APPEAL PROCEDURES
TO CLAIMANT OR CLAIMANT'S DULY AUTHORIZED REPRESENTATIVE

Please refer to your Summary Plan Description Booklet for important features of your Health FSA and/or HRA such as terms, conditions, limitations and exclusions in the FSA and/or HRA Plan Document. You may call us concerning your claim at 1-877-424-3570, or write to us at the address below. Plan design features are determined by the Plan Sponsor and cannot be appealed but if you do not agree with the Plan's decision regarding the specific benefit request described on this document, the Plan provides a review process for reconsideration of claims.

You must file a written request for a review of the claims decision within one hundred eighty (180) days of the date of this notice. If you do not file a written request for review within 180 days, your request for review will be denied. Your request should contain the reasons why you do not agree with the Plan's decision along with any additional documentation you would like the Plan to review to provide full and fair reconsideration of the claim. Send your request and additional information to the address below. If you request a review within 180 days, the Plan Supervisor will review the claim.

Additional FLEX Appeal Procedure: The Plan Administrator will review your appeal, Plan Document and applicable federal law and make a decision within sixty (60) days. If the Plan Administrator needs additional information, the claims processing center will request that information from you, and you will have forty-five (45) days to provide it. The sixty (60) day time frame will be suspended during the time it takes you to produce this information. Following receipt of complete information a decision will be provided to you within the balance of the sixty (60) day period remaining. You or your authorized representative may request to review all information denial of the disputed portion of the claim was based on. You must submit your request for the information to the address below.

Additional HEALTH REIMBURSEMENT ARRANGEMENT (HRA) Appeal Procedure:
First Level of Review - If the Plan needs additional information from you the claims processing center will request that information from you, and you will have forty-five (45) days to provide it. Upon receipt of complete information from you, a decision will be provided within thirty (30) days from the date the Plan received your request.
Second Level of Review – (By the Plan Administrator**)** If you are not satisfied with the Plan Supervisor' decision, you may appeal to the Plan Administrator by filing a written request for appeal within sixty (60) days after receiving the Plan Supervisor's decision. If you do not file the written request within sixty (60) days, the Plan Administrator will not consider your appeal and the claim determination will become final. If you submit your appeal request within sixty (60) days, the Plan Administrator will provide a final determination within thirty (30) days from the date the Plan receives your request. You have the right to bring a civil action under Section 502 of ERISA (or other applicable law for non ERISA plans) following an adverse benefit determination by the Plan Administrator on appeal. Please be aware that all civil actions require that they be brought within specific timeframes. You or your authorized representative may request to review all information denial of the disputed portion of the claim was based on. You must submit your request for the information to the Plan at the address below.

All HRA and FLEX appeals should be mailed to: P.O. Box 4346, Missoula, MT 59806