2016 Employee Annual Change Book
A Message from DOA Director Sheila Hogan

Dear Members of the State Employee Benefit Plan,

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:
• If you live near a Montana Health Center, make one of their providers your “regular doctor.”
• 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.
• If you’re retired or plan to do so soon, 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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Benefit Term Decoder

The following explanations are to help you understand the terms in this book and do not replace the definitions found in the Summary Plan Document. The definitions in the Summary Plan Document govern the rights and obligations of the Plan and Plan members.

Allowable Charges-The amount a provider agrees to accept for a service based on what the network administrator agrees to pay.

Balance Billing-The amount over the Plan’s allowable charge that may be billed to the member by an out-of-network provider.

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

Coinsurance-Coinsurance is the percent of an allowable charge you pay after you meet any applicable deductible.

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

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

Out-of-Pocket Maximum-The out-of-pocket maximum is the most you’ll have to pay for covered services in a Plan year. There are separate out-of-pocket maximums for in-network and out-of-network providers and for members vs. families. (See the out-of-pocket chart on p. 8).

In-Network Provider-Providers who are contracted with the network administrator and agree to accept allowable charges. In-Network providers usually cost less to the member and the Plan.

Out-of-Network Provider—Providers who have not contracted with the network administrator. Out-of-Network providers are usually more expensive to both the member and the Plan.

Certification/Pre-certification—Certification means the third party administrator decides if an inpatient hospital stay meets the criteria to be covered by the plan. Pre-certification is getting approval for non-emergency hospital stays ahead of time.

Prior Authorization—Prior authorization is getting approval for a service, medication, or medical supply before you have it to make sure it will be covered by the Plan. Getting prior authorization ensures that you’re getting the right services for the right price. This saves the member and the Plan money. See the Summary Plan Document for more information on obtaining a prior authorization.

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.

Plan Year—Our Plan year starts January 1 and ends December 31 each year.

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. Then the whole family shares on out-of-pocket maximum, and may have a slightly lower benefits payment than enrolling separately.
How to Do Elections Online

For access from MINE:
1. Log into MINE: http://mine.mt.gov
2. Click Employee Self Service
3. Click Benefits Enrollment
4. Follow the online directions.

To access MINE from home:
1. Go to the State Employee Access page at www.mt.gov/employee
2. Click on the MINE Employee Self Service Portal
3. Follow the directions above for access from MINE
### Benefit Cost Worksheet

#### For Employees and Legislators

**Core Benefits**
- Medical Plan (Rates on p. 8) $_______ (a)
- Dental Plan (Rates on p. 16) $_______ (b)
- Basic Life Insurance of $14,000 (p. 24) $1.90 (c)
- **Total Core Benefits Contribution** Add lines a, b, and c = $_______ (d)

**Optional Benefits**
- Flexible Spending Accounts (FSA) (p. 22) $_______ (e)
  - Medical FSA $_______ (e)
  - Dependent Care FSA $_______ (f)
- Vision Hardware (Rates on p. 18) $_______ (g)
- Life Insurance (Rates on p. 24) $_______ (h)
  - Dependent Life $_______ (h)
  - Optional Employee Life $_______ (i)
  - Supplemental Spouse $_______ (j)
- Accidental Death & Dismemberment (Rates on p. 24) $_______ (k)
- Long Term Disability (LTD) (p. 24) $_______ (l)
- **Optional Benefits Contribution Total** Add lines e, f, g, h, i, j, k, and l = $_______ (m)

**Totals**
- **Core Benefits** Enter amount from line d $_______ (n)
- **Optional Benefits** Enter amount from line m $_______ (o)
- **Total Benefits** Add lines n and o $_______ (p)

**State Contribution** $976(q)

**Live Life Well Incentive total**
- *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)
  - Joint core members may qualify for a total monthly discount of up to $120. See benefits.mt.gov/pages/incentive.faqs.html for full details.
- **Member's Total Monthly Costs for 2016 Benefits** Subtract lines q and r from line p $_________

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Medical Plan Details

Capitol Plan Includes
- One eye exam per Plan member each year with a $10 copay at an in-network provider
- URx Prescription Drug Coverage
- Use of all Montana Health Centers at no cost
- No-cost health screening provided by CareHere

Monthly Cost
The amount below will be subtracted from the State Share ($976) to see what, if any, cost the Plan member will pay per month.

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Employee &amp; Spouse</th>
<th>Employee &amp; Children</th>
<th>Employee &amp; Family</th>
<th>Joint Core</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Cost</td>
<td>$963</td>
<td>$1,183</td>
<td>$1,034</td>
<td>$1,260</td>
<td>$995</td>
</tr>
</tbody>
</table>

Out-of-Pocket Costs

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montana Health Center</td>
<td>$0 Copay</td>
<td></td>
</tr>
<tr>
<td>Primary Care Office Visit (including naturopathic)</td>
<td>$25 Copay</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$35 Copay</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Office Visit</td>
<td>$35 Copay</td>
<td></td>
</tr>
<tr>
<td>Annual Deductible (Counts towards Annual Max Out-of-Pocket) Applies 1/1/16 — 12/31/16</td>
<td>$1,000/member No Family Deductible</td>
<td>A separate $1,500/member</td>
</tr>
<tr>
<td>Coincurrence %</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Annual Max Out-of-Pocket</td>
<td>$4,000/member $8,000/family</td>
<td>A separate $4,950/member A separate $10,900/family + balance billing</td>
</tr>
<tr>
<td>Annual URx Max Out-of-Pocket</td>
<td>$1,800/member $3,600/Family</td>
<td></td>
</tr>
</tbody>
</table>

Eligibility

## General/Preventive Medical Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional outpatient physical, occupational, cardiac, pulmonary, &amp; speech therapy (max 30 combined days/yr)</td>
<td>$25/visit</td>
<td>35% + balance billing/visit</td>
</tr>
<tr>
<td>Professional Lab/Diagnostic/Injectables</td>
<td>25% (no deductible on injectables without an office visit)</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Durable medical equipment and prosthetics—May require prior authorization</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Allergy shots</td>
<td>Office visit copay + 25% coinsurance (no deductible; if no office visit)</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Routine Vision Exam (One per member per Plan Year)</td>
<td>$10</td>
<td>Balance billing for cost over $45</td>
</tr>
<tr>
<td>Preventive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult preventive services—See p. 12-13 for more details</td>
<td>$0</td>
<td>35% + balance billing (No deductible for mammograms)</td>
</tr>
<tr>
<td>Adult Immunizations—See p.13</td>
<td>$0</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Well child checkups and immunizations—See the schedule listed in the Summary Plan Document</td>
<td>$0</td>
<td>35% + balance billing</td>
</tr>
</tbody>
</table>

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[D] = Must meet deductible before coinsurance applies.

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<table>
<thead>
<tr>
<th>Emergency and Urgent Care Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance services for medical emergency</td>
<td>25%</td>
<td>25% + balance billing</td>
</tr>
<tr>
<td>Emergency department and hospital charges—Copay includes all services</td>
<td>$250/visit</td>
<td>$250/visit $100 for physician services</td>
</tr>
<tr>
<td>(no deductible or coinsurance); copay waived if admitted, then all inpatient benefits apply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency department professional and ancillary charges</td>
<td>N/A</td>
<td>Balance billing</td>
</tr>
<tr>
<td>Urgent care facility and professional charges</td>
<td>$35 (covers visit charge only)</td>
<td>$35 (covers visit charge only) + balance billing</td>
</tr>
<tr>
<td>Urgent care ancillary (lab/diagnostic/surgical charges)</td>
<td>25%</td>
<td>25% + balance billing</td>
</tr>
</tbody>
</table>

**Hospital Care**

| Inpatient services                                                   | 25%        | 35% + balance billing               |
| Outpatient services and Surgical Center Services                      | 25%        | 35%                                 |
| Transplants—Prior authorization, pre-certification, case management are required. Services must be rendered at a Center of Excellence with the designated transplant network. | 25%        | Not covered                         |

**Mental Health and Substance Abuse**

| Outpatient professional services                                      | $25/visit (covers office visit charge only) | 35% + balance billing |
| Inpatient services                                                   | 25%        | 35% + balance billing               |

*D = Must meet deductible before coinsurance applies.
*Developmental delays are not covered

<table>
<thead>
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<th>Maternity Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Physician charges</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Ultrasounds</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routine Newborn Care</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital and physician charges for routine newborn care</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extended Care Services (prior authorization recommended)</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (Max 70 Days/Plan Year)</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Hospice</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Skilled nursing (Max 70 Days/Plan Year)</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Inpatient rehabilitation (max 60 days per Plan Year total) See the SPD for details(^2)</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary/Nutritional counseling Max 3 days/Plan Year</td>
<td>$0 (no deductible, no coinsurance)</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>Chiropractic/Acupuncture (combined maximum of 20 days/Plan Year)</td>
<td>$25/day</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>PKU supplies</td>
<td>25%</td>
<td>35% + balance billing</td>
</tr>
<tr>
<td>TMJ treatment—Requires prior authorization</td>
<td>25% Surgical only</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

\(^2\)Residential services are not covered

\[D\]=Must meet deductible before coinsurance applies.
Covered Preventive Services

Age and gender appropriate preventive care from an in-network provider is covered at 100% of the allowed amount without any deductible, coinsurance, or copayment for Plan members. This complies with the Patient Protection and Affordable Care Act (PPACA).

<table>
<thead>
<tr>
<th>Periodic exams—Appropriate screening tests (see the Summary Plan Document for a full list of tests)</th>
</tr>
</thead>
</table>
| **Well child care** | Age 0 months through 4 year—up to 14 visits  
Infant through age 17  
Age 5 years through 17 years—one visit per Plan Year |
| **Adult routine exam** | Age 18 through 65+—one visit per Plan Year  
Exams may include screening/counseling and/or risk factor reduction interventions for depression, obesity, tobacco use, drug and/or alcohol abuse |

<table>
<thead>
<tr>
<th>Preventive Screenings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anemia screening (CBC)</strong></td>
</tr>
</tbody>
</table>
Pregnant women |
| **Bacteruria screening (UA)** |  
Pregnant women and others at risk |
| **RH incompatibility screening** |  
Pregnant women |
| **STD screening** |  
Pregnant women and others at risk |
| **HIV screening** |  
Breast cancer screening (mammography) | Women age 40+—one per Plan Year |
| **Cervical cancer screening (PAP)** | Women age 21 through 65—one per Plan Year |
| **Cholesterol screening (lipid profile)** | Men age 35+ (age 20-35 if risk factors for coronary heart disease are present)  
Women age 45+ (age 20-45 if risk factors for coronary heart disease are present) |
| **Prostate cancer screening (PSA) age 50+** | One per Plan Year (age 40+ with risk factors) |

### Preventive Screenings Continued

<table>
<thead>
<tr>
<th>Preventive Screening</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Colorectal cancer screening</strong></td>
<td>• Fecal occult blood testing once per Plan Year; OR</td>
</tr>
<tr>
<td></td>
<td>• Sigmoidoscopy every 5 years; OR</td>
</tr>
<tr>
<td></td>
<td>• Members age 50+ and members under 50 who meet the medical policy criteria established by the Third Party Administrator may receive one colonoscopy per Plan Year regardless of diagnosis at zero cost if provided by an in-network provider. Any additional services related to the colonoscopy (i.e. laboratory, surgical, radiology) services are subject to deductible and coinsurance.</td>
</tr>
<tr>
<td></td>
<td>• Out-of-network services are subject to regular benefits and colonoscopies billed as preventive will only be allowed every 10 years for age 50 or older. Preventive colonoscopies for members under age 50 are not covered unless the member</td>
</tr>
<tr>
<td><strong>Osteoporosis screening</strong></td>
<td>Post menopausal women—65+ (60+ with risk factors)—one bone density x-ray (DXA) every two years</td>
</tr>
<tr>
<td><strong>Abdominal aneurysm screening</strong></td>
<td>Men age 65-75 who have ever smoked—one screening by ultrasound per Plan Year</td>
</tr>
<tr>
<td><strong>Diabetes screening</strong></td>
<td>Adults with high blood sugar</td>
</tr>
<tr>
<td><strong>Routine immunizations</strong></td>
<td>Diphtheria, tetanus, pertussis (DTaP; Tdap; TD), haemophilus influenza (HIB), hepatitis A &amp; B, human papillomavirus (HPV), influenza, measles, mumps, rubella (MMR), meningococcal, pneumococcal (pneumonia), poliovirus, rotavirus, varicella (smallpox); for age 50 and older: zoster (shingles)</td>
</tr>
</tbody>
</table>

Prescription Drug Plan

What is URx?
URx is your prescription drug benefit. It is administered by MedImpact. You are enrolled in URx when you enroll in the medical plan. URx aims to make sure members get the best prescription for them at the best price. Just because a medicine costs more, does NOT mean it is better.

Drug Tiers
Look up the tier of your drug at: https://mp.medimpact.com/mtn. Then, talk to your doctor about the options for your medication.
If your drug falls into the D or F tiers, consider asking your doctor for an alternative from the A, B, or C tiers. If no alternative is available, you can apply for an exception by filling out the URx Plan Exception form found at www.benefits.mt.gov.

<table>
<thead>
<tr>
<th>2016 In-network Prescription Max Out-of-Pocket: $1,800/individual and $3,600/family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Tier</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>Specialty</td>
</tr>
<tr>
<td>Specialty NC</td>
</tr>
</tbody>
</table>

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

SAVE BIG with Mail Order Pharmacies
You can get a three month supply of some medication for the price of two months! The Plan pays less for many medications through mail order pharmacies, Costco and Ridgeway. We pass those savings on to you.

- Costco (You do NOT need to be a Costco member) (800) 607-6861
- Ridgeway (800) 630-3214

Specialty Pharmacy
Diplomat Specialty Pharmacy is the 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.

- Diplomat Specialty Pharmacy (877) 319-6337

Questions about drug tiers, alternative medications, or drug interactions?
Call the URx Ask-a-Pharmacist program
Monday-Friday 8am-5pm
(888) 527-5879

Dental Plan

Monthly Cost

<table>
<thead>
<tr>
<th>Plan Description</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; Children</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>

Premium Dental will be the core benefit in 2016 to offer members the protection they need.

Eligibility
Employees, Legislators, Retirees*, and eligible dependents.
*Retirees under age 65 are required to elect a dental plan unless they waive the entire benefits package; once Medicare eligible, dental coverage is optional.

Delta Dental Networks
Find an in-network dentist, view claims, check benefits, and manage your profile Online and on your mobile phone. www.deltadentalins.com/stateofmontana or call (866) 496-2370.

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

$$ Premier
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
If you see a non-Delta Dental dentist, you will be responsible for the difference between the allowable charge set by Delta and what that dentist bills.
### Dental Plan Details

| Premium Plan | Deductible for B & C Services and Implnats-  
| | • $50 per member  
| | • $150 per family  
| | Deductible is waived for Type A services including Diagnostic & Preventive |

#### Examples of Covered Services*

<table>
<thead>
<tr>
<th>Type A Services</th>
</tr>
</thead>
</table>
| Sealants- children to age 16  
| Fluoride- children to age 19  
| Diagnostic & Preventive  
| • X-Rays  
| • Cleanings  
| • Exams  
|  
| Plan pays up to a combined total $1,800 worth of A, B, and C services per member per year. Member pays 100% after that. |

<table>
<thead>
<tr>
<th>Type B Services</th>
</tr>
</thead>
</table>
| Endodontics (root canals)  
| Oral Surgery  
| Periodontics (gum treatment)  
| Restorative (all filings)  
|  
| 20% Co-insurance on type B Services  
| 50% Co-insurance on type C Services |

<table>
<thead>
<tr>
<th>Type C Services</th>
</tr>
</thead>
</table>
| Crowns  
| Prosthodontics (inlays, onlays, bridges, and dentures)  
| Implants  
|  
| 50% coinsurance  
| $1,500 Lifetime Limit. Member Pays 100% after that. |

*These are just examples of covered services. Other services may be available and some services have exclusions and limitations. Be sure to call Delta (866) 496-2370 to learn more.

Vision Hardware Plan

- All members covered on the medical plan get one routine vision and eye health evaluation each year for a $10 copay at an in-network provider.
- Members must re-enroll each year for the Vision Hardware Plan.

**Monthly Cost**
If you choose vision hardware coverage, it will apply to everyone covered on your medical Plan. For example, if your plan covers “Member and spouse,” but your spouse doesn’t wear glasses, you will still pay $14.42/month if you elect the Vision Hardware Plan.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Only</strong></td>
<td>$7.64</td>
</tr>
<tr>
<td><strong>Member &amp; Spouse</strong></td>
<td>$14.42</td>
</tr>
<tr>
<td><strong>Member &amp; Children</strong></td>
<td>$15.18</td>
</tr>
<tr>
<td><strong>Member &amp; Family</strong></td>
<td>$22.26</td>
</tr>
</tbody>
</table>

**Eligibility**
Employees, retirees, legislators, COBRA members, and dependents covered on the medical plan.

**More Details**
# Vision Hardware Plan Details

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials Copay</td>
<td>$20</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Lenses</strong> - One pair per plan year instead of contact lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plastic or glass</td>
<td></td>
<td>Up to $45</td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>100% after Copay</td>
<td>Up to $65</td>
</tr>
<tr>
<td>(covered for under 18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision, Bifocal,</td>
<td></td>
<td>Up to $80</td>
</tr>
<tr>
<td>Trifocal, Lenticular</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One every two Plan Years</td>
<td>Plan Pays: Up to $130</td>
<td>Plan Pays: Up to $52</td>
</tr>
<tr>
<td>instead of contact lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One time benefit per Plan</td>
<td>$130</td>
<td>Up to $95</td>
</tr>
<tr>
<td>Year instead of lenses or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lenses and frames</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Elective Therapeutic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(must meet medically</td>
<td>100%</td>
<td>Up to $210</td>
</tr>
<tr>
<td>necessary criteria)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Montana Health Centers
Anaconda, Butte, Billings, Helena, Miles City, Missoula

Visit
WWW.HEALTHCENTER.MT.GOV
Learn all about your Montana Health Center:
Services, hours of operation, provider bios and more!

The Montana Health Centers operated by CareHere offer no
cost primary care services and health coaching to help you
on your journey to well-being. Consider making a Montana
Health Center near you your “regular doctor!”

Services
Primary care, same day services with appointment, flu
shots and other vaccinations, health screenings, lab
services, diagnostic service referral, health coaching, and
much more!

Who Can Use Montana Health Centers
Active employees and non-Medicare retirees and their
dependents age two and older who are covered on the 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 to State of Montana Plan members. 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…

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

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

Nursing
Blood pressure, asthma, medication management, diabetes…

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

Flexible Spending Accounts

Visit www.allegianceflexadvantage.com for full details.

You must RE-ENROLL each year for FSA!

If you enroll in a Medical or Dependent Care Flexible Spending Account (FSA), your contributions are taken out of each paycheck—before taxes—in equal installments throughout the Plan Year and put into medical and/or dependent care FSA accounts.

Medical FSA

- Annual maximum contribution per employee $2,550+$500 rollover.
- Can be used for: Deductibles, copays, and coinsurance, prescription drug costs, dental and vision, non-covered medical expenses
  See a complete list by visiting www.allegianceflexadvantage.com
- Entire yearly contribution becomes accessible the 2nd paycheck of January. $500 rollover not available until after 120 day period to claim the previous plan year’s expenses.

Dependent Care FSA

- Annual maximum contribution per household $5,000 or $2,500 if married but filing taxes separately.
- Can be used for: Child care (age 12 and under), Disabled dependent care
- Funds available only as contributed starting the 2nd paycheck of January.

Medical FSA funds cannot be used for dependent care expenses, and Dependent Care FSA funds cannot be used for medical expenses.

Administered by Allegiance Benefit Plan Management
(866) 339-4310, (406) 523-3149, or FAX (877) 424-3539
www.allegianceflexadvantage.com

Other Info
- $120/year minimum for both types of FSAs
- $2.26/month fee for one or both types of FSAs
- $1/month fee for debit card
- Claims can be made for the previous year until April 30 of the current year.
- $500 Flex Rollover-The IRS allows you to rollover $500 of Medical FSA from one year to another. Visit www.benefits.mt.gov/Flexible-Spending/Rollover to learn all the details.
- Excess State Share cannot be used for FSAs or FSA fees.

FSA Reimbursement Options

Traditional-File claims with Allegiance by fax, mail, or securely through the Allegiance website.

Joint Processing-Your portion of claims are automatically forwarded to Allegiance and Allegiance sends you your reimbursement until your flex funds are gone.
- This option is only available with participating TPAs. Visit www.benefits.mt.gov/flexible-spending for more details.
- If you use flex funds to pay for items later in the year like a child’s braces, this option may not be the best for you.
- If you select joint processing on medical flex, you must file paper forms for dependent care flex.

OR

Debit Card-Used just like a regular debit card for any qualified medical expense. You are responsible for keeping all receipts in case you are audited. If you select the debit card:
- You must use it for both Medical and Dependent Care if you have both.
- You can always file paper forms
- $1/month fee for debit card
Life Insurance

Fully insured and administered by The Standard insurance company.

- Plans are term life.
- They provide inexpensive protection but do not earn any cash value.
- A member may carry all life Plans until separation from employment. At separation, contact The Standard for conversion or portability options.
- At retirement, only Plan A—Basic Life—can be continued until age 65 or Medicare eligible.

Eligibility

Basic Life Insurance is a core benefit for all active employees, legislators, and non-Medicare retirees. Optional life insurance and Accidental Death & Dismemberment are available for employees, spouses, and dependents. Refer to the SPD for more information on eligibility.

During Annual Change You May:

- Delete Plans B, C, D, and E.
- Decrease coverage in Plan C down to your annual salary, rounded to the next highest $5,000 increment.
- Apply for, increase, or decrease coverage under Plans C and D.
- Add, increase, or decrease Plan E.

<table>
<thead>
<tr>
<th>Plans</th>
<th>Monthly Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan A: Basic Life</td>
<td>$1.90 per month</td>
</tr>
<tr>
<td>Plan B: Dependent Life</td>
<td>$0.52 per month</td>
</tr>
<tr>
<td>Plan C: Optional Employee Life</td>
<td>(every $1,000 of coverage) x (Age Rate*)</td>
</tr>
<tr>
<td>Plan D: Optional Spouse Life</td>
<td>(every $1,000 of coverage) x (Age Rate*)</td>
</tr>
<tr>
<td>Plan E: AD&amp;D—Employee only</td>
<td>$0.020 / $1,000 of coverage</td>
</tr>
<tr>
<td>AD&amp;D—Employee plus dependents</td>
<td>$0.030 / $1,000 of coverage</td>
</tr>
</tbody>
</table>

*Age Rates* for Plans C & D Based on employee’s age on the last day of the month that contributions are paid. The first payment after the employee’s birthday will reflect the new rate.

0-29=$0.025, 30-34=$0.042, 35-39=$0.067, 40-44=$0.084, 45-49=$0.126, 50-54=$0.193, 55-59=$0.361, 60-64=$0.554, 65+= $0.823

Life Insurance Plan Details

Plan A – Basic Life
Core benefit for state employees
- $1.90/month=$14,000 of term-life coverage

Plan B – Dependent Life
Available during 31-day enrollment period, or within the first 60 days of marrying or having your first child
- $0.52/month=$2,000 of coverage for a spouse and $1,000 of coverage per dependent child.

Plan C – Optional Employee Life
Available during 31-day enrollment period without EOI* up to the member’s annual salary. Enrollment after the 31 days requires EOI*.
- Minimum of your annual salary rounded to the next highest $5,000 up to $500,000 with EOI*.
- During Annual Change, those employees with existing Plan C coverage may add an extra $5,000 or $10,000 to their coverage without EOI* each year up to the cap of $500,000.

Plan D – Optional Spouse Life
May make a NEW election of Plan D coverage of up to $10,000 without EOI* during 31-day enrollment period and annual change.
- Employee must be enrolled in Plan C for the spouse to be eligible for Plan D.
- Spouse’s rate is based on the employee’s age, not the spouse’s age.
- Coverage is for a minimum of $5,000.
- Additional amounts are available in $5,000 increments, up to the amount of optional employee Plan C.
- If increasing to existing coverage EOI* required

Plan E—Optional Accidental Death & Dismemberment
Available without EOI*.
- Employee Only: $25,000-$500,000 in increments of $25,000 up to 10 times your annual salary rounded down to the next $25,000.
- Employee and Dependents: A spouse with no children is eligible for 50% of the employee coverage. A spouse with children is eligible for 40% of the employee coverage. Children are eligible for 10% of the employee coverage.

*Evidence of Insurability (EOI) is a medical application to prove good health.

Long Term Disability

Voluntary Long Term Disability (LTD) is a benefit plan that pays a monthly benefit to you if you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, helping you with financial costs in a time of need.

Cost
$9.90 per member per month. Payments will be taken from your pay AFTER TAX in order to maximize the benefit should you ever need it. When money is put into LTD after tax, the benefit is paid out tax free.

Eligibility
Available to active employees who are enrolled in the medical Plan. Retirees, legislators, and COBRA members are not eligible to participate. New hires may enroll within 31 days of being hired without Evidence of Insurability* (EOI). All other applicants must provide EOI*. Refer to the SPD for more information on eligibility.

Benefit Amount
The monthly LTD benefit is 60% of your insured pre-disability earnings—the amount you were earning before you became disabled—reduced by deductible income.

*Evidence of Insurability (EOI) is a medical application to prove good health.
Benefit Duration
If you become disabled and your claim for LTD benefits is approved, LTD benefits are payable after you have been continuously disabled for 180 days and remain continuously disabled. LTD benefits are not payable during this benefit waiting period.
If you become disabled:
• Before age 60—LTD benefits may continue during disability until you reach Social Security Normal Retirement Age.
• 60 or older—benefit duration is determined by your age when disability begins.
• 60-64—maximum benefit period is five years.
• 65-68—maximum is to age 70.
• 69 and over—maximum is one year.

More Information
Also LTD brochures can be found on the HCBD website www.benefits.mt.gov or by contacting Health Care and Benefits Division at (800) 287-8266, TTY (406) 444-1421, or benefitsquestions@mt.gov.

The information in this booklet is only a summary of the Life and LTD benefit. The controlling provisions are the group policy issued by The Standard Insurance Company. Refer to the Life and LTD policy at http://benefits.mt.gov/pages/forms.publications for further information.
Employee Assistance Program

The State of Montana’s new EAP (Employee Assistance Program) launches January 1, 2016. EAP helps you privately solve problems that may interfere with your work, family, and life in general. EAP services are FREE to you, your dependents, and all household members. EAP services are confidential and provided by experts.

Confidential Counseling
24-hour Crisis Help – toll-free access for you or a family member experiencing a crisis.

In-person Counseling
Up to four (4) face-to-face counseling sessions are available for each new issue. Simply call for access to qualified, local counselors who can help you with a variety of problems such as family, parenting, relationship, stress, anxiety, and other challenges.

Online Consultations
Convenient access to online consultations with licensed counselors through RBH eAccess at MyRBH.com. Online consultations are a great way to try counseling for the first time or to get support even when time is limited.

For general information: Karen Wood-Employee Assistance Program Manager State Human Resource Division (406) 444-2466
Life-Balance Resources

- **Child Resources** – Childcare professionals provide information and support for parenting, school issues, adoption, college planning, teenager challenges, summer camps, daycare, and other important issues for parents.

- **Adult and Eldercare Services** – Adult and eldercare specialists assist with finding quality information and services including transportation, meals, exercise, activities, prescription drug information, in-home care, daytime care, and housing.

- **Legal Services** – Access a free, half-hour consultation, by phone or in person, for any non-work related issue, followed with a 25% discount in legal fees.

- **Financial Services** – Access free phone support for up to 30 days for each new financial issue, such as debt counseling, budgeting, and college or retirement planning.

- **Mediation Services** – Request free consultations for personal, family, and non-work related issues such as divorce, neighbor disputes, or real estate transactions.

- **Home Ownership Program** – Get free support and information about making smarter choices when shopping for a new home, making financing decisions, relocating, or selling a home.

- **Identity Theft Services** – Access support in planning the recovery process for restoring your identity and credit after an incident.

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**MYRBH.COM**

Access current health news, tools for parenting, health topic movies, wellness resources, financial calculators, legal forms, and over 50 online trainings for personal and professional development.
Who Is Eligible?
All active State of Montana employees are eligible for Workers’ Compensation programs.

Working Safely
- *Take safety seriously.* A moment of distraction or carelessness is all it takes to cause a lifetime of disability.
- *Take responsibility* for keeping yourself and others safe.
- *Be aware of your environment!* Head off problems before an injury occurs.
- *Participate in safety* training and programs to learn how to keep yourself, your work environment, and your coworkers safe.
- *Use proper safety equipment* and follow recommended safety instructions.

Reporting an Injury
Work-related injuries and diseases must be reported to the Montana State Fund, within 24 hours. Learn more about reporting an injury at www.workerscomp.mt.gov.

Return to Work
Getting injured employees back to work is one of the most important things we can do for injured workers. Visit www.workerscomp.mt.gov/About-RTW to learn more about getting workers back to work as soon as possible.
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: agodbout@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.
## Contact Information

### ELIGIBILITY AND GENERAL QUESTIONS
- (800) 287-8266, (406) 444-7462; TTY (406) 444-1421
- benefitsquestions@mt.gov
- www.benefits.mt.gov
- 100 N Park Ave Suite 320 PO Box 200130
- Helena, MT 59620-0130

### ALL MONTANA HEALTH CENTERS
- (855) 200-6822
- help.montana@carehere.com
- General: Info www.healthcenter.mt.gov
- Appointments: www.carehere.com
- Registration Code: MANA9

### NEW MEDICAL & VISION TPA
We are still in the process of choosing our new third party administrator (TPA) for medical and vision services. You will receive a post card in the mail with their information as soon as this decision has been made.

### PRESCRIPTIONS AND URX CUSTOMER SERVICE
- (888) 648-6764
- askurx@mt.gov
- www.mp.medimpact.com/mtn

**Mail Order Prescription Drugs:**
- Costco (800) 607-6861
- Ridgeway Pharmacy (800) 630-3214
- Specialty Meds
- Diplomat Specialty Pharmacy (877) 319-6337

### DENTAL BENEFITS, CLAIMS, & CUSTOMER SERVICE
- Phone: (866) 496-2370
- Web: www.deltadentalins.com/stateofmontana

### FLEXIBLE SPENDING
- Phone: (866) 339-4310
- FAX: (406) 523-3149 or (877) 424-3539
- Web: www.allegianceflexadvantage.com

### LIFE & LONG TERM DISABILITY INSURANCE
- For questions about benefits, claims, status of application:
  - (800) 759-8702
- www.standard.com
- For all other questions call HCBD: (800) 287-8266

### WORKERS’ COMPENSATION
- Workers’ Compensation Program (406) 444-5689
- Safety and Loss Control (406) 444-0122
- Return to Work (406) 444-7016
- www.workerscomp.mt.gov