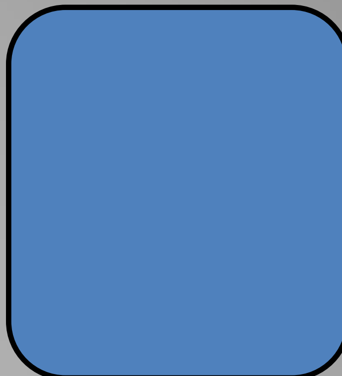
Your wellness is our focus.

2017 EMPLOYEE BENEFIT GUIDE



Holman Enterprises

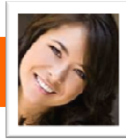
Glacier Restaurant Group

Full-time Management

Welcome to your 2017 Annual Benefit Guide!

Open enrollment is your annual opportunity to review your benefits coverages and make any changes for the following year. Please review this Benefit Guide carefully and make your benefit choices for the January 1, 2017 –December 31, 2017 plan year.

Benefit Highlights



Medical Insurance

Blue Cross Blue Shield will continue to be the carrier for the medical insurance. Employees will, now have three plan options: the Blue Dimensions PPO plan, the High Deductible Health Plan (HDHP) with HSA, and a new PPO plan. You may choose the plan that best fits the needs of you and your family. Reminder—employees who elect the HDHP with HSA plan are eligible to open a Health Savings Account to help pay for medical expenses. More information on the Health Savings Account is located on pages 6 and 7 of this guide.

As of January 1, 2017, if you are enrolled in the Base Plan (High Deductible Health Plan-HDHP) certain prescription medications (those identified on the Blue Cross Blue Shield (BCBS) Preventive Drug Listing) taken for preventive reasons will be covered at 100% and not subject to the deductible. There is no cost to you. Your medications must be prescribed for preventive reasons only and must be on the approved list.

Also, BCBS is making a significant change to the pharmacy network effective January 1, 2017. CVS and Target will no longer be part of the BCBS pharmacy network. If you are filling prescriptions at CVS or Target, you will want to locate a different network pharmacy so you still have access to prescription copays and the discounts network providers offer. You may contact BCBS Customer Service or go to bcbsmt.com to identify alternate pharmacies in your area.

Dental Insurance

Principal remains the insurance carrier for the dental benefits and employees have access to two dental plan options—a low option and a high option plan. The benefits for these two plans are almost identical, but the high option plan covers orthodontia for both children and adults. There is no change to the payroll deductions for either dental plan for 2017. Note: This benefit is now offered to full-time non-management employees.

Vision Insurance

Principal also remains the insurance carrier for the vision plan. The plan includes benefits for eye exams, frames, eyeglasses and contact lenses. There is also no change to the payroll deductions for 2017 vision coverage. Note: This benefit is now offered to full-time non-management employees.

Basic Life and AD&D, Voluntary Life, Voluntary STD, and Voluntary LTD

Reliance Standard will continue to insure the Basic Life and AD&D, Voluntary Life, Voluntary STD, and Voluntary LTD benefits. There are no changes to the rates for these products, but if you are currently enrolled in one of the voluntary plans and have moved into a new age bracket in the past year, your cost for coverage could increase in 2017. Please review the rates and benefits on page 10 of this guide. Note: With the exception of Basic Life and AD&D, these voluntary benefits are now offered to full-time non-management employees.

Benefit Highlights, continued...

Employee Assistance Program

We are now offering an Employee Assistance Program to all employees enrolled in a Blue Cross Blue Shield medical plan option at no cost to you. An EAP is a work-based well-being program designed to identify and confidentially assist employees in resolving personal concerns (e.g., marital, financial or emotional difficulties; family issues; alcohol or substance abuse) that may be adversely affecting the employee's performance or state of mind. The benefit is available to you and your covered family members free of charge and includes up to three face-to-face visits per incident per covered member per year.

Flexible Spending Account

The Health Care FSA and Dependent Care FSA will be offered again this year through Employee Benefits Corporation (EBC). Please make your elections carefully as any FSA funds not used by the end of the plan year will be forfeited. Note—if you enroll in the HDHP with HSA plan, you are ***ineligible*** to elect the Health Care portion of the FSA.

Rollover Reminder! Employees who elected the Health Care FSA for 2016 have the opportunity to roll over up to $500 of unused funds to the 2017 FSA plan year. If you have money left in your Health Care FSA account at the end of December, 2016, you will be able to keep up to $500 of any unused FSA dollars and use them for medical expenses in 2017.

Unum Accident

The voluntary accident policy is available through Unum. In the event of a covered accident, the Unum plan will pay a cash benefit to help with out of pocket expenses like ambulance rides, emergency room visits, wheelchairs, and bandages/casts. Coverage is available to employees, spouses, and dependent children. For more information, you can contact Unum at 1-877-225-2712.

Eligibility

You are eligible to participate in the benefits described in this guide on the 1st of the month following 60 days of employment. Exceptions are noted in the Basic Life and Basic AD&D section.

Your dependents may only enroll in coverage you have for yourself. Your eligible dependents include your:

- Legally married spouse
- Children up to age 26 who are not on active military duty,
- Dependent children who are physically or mentally disabled and dependent on you.

Provided they meet the requirements above, eligible dependent children (regardless of where they reside) include your:

- Natural children,
- Adopted children or children placed with you for adoption,
- Stepchildren, and/or
- Children for whom you are the legal guardian.

Dependent children also may be covered under the medical plan if they are required to be covered by a Qualified Medical Child Support Order as an "Alternate Recipient".

Mid Year Election Changes

There are special circumstances, often referred to as life event changes, that allow you to make plan changes at any time during the year when they occur. You must inform your Employee Benefits Department within 30 days of the event in order to make a qualified change. All other changes will be deferred to open enrollment. Examples of life event changes are located in the box below:

Marriage	Loss of Coverage for a Spouse
Divorce	Death of a Dependent
Birth or Adoption	Loss of a Dependent Status
Change in employment Status, Addition of a New Benefits Package, and Open Enrollment for a Spouse.	

Terms to Know

Coinsurance: The percentage of the charges you are responsible for paying when you get care once you meet your annual deductible.

Copayment: A flat fee you pay to the provider based on the care or service you receive.

Deductible: The amount you pay for certain services each calendar year before the plan starts paying benefits. You pay the full cost of care you receive until what you have paid equals the amount of your deductible.

In network: The doctors, hospitals, labs, pharmacies, etc that are members of the plan's network. When you see a provider "in the network", the plan pays a higher benefit.

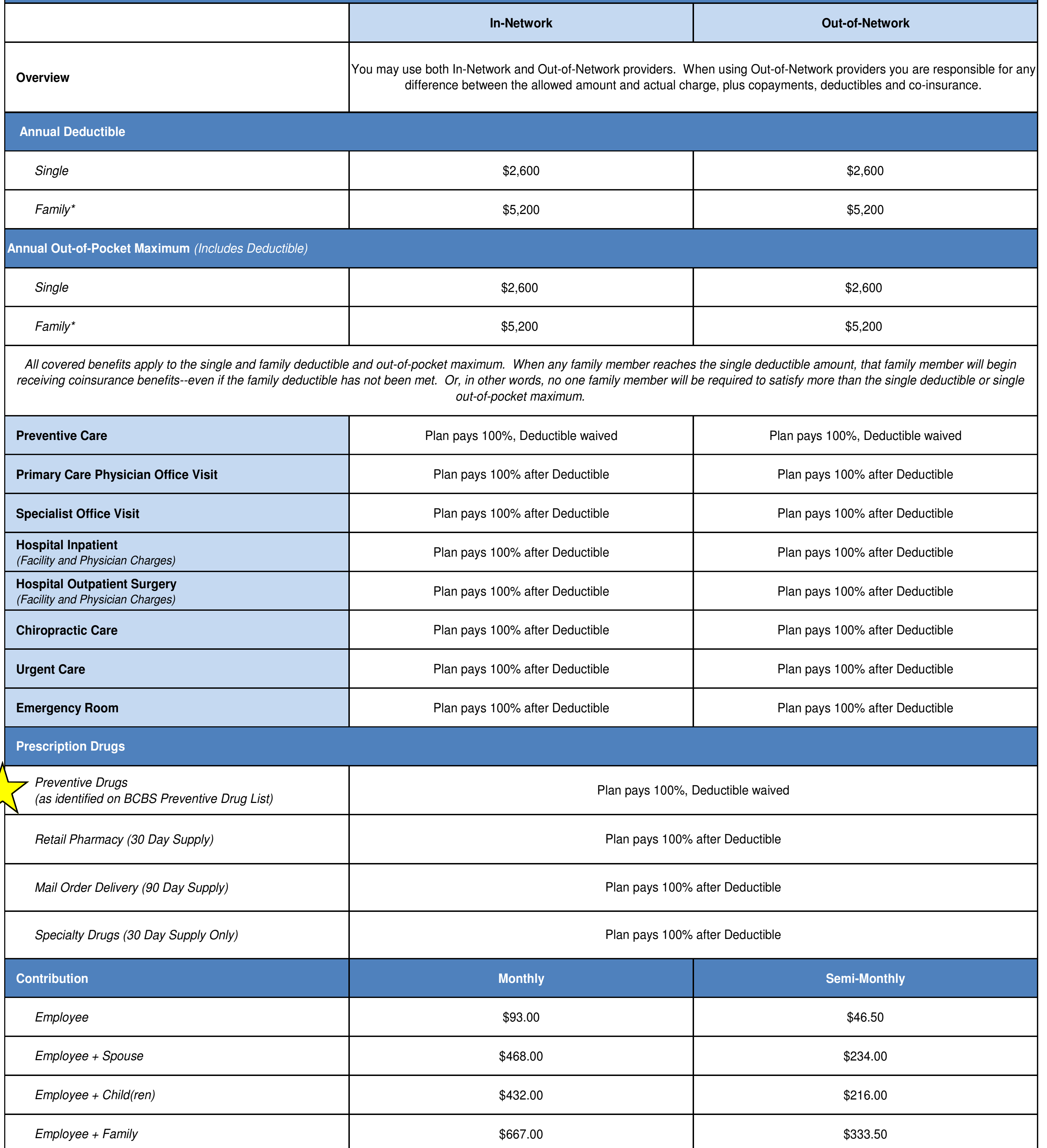
Out of network: The doctors, hospitals, labs, pharmacies, etc. that are not members of the plan's network. When you see a provider "outside the network", the plan pays a lower benefit (or no benefit at all).

Out-of-pocket maximum: The maximum amount you would pay for covered care during the year after you pay your deductible. If you reach this maximum, the plan will pay 100% of your covered care for the rest of the year.

Preventive care: Routine services to prevent illness and improve health, including annual check-ups, immunizations, and certain screenings.

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
Contact BC/BS of MT
1-800-447-7828 or www.bcbsmt.com
Group #: 124029
Plan Name: Holman Enterprises



BASE PLAN - High Deductible Health Plan (HDHP) with HSA		
	In-Network	**Out-of-Network**
Overview	You may use both In-Network and Out-of-Network providers. When using Out-of-Network providers you are responsible for any difference between the allowed amount and actual charge, plus copayments, deductibles and co-insurance.	
Annual Deductible		
Single	$2,600	$2,600
*Family**	$5,200	$5,200
Annual Out-of-Pocket Maximum *(Includes Deductible)*		
Single	$2,600	$2,600
*Family**	$5,200	$5,200
All covered benefits apply to the single and family deductible and out-of-pocket maximum. When any family member reaches the single deductible amount, that family member will begin receiving coinsurance benefits--even if the family deductible has not been met. Or, in other words, no one family member will be required to satisfy more than the single deductible or single out-of-pocket maximum.		
Preventive Care	Plan pays 100%, Deductible waived	Plan pays 100%, Deductible waived
Primary Care Physician Office Visit	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Specialist Office Visit	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Hospital Inpatient *(Facility and Physician Charges)*	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Hospital Outpatient Surgery *(Facility and Physician Charges)*	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Chiropractic Care	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Urgent Care	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Emergency Room	Plan pays 100% after Deductible	Plan pays 100% after Deductible
Prescription Drugs		
Preventive Drugs (as identified on BCBS Preventive Drug List)	Plan pays 100%, Deductible waived	
Retail Pharmacy (30 Day Supply)	Plan pays 100% after Deductible	
Mail Order Delivery (90 Day Supply)	Plan pays 100% after Deductible	
Specialty Drugs (30 Day Supply Only)	Plan pays 100% after Deductible	
Contribution	**Monthly**	**Semi-Monthly**
Employee	$93.00	$46.50
Employee + Spouse	$468.00	$234.00
Employee + Child(ren)	$432.00	$216.00
Employee + Family	$667.00	$333.50

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
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Plan Name: Holman Enterprises

BUY UP PLAN - Blue Dimensions Traditional PPO		
	In-Network	**Out-of-Network**
Overview	You may use both In-Network and Out-of-Network providers. When using Out-of-Network providers you are responsible for any difference between the allowed amount and actual charge, plus copayments, deductibles and co-insurance.	
Annual Deductible		
Single	$1,000	$1,000
Family	$2,000	$2,000
Annual Out-of-Pocket Maximum *(Includes Deductible)*		
Single	$3,000	$3,000
Family	$6,000	$6,000
All covered benefits apply to the single and family deductible and out-of-pocket maximum. When any family member reaches the single deductible amount, that family member will begin receiving coinsurance benefits--even if the family deductible has not been met. Or, in other words, no one family member will be required to satisfy more than the single deductible or single out-of-pocket maximum.		
Preventive Care	Plan pays 100%, Deductible and Copays waived	Plan pays 100%, Deductible and Copays waived
Primary Care Physician Office Visit	$30 Copay	Plan pays 65% after Deductible
Specialist Office Visit	$30 Copay	Plan pays 65% after Deductible
Hospital Inpatient *(Facility and Physician Charges)*	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Hospital Outpatient Surgery *(Facility and Physician Charges)*	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Chiropractic Care	$30 Copay 10 visit maximum per calendar year	Plan pays 65% after Deductible 10 visit maximum per calendar year
Urgent Care	$30 Copay	Plan pays 65% after Deductible
Emergency Room	$100 Copay	$100 Copay
Prescription Drugs		
Annual Prescription Deductible	**$150 per member enrolled. Deductible does not apply to Tier 1 prescriptions.**	
Retail Pharmacy (30 Day Supply)	$10 Copay for Tier 1 Generic Drugs $40 Copay for Tier 2 Preferred Brand Drugs 40% up to a $200 max per Rx for Tier 3 Non Preferred Brand Drugs	
Mail Order Delivery (90 Day Supply)	$20 Copay for Tier 1 Generic Drugs $80 Copay for Tier 2 Preferred Brand Drugs 40% up to a $400 max per Rx for Tier 3 Non Preferred Brand Drugs	
Specialty Drugs (30 Day Supply Only)	$100 Copay for Formulary Drugs $200 Copay for Non Formulary Drugs	
Contribution	**Monthly**	**Semi-Monthly**
Employee	$151.00	$75.50
Employee + Spouse	$586.00	$293.00
Employee + Child(ren)	$541.00	$270.50
Employee + Family	$834.00	$417.00

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider?
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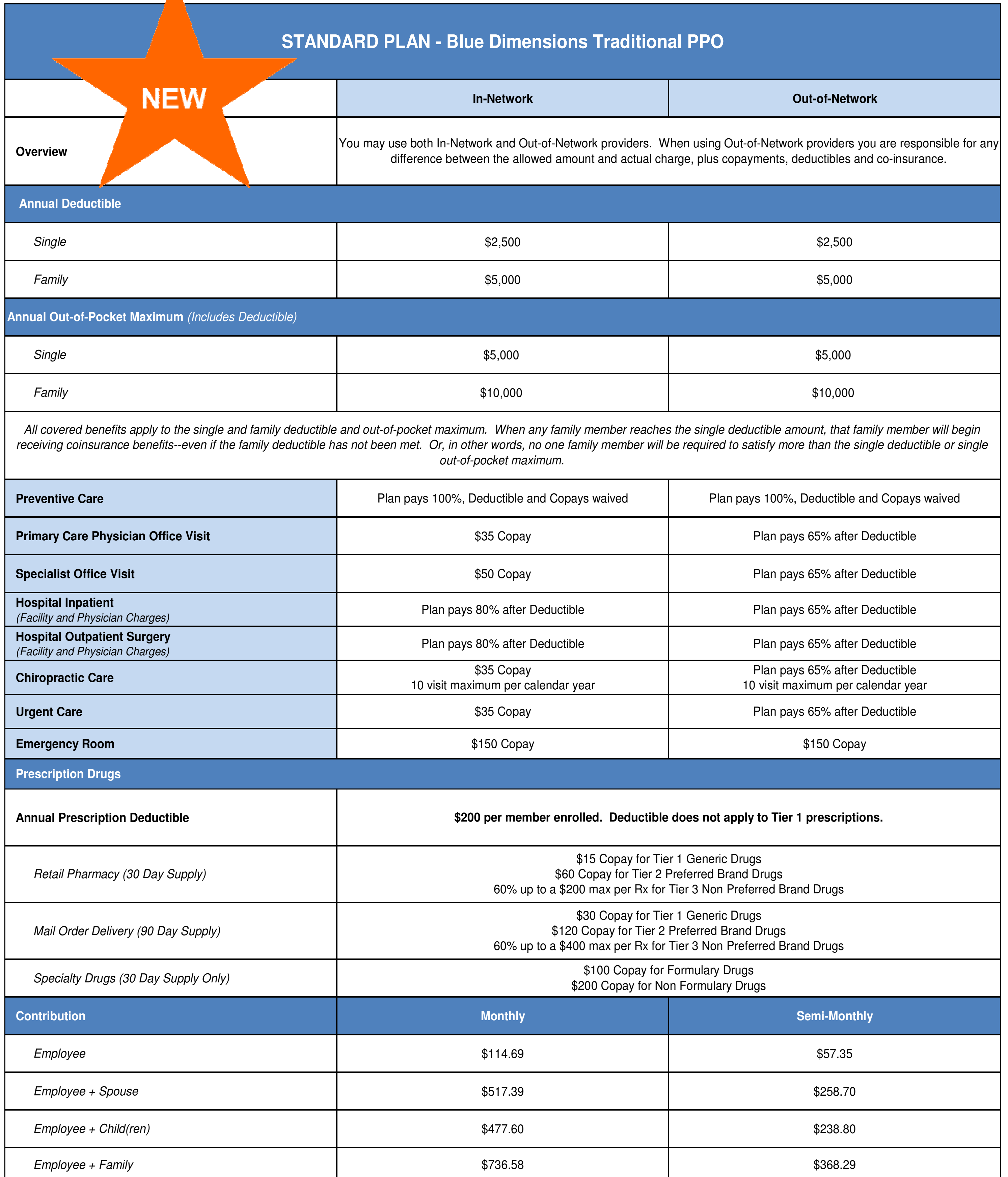


STANDARD PLAN - Blue Dimensions Traditional PPO		
	In-Network	**Out-of-Network**
Overview	You may use both In-Network and Out-of-Network providers. When using Out-of-Network providers you are responsible for any difference between the allowed amount and actual charge, plus copayments, deductibles and co-insurance.	
Annual Deductible		
Single	$2,500	$2,500
Family	$5,000	$5,000
Annual Out-of-Pocket Maximum *(Includes Deductible)*		
Single	$5,000	$5,000
Family	$10,000	$10,000
All covered benefits apply to the single and family deductible and out-of-pocket maximum. When any family member reaches the single deductible amount, that family member will begin receiving coinsurance benefits--even if the family deductible has not been met. Or, in other words, no one family member will be required to satisfy more than the single deductible or single out-of-pocket maximum.		
Preventive Care	Plan pays 100%, Deductible and Copays waived	Plan pays 100%, Deductible and Copays waived
Primary Care Physician Office Visit	$35 Copay	Plan pays 65% after Deductible
Specialist Office Visit	$50 Copay	Plan pays 65% after Deductible
Hospital Inpatient *(Facility and Physician Charges)*	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Hospital Outpatient Surgery *(Facility and Physician Charges)*	Plan pays 80% after Deductible	Plan pays 65% after Deductible
Chiropractic Care	$35 Copay 10 visit maximum per calendar year	Plan pays 65% after Deductible 10 visit maximum per calendar year
Urgent Care	$35 Copay	Plan pays 65% after Deductible
Emergency Room	$150 Copay	$150 Copay
Prescription Drugs		
Annual Prescription Deductible	**$200 per member enrolled. Deductible does not apply to Tier 1 prescriptions.**	
Retail Pharmacy (30 Day Supply)	$15 Copay for Tier 1 Generic Drugs $60 Copay for Tier 2 Preferred Brand Drugs 60% up to a $200 max per Rx for Tier 3 Non Preferred Brand Drugs	
Mail Order Delivery (90 Day Supply)	$30 Copay for Tier 1 Generic Drugs $120 Copay for Tier 2 Preferred Brand Drugs 60% up to a $400 max per Rx for Tier 3 Non Preferred Brand Drugs	
Specialty Drugs (30 Day Supply Only)	$100 Copay for Formulary Drugs $200 Copay for Non Formulary Drugs	
Contribution	**Monthly**	**Semi-Monthly**
Employee	$114.69	$57.35
Employee + Spouse	$517.39	$258.70
Employee + Child(ren)	$477.60	$238.80
Employee + Family	$736.58	$368.29

UNDERSTANDING YOUR HSA PLAN

If you enroll in the Blue Cross Blue Shield High Deductible Health Plan (HDHP)— you are eligible to open and contribute to a Health Savings Account (HSA).

An HSA is an employee-owned account that allows you to set aside money for your eligible medical expenses (including vision and dental expenses) incurred this year or in future years. Your contributions to the account are tax exempt, so you can save on taxes when you contribute. Unlike a Flexible Spending Account, any unused balance in your HSA rolls over from year to year—there is no "use it or lose it" rule.

You must be enrolled in a Qualified High Deductible Health Plan in order to contribute to an HSA. In future years, if you decide to dis-enroll from the HDHP plan, you can continue to use any money in your HSA for qualified medical expenses, but you are ineligible to contribute any additional funds to the account.

If you withdraw funds from the account for non medical expenses, you will be subject to a penalty. At age 65, however, any unused funds in your HSA can be withdrawn without penalty for non-medical purposes. If you withdraw the funds in your HSA after age 65, you would be subject to normal income tax on the money in the account, but you would not be limited to using the money for just medical related expenses.

Once you have set up your HSA, you will receive a debit card for easy access to your funds. You can use this debit card to pay for qualified medical expenses without having to file any paperwork for reimbursement—your card can be used at doctor's offices, pharmacies, hospitals, and other healthcare provider locations. It is recommended to save the receipts for every purchase you make with the card as you may need the receipts to verify expenses should you ever be audited.

There are limits to how much you can contribute to your HSA each calendar year. For 2016, the contribution limits are:

		*Age 55+
Individual	$3,400	$4,400
Family	$6,750	$7,750

*If you are over age 55, you can contribute an additional $1,000 to your HSA for 2016 as a "catch-up" contribution.

Please use the list on the next page as a guide to help you determine whether a medical expense is qualified or not for an HSA distribution.

The following items are qualified medical expenses and may be paid for using your HSA:

- Ambulance
- Annual Physical
- Artificial Limb
- Artificial Teeth
- Nursing Home (for medical care)
- Thermometers
- Abortion
- Acupuncture
- Bandages
- Birth Control Pills
- Blood Pressure Monitor
- Blood Sugar Test Kit
- Blood Tests
- Body Scan
- Braille Books
- Breast Pump/Supplies
- Breast Reconstruction
- Christian Science (fees to practitioners for care)
- Cold/Hot Pack for medical care
- Condoms
- Contact Lenses and supplies
- Contraceptives
- Crutches
- Dental Treatment
- Dentures and cleaners
- Dermatologist
- Diabetic Supplies
- Diagnostic Devices
- Doctor's fees not covered by insurance
- Drug Addiction (inpatient treatment)
- Drugs (with prescription)
- Eye Exams
- Eye Surgery (including laser eye surgery)
- Eyeglasses
- Fertility Enhancement
- First Aid Supplies
- Flu Shot
- Guide Dog (including maintenance costs)
- Gynecologist
- Hearing Aids (including batteries and repair)
- Homeopathic Care
- Immunizations
- Laboratory Fees
- Lactation Expenses
- Medical Alert Bracelet
- Operations (non cosmetic)
- Optometrist
- Orthopedist
- Orthotic Inserts
- Osteopath
- Out-of-Network charges
- Oxygen for medical condition
- Physical Examination
- Pregnancy Test Kit
- Prosthesis
- Psychiatric Care
- Psychoanalysis
- Psychologist
- Splints
- Sterilization
- Therapy
- Vasectomy
- Wheelchair
- X-Ray

The following are NOT qualified medical expenses:

- Babysitting
- Controlled Substances
- Cosmetic Surgery
- Cosmetics
- CPR Class
- Dancing Lessons
- Dental Floss
- Diaper Service
- Diet Foods
- Electrolysis
- Exercise Equipment
- Facial Tissues
- Funeral Expenses
- Health Club Dues
- Household Help
- Illegal Treatments
- Marijuana
- Maternity Clothes
- Medigap Premiums
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees

UNDERSTANDING YOUR DENTAL PLAN

Dental Questions? Need to Locate a Provider?
Contact Principal
1-800-986-3343 or www.prinicpal.com

Dental Coverage		
Type of Plan	**Principal - Low Option PPO**	
	In-Network	**Out-of-Network** *(*Subject to 90th Percentile of Reasonable and Customary)*
Deductible	Single: $2 Family: $75	Single: $25 Family: $75
Annual Maximum Benefit *(per member enrolled)*	$1,000	
Unit 1-Preventive Services *(oral exam, cleaning, x-rays)*	100%	100%*
Unit 2-Basic Services *(fillings, root canal, oral surgery, periodontics)*	80% after Deductible	80% after Deductible*
Unit 3-Major Services *(crowns, dentures, bridges)*	50% after Deductible	50% after Deductible*
Orthodontia Services	Not Covered	
Contribution	**Monthly**	**Semi-Monthly**
Employee	$35.07	$17.54
Employee + Spouse	$72.94	$36.47
Employee + Child(ren)	$75.56	$37.78
Employee + Family	$117.48	$58.74
Type of Plan	**Principal - High Option PPO**	
	In-Network	**Out-of-Network** *(*Subject to 90th Percentile of Reasonable and Customary)*
Deductible	Single: $25 Family: $75	Single: $25 Family: $75
Annual Maximum Benefit *(per member enrolled)*	$1,000	
Unit 1-Preventive Services *(oral exam, cleaning, x-rays)*	100%	100%*
Unit 2-Basic Services *(fillings, root canal, oral surgery, periodontics)*	80% after Deductible	80% after Deductible*
Unit 3-Major Services *(crowns, dentures, bridges)*	50% after Deductible	50% after Deductible*
Unit 4-Orthodontia Services *(child and adult)*	Plan pays 50%, $1,000 Lifetime Benefit	
Contribution	**Monthly**	**Semi-Monthly**
Employee	$37.72	$18.86
Employee + Spouse	$78.46	$39.23
Employee + Child(ren)	$81.27	$40.64
Employee + Family	$126.36	$63.18
Limitations and Exclusions		
Late Entrant Waiting Period	Late entrants (those enroling more than 31 days after becoming eligible) will be subject to an individual benefit waiting period, subject to plan guidelines.	

Note: Full-time Non-management employees are now eligible to enroll, effective January 1, 2017.

UNDERSTANDING YOUR VISION PLAN

Vision Questions? Need to Locate a Provider?
Contact Principal
1-800-986-3343 or www.principal.com

Vision Coverage		
Voluntary Vision - Principal		
The vision benefits are provided on a scheduled basis. Covered charges equal the actual cost charged to the member, up to the allowance shown in the plan design below.		
	The vision plan covers a routine eye exam every 12 months and one of the following: 1. A set of frames each 24 months and two lenses (one pair) each 12 months**, or** 2. Two contact lenses (one pair). The maximum payment for a pair of contact lenses will be equal to the maximum payment for single vision lenses plus frames. For example: single vision lenses $50 plus frames $100 would equal a contact lens benefit total of $150 for the first 12 months. The contact lens benefit for the next 12 months, or second year, would equal $50. This is because the frame benefit of $100 is only payable once in any period of 24 consecutive months.	
Examination	Once every 12 months	
	$50 Allowance	
Eyeglass Lenses	Once every 12 months	
Single Vision	$50 Allowance	
Bifocal	$75 Allowance	
Trifocal	$100 Allowance	
Lenticular	$150 Allowance	
Frames	Once every 24 months	
	$100 Allowance	
Contact Lens	Once every 12 months (in lieu of frames and lenses)	
	$150 Allowance	
Contribution	**Monthly**	**Semi-Monthly**
Employee	$6.60	$3.30
Employee + Spouse	$17.34	$8.67
Employee + Child(ren)	$16.07	$8.04
Employee + Family	$26.81	$13.41

Note: Full-time Non-management employees are now eligible to enroll, effective January 1, 2017.

Questions?
Contact Reliance Standard
1-800-351-7500
www.reliancestandard.com
Group ID: Holman Enterprises

Basic Life & AD&D- Reliance Standard

Employee Basic Life and AD&D (Full-time Management only)	$25,000
Benefit Reduction	Reduce to 65% at age 65; 40% at age 70
Contribution	100% Employer Paid

Voluntary Long Term Disability (LTD) - Reliance Standard

Amount of Benefit	60% of covered monthly earnings to a maximum of $5,000 per month	
When Benefits Begin	181st day of disability	
Rates *(shown monthly)*	**Age**	**Cost Per $100 of Covered Payroll**
	<25	0.050
	25-29	0.080
	30-34	0.140
	35-39	0.220
	40-44	0.380
	45-49	0.500
	50-54	0.710
	55-59	0.920
	60-64	0.710
	65-69	0.480
	70+	0.350
Duration of Benefits	To Social Security Normal Retirement Age if you continue to meet the definition of disabled.	

Voluntary Short Term Disability (STD) - Reliance Standard

Amount of Benefit	60% of covered weekly earning up to a maximum of $1,000 per week	
When Benefits Begin	On the 15th day of disability due to accident or illness.	
Maximum Benefit Period	26 Weeks	
Rates *(shown monthly)*	**Age**	**Rate per $10 Benefit**
	<25	0.410
	25-29	0.450
	30-34	0.460
	35-39	0.410
	40-44	0.420
	45-49	0.510
	50-54	0.710
	55-59	0.830
	60-64	0.920
	65-69	1.150
	70+	1.510

Voluntary Life Coverage - Reliance Standard

Employee	Increments of $10,000 up to a $500,000 maximum. Guaranteed Issue of $70,000 is available at intial enrollment only. Amounts requested over the Guaranteed Issue are subject to Evidence of Insurability.	
Spouse	Increments of $10,000 up to a $500,000 maximum. Guaranteed Issue of $10,000 is available at intial enrollment only. Amounts requested over the Guaranteed Issue are subject to Evidence of Insurability.	
Limitations	An employee can elect life insurance for spouse without electing coverage for self. The total employee and spouse life election cannot exceed $500,000.	
Rates *(shown monthly)*	**Age**	**Monthly Employee and Spouse Rate Per $1,000**
	<25	0.107
	25-29	0.075
	30-34	0.081
	35-39	0.113
	40-44	0.185
	45-49	0.309
	50-54	0.501
	55-59	0.849
	60-64	1.047
	65-69	1.577
	70+	3.064
Eligible Child(ren)	Benefit in increments of $2,500 to a $10,000 maximum. Children covered to age 20 (or 26 if full time student)	Child Life Rate: $0.41 per $2,500

Note: With the exception of Basic Life and AD&D, these voluntary benefits are now offered to full-time non-management employees.

FLEXIBLE SPENDING ACCOUNTS

Questions?
Contact Employee Benefits Corporation (EBC)
1-800-346-2126 or www.ebcflex.com

A Flexible Spending Account is an arrangement that permits you to pay for certain out-of-pocket expenses with funds that you have set aside, by payroll deduction, on a tax-free basis. There are two types of Flexible Spending Accounts available: The Health Care Reimbursement Account is for out-of-pocket medical expenses including medical, dental, vision, and prescription drug expenses for you and your dependents. The Dependent Care Assistance Account is designed to help you pay for daycare services so that you and your spouse (if married) can work or be a full-time student.

Account Type	Examples of Eligible Expenses	Contribution Limits	Access to Funds	Pre Tax Benefits
Health Care	· Medical Plan Deductibles · Most Insurance Co-payments · Prescription Drugs · Some OTC medicines (Only if prescribed by your doctor) · Vision Exams/Eyeglasses/Contacts · Laser Eye Surgery · Weight Loss Programs · Dental and Orthodontia (Braces)	Maximum annual contribution is $2,600	Allows immediate access to the entire contribution amount from the 1st day of the benefit year, before all scheduled contributions have been made.	Save 20% - 40% on your health care expenses Save on purchases not covered by insurance. Reduces your taxable income.
Dependent Care	· Daycare · Day Camp · Eldercare · Before and After School Care	Minimum contribution is $100 per year Maximum contribution is $5,000 per year ($2,500 if married and file separate	You will be able to submit claims up to your year-to-date accumulated amount in your account (You will only be reimbursed based on your acumulated contribution amounts)	Save 20% - 40% on your dependent care expenses. Reduces your taxable income.
"Use it or Lose it" Rule	You should plan your contributions carefully. According to IRS guidelines, any money in your FSA at the end of the year must be forfeited. Beginning with the 2015 plan year, you will be able to roll over up to $500 of unused FSA funds to your 2016 FSA account. Any funds beyond the first $500 will be forfeited.			
Eligibility	You may incur claims beginning January 1, 2017 through December 31, 2017. All claims must be submitted between January 1, 2017 through March 31, 2018. You MUST re-enroll in the FSA every year– FSA elections will not roll over to 2017. ***You cannot elect the Health Care portion of the FSA if you have elected to enroll in the HDHP medical plan.***			

Questions?
Contact Magellan Health
1-800-327-1393 or magellanhealth.com/member

Employee Assistance Program

From simple questions like quick ways to de-stress or how to find more time in your schedule, to more difficult issues like finding support after the loss of a loved one, your program is there to work with you and offer suggestions, options and information. If you are covered by a Blue Cross Blue Shield medical plan option through Holman Enterprises, you and your dependents have access to tools, resources and experts who can help with many of the day-to-day things that can happen in life. You will even have access to the LifeMart® discount center which offers valuable discounts on things such as travel, clothing, restaurants, and more.

The EAP is a work-based well-being program designed to identify and confidentially assist employees in resolving personal concerns that may be adversely affecting the employee's performance or state of mind. The benefit is available to you free of charge and includes up to three face-to-face visits per incident per covered member per year.

All confidential and at no cost to you. Some of the topics Magellan Health can help with include:
- **Resiliency**—overcoming stress and crisis at home and at work.
- **Emotional Wellness**—addiction, depression, anxiety and assistance with other emotional wellness issues.
- **Workplace success**—career goals, team conflict, crisis, management support.
- **Wellness and balance**—work-life balance, stress, relaxation, personal well-being.
- **Personal and family goals**—relationship, children, and teens or aging loved ones. Changes in finances or personal situations.

WELLNESS BENEFITS

Well onTarget®

Well onTarget can give you the support you need to make healthy choices — while rewarding you for your hard work. There are personalized tools and resources to help you – no matter where you are on path to health and wellness.

MEMBER WELLNESS PORTAL

The heart of Well onTarget is the member portal, available at wellontarget.com. It uses the latest technology to offer you an enhanced online experience. This engaging portal links you to a suite of innovative programs and tools.

- Self-directed courses: These courses let you work at your own pace to reach your health goals. Learn more about nutrition, fitness, losing weight, quitting smoking and managing stress. Track your progress and reach your milestones as you make your way through each lesson. Reach your milestones and earn Blue PointsSM.*
- Health and wellness content: The health library teaches and empowers through evidence-based articles.
- Tools and trackers: These resources can help keep you on course while making wellness fun. Use a food and exercise diary, symptom checker and health trackers.

* Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal at wellontarget.com for further information.

HEALTH ASSESSMENT (HA)

The HA uses adaptable questions to learn more about you. You will get a confidential personal wellness report offering you tips for living your healthiest life. Your answers will help tailor the Well onTarget portal with programs that may help you reach your goals.

BLUE POINTS PROGRAM

Earn Blue Points for participating in wellness activities. Points can be redeemed in the online shopping mall and because the program gives you points instantly, you can use them right away.

FITNESS TRACKING

Track your fitness activity using popular fitness devices and mobile apps.

Take Wellness on the Go!

Check out the Well onTarget mobile app, available for iPhone® and Android® smartphones. It can help you work on your health and wellness goals — anytime and anywhere.

WELLNESS PROGRAM QUESTIONS?

Call Customer Service at 877-806-9380

FITNESS PROGRAM**

The Fitness Program is a flexible membership program that gives you unlimited access to a nationwide network of more than 9,000 fitness centers. Other Fitness Program perks include:

- No long-term contract: Membership is month to month at $25 per month per member, with a one-time enrollment fee of $25 per member.
- Blue Points: Get 2,500 points for joining the Fitness Program. Earn additional points for weekly visits.
- Convenient payment: Monthly fees are paid via automatic credit card or bank account withdrawals.
- Web resources: You can go online to locate gyms and track your visits.
- Health and wellness discounts: Save money through a nationwide complementary and alternative medicine network of 40,000 health and well-being providers, such as massage therapists, personal trainers and nutrition counselors.

It's easy to join the Fitness Program! Just call the toll-free number 888-762-BLUE (2583) Monday through Friday, from 8 a.m. to 9 p.m.

** The Fitness Program is provided by Healthways, Inc., an independent contractor that administers the Prime Network of fitness centers. The Prime Network is made up of independently owned and operated fitness centers.

ENROLLMENT 2017

Beginning the week of November 14th, employees will be able to log in to the enrollment portal and enroll, decline, or change benefit elections for the 2017 plan year. You will receive more information and links to the site via email, but you can also go to https://www.eenroller.net/login.asp?ST=GLCR3133 and enter your username and password.

Your username is the first six letters of your last name plus the last four digits of your social security number. Your password is the last four digits of your social security number. Eg: Robert Anderson, SSN 123-45-6789. Username would be ANDERS6789. Password would be 6789.

For current employees who have used the BeneTrac portal before and are having trouble logging in again, simply click on the "Forgot your Username or Password?" link on the login page and follow the prompts to reset your login credentials.

Below are some screen shots with helpful hints on how to navigate the website:

Review your personal information on the My Family page

1. **Click your name to update your personal information. You can also change your password in this area.**
2. **Click here to add your spouse.**
3. **Click here to add your dependents.**

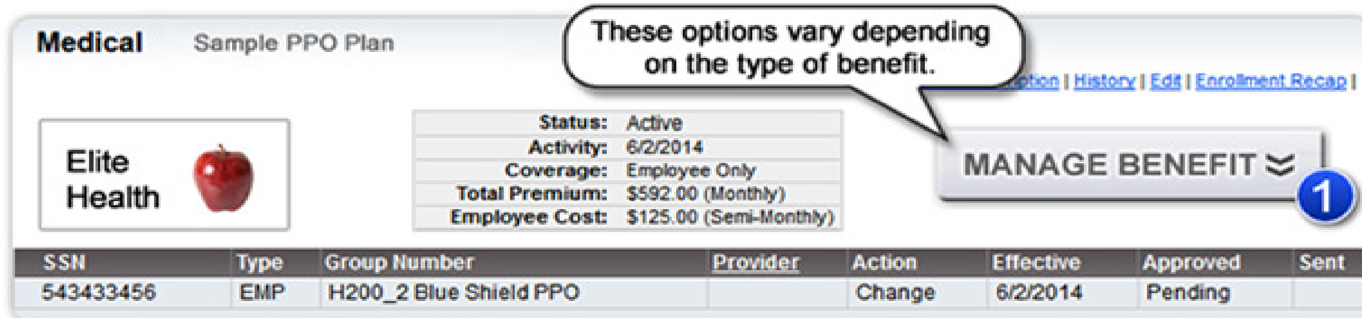
Enroll in your benefits

1. **Click a link under the Benefits menu to review a particular category of benefits.**
2. **In each benefit block, make a selection from your list of Manage Benefit options.**

Change existing benefits

Your current elections will appear in a similar fashion as shown in the picture below. To make a change, select an option from the list in the Manage Benefit section.

1. Click here to select a Manage Benefit option. The system will guide you through the process of making changes to your elections.



Finalize your Changes

You can review your changes during the log out process.

SUMMATION - Amounts per (Semi-Monthly) pay period

Total Cost of Elections:	$500.00
Total Benefit dollars:	$0.00
Out of pocket expense:	$500.00
Enrollment update	

REVIEW & FINALIZE

NOTE: This button may not appear at the bottom of your Benefits page if you have made no changes during this session. In this case, you may log out.

Logging out will give you a final opportunity to review and print your Election Summary

Once you have finalized your benefit elections, please print or save a copy of your Election Summary .

2017 Health Plan Notices

Women's Health and Cancer Rights Act of 1998

Your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The law prevents discrimination from health insurers and employers.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are an employee declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, if employees have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

There is an additional enrollment period if an employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Important Notice from Holman Enterprises About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Holman and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Holman has determined that the prescription drug coverage offered by BC/BS of MT is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Holman coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Holman coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Holman and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes through Holman. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: Glacier Restaurant Group
Contact--Position/Office: Melissa Schara, Assistant Controller
Address: 911 Wisconsin Suite 103, Whitefish, MT 59937
Phone Number: 406-863-2064

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Holman Enterprises

Glacier Restaurant Group

Glacier Jet Center

Rock Creek Cattle Company

Disclaimer: This Benefit Guide provides a brief summary of the benefits available under the Glacier Restaurant Group/Holman Enterprises Benefit Program. In the event of any discrepancy(ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. Glacier Restaurant Group/Holman Enterprises retains the right to modify or eliminate these benefits at any time and for any reason.