for self-funded benefit or insurance, and (2) the self-funded benefit or insurance is in effect for the employee.

If the employee elects to cover the employee's children up to age 26 under the employee's self-funded benefit or insurance, the employee may pay for that coverage through the Plan.

V
BENEFIT PAYMENTS

1. When may the employee receive payments from their accounts?

During the course of the Plan Year, the employee may submit requests for reimbursement of expenses the employee has incurred. Expenses are considered "incurred" when the service is performed not necessarily when it is paid. The Plan Administrator shall provide the employee with acceptable forms for submitting requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, the employee shall receive a reimbursement payment thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of self-funded or insured benefits should be made directly to the self-funded plan administrator or the insurer. The employee may only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover the employee's request.

2. What happens if an employee does not spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year are forfeited, except for the Health Flexible Spend Account where $500 may be carried over into the next Plan Year however the employee must have a balance of $120 in order to be eligible to carryover any balance. Qualifying expenses that the employee incurs late in the Plan Year for which the employee seeks reimbursement after the end of such Plan Year must be paid first before any amount is forfeited. For the Health Flexible Spending Account, the employee shall submit claims no later than 120 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, the employee shall submit claims no later than 120 days after the end of the Plan Year. Because it is possible that the employee may forfeit amounts in the Plan if the employee does not fully use the contributions that have been made, it is important that the employee decides how much to place in each account carefully and conservatively. Remember, the employee shall decide to which benefits the employee wants to contribute and how much to place in each account before the Plan Year begins. The employee must be as certain as possible that the amount the employee decides to place in each account may be used entirely.

3. Family and Medical Leave Act (FMLA)

If the employee takes leave under the Family and Medical Leave Act, the employee may revoke or change the employee's existing elections for self-funded benefits or insured benefits, the Health Flexible Spending Account, and the Dependent Care Flexible Spending Account. If the employee's coverage in these benefits terminates, due to the employee's revocation of the benefit while on FMLA leave or due to the employee's non-payment of contributions while on FMLA leave, the employee may be permitted to reinstate coverage for the remaining part of the Plan Year upon the employee's return. For the Health Flexible Spending Account, the employee may continue the employee's coverage or the employee may revoke the employee's coverage and resume it when the employee returns from FMLA. The employee may resume the employee's coverage at its original level and make payments for the time that the employee is on leave. For

example, if the employee elects $1,200 for the year and is out on leave for 3 months, then returns and elects to resume the employee's coverage at that level, the employee's remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively, the employee's maximum amount may be reduced proportionately for the time the employee was out on FMLA leave. For example, if the employee elects $1,200 for the year and is out on leave for 3 months, the employee's amount may be reduced to $900. The expenses the employee incurs during the time the employee is not in the Health Flexible Spending Account are not reimbursable.

If the employee continues the employee's coverage during the employee's unpaid leave, the employee may pre-pay for the coverage, the employee may pay for the employee's coverage on an after-tax basis while the employee is on leave or the employee and the Employer may arrange a schedule for the employee to "catch up" the employee's payments when the employee returns.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If the employee is going into or returning from military service, the employee may have special rights to health care coverage under the employee's Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights may include extended health care coverage. If the employee may be affected by this law, ask the employee's Plan Administrator for further details.

5. What happens if I terminate employment?

If the employee terminates employment during the Plan Year, the employee's right to benefits are determined in the following manner:

(a) The employee remains covered by the self-funded benefit plan or insured benefits but only for the period for which contributions or premiums have been paid prior to the employee's termination of employment.

(b) The employee may request reimbursement for qualifying dependent care expenses incurred during the remainder of the Plan Year from the balance remaining in the employee's dependent care account at the time of termination of employment. However, no further salary redirection contributions may be made on the employee's behalf after the employee terminates. The employee shall submit claims within 120 days after the end of the Plan Year in which termination occurs.

(c) The employee may request reimbursement from the balance remaining in the employee's Health Flexible Spending Account at the time of termination of employment for qualifying medical expenses incurred prior to the employee's termination date. However, no further salary redirection contributions may be made on the employee's behalf after the employee terminates. The employee shall submit claims within 120 days after termination of employment. However, the employee may elect to continue the employee's participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. The employee may only continue to participate in the Health Flexible Spending Account if the employee has contributed more money than the employee has received reimbursement for claims. For example, if the employee elected to contribute an annual amount of $500 and, at the time the employee terminates employment, the employee has contributed $300 but only claimed

$150, the employee may elect to continue coverage under the Health Flexible Spending Account. If the employee elects to continue coverage, then the employee may be able to continue to receive the employee's health care reimbursements up to the $500. However, the employee is required to continue to pay for the coverage, just as if the money had been taken out of the employee's paycheck but on an after-tax basis. The Plan may also charge the employee an additional amount (see COBRA Continuation of Coverage section for details) to provide this benefit. If the employee is eligible to continue participation in the Health Flexible Spending Account, the employee's dependents may also have an independent right to elect COBRA continuation coverage (see COBRA Continuation of Coverage section for details).

6. Will my Social Security benefits be affected?

The employee's Social Security benefits may be slightly reduced because when the employee receives tax-free benefits under our Plan, it reduces the amount of contributions that the employee makes to the federal Social Security system as well as the Employer contribution to Social Security on the employee's behalf.

7. Qualified Reservist Distributions

If the employee is a member of a reserve unit and if the employee is ordered or called to active duty, then the employee may request a Qualified Reservist Distribution (QRD). A Qualified Reservist Distribution is a distribution of all or a portion of the amounts remaining in the employee's Health Flexible Spending Account. The employee may only request this distribution if the employee is called to active duty for a period of 180 days or more or for an indefinite period. The distribution must be made during the period beginning on the date of the call and ending on the last date that reimbursements may otherwise be made under the Plan for the Plan Year which includes the date of the call.

The employee may receive the amount actually contributed as of the date of the distribution request, minus any reimbursements the employee has already received (or are in process). The amount the employee requests may be adjusted if needed to conform with the employee's actual account balance. The employee shall request the QRD before the last day of the Plan Year. Any claims that the employee submits after the date the employee request the QRD may not be processed. The employee may only request one QRD for a Plan Year.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. The employee may be notified by the Plan Administrator each Plan Year whether the employee is a highly compensated employee or a key employee.

If the employee is within these categories, the amount of contributions and benefits for the employee may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan may be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under the Plan.

Plan experience dictates whether contribution limitations on highly compensated employees or key employees applies. The employee shall be notified of these limitations if the employee is affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Plan Administrator shall provide the employee with a statement of the employee's account periodically during the Plan Year that shows the employee's account balance. It is important to read these statements carefully so the employee understands the balance remaining to pay for a benefit. Remember, the employee wants to spend all the money the employee has designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which the employee may need to know about the Plan.

1. General Plan Information

State of Montana Flexible Benefits Plan is the name of the Plan.

The Employer has assigned Plan Number 501 to the Plan.

The provisions of the re-stated Plan become effective on January 1, 2017. The Plan was originally effective on September 1, 1997.

The Plan's records are maintained on a twelve-month time period. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

The Employer's name, address, and tax identification number are:

State of Montana
Health Care & Benefits Division
100 N Park Avenue Suite 320
Helena, Montana 59601
81-0302402

3. Plan Administrator Information

The name, address and business telephone number of the Plan's Administrator are:

Allegiance Benefit Plan Management, Inc.
P.O. Box 4346
Missoula, Montana 59806

Website: www.askallegiance.com/som
Phone: (877)424-3570
Fax: (877)424-3539

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator shall also answer any questions the employee may have about the Plan. The employee may contact the Plan Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

State of Montana
Health Care & Benefits Division
100 N Park Avenue Suite 320
Helena, Montana 59601

5. Type of Administration

The type of Administration is Employer Administration. The Employer has contracted with Allegiance Benefit Plan Management, Inc. to provide Plan Administration services.

6. Claims Submission

Claims for expenses must be submitted to:

Allegiance Benefit Plan Management, Inc.
P.O. Box 4346
Missoula, Montana 59806

Website: www.askallegiance.com/som
Phone: (877)424-3570
Fax: (877)424-3539

IX
ADDITIONAL PLAN INFORMATION

1. Claims Process

All reimbursement claims for the Plan Year must be submitted by the employee. For the Health Flexible Spending Account, the employee shall submit claims no later than 120 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, the employee shall submit claims no later than 120 days after the end of the Plan Year. Any claims submitted after that time may not be considered.

If elected by the Participant, claims may be reimbursed through the use of a debit card issued by the Plan Administrator. Substantiation of the claims as covered expenses under this Plan may still be required after use of the debit card. Failure to substantiate debit card transactions when requested may result in tax consequences to the Participant and if there are repeated failures, cancellation of the debit card. The debit card will only be available for use during Plan Years in which the employee has made an active Plan Year election.

If elected by the Participant through a process called Joint Processing, certain medical claims that are subject to the deductible, copayments or benefit percentage of the group medical plan may be processed automatically under the Health Flexible Spending Account.

Claims for benefits that are insured or self-funded may be reviewed in accordance with procedures contained in the policies or Plan Documents. All other general claims or requests must be directed to the Plan Administrator of the Plan. If a claim under the Plan is denied in whole or in part, the employee or the employee's beneficiary shall receive written notification from the Plan Administrator. The notification includes the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. Within 180 days after denial, the employee or the employee's authorized representative may submit a written request for reconsideration of the claim to the Plan Administrator. The Plan Administrator has a maximum of 30 days from the date the written appeal is received to make a final decision regarding the appeal. The employee may have additional rights for some reimbursement decisions to appeal to a federal district court with jurisdiction, however, in order to do so the employee shall exhaust all of the employee's rights to appeal the claim to the Plan Administrator as outlined.

X
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under the Health Flexible Spending Account may have the right to elect to continue coverage under the Health Flexible Spending Account for the remainder of the Plan Year (called "COBRA continuation coverage"), where coverage under the Health Flexible Spending Account would otherwise end. This notice is intended to inform Plan participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be

provided by the Plan Administrator to Plan participants who become Qualified Beneficiaries under COBRA. Whenever "Plan" is used in this section, it means the Health Flexible Spending Account.

COBRA Continuation Coverage is available to any Qualified Beneficiary* whose coverage would otherwise terminate due to a Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day following the date coverage terminates.

*Qualified Beneficiary for the purposes of this section means only an employee or former employee who is eligible to continue coverage in accordance with applicable provisions of federal COBRA law.

Qualifying Events:

Qualifying Events for former employee participants, for purposes of this section, are the following events, if that event causes a loss of coverage under the Health Flexible Spending Account:

1. Termination (other than by reason of gross misconduct) of the former employee participant's employment; or

2. Reduction in hours of the former employee participant's employment.

Giving Notice of a Qualifying Event:

The Plan offers COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is termination of or reduction of hours of employment.

NOTICE PROCEDURES:

The Plan Administrator is:
State of Montana
Health Care & Benefits Division
100 N Park Avenue Suite 320
Helena, MT 59601

COBRA Continuation Coverage for the Plan is administered by:
Allegiance COBRA Services, Inc.
P.O. Box 2097
Missoula, MT 59806
406-721-2222

Any notice the employee provides must be **in writing**. The employee must mail, fax or hand-deliver the notice to the address above.

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice the employee provides must state:

- the **name of the plan(s)** under which the employee lost or are losing coverage;
- the **name and address of the employee** covered under the plan;
- the **name(s) and address(s) of the Qualified Beneficiary(s)**; and
- the **Qualifying Event** and the **date** it happened.

Notice of Election to Continue Coverage:

When the Plan Administrator is notified of a Qualifying Event, the Plan Administrator shall notify the Qualified Beneficiary of the right to elect COBRA continuation coverage, if applicable. Notice of this right must be sent within fourteen (14) days after the Plan Administrator receives notice of the Qualifying Event from the Employer or the employee.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notice from the Plan Administrator, whichever is later, to elect to continue coverage. Failure to elect continuation coverage within that period causes coverage to terminate.

Monthly Contribution Amounts:

A Qualified Beneficiary who elects to continue coverage shall pay the full cost of COBRA continuation coverage. Monthly contribution amounts for COBRA continuation coverage must be paid in advance to the Plan Administrator. The monthly payment for coverage will be an amount equal to one hundred and two percent (102%) of the former employee participant's monthly contribution amount (including the Employer's share) prior to the Qualifying Event.

Payment of any reimbursement requests submitted by a COBRA participant during the period of COBRA coverage are contingent upon timely payment of the monthly contributions by the COBRA participant. Monthly contributions are due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month is allowed for payment. Payment must be made in a manner prescribed by the Plan Administrator.

When Cobra Continuation Coverage Ends:

COBRA Continuation Coverage under the Health Flexible Spending Account will cease at the end of the Plan Year for any COBRA participant.

IF THE EMPLOYEE HAS QUESTIONS

If the employee has questions about COBRA continuation coverage, the employee should contact the Plan Administrator or its designee. For more information about the employee's rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP THE PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect the employee's family's rights, the employee shall keep the Plan Administrator informed of any changes in the addresses of family members. The employee shall

also keep a copy, for their records, of any notices the employee sends to the Plan Administrator or its designee.

XI
SUMMARY

The money the employee earns is important to the employee and their family. The employee needs it to pay the employee's bills, enjoy recreational activities and save for the future. The flexible benefits plan helps the employee keep more of the money they earn by lowering the amount of taxes the employee pays. The Plan is the result of continuing efforts to find ways to help the employee get the most for the employee's earnings.

If the employee has any questions, please contact the Administrator.

State of Montana:

Non-Discrimination Statement: State of Montana complies with applicable federal civil rights laws, state and local laws, rules, policies and executive orders and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana does not exclude people or treat them differently because of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If the employee need these services, contact customer service at 855-999-1062. If the employee believe that State of Montana has failed to provide these services or discriminated in another way on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status the employee can file a grievance. If the employee need help filing a grievance, John Pavao, State Diversity Coordinator, is available to help the employee. The employee may file a grievance in person or by mail, fax, or email:

John Pavao
State Diversity Program Coordinator
Department of Administration
State of Montana, Human Resources Division
125 N. Roberts
P.O. Box 200127
Helena, MT 59620
Phone: (406) 444-3984
Email: jpavao@mt.gov

The employee may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Language Access Services: The information below is a requirement of Section 1557 of the Affordable Care Act effective August 18, 2016. It is required to assist those who may need assistance with the English language or translation assistance to a different language in which they are more fluent.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけま.1-855-999-1062（TTY:1-855-999-1063）まで、お電話にてご連絡ください.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés ratuitement. ppelez le 1-855-999-1062 (ATS: 1-855-999-1063).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1062) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- 1062-999—855(رقم هاتف الصم والبكم: 1-855-999-1062).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-999-1062 (TTY: 1-855-999-1062).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-999-1062 (TTY: 1-855-999-1063).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-999-1062 (телетайп: 1-855-999-1063).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).