MACo HEALTH CARE TRUST

BENEFIT SUMMARY

Dental and Vision

July 1, 2023

IT’S ALL ABOUT TRUST
Mission
The mission of MACo HCT is to provide quality group health benefits for Montana Counties. We accomplish this through member directed leadership, outstanding member service, excellent benefit plans including preventive care and wellness, premium rate stability through shared risk pooling, and responsible transparent financial management.

Open Enrollment & Special Enrollments
After initial enrollment, changes to your plan options can only be made during Open Enrollment each year. The only time you may change plans outside of Open Enrollment is if you meet criteria for a Special Enrollment. Special Enrollments are allowed upon marriage, divorce, birth or adoption, death of a spouse or child, loss of other coverage, or change in you or your spouse’s employment. Changes must be made within 60 days of the Special Enrollment. Changes for other reasons are allowed only during Open Enrollment periods. For complete details, please refer to the Summary Plan Description.

Contact Information
Allegiance Benefit Plan Management
MACo Health Care Trust
Customer Service & Claims
Administration
Dental and Vision coverage claims questions
Enrollment and eligibility questions
888-883-3233
406-443-8102
askallegiance.com
mtcounties.org/hct

DENTAL BENEFITS

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible per Individual</td>
<td>$25</td>
</tr>
<tr>
<td>Type A - Diagnostic/Preventive Care</td>
<td>100%</td>
</tr>
<tr>
<td>Type B - Routine/Basic Care</td>
<td>80/20%</td>
</tr>
<tr>
<td>Type C - Major Restorative</td>
<td>50/50%</td>
</tr>
<tr>
<td>Maximum Dental Benefit per Period per Individual</td>
<td>$1,600</td>
</tr>
<tr>
<td>(Type A, B and C Expenses)</td>
<td></td>
</tr>
<tr>
<td>Orthodontia Benefit</td>
<td>50/50%</td>
</tr>
<tr>
<td>(For Dependents Under Age 19)</td>
<td></td>
</tr>
<tr>
<td>Maximum Lifetime Orthodontia Benefit</td>
<td>$1,000</td>
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</table>

VISION BENEFITS

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible per Individual</td>
<td>$0</td>
</tr>
<tr>
<td>Exam</td>
<td>$100/annual allowance</td>
</tr>
<tr>
<td>Hardware</td>
<td>$350/annual allowance</td>
</tr>
</tbody>
</table>

The Vision Hardware benefit may be used towards:
- one pair of frames & prescription lenses, or
- one pair of frames & prescription sunglasses, or
- a 12-month supply of prescription contact lenses

- Members are welcome to seek treatment from any Dental and Vision providers of their choice
- Dental and/or Vision benefits may be voluntarily canceled only during Open Enrollment
- If Dental and/or Vision benefits are voluntarily canceled, there is a two-year waiting period before coverage can be reinstated.

How To File Dental & Vision Claim

Point of Service
Present your MACo HCT ID Card at the time of service which allows your provider to submit a claim on your behalf.

Online
Go to: www.askallegiance.com
Click: “Submit a Claim” Click: “Health” for claim type
Enter personal information, attach documentation to “Upload and Submit”

Fax
Copy your MACo HCT ID Card or write your name and ID Number on your detailed Dental or Vision Invoice then fax to: 866-201-0522

Mail
Copy your MACo HCT ID Card or write your name and ID Number on your detailed Dental or Vision Invoice then mail to: MACo Health Care Trust Claims, P.O. Box 1966, Missoula, MT 59806
**DENTAL BENEFITS**

Dental Benefits are available only to those Participants whose Member Group or Sub-Entity has opted for this coverage and who have individually elected the coverage and the premium has been paid. If a Participant elects this coverage, election for Dental Benefits may be voluntarily terminated only during the Open Enrollment Period or Special Enrollment Event. If Dental benefits are voluntarily terminated, there will be a two (2) year waiting period before the coverage can be reinstated. All general Plan provisions apply to this Plan.

**SCHEDULE OF DENTAL BENEFITS**

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND LIMITS OF THE PLAN.

The Benefit Period is the coverage period for each Member Group or Sub-Entity. Please refer to the Benefit Period listed in the Schedule of Medical Benefits for the applicable Participant’s Plan.

- **Annual Deductible** per Covered Person per Benefit Period $25

  **Type A (Diagnostic/Preventive Care) Dental Expenses**
  - Deductible..........................................................Applies
  - Benefit Percentage........................................100%

  **Type B (Routine/Basic Care) Dental Expenses**
  - Deductible..........................................................Applies
  - Benefit Percentage........................................80%

  **Type C (Major Restorative) Dental Expenses**
  - Deductible..........................................................Applies
  - Benefit Percentage........................................50%

  **Orthodontic Treatment** (up to 19 years of age only)
  - Deductible..........................................................Applies
  - Benefit Percentage........................................50%

  - **Maximum Benefit per Benefit Period per Covered Person (Type A, B and C Expenses)** $1,400
  - **Maximum Lifetime Benefit for Orthodontic Treatment per Covered Person** $1,000

**TYPE A (DIAGNOSTIC/PREVENTIVE CARE) EXPENSES**

The following general dental expenses will be considered “Type A” for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Oral Examination (including prophylaxis scaling and cleaning of teeth), but not more than twice in any Benefit Period.
2. Topical application of sodium fluoride or stannous fluoride in conjunction with prophylaxis, limited to once per Benefit Period.
3. Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment; also, other dental x-rays, but not more than one full mouth x-ray or series in any three Benefit Periods and not more than two sets of supplementary bitewing x-rays in any Benefit Period.
4. Space maintainers, used to maintain the present position of a tooth, but not to move the tooth.
5. Sealants for Dependent children under age nineteen (19) but limited to one (1) sealant per permanent tooth per lifetime.

**TYPE B (ROUTINE/BASIC CARE) EXPENSES**

The following general dental expenses will be considered “Type B” for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Extractions, including extractions related to orthodontia for a Dependent child under age nineteen (19).
2. Oral surgery.
3. Restorative Services: Provides amalgam, synthetic porcelain and plastic restorations for treatment of decay (one restoration per surface; benefits may be paid for restorations placed on the same surface once each eighteen months) except the maximum fee payable for restoration of primary teeth is the charge for a stainless steel crown.
4. Sedative fillings.
5. General anesthesia or conscious intravenous “IV” sedation when Medically Necessary and administered in connection with oral surgery or other Covered Dental Benefits.
6. Treatment, including periodontal surgery of diseased periodontal structures for periodontal and other diseases affecting such structures.
7. Endodontic treatment including root canal therapy.
8. Injection of antibiotic drugs.
TYPE C (MAJOR RESTORATIVE) EXPENSES

The following general dental expenses will be considered “Type C” for reimbursement purposes:

1. Gold restorations, inlays, onlays or crowns (including precision attachments for dentures) once every five (5) years only when the tooth cannot be restored with another filling material, and then such charges will be considered prosthetic services.

2. Prosthetic Services: Procedures for construction of bridges, partial and complete dentures, including gold restorations, crowns and jackets, onlays when the teeth cannot be restored with another material, except:
   A. Prosthetic benefits including a replacement of a crown are payable only once every five (5) years;
   B. If an existing appliance can be made serviceable, only the charges for improving the appliance will be eligible (not replacement costs);
   C. Reline will be eligible only once in any three (3) year period.

3. Charges for implants.

4. Appliances to reduce or prevent pain or damage from bruxism (grinding of the teeth) or occlusion.

ORTHODONTIC TREATMENT (UP TO NINETEEN (19) YEARS OF AGE ONLY)

The following expenses will be considered “Orthodontic” for reimbursement purposes and will be payable as stated in the Schedule of Dental Benefits and subject to a Maximum Lifetime Benefit applicable to Orthodontic Treatment:

1. Treatment for a diagnosed malocclusion.

2. Cephalometric X-ray once in any two (2) consecutive Benefit Periods.

3. One set of study models per Covered Person.

4. Initial placement of braces or appliances, ongoing treatment adjustment, removal and follow-up related to said initial placement.

5. Orthodontic extractions.

If Orthodontic Treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received.

DENTAL BENEFIT LIMITATIONS

Charges for the replacement of existing dentures or removable or fixed bridgework will be considered an Eligible Expense only if the existing appliance is not serviceable and cannot be repaired.

DENTAL BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Dental Benefits in addition to the following Dental Benefit Exclusions:

1. Charges for dental services or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by a Member Group or Sub-Entity, to the extent that the expenses have been paid by another applicable portion of this Plan or any other insurance or employee benefit plan.

2. Charges for treatment which is not rendered by or in the presence of a Dentist or other Licensed Health Care Provider covered by the Plan, except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist if the treatment is rendered under the supervision of the direction of the Dentist.

3. Charges for dentures, crowns, inlays, onlays, bridgework or other appliances which are not Dentally Necessary and performed solely or primarily for Cosmetic or personal reasons, personal comfort, convenience, or beautification items, including charges for personalization or characterization of dentures.

4. Charges for facility, Ambulatory Surgery Center and Hospital charges.

5. Charges for local anesthesia administered in conjunction with covered dental services or procedures, when billed separately (unbundled) from the charge for the Covered Service or procedure.

6. Charges for the replacement of a lost, missing, or stolen appliance device or for an additional (spare) appliance.

7. Charges for any services or supplies which are for Orthodontic Treatment, including orthodontic extractions, except as specifically provided for by the Plan.

8. Service to increase vertical dimension, equilibration and extra-coronal or other periodontal splinting.

9. Charges for root canal therapy for which the pulp chamber was opened before the individual became a Covered Person.

10. Charges for dentures, crowns, inlays, onlays, bridgework or other appliances which are not necessary and performed solely for Cosmetic or personal reasons.

11. Charges for oral hygiene and dietary instructions.


13. Charges for fixed bridges for Covered Persons under sixteen (16) years of age.

14. Charges for replants, transplants or any treatment rendered on such teeth.

15. Charges for root canals on primary teeth.

16. Charges in excess of the PRIME (Referenced Based Pricing).

17. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis, or treatment of any nature 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 retrusion.

18. Charges for any services, supplies or appliances which are not specifically listed as a benefit of this Plan.

19. Charges for broken or missed appointments.
DENTAL BENEFIT EXCLUSIONS—cont.

20. Charges for infection control (OSHA) fees or claim filing.
21. Charges for non-dental services such as training, education, instructions or educational materials, even if they are performed or provided by a dental service provider.
22. Charges for hypnosis, prescribed drugs, pre-medications, nitrous oxide or any euphoric drugs.
23. Charges for biopsies or oral pathology, except as specifically provided for under Covered Dental Services.
24. To the extent that the Covered Person could have obtained payment, in whole or in part, if he/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.

DENTAL BENEFIT DETERMINATION PROVISIONS

ELIGIBLE EXPENSES

Services, treatments or supplies are a Covered Dental Benefit if they meet all of the following requirements:

1. They are administered, provided or ordered by a Dentist, Denturist, Dental Hygienist or other Licensed Health Care Provider covered by the Plan; and
2. They are Dentally Necessary for the diagnosis and treatment of a dental condition or dental disease unless otherwise specifically included as an Eligible Expense; and
3. Charges therefore do not exceed the Eligible Expense. If two or more procedures are separately suitable for the correction of a specific condition, the Eligible Expense will be based upon the least expensive procedure; and
4. They are not excluded under any provision or section of this Plan.
5. “Dentally Necessary” 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:
6. Are to treat or diagnose a Dental condition or dental disease; and
7. 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
8. Are not primarily for the convenience of the Covered Person, Dentist or other Licensed Health Care Provider; and
9. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person; and
10. Are not of an Experimental/Investigational or solely educational nature; and
11. Are not provided primarily for dental, medical or other research; and
12. Do not involve excessive, unnecessary or repeated tests; and
13. Are commonly and customarily recognized by the dental profession as appropriate in the treatment or diagnosis of the diagnosed condition; and
14. Are approved procedures or guidelines by the Food and Drug Administration, Healthcare Financing Administration (HCFA) and the American Dental Association, pursuant to that entity’s program oversight authority based upon the dental treatment circumstances.

DEDUCTIBLE AND BENEFIT PERCENTAGE

The Deductible applies to Eligible Expenses Incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period.

After satisfaction of the applicable Deductible, Eligible Expenses Incurred by a Covered Person will be paid by the Plan according to the applicable Benefit Percentage stated in the Schedule of Dental Benefits. The Plan will pay the percentage of the Eligible Expense indicated as the Benefit Percentage.

MAXIMUM BENEFIT PAYABLE

The Maximum Benefit per Benefit Period as specified in the Schedule of Dental Benefits is the maximum amount that may be paid by the Plan for Eligible Expenses Incurred by each individual Covered Person in each Benefit Period as indicated in the Schedule of Dental Benefits.

EXPENSES INCURRED

For a dental appliance or modification of a dental appliance, an expense is considered Incurred at the time the impression is made. For a crown, bridge or gold restoration, an expense is considered Incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered Incurred at the time the pulp chamber is opened. All other expenses are considered Incurred at the time a service is rendered or a supply furnished.
VISION BENEFITS

Vision Benefits are available only to those Participants whose Member Group or Sub-Entity has opted for this coverage and who have individually completed an enrollment form requesting coverage and the premium has been paid. If a Participant elects this coverage, election for Vision Benefits may be voluntarily terminated only during the Open Enrollment Period or Special Enrollment Period. If Vision benefits are voluntarily terminated, during the Open Enrollment Period or Special Enrollment Period, there will be a two (2) year waiting period before the coverage can be reinstated. All general Plan provisions apply to this Plan.

PAYMENT OF BENEFITS

If a covered Person, while covered for Vision Benefits, incurs charges for Covered Vision Care Services, benefits are payable under the Plan up to the maximums stated in the Schedule of Vision Benefits.

SCHEDULE OF VISION BENEFITS

The Benefit Period is the coverage period for each Member Group of Sub-Entity. Please refer to the Benefit

<table>
<thead>
<tr>
<th>PAYMENT PROVISIONS AND LIMITATIONS</th>
<th>MAXIMUM PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANNUAL DEDUCTIBLE</td>
<td>None</td>
</tr>
<tr>
<td>BENEFIT PERCENTAGE</td>
<td>100% of eligible charges, up to the schedule amount</td>
</tr>
<tr>
<td>EXAMINATION (spectacles lenses or contacts)</td>
<td>Limited to one exam per Covered Person per Benefit</td>
</tr>
<tr>
<td></td>
<td>$100</td>
</tr>
<tr>
<td>MATERIALS</td>
<td>Limited to one pair of glasses (frames and lenses) or contact lenses, but not both, per Benefit Period</td>
</tr>
<tr>
<td></td>
<td>$350</td>
</tr>
</tbody>
</table>

COVERED VISION CARE SERVICES

The reasonable and customary fees, as set forth in the Schedule of Vision Benefits, for the following services and supplies will be considered eligible when they are necessarily incurred upon recommendation of a Physician, ophthalmologist or optometrist:

1. Vision Examinations - including a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities, limited to one exam per Benefit Period.

2. Necessary Contact Lenses - When deemed necessary by the Physician, the expenses incurred for the evaluation, fitting and materials for the dispensing of contact lenses will be provided, in lieu of frames and lenses, but not more frequently than once per Benefit Period. Contact Lenses are necessary for any of the following conditions:
   A. Following cataract surgery:
   B. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses
   C. Certain conditions of Anisometropia;
   D. Keratoconus.

3. Elective Contact Lenses - When a Covered Person chooses contact lenses for reasons other than those conditions for Necessary Contact Lenses, the expenses incurred for the evaluation, fitting and materials for contact lenses for the dispensing of contact lenses will be provided, in lieu of frames and lenses, but not more frequently than once per Benefit Period. The vision examination will be payable as stated in the Schedule of Vision Benefits.

4. Frames - limited to one set per Benefit Period, and then only if needed.

5. Scratch coating, photosensitive, photosyn, photochromatic or anti-reflective lens coatings up to the Eligible Expense.

6. Prescription sunglasses when obtained in lieu of prescription glasses or contacts up to the maximum payment for materials stated in the Schedule of Vision Benefits.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The General Plan Exclusions and Limitations of the Plan apply to Vision Benefits in addition to the following Vision Benefit Exclusions:

1. Services or supplies for which the Covered Person is entitled to benefits under any other section of the Plan or as provided under any other section of the Plan.

2. Drugs or any other medication not administered for the purpose of a vision examination.

3. Medical or surgical treatment of the eye.

4. Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids and aniseikonia lenses.

5. Two pair of glasses in lieu of bifocals.


7. Services rendered or ordered while not covered for Vision Benefits.

8. Services or supplies not prescribed as necessary by a Licensed Physician, ophthalmologist, optometrist or optician or when no prescription change is warranted.

9. Replacement of lenses or frames which are lost or broken except at the normal intervals indicated.

10. Services required by an employer as a condition of employment.

11. That portion of any otherwise eligible expense which is in excess of the schedule allowance.

12. Oversize frames or lenses.

IMPORTANT NOTE

This document is intended to provide an easy-to-use reference. The Summary Plan Description and other materials specific to your plan will supersede this general information with regard to individual participants eligibility and benefits.