A Message from DOA Director Sheila Hogan
To State of Montana Benefits Plan (State Plan) members planning retirement,

As you know, health care costs around the country continue to rise. The Health Care and Benefits Division (HCBD) is working hard to control costs to our self-funded plan in many ways such as looking at new ways to cut medical costs, increasing case management on high dollar claims like cancer and heart attacks, and piloting new programs to save money on prescriptions, but they need your help.

I hope you join me in taking these steps to better health:
• Use in-network doctors and dentists.
• Consider switching to a mail-order pharmacy if you take a medication regularly.
• Live Life Well by participating in wellness programs and challenges offered by the State.
• As a Retiree, consider alternative coverage options like the Health Care Marketplace (under 65) or Medicare supplement options (over 65.)

Following these tips can save you money, and help curb the State Plan costs.

Finally, be sure to pay close attention to communications from HCBD. They send important information throughout the year via email and paper mail that you don’t want to miss.

Yours in good health,

Sheila Hogan, Director
Department of Administration
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This book contains valuable information about your options for health benefits as a State of Montana Retiree.

**Eligibility for State Plan Coverage in Retirement**

You may continue coverage with the State of Montana Benefit Plan (State Plan) if you are eligible at the time you leave active State employment to receive a monthly retirement benefit under the applicable provisions of your retirement system.

You may stay on the State Plan if you are on defined contribution whether you draw a monthly benefit, elect the lump sum distribution, or postpone withdrawal of your benefit.

**Alternative Coverage Options**

Keep in mind, Retirees now have more options than before when it comes to health coverage. The State Plan may not be the best option for everyone. We encourage all retirees to contact a Certified Insurance Agent and check with that person each fall to be sure you have the right coverage for your needs.

Learn more about alternative coverage options on page 12-17 of this book.

**How to Continue Coverage on the State Plan**

- Complete the necessary forms and return them and payment to HCBD PO Box 200130, Helena MT 59620-0130 within 60 days after your employee coverage terminates.
  - Retiree Election Form - To continue State Plan coverage, you must complete this form by circling the coverage you wish to continue, the Members you wish to cover and the method of payment. Return this form to HCBD.
  - Standard Life Insurance Form - Non-Medicare Retirees are required to fill out this form to designate their Life Insurance beneficiaries in retirement. Medicare Retirees are not eligible for the $14,000 Basic Life Insurance, so they do not need to complete this form.
- Electronic Deduction Form - Fill out this form and return it to HCBD with a voided check if you wish to have your payments for benefits electronically deducted from your checking or savings account on the 6th of every month.

- Your Retiree coverage will begin retroactive to the day your employee coverage ended as soon as payment is received.
- If you do not complete and return this form, your State Plan coverage will be terminated.
- If you decide not to stay on the State Plan, and do not experience a lapse in coverage (a time with no insurance), you may be eligible for Retreat Rights which give you a chance to come back to the State Plan one time within two years of terminating State Plan coverage. See p. 18 for details.

How to Transfer Coverage to Spouse/Domestic Partner
- A Retiree may choose to become a dependent of an employed or retired spouse/domestic partner on the State Plan while still keeping the right to return to coverage under his or her own name at a later date.
- A Retiree who transfers onto another State Plan member’s coverage does not have to begin a new deductible for the remainder of the plan year.
- If you transfer to your spouse/domestic partner’s coverage and your spouse/domestic partner is an active employee, you may be able to transfer some or all of your plan C elective life insurance. Contact Health Care and Benefits Division (HCBD) for more information.
- If you transfer to your retired spouse/domestic partner’s coverage, you lose all life insurance coverage.
- If your Retiree coverage is reinstated due to termination of your spouse/domestic partner’s employment, death, or divorce, and you are not Medicare eligible, Plan A basic life coverage is reinstated.

For complete details about the State Plan, refer to the Summary Plan Documents (SPDs) available on the website www.benefits.mt.gov.
Your Benefits in Retirement

The following chart gives you an outline of your State Plan coverage options in retirement. It shows what’s required, what's optional, and what benefits you are not eligible for as a Retiree.

<table>
<thead>
<tr>
<th></th>
<th>Non-Medicare (Under 65)</th>
<th>Medicare Eligible (Over 65)</th>
<th>Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/Prescription</td>
<td>Required</td>
<td>Required</td>
<td>Optional*</td>
</tr>
<tr>
<td>Dental</td>
<td>Required</td>
<td>Optional</td>
<td>Optional (If Retiree has dental)</td>
</tr>
<tr>
<td>Basic Life</td>
<td>Required</td>
<td>May Convert-See p. 6</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Life Plans B, C, &amp; D</td>
<td>May Convert-See p. 6 &amp; 34</td>
<td>May Convert-See p. 6 &amp; 34</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Vision Hardware</td>
<td>Optional</td>
<td>Optional</td>
<td>Optional (If Retiree has vision)</td>
</tr>
<tr>
<td>Flexible Spending</td>
<td>Option to prepay for rest of year in which you retire-See p. 7</td>
<td>Option to prepay for rest of year in which you retire-See p. 7</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
</tr>
</tbody>
</table>

*If you currently have dependents who are covered under your Dental Plan, but not your Medical Plan, you can only add them to your Medical Plan during a special enrollment period.
For complete details about the State Plan, refer to the Summary Plan Documents (SPDs) available on the website www.benefits.mt.gov.
As you plan for retirement, we strongly recommend you contact The Standard Life Insurance Company at (800) 378-4668 to discuss the portability and conversion options for your current Life Insurance coverage.

**Non-Medicare Retirees (Under 65)**
- Plan A-Basic Life is required if you want to stay on the State Plan.-Complete and return the Life Insurance Enrollment/Change form and the Life Insurance Beneficiary Designation form within 60 days of your employee coverage termination.
- Plans B, C, and D plans may be converted (see below)
- Plan E-Accidental Death and Dismemberment cannot be continued or converted.

**Medicare Retirees (Over 65)**
If you are over 65 and/or Medicare eligible when you retire or become Medicare eligible after retirement, you are no longer eligible for group life insurance. Any group life plans you have, except Accidental Death and Dismemberment (AD&D), are eligible for conversion (see below).

**Conversion**
If you want to keep the Life Insurance coverage you had while employed, you have 31 days after becoming a Medicare eligible Retiree to convert by doing the following: 1) Request conversion information before the end of your conversion period; and 2) Complete and return all forms, along with payment, to The Standard Insurance Company.

For more information, contact The Standard at (800) 759-8702 or visit their website www.standard.com.
Other Benefits in Retirement

Disability Waiver of Life Insurance Payments
If you are retiring prior to age 60 and are permanently and totally disabled, you may qualify for waiver of Life Insurance payments through The Standard. Contact The Standard for more information.

Long Term Disability Coverage
If enrolled in long term disability, your coverage ends the date you retire.

Flexible Spending Account (FSA) Options
You have two options for your FSA(s) as you retire:
• You can pre-pay the remainder of your annual FSA election with your final paycheck. Then, your FSA will continue until the end of the year in which you retire

OR
• If you do not pay the remainder of your annual flexible spending account election from your final paycheck, your account terminates the end of the month in which full or partial payment has been made.

Other Information:
• You have 120 days after the date your account terminates to submit receipts for eligible expenses incurred during the time your account was active this Plan Year.
• Contact Allegiance Benefit Plan Management at (866) 339-4310 or visit their website www.askallegiance.com to see your account balances, elections, and eligible expenses.
10 Retirement Benefits Payment Options

Mark your method of payment on the Retiree Election Form. If you do not check an option, we will assume you are self-paying monthly. You must send the first month’s payment and your forms within 60 days of your employee coverage terminating. Your Retiree coverage will begin retroactive to when your employee coverage ended once your forms and payment are received by HCBD.

#1 - Pre-payment from Your Final Pay Check
You may prepay benefits payments from your final check. This option is only available if your final paycheck has not yet been issued. To pre-pay, you must complete and return a Retiree Pre-Payment Option Form (available from your payroll person), along with all applicable forms listed on pages 4-5, to your payroll person.

VEBA
If you will have a VEBA account upon retiring, you can select any of the options below. With VEBA, you will pay the State for your benefits and VEBA will reimburse you.

#2 - Electronic Deduction of Benefits Payments from a Checking or Savings Account
Benefits payments are deducted from your designated account on the 6th of each month or the following working day if the 6th falls on a weekend or holiday. You must complete an Electronic Benefits Payments Deduction Authorization Form to elect this option.

#3 - Automatic Deduction from MPERA Benefit Allowance
Contact HCBD to find out when your first payment can be deducted from your MPERA retirement benefit. You must self-pay benefits payments to HCBD for any months prior to the date MPERA deductions begin.

#4 - Monthly Self-Payment to HCBD
Benefits payments are due on the first of each month with a 10 day grace period. You will not receive a monthly bill, but HCBD will provide you with a payment book annually.
It is very important that Retirees and their spouses/domestic partners on the State Plan enroll in Medicare Parts A and B upon turning 65. When you enroll in Medicare Parts A and B, we will coordinate your State Plan benefits with the benefits you are eligible for with Medicare. If you do not enroll in both Medicare Parts A and B, the State Plan will pay claims as if you were enrolled, which WILL result in larger out-of-pocket costs for you.

**Medicare Retiree Rate**
Your monthly premium contribution amount (see rates on page 25) will automatically be reduced to the Medicare Retiree Rate the first of the month following the date you or your spouse/domestic partner turn 65 and become Medicare eligible.

**Medicare Part A and B Enrollment Upon Retirement**
If you or your spouse/domestic partner are a) over age 65, b) waived Medicare Parts A and/or B at the time you turned 65 because you were an active employee, and c) plan to elect Medicare Parts A and B now due to retirement, you must act promptly to avoid penalties by Medicare for late enrollment. Contact HCBD for a letter verifying your State Plan coverage for Medicare purposes.

**Medicare Part D Enrollment**
Medicare Part D is prescription drug coverage available through insurance providers who are licensed to sell Medicare supplements and Part D coverage. Currently, if you enroll in Medicare Part D, you may NOT stay on the State Plan. A change is coming in January 2017 which may require you to enroll in Medicare Part D through the State Plan’s pharmacy benefit manager. You do not need to take any action at this time, but please watch for more information during the Annual Change period in September and October 2016 for more information.
Many retirees have had State Plan coverage for years and aren’t aware of other available options. Much has changed in the health insurance market in the last few years including the cost, benefits, and availability of private and marketplace plans. Please take the time to educate yourself and find the best insurance option for you and your family. Here are a few things to consider choosing coverage. 

- **Premiums**: Coverage sold through the Health Insurance Marketplace (under 65) or Medicare Supplements (over 65) may be less expensive the State Plan coverage.
- **Pre-existing conditions**: Non-Medicare (under 65) retirees CANNOT be denied coverage or charged more for coverage because of pre-existing conditions for plans on the Health Insurance Marketplace.
- **Providers**: If you’re currently getting care or treatment for a condition, a change in your health insurance may affect your access to a particular health care provider. You should see if your current health care providers will accept any new insurance coverage you consider.
- **Service Areas**: Some plans do not have extensive out of state healthcare provider access. You should check out of state provider access if you travel for extended periods of time. If you move permanently to another area of the country, you will need to inform your insurer immediately and you may need to change your health plan or Medicare supplement coverage. Some health plans available in the Health Insurance Marketplace have narrower provider access, but those plans are often cheaper.
• Drug Formularies: If you’re currently taking medication, a change in your health insurance may affect the cost of your medication – and in some cases, your medication may not be covered by another insurance plan. Make sure you check if your current medications are listed in the drug formularies for other health insurance coverage.

• Other Cost-Sharing: In addition to premiums or contributions for health insurance coverage, be sure to consider copays, deductibles, coinsurance, and other cost sharing amounts when comparing insurance options. Cost sharing can vary significantly among different plans, so you should shop carefully for a plan that fits your health and financial needs. For example, one option may have much lower monthly premiums, but much higher deductible, coinsurance and maximum out of pocket.

• Out-of-network: Healthcare services from out-of-network providers may have high cost-sharing. Be aware of how going out-of-network or using non-participating providers or facilities could effect you.
Alternative Coverage Options Under 65

Under 65

If you are not eligible for Medicare, you may be able to get coverage through the Health Insurance Marketplace that costs less than State of Montana Retiree coverage.

Health Insurance Marketplace

The Marketplace offers “one-stop shopping” to find and compare most private health insurance options. You can access the Montana Marketplace at www.healthcare.gov.

- You might be eligible for a tax credit that lowers your monthly premiums and offers cost-sharing reductions.
- You can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.
- Can learn if you qualify for free or low-cost coverage from Medicaid.

Eligibility

Being offered State of Montana Retiree coverage won’t limit your eligibility for coverage or for a possible tax credit through the Health Insurance Marketplace. However, you must disenroll from your Retiree plan before you begin to receive premium tax credits.

You should consult with an insurance professional (see next page) about this process.
Contact an Expert for FREE

Insurance professionals available to assist with alternative coverage options include:

- **Certified Insurance Agents** or Certified Exchange Producers (CEPs) are registered Montana Insurance Agents who have taken special training to understand the Health Insurance Marketplace. CEPs are found throughout the state.

- **Certified Application Counselors (CACs)** are health care provider staff who have been trained to help people understand, apply for and enroll in insurance coverage through the Health Insurance Marketplace. You will find these individuals in hospitals and community health centers throughout the state.

- **Navigators** are public advisors who help people compare the health insurance options on the Health Insurance Marketplace website. Navigators have taken Federal and State training and have been fingerprinted and undergone a Montana background check.

**Note: You should consult only with insurance professionals who are certified by the Montana Insurance Commissioner.**

A list of these experts can be found at:

**Web:** [www.montanahealthanswers.com/talk-to-a-human/](http://www.montanahealthanswers.com/talk-to-a-human/)

Scroll down to see contact lists for Navigators, CACs, and Certified Insurance Agents in your area.

**Call:** The Office of the Commissioner of Securities and Insurance (800) 332-6148

For complete details about the State Plan, refer to the Summary Plan Documents (SPDs) available on the website www.benefits.mt.gov.
Over 65
If you’re over 65 and eligible for Medicare, you do not qualify for a plan on the Health Insurance Marketplace, but you might want to consider Medicare Supplemental Insurance or Medicare Advantage Plans.

Contact an Expert for FREE
The Montana State Health Insurance Assistance Program (SHIP) is a FREE health-benefits counseling and advocacy service for Medicare beneficiaries and their families or caregivers. Its mission is to educate, advocate FOR, counsel and empower people to make informed benefit decisions. You may also consult with a Certified Insurance Agent who is trained in Medicare supplement or Medicare advantage plans.
Call: 1-800-551-3191
Web: www.dphhs.mt.gov/sltc/aging/ship.aspx
Alternative Coverage FAQs

What if I sign up for the State Plan in retirement, but later decide to enroll in a different plan?
If you would like to leave the State Plan, you must contact the Health Care and Benefits Division prior to the 1st of the month in which you would like your coverage to end.
Phone: 1-800-287-8266
Email: benefitsquestions@mt.gov
Address: Health Care and Benefits Division
PO Box 200130
Helena, MT 59620-0130

What if I leave the State Plan but later want to come back?
Retirees who leave the State Plan due to enrollment in another health plan offering “minimum essential coverage” as defined by federal law and never experience a lapse in coverage will have a one-time opportunity to return to the State Plan. This is called a Retreat Right. For more information on Retreat Rights, see page 16.

What if I’m in a VEBA?
The Affordable Care Act (ACA) regulations state participation in a VEBA may potentially disqualify participants from becoming eligible for a premium tax credit to purchase qualified health insurance from the Health Insurance Marketplace. If you are a State of Montana VEBA participant, please contact the State of Montana’s VEBA administrator, Rehn & Associates, at (800) 872-8979 to inquire about your options.
Retirees who leave the State Plan and enroll in another health plan offering “minimum essential coverage” as defined by federal law will have a one-time opportunity to return to the State Plan. This is called a Retreat Right.

- A Retiree wishing to re-enroll in State Plan coverage must notify HCBD within two years of their State Plan termination date.
- Re-enrollment is not allowed if there is any lapse in coverage.
- Re-enrollment requests must include a Certificate of Creditable Coverage from the other health plan along with a Retiree Re-enrollment Form found on www.benefits.mt.gov.

If the Retiree voluntarily leaves other coverage within the two-year time period;
- The Retiree may only re-enroll during the Annual Change period (typically held in the fall of each year) following request for re-enrollment;
- Coverage on the State Plan will be effective January 1 of the following plan year;
- The Retiree must ensure there is not a lapse in coverage when cancelling their other coverage; and
- Only dependents that were covered at the time the Retiree terminated the State Plan will be eligible to re-enroll, unless otherwise allowed by Annual Change rules.

If a Retiree experiences an involuntary loss of other coverage within the two-year time period;
- The Retiree must notify HCBD within 60 days of losing other coverage to avoid a lapse in coverage;
- Coverage will begin retroactive to the date other coverage ends following receipt of the Re-enrollment Form and payment; and
- Only dependents covered at the time the Retiree terminated the State Plan will be eligible to re-enroll, unless those dependents also experienced an involuntary loss of coverage.

A Retiree’s coverage and cost options for the State Plan after exercising their Retreat Right will be subject to the available plans and eligibility rules of the year in which the Retiree is eligible to re-enroll. See the Summary Plan Documents available at www.benefits.mt.gov to see current eligibility rules.
HIPAA Notice

STATE OF MONTANA HIPAA NOTICE OF PRIVACY PRACTICES

The State of Montana HIPAA Notice is available on our website www.benefits.mt.gov.

If you have any questions about your privacy rights, please contact the Health Plan at the following address:
• Contact Office or Person: Amber Godbout, Privacy Official
• Health Plan Name: State of Montana Employee Benefit Plan
• Telephone:(406) 444-7462 (in Helena) or (800) 287-8266; TTY (406) 444-1421
• Email: benefitsquestions@mt.gov
• Address: Health Care and Benefits Division
  PO Box 200130
  Helena, MT 59620-0130

Copies of the HIPAA Notice are also available at 100 North Park Avenue, Suite 320, Helena, MT 59601. You may request the Notice by calling Health Care and Benefits or sending a request by email to the above address.

DISCLAIMER
The Patient Protection and Affordable Care Act (PPACA) was enacted on March 23, 2010. The United States Departments of Health and Human Services, Labor, and Treasury have issued regulations to help entities comply with PPACA. However, additional clarifications to address issues that may arise under these regulations could also be published by the Departments on an on-going manner through administrative guidance possibly in another form than a regulation. Where the statutes or regulations were not clear regarding benefits, the State of Montana made a reasonable interpretation of the act and made a good faith effort to comply with the statutes and regulations. The State of Montana reserves the right to alter provisions of this document and its plan in order to comply with applicable law.
Annual Change - A period each fall in which you have the opportunity to make changes to your State Plan options. These changes take effect January 1 of the following year.

Balance Billing - The amount over the State Plan’s allowable charge that may be billed to the member by an non-participating provider.

Benefits Payment/Contribution - What you pay each month for your State Plan coverage.

Benefit Percentage - The percent the State Plan pays after you meet your deductible.

Copay - A copay is a fixed dollar amount you pay for a covered service. The State Plan pays the rest of the fair amount the State Plan will pay for a service.

Deductible - A deductible is how much you must pay each Plan Year before the State Plan starts to pay.

Grandfather Month - If you were hired before August 1, 1998 and have had no lapse in service, you are entitled to one extra month of State Share and benefits coverage upon retiring or leaving State employment.

Joint Core - If you and your spouse both work for the State and have at least one dependent enrolled on the State Plan, you can elect to be Joint Core. Your family shares 1 family maximum out-of-pocket.
Out-of-Pocket Maximum - The out-of-pocket maximum is the most you’ll have to pay for covered services in a Plan Year. See page 14-15 for details.

Non-Participating Providers - Non-participating providers and facilities have chosen not to sign a contract with Allegiance in Montana or Cigna outside of Montana. If you use a non-participating facility or provider, the State Plan will pay a fair rate for your care, but the non-participating provider may balance bill you for more. You are responsible for any balance bills you receive.

Participating Provider - Participating providers and facilities have contracted with Allegiance in Montana and Cigna outside of Montana to accept a low, fair rate (the PBME) for your care.

Plan Member - Anyone covered on the State Plan including employees, legislators, Retirees, COBRA members, and eligible spouse/domestic partner and/or dependents.

Plan Year - The Plan year starts January 1 and ends December 31 each year regardless of when you were hired.

Pre-Admission Certification Review - Calling Allegiance so they can determine if an inpatient hospital stay meets the criteria to be covered by the State Plan. It’s important to get this approval for non-emergency hospital stays ahead of time and within 72 after a non-planned admission.

Pre-Treatment Review - Calling Allegiance before you have a medical service to make sure it meets “medically necessary” criteria. This is not a guarantee of payment.

Procedure Based Maximum Expense (PBME) - The fair amount the State Plan will pay for a service.

Specialty Drugs - Specialty drugs usually require special handling, administration, unique inventory management, a high level of patient monitoring and more intense support than conventional therapies. They could include all routes of administration (self-injectable, oral, or infused). They are typically very expensive.

## Benefit Cost Worksheet
### For Retirees

### Core Benefits
At age 65 and/or upon Medicare Eligibility:
- Dental becomes optional and
- The Retiree is no longer eligible for Basic Life Insurance.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plan</td>
<td>Rates on p. 25</td>
<td>$_______ (a)</td>
</tr>
<tr>
<td>Dental Plan</td>
<td>Rates on p. 32 (Optional over 65)</td>
<td>$_______ (b)</td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>$14,000 Available to Retirees under age 65 and not Medicare eligible (See p. 36)</td>
<td>$1.90 (c)</td>
</tr>
<tr>
<td>Total Core Benefits Contribution</td>
<td>Add lines a, b, and c</td>
<td>$_______ (d)</td>
</tr>
</tbody>
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### Optional Benefits
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Rate</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Vision Hardware</td>
<td>Rates on p. 34</td>
<td>$_______ (e)</td>
</tr>
<tr>
<td>Optional Benefits Contribution Total</td>
<td>Line e</td>
<td>$_______ (f)</td>
</tr>
</tbody>
</table>

### Totals
<table>
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<tr>
<th>Section</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Benefits</td>
<td>$_______ (g)</td>
</tr>
<tr>
<td>Optional Benefits</td>
<td>$_______ (h)</td>
</tr>
<tr>
<td>Total Benefits</td>
<td>$_______ (i)</td>
</tr>
<tr>
<td>Live Life Well Incentive total*</td>
<td>$_______ (j)</td>
</tr>
</tbody>
</table>

*Enter $10 for each of the following:
- You attended a 2015 State sponsored health screening ($10)
- You are tobacco-free or completed a tobacco cessation program. ($10)
- You completed four Next Step activities. ($10)
- Your dependent over age 18 completed any or all of the three steps above. ($10-$30)

See benefits.mt.gov/pages/incentive.faqs.html for full details.

### Member’s Total Monthly Costs for Benefits
<table>
<thead>
<tr>
<th>Section</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subtract lines j from line i</td>
<td>$__________</td>
</tr>
</tbody>
</table>
For complete details about the State Plan, refer to the Summary Plan Documents (SPDs) available on the website www.benefits.mt.gov.
Live Life Well Incentive Program

• Earn up to $30/month off your 2017 benefit payment by completing the following activities between November 1, 2016 and October 31, 2017.
• Double your discount and earn up to $60/month if you and your covered spouse/domestic partner complete the incentive program.
• New employees who begin after October 15, 2016 are not eligible to participate in the 2017 Incentive Program.

Make an account at www.myactivehealth.com/som to report your incentive activities and track your discount!

$5 Health Screening Discount
Have a State-sponsored health screening with CareHere by Oct. 31, 2016.

A State sponsored health screening is required in order to qualify for any part of the Live Life Well Incentive Program.

$10 Nicotine Free Discount
Your State sponsored health screening indicates you are nicotine free OR your State sponsored health screening indicates you are NOT nicotine free and you:
  • Complete a nicotine cessation program OR
  • Have a nicotine counseling session with your primary care provider.

$15 Next Steps Discount
Complete an eligible activity related to your health screening results.
  • See www.benefits.mt.gov/discount for details.

The State Plan offers the incentive program to all plan members and their enrolled spouse/domestic partner. If you think you may be unable to meet a standard of the incentive program, you may qualify for an alternative program or different means to earn the incentive. You must contact the Health Care & Benefits Division (HCBD) as soon as possible at 800-287-8266 or email livelifewell@mt.gov. We will work with you (and if you wish, your doctor) to design a program with the same incentive that is right for you.

Any personal medical information gathered during the course of the incentive program is protected by and will be treated consistent with the HIPAA Privacy and Security Rules. A copy of the Plan’s privacy notice is available upon request or at www.benefits.mt.gov/Portals/59/Documents/hipaa%20notice.pdf.
Capitol Medical Plan

Monthly Cost

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medicare Retiree Rates</td>
<td></td>
</tr>
<tr>
<td>Retiree Only</td>
<td>$1,043</td>
</tr>
<tr>
<td>Retiree &amp; Spouse</td>
<td>$1,472</td>
</tr>
<tr>
<td>Retiree &amp; Child(ren)</td>
<td>$1,251</td>
</tr>
<tr>
<td>Retiree &amp; Family</td>
<td>$1,506</td>
</tr>
<tr>
<td>Retiree &amp; Medicare Spouse</td>
<td>$1,248</td>
</tr>
<tr>
<td>Retiree &amp; Medicare Spouse &amp; Child(ren)</td>
<td>$1,326</td>
</tr>
</tbody>
</table>

| Medicare Retiree Rates        |        |
| Retiree Only                  | $416   |
| Retiree & Spouse              | $826   |
| Retiree & Child(ren)          | $680   |
| Retiree & Family              | $863   |
| Retiree & Medicare Spouse     | $724   |
| Retiree & Medicare Spouse & Child(ren) | $742   |

Plan Includes
- One eye exam per Plan Member per Plan Year with a $10 copay at a participating provider
- Prescription Drug Coverage
- Use of all Montana Health Centers at no cost see page 20

Questions

1-855-999-1057
www.askallegiance.com/som

- Claims/Billing
- Participating Providers
- Online Account Information
- What’s Covered
- Pre-Certification/Pre-Treatment Review
- Case Management

Eligibility
For detailed information on who’s eligible for the State Plan, please refer to the Summary Plan Documents available at www.benefits.mt.gov.

For complete details about the State Plan, refer to the Summary Plan Documents (SPDs) available on the website www.benefits.mt.gov.
Medical Plan Cost Sharing

**Transparent Pricing**
Providers and medical facilities are either participating or non-participating.

**Check Your Provider/Facility Before You Go!**
www.askallegiance.com/som or (855) 999-1057
- Allegiance participating inside Montana.
- Cigna participating outside Montana.

**Participating**
Participating providers and facilities have contracted with Allegiance in Montana and Cigna outside of Montana to charge a low, fair rate for your care.

**Cost Sharing**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montana Health Center</td>
<td>$0 Copay</td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Urgent Care Office Visit</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Deductible (Counts towards Max Out-of-Pocket)</td>
<td>$1,000 per member per Plan Year</td>
</tr>
<tr>
<td>Benefit % (What the plan pays after you meet your deductible. Counts towards max out-of-pocket.)</td>
<td>75% after deductible is met 100% after max out-of-pocket is met</td>
</tr>
<tr>
<td>Max Out-of-Pocket</td>
<td>$4,000/member $8,000/family</td>
</tr>
</tbody>
</table>

**In-State Non-Participating**
In-State Non-Participating providers and facilities have chosen not to sign a contract with Allegiance. If you use non-participating facility or provider in Montana, you pay the cost sharing shown above and the State Plan will pay a fair rate for your care, but the non-participating provider may balance bill you for more. You are responsible for this balance bill and it does not count toward your deductible or max out-of-pocket.)
Out-of-State Non-Participating
If you go out-of-state and use a non-Cigna provider/facility, the cost sharing is as follows:

Cost Sharing
Applies to all services unless stated otherwise in the SPD.

<table>
<thead>
<tr>
<th>Annual Deductible (Counts towards Max Out-of-Pocket)</th>
<th>$1,500 per member per Plan Year (This is separate from the $1,000 deductible on page 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit % (What the plan pays after you meet your deductible.) Balance bill does not count towards max out-of-pocket.</td>
<td>65% + balance billing</td>
</tr>
<tr>
<td>Max Out-of-Pocket</td>
<td>$4,950/member + balance billing $10,900/family + balance billing (These are separate from annual max out-of-pockets shown on page 24)</td>
</tr>
</tbody>
</table>

Prescriptions
There is separate cost sharing for prescriptions, including a separate max out-of-pocket. See page 26-27 for more details.

<table>
<thead>
<tr>
<th>What You Pay</th>
<th>Annual URx Max Out-of-Pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,800/member</td>
<td>$3,600/Family</td>
</tr>
</tbody>
</table>

For complete details about State Plan medical coverage, refer to the Summary Plan Document (SPD) at www.benefits.mt.gov.
URx
URx is your prescription drug benefit. It is administered by MedImpact. You are automatically enrolled in URx when you enroll in the Medical Plan.

Drug Tiers
Look up the tier of your drug at: https://mp.medimpact.com/mtn.

<table>
<thead>
<tr>
<th>Drug Tier</th>
<th>Deductible</th>
<th>Retail Rx 30 day supply</th>
<th>Mail Rx 90 day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$0</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>B</td>
<td>$0</td>
<td>$15 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>C</td>
<td>$0</td>
<td>$50 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>D*</td>
<td>$0</td>
<td>50%**</td>
<td>50%**</td>
</tr>
<tr>
<td>F*</td>
<td>$0</td>
<td>100%**</td>
<td>100%**</td>
</tr>
</tbody>
</table>
| Specialty | $0         | • Diplomat-$150 or $250 copay  
• Pharmacy other than Diplomat-50% coinsurance** | Not covered |
| Specialty NC | Not covered | Not covered |

*If your drug is a D or F, call URx Ask A Pharmacist at (888) 527-5879 for lower cost alternatives.

**Does not count toward your out-of-pocket maximum.

Max Out-of-Pocket
There is separate max-out-of-pocket for prescriptions.

<table>
<thead>
<tr>
<th>Annual URx Max Out-of-Pocket</th>
<th>What You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,800/member</td>
<td>$3,600/Family</td>
</tr>
</tbody>
</table>
SAVE BIG with Mail Order Pharmacies
You can get a three month supply of some medication for the price of two months!
The State Plan pays less for many medications through mail order pharmacies, Costco Mail Order Pharmacy and Ridgeway Mail Order Pharmacy. We pass those savings on to you by reducing your copay.
• Costco (You do NOT need to be a Costco member) (800) 607-6861
• Ridgeway (800) 630-3214

Specialty Pharmacy
Diplomat Specialty Pharmacy is the State Plan’s preferred pharmacy to handle specialty medications (drugs that require special administration). Using a pharmacy other than Diplomat for specialty medications could cost significantly more and does not accumulate toward your prescription annual max out-of-pocket.
• Diplomat Specialty Pharmacy (877) 319-6337

For complete details about the State Plan, refer to the Summary Plan Documents (SPDs) available on the website www.benefits.mt.gov.
The Montana Health Centers offer the same kinds of services you’d find at your regular doctor’s office and more, all at no-cost to you and a much lower cost to our self-funded State Plan! ***Medicare Retirees may only use the Health Center for flu shots and health screenings.***

**Services**
Primary care including treatment for colds, flus, allergies, hypertension, diabetes, high cholesterol, minor wound care, health screenings, routine blood work, skin checks and biopsies, health coaching, wellness programs, well-woman exams, birth control, and more.

**Who Can Use Montana Health Centers**
Active employees and non-Medicare Retirees and their spouse/domestic partners and their dependents age two and older who are covered on the State Plan may receive all available services at any Montana Health Center location. **Medicare Retirees may only use the Health Center for flu shots and health screenings.***

**Appointments**
Visit www.carehere.com or call (855) 200-6822. The first time you go to www.carehere.com, you will need to register. The system will ask you for your code. The code is MANA9.
Well-Being Services

Live Life Well and the Montana Health Centers partner to offer many lifestyle and condition management programs. Some programs offer co-payment reductions on applicable medications for participating members.

Five Ways to Connect with a Health Coach
1. Call or email one of the coaches found at:
   www.healthcenter.mt.gov/Health-Coaching.
2. Call 1-855-200-6822 and ask for a health coaching appointment.
3. Follow the steps below:
   a) Have your state-sponsored health screening.
   b) Have a follow-up appointment with a Health Center provider.
   c) Ask the provider about making an appointment with a coach.
4. Attend a wellness presentation or invite a coach to your workplace.
5. If you live outside a health center area, you can either travel to a Health Center to visit one of the Health Center health coaches in-person or you can contact HCBD at livelifewell@mt.gov or (800) 287-8266.

Nutrition
Diabetes, weight management, lowering cholesterol, allergies, sports performance, etc.

Exercise
Group fitness classes, personal training, personalized plans, working with injuries, etc.

Tobacco, Stress, etc.
Stress management, tobacco cessation, work/life balance, etc.

Nursing
Blood pressure, asthma, medication management, diabetes, etc.

Other Medical Conditions
Teams of healthcare professionals including physicians, mental health care providers, physician assistants, nurse practitioners, nurses, dietitians, and fitness experts give you the best overall care. Talk with a Montana Health Center provider for plan that is right for you.

For complete details about the State Plan, refer to the Summary Plan Documents (SPDs) available on the website www.benefits.mt.gov.
Dental Plan

Monthly Cost

<table>
<thead>
<tr>
<th></th>
<th>Premium Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member only</td>
<td>$41.10</td>
</tr>
<tr>
<td>Member &amp; Spouse</td>
<td>$62.50</td>
</tr>
<tr>
<td>Member &amp; Child(ren)</td>
<td>$61</td>
</tr>
<tr>
<td>Member &amp; Family</td>
<td>$70</td>
</tr>
<tr>
<td>Joint Core</td>
<td>$48</td>
</tr>
</tbody>
</table>

Eligibility

Employees, legislators, Retirees*, COBRA members, and eligible spouse/domestic partners and dependents.

*Retirees under age 65 are required to elect the Dental Plan unless they waive the entire benefits package; once Medicare eligible, dental coverage is optional.

Delta Dental Networks

$ Preferred Provider (PPO Dentist)
You usually pay the least when you visit a PPO Dentist because they agree to Delta’s lowest contracted fees.

$$ Premier Dentist
Premier Dentists have slightly higher contracted fees than PPO Dentists. You may end up paying more out-of-pocket at a Premier Dentist.

$$$ Non-Network Dentist
If you see a Non-Network Dentist, you will be responsible for the difference between the allowable charge set by Delta Dental and what that dentist bills.
Dental Plan Cost Sharing

Deductibles and maximums will be based upon a Plan Year, which is January 1st through December 31st.

<table>
<thead>
<tr>
<th>Services</th>
<th>% Plan pays after Deductible is met up to Maximum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic &amp; Preventive Benefits</td>
<td>100%*</td>
</tr>
<tr>
<td>Basic Benefits**</td>
<td>80%</td>
</tr>
<tr>
<td>Major Benefits**</td>
<td>50%</td>
</tr>
<tr>
<td>Implant Benefits</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductibles</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Enrollee per Calendar Year</td>
<td>$50</td>
</tr>
<tr>
<td>Per Family per Calendar Year</td>
<td>$150</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum amount plan pays per member</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Calendar Year</td>
<td>$1,800</td>
</tr>
<tr>
<td>Lifetime for Implant Benefits</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

*Diagnostic and Preventive Benefits are not subject to the deductible.

**For details including what is covered under Basic and Major Benefits see the Dental SPD at www.benefit.mt.gov or call Delta Dental (866) 496-2370.

Third Party Administrator
Delta Dental processes dental claims for the State Plan. Remember, it’s the State that decides rates, out-of-pocket costs, and what’s covered.
Vision Hardware Plan

Eye Exam
ALL members covered on the Medical Plan may have one routine vision and eye health evaluation each year for a $10 copay at a participating Cigna vision provider.

Vision Hardware Coverage
You may enroll for Vision Hardware coverage each year for an extra cost.
- If you elect vision hardware coverage, it will apply to everyone covered on your Medical Plan.
- You must re-enroll each year

Monthly Cost

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Only</td>
<td>$7.64</td>
</tr>
<tr>
<td>Member &amp; Spouse</td>
<td>$14.42</td>
</tr>
<tr>
<td>Member &amp; Child(ren)</td>
<td>$15.18</td>
</tr>
<tr>
<td>Member &amp; Family*</td>
<td>$22.26</td>
</tr>
</tbody>
</table>

Cigna Vision
(877) 478-7557
stateofmontana@cigna.com
https://cigna.vsp.com
Check to make sure BOTH your eye doctor and the store where you purchase your hardware are participating.

Eligibility
Employees, Retirees, legislators, COBRA members, and eligible spouse/domestic partners and dependents covered on the Medical Plan.
**Vision Hardware Cost Sharing**

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Plan will pay 100% after any copayment, subject to any maximum shown below</strong></td>
<td>The plan will reimburse you at 100%, subject to any maximum shown below</td>
<td></td>
</tr>
<tr>
<td><strong>Examinations</strong></td>
<td><strong>$10 Copay</strong></td>
<td><strong>$45</strong></td>
</tr>
<tr>
<td>One Eye Exam every Calendar Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lenses &amp; Frames</strong></td>
<td><strong>$20 Copay</strong>*</td>
<td></td>
</tr>
<tr>
<td>*Note: Lenses &amp; Frames Copay does not apply to Contact Lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One pair per Plan Year instead of contacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>100%</td>
<td><strong>$40</strong></td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>100%</td>
<td><strong>$65</strong></td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>100%</td>
<td><strong>$75</strong></td>
</tr>
<tr>
<td>Lenticular Lenses</td>
<td>100%</td>
<td><strong>$100</strong></td>
</tr>
<tr>
<td>Progressive Lenses</td>
<td>100%</td>
<td><strong>$75</strong></td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One benefit per Plan Year instead of Lenses or lenses and frames.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>100% up to $130</td>
<td><strong>$115</strong></td>
</tr>
<tr>
<td>Therapeutic</td>
<td>100%</td>
<td><strong>$210</strong></td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One pair in any 2 Calendar Years</td>
<td>100% up to $130</td>
<td><strong>$71</strong></td>
</tr>
</tbody>
</table>

For complete details about the State Plan, refer to the Summary Plan Documents (SPDs) available on the website www.benefits.mt.gov.
Basic Life Insurance
Core benefit for non-Medicare Retirees. 
$1.90/month=$14,000 of term-life coverage

Basic Life provides $14,000 of term-life coverage. It is available to non-Medicare Retirees under age 65 who keep the State Plan into retirement.

The life insurance plans are term life, meaning they provide inexpensive protection but do not earn any cash value.

Often choosing other life insurance is best if you want post-employment protection.

However, both conversion (changing your group life to individual life) or portability (taking your group life insurance with you after separation) may be available if requested when the coverage ends.

The Standard
(800) 759-8702
www.standard.com
## Contact Information

<table>
<thead>
<tr>
<th>ELIGIBILITY AND GENERAL QUESTIONS</th>
<th>ALL MONTANA HEALTH CENTERS</th>
<th>CLAIMS, BENEFITS, PARTICIPATING PROVIDERS, ETC.</th>
<th>PRESCRIPTIONS AND URX CUSTOMER SERVICE</th>
<th>DENTAL BENEFITS, CLAIMS, &amp; CUSTOMER SERVICE</th>
<th>VISION SERVICE PROVIDERS AND HARDWARE COVERAGE</th>
<th>FLEXIBLE SPENDING</th>
<th>LIFE &amp; LONG TERM DISABILITY INSURANCE</th>
<th>WORKERS’ COMPENSATION</th>
</tr>
</thead>
</table>