

2016
Retirement
Health Benefits
Planning Book



A Message from DOA Director Sheila Hogan

To 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.

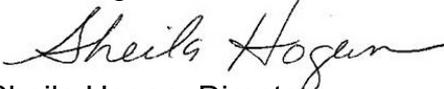
I hope you join me in taking these steps to better health:

- 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,



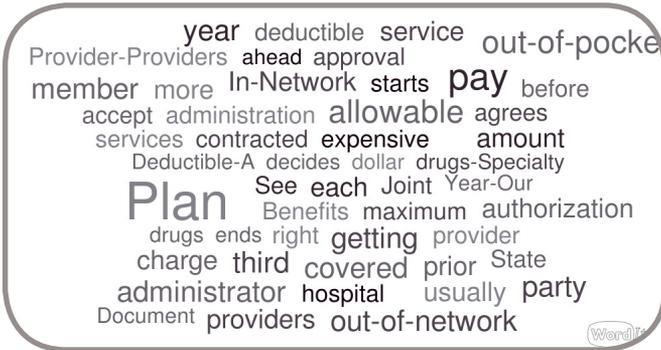
Sheila Hogan, Director
Department of Administration

Table of Contents

Benefit Term Decoder	4
General Information for Retiring	6
Your Benefits in Retirement	7
Life Insurance in Retirement	8
Other Benefits in Retirement	9
Retirement Benefit Payment Options	10
Medicare Eligibility and Enrollment	11
Alternative Coverage-Things to Consider	12
Alternative Coverage Options Under 65	14
Alternative Coverage Options Over 65	16
Alternative Coverage FAQs	17
Retreat Rights	18
HIPAA Notice	19
Benefit Cost Worksheet	20
Medical Plan Details	21
Out-of-Pocket Costs	22
General/Preventive Medical Services	23
Emergency, Hospital, & Mental Health	24
Maternity, Extended Care, & Misc.	25
Covered Preventive Services	26
Prescription Drug Plan	28
Mail Order & Specialty Pharmacy	29
Dental Plan	30
Dental Plan Details	31
Vision Hardware Plan	32
Vision Hardware Plan Details	33
The Montana Health Centers	34
Health Coaching	35
Life Insurance Plan Details	36

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 Plan 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. 14).

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.

For complete details about the Plan, refer to the Summary Plan Document (SPD) available on the website www.benefits.mt.gov.

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.



General Information for Retiring

This book contains information about your options to continue with the State of Montana Benefit Plan (State Plan) as a retiree in 2016.

Eligibility for State Plan Coverage in Retirement

You may continue coverage with the 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.

How to Continue Coverage

- Complete the Retiree Election form you will receive from HCBP two to three weeks after retiring and return it and payment to HCBP PO Box 200130, Helena MT 59620-0130 within 60 days after your employee coverage terminates.
- 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 (HCBP) 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.

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.

	Non-Medicare (Under 65)	Medicare Eligible (Over 65)	Dependents
Medical/ Prescription	Required	Required	Optional*
Dental	Required	Optional	Optional (If retiree has dental)
Basic Life	Required	May Convert- See p. 8	Not Eligible
Life Plans B, C, & D	May Convert- See p. 8	May Convert- See p. 8	Not Eligible
Accidental Death & Dismemberment	Not Eligible	Not Eligible	Not Eligible
Vision Hardware	Optional	Optional	Optional (If retiree has vision)
Flexible Spending	Option to prepay for rest of year in which you retire- See p. 9	Option to prepay for rest of year in which you retire- See p. 9	Not Eligible
Long Term Disability	Not Eligible	Not Eligible	Not Eligible

*If you currently have dependents who are covered under your dental, but not your medical, you can only add them to your medical plan with a qualifying event.

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 p. 12-17 of this book.

Life Insurance in Retirement

We strongly recommend you contact The Standard Life Insurance Company at (800) 378-4668 to discuss the portability and conversion options as your plan your retirement.

Non-Medicare Retirees

- 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, which are included in this packet.
- Plans B,C, and D plans may be converted (see below)
- Plan E-Accidental Death and Dismemberment cannot be continued or converted.

Medicare Retirees-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.

Conversion

If you want to keep your life coverage, you have 31 days after becoming a Medicare eligible retiree to convert by doing the following:

- 1) Request conversion information before the end of their conversion period; and
- 2) Complete and return all forms, along with payment, to The Standard Insurance Company.

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 Standard Life Insurance. 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 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.
- 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.
- You have 120 days after the date your account terminates to submit receipts for eligible expenses incurred during the time your account was active (between January 1 and the date your employee coverage terminates in the year you retire).
- If you submit receipts more than 120 days after your account terminates, you will not be eligible for reimbursement for those expenses.
- To see how much you have in Flex, contact Allegiance Benefit Plan Management at (866) 339-4310 or visit their website www.askallegiance.com.

10 Retirement Benefit Payment Options

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

Pre-payment Prior to Leaving

You may prepay benefits payments out of your final check. This option is only available if your final paycheck has not yet been received. To pre-pay, you must complete a Retiree Pre-Payment Option form, a Retiree Statement of Current Coverage, and life forms if applicable (included in this packet if you have not yet retired). This is done through your payroll office.

Automatic Deduction from MPERA Benefit Allowance

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

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. HCBD provides a payment book. VEBA reimbursement falls in this category. With VEBA, you will be reimbursed directly for your out-of-pocket benefits payments.

Electronic Deduction of Benefits Payments from a Checking or Savings Account

Benefits payments are deducted from the 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 (included in this packet).

For complete details about the Plan, refer to the Summary Plan Document (SPD) available on the website www.benefits.mt.gov.

Medicare Eligibility and Enrollment

Notify HCBD right away when you enroll in Part A and Part B Medicare coverage. If you do not provide proof of enrollment in Part A and Part B coverage your rate will continue to be based on the higher non-Medicare benefits rate for you and/or your spouse/domestic partner, and will not drop until you provide proof of Medicare coverage. You will receive a refund for overpayment of benefits for up to one year. To assure full coverage, contact your local Social Security Administration office to enroll in Part B, if you have not already done so, and to confirm Part A coverage.

Spouse Medicare Part B Enrollment

If you or your spouse/domestic partner are a) over age 65, b) waived Medicare Part B coverage at the time you turned 65 because you were an active employee with State Plan coverage, and c) plan to elect Medicare Part 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. State of Montana retirees may have better prescription drug coverage at a lower cost by keeping the State of Montana plan and not enrolling in Medicare Part D. Please visit with a licensed insurance representative to compare programs. If you enroll in Medicare Part D, you may not stay on the State's health plan and may not return to the plan. However, if you enroll in Medicare Part D in addition to a Medicare supplement plan, you may be entitled to Retreat Rights. Please see page 18 or contact HCBD for more information.

12 Alternative Coverage-Things to Consider

Many retirees have had State Plan coverage for years and aren't aware of other available options. Much has changed in the health care world in the last few years including the cost, benefits, and availability of private plans. Please take the time to educate yourself and find the best plan for you and your family. Here are a few things to consider choosing coverage.

- **Premiums:** The State of Montana retiree monthly contributions for coverage have increased. Coverage sold through the Health Insurance Marketplace (under 65) or Medicare Supplements (over 65) may be less expensive.
- **Pre-existing conditions:** Non-Medicare retirees CANNOT be denied coverage or charged more for coverage because of pre-existing conditions for plans on the health insurance marketplace.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You should see if your current health care providers participate in a network as you consider options for health coverage.
- **Service Areas:** Some plans do not have extensive out of state healthcare provider networks. You should check out of state network 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 for sale in the Health Insurance Marketplace have narrower networks, but those plans are often cheaper.

- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You should check to see if your current medications are listed in the drug formularies for other health coverage.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, if you purchase coverage in the Health Insurance Marketplace, you will pay copays, deductibles, coinsurance, or other amounts as you use your benefits. The cost sharing varies significantly among the different plans offered in the Health Insurance Marketplace, 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 have high cost-sharing in all individual health insurance plans.



14 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 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 Marketplace. However, you must plan to disenroll from your retiree plan before you begin to receive premium tax credits.

You should consult with a professional assister (see below) or insurance agent about this process.

Contact an Expert for FREE

You have choices when it comes to who to get your insurance advice from.

- *Certified Insurance Agents* or Certified Exchange Producers (CEPs) are registered Montana Insurance Agents who have taken special training to understand the 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 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 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 agents and assisters 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/
Scroll down to see contact lists for Navigators, CACs, and agents in your area.

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



16 Alternative Coverage Options Over 65

Over 65

If you're over 65 and eligible for Medicare, you do not qualify for a plan on the Health Insurance Marketplace, but might consider looking into 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 an 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



What if I sign up for the State of Montana Health 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. 1-800-287-8266

What if I leave the State Plan but later want to come back?

Retirees who leave the State of Montana Benefit Plan (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 p. 18.

What if I’m in a VEBA?

The Affordable Care Act (ACA) regulations state that participation in a VEBA plan may potentially disqualify participants from becoming eligible for a premium tax credit to purchase qualified health insurance from the Health Insurance Marketplace. If you have contributed to a VEBA account or are a VEBA participant, please contact the State of Montana’s VEBA administrator, Rehn & Associates, at (800) 872-8979 to inquire about your options.

Retreat Rights

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 the Health Care and Benefits Division (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 September and October 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 re-enrollment forms and payment; and
- Only dependents that were 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 document 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: 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.

Benefit Cost Worksheet

For Retirees

Core Benefits		
At age 65 and/or upon Medicare Eligibility:		
<ul style="list-style-type: none"> • Dental becomes optional and • The Retiree is no longer eligible for Basic Life Insurance. 		
Medical Plan (Rates on p. 21)		\$ _____ (a)
Dental Plan (Rates on p. 30)	(Optional over 65)	\$ _____ (b)
Basic Life Insurance of \$14,000 Available to retirees under age 65 and not Medicare eligible (See p. 36)		\$1.90 (c)
Total Core Benefits Contribution	Add lines a, b, and c =	\$ _____ (d)
Optional Benefits		
Vision Hardware (Rates on p. 32)		\$ _____ (e)
Optional Benefits Contribution Total	Line e	\$ _____ (f)
Totals		
Core Benefits	Enter amount from line d	\$ _____ (g)
Optional Benefits	Enter amount from line f	\$ _____ (h)
Total Benefits	Add lines g and h	\$ _____ (i)
Live Life Well Incentive total*		\$ _____ (j)
<p>*Enter \$10 for each of the following:</p> <ul style="list-style-type: none"> • 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) <p>See benefits.mt.gov/pages/incentive.faqs.html for full details.</p>		
Member's Total Monthly Costs for 2016 Benefits	Subtract lines j from line i	\$ _____

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 for non-Medicare Retirees
- No-cost health screening provided by CareHere

Monthly Cost

Non-Medicare Retiree Rates

Retiree Only	\$1,043
Retiree & Spouse	\$1,472
Retiree & Children	\$1,251
Retiree & Family	\$1,506
Retiree & Medicare Spouse	\$1,248
Retiree & Medicare Spouse & Children	\$1,326

Medicare Retiree Rates

Retiree Only	\$416
Retiree & Spouse	\$826
Retiree & Children	\$680
Retiree & Family	\$863
Retiree & Medicare Spouse	\$724
Retiree & Medicare Spouse & Children	\$742

Eligibility

For detailed information on who's eligible for the State of Montana Benefit Plan, please refer to the Summary Plan Document available at www.benefits.mt.gov.

Out-of-Pocket Costs

Out-of-Pocket Costs

	In-Network	Out-of-Network
Montana Health Center (for Non-Medicare retirees)	\$0 Copay	
Primary Care Office Visit (including naturopathic)	\$25 Copay	35% + balance billing
Specialist Office Visit	\$35 Copay	
Urgent Care Office Visit	\$35 Copay	
Annual Deductible (Counts towards Annual Max Out-of-Pocket) Applies 1/1/16 — 12/31/16	\$1,000/member No Family Deductible	A separate \$1,500/member
Coinsurance %	25%	35% + balance billing
Annual Max Out-of-Pocket	\$4,000/member \$8,000/family	A separate \$4,950/member A separate \$10,900/family + balance billing
Annual URx Max Out-of-Pocket	\$1,800/member \$3,600/Family	



For complete details about the Plan, refer to the Summary Plan Document (SPD) available on the website www.benefits.mt.gov.

General/Preventive Medical Services

	In-Network	Out-of-Network
General Medical Services		
Professional outpatient physical, occupational, cardiac, pulmonary, & speech therapy (max 30 combined days/yr)	\$25/visit	35% + balance billing/visit D
Professional Lab/Diagnostic/Injectables	25% (no deductible on injectables without an office visit) D	35% + balance billing D
Durable medical equipment and prosthetics—May require prior authorization	25% D	35% + balance billing D
Allergy shots	Office visit copay + 25% coinsurance (no deductible; if no office visit) D	35% + balance billing D
Routine Vision Exam (One per member per Plan Year)-If exam is medical, deductible and coinsurance apply. Talk to your provider to find out if your exam is considered routine.	\$10	Balance billing for cost over \$45
Preventive Services		
Adult preventive services—See p. 26-27 for more details	\$0	35% + balance billing (No deductible for mammograms) D
Adult Immunizations--See p.27	\$0	35% + balance billing D
Well child checkups and immunizations—See the schedule listed in the Summary Plan Document	\$0	35% + balance billing D

D =Must meet deductible before coinsurance applies.

24 Emergency, Hospital, & Mental Health

	In-Network	Out-of-Network
Emergency and Urgent Care Services		
Ambulance services for medical emergency	25% <input type="checkbox"/>	25% + balance billing <input type="checkbox"/>
Emergency department and hospital charges—Copoly includes all services (no deductible or coinsurance); copay waived if admitted, then all inpatient benefits apply.	\$250/visit for facility charges+\$100 for physician services	\$250/visit for facility charges +\$100 for physician services + balance billing
Emergency department professional and ancillary charges	N/A	Balance billing
Urgent care facility and professional charges	\$35 (covers visit charge only)	\$35 (covers visit charge only) + balance billing
Urgent care ancillary (lab/diagnostic/surgical charges)	25% <input type="checkbox"/>	25% + balance billing <input type="checkbox"/>
Hospital Care		
Inpatient services	25% <input type="checkbox"/>	35% + balance billing <input type="checkbox"/>
Outpatient services and Surgical Center Services	25% <input type="checkbox"/>	35% <input type="checkbox"/>
Transplants—Prior authorization, pre-certification, case management are required. Services must be rendered at a Center of Excellence with the designated transplant network.	25% <input type="checkbox"/>	Not covered
Mental Health and Substance Abuse		
Outpatient professional services	\$25/visit (covers office visit charge only)	35% + balance billing <input type="checkbox"/>
Inpatient services	25% <input type="checkbox"/>	35% + balance billing <input type="checkbox"/>

=Must meet deductible before coinsurance applies.

*Developmental delays are not covered

Maternity, Extended Care, & Misc.

	In-Network	Out-of-Network
Maternity Services		
Hospital charges	25% <input type="checkbox"/>	35% + balance billing <input type="checkbox"/>
Physician charges	25% <input type="checkbox"/>	35%+ balance billing <input type="checkbox"/>
Ultrasounds	25% <input type="checkbox"/>	35% + balance billing <input type="checkbox"/>
Routine Newborn Care		
Inpatient hospital and physician charges for routine newborn care	25%	35% + balance billing
Extended Care Services (prior authorization recommended)		
Home health care (Max 70 Days/ Plan Year)	25% <input type="checkbox"/>	35% <input type="checkbox"/>
Hospice	25% <input type="checkbox"/>	35% + balance billing <input type="checkbox"/>
Skilled nursing (Max 70 Days/ Plan Year)	25% <input type="checkbox"/>	35% + balance billing <input type="checkbox"/>
Inpatient rehabilitation (max 60 days per Plan Year total) See the SPD for details ²	25% <input type="checkbox"/>	35% + balance billing <input type="checkbox"/>
Miscellaneous Services		
Dietary/Nutritional counseling Max 3 days/Plan Year	\$0 (no deductible, no coinsurance)	35% + balance billing <input type="checkbox"/>
Chiropractic/Acupuncture (combined maximum of 20 days/Plan Year)	\$25/day	35% + balance billing <input type="checkbox"/>
PKU supplies	25% <input type="checkbox"/>	35% + balance billing <input type="checkbox"/>
TMJ treatment—Requires prior authorization	25% Surgical only <input type="checkbox"/>	Not covered

=Must meet deductible before coinsurance applies.

²Residential services are not covered

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 copay for Plan members. This complies with the Patient Protection and Affordable Care Act (PPACA).

Periodic exams —Appropriate screening tests (see the Summary Plan Document for a full list of tests)	
Well child care Infant through age 17	Age 0 months through 4 year—up to 14 visits Age 5 years through 17 years—one visit per Plan Year
Adult routine exam Exams may include screening/counseling and/or risk factor reduction interventions for depression, obesity, tobacco use, drug and/or alcohol abuse	Age 18 through 65+—one visit per Plan Year
Preventive Screenings	
Anemia screening (CBC)	Pregnant women
Bacteruria screening (UA)	
RH incompatibility screening	
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	
Colorectal cancer screening	<ul style="list-style-type: none"> • Fecal occult blood testing once per Plan Year; OR • Sigmoidoscopy every 5 years; OR • 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. • 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
Osteoporosis screening	Post menopausal women—65+ (60+ with risk factors)—one bone density x-ray (DXA) every two years
Abdominal aneurysm screening	Men age 65-75 who have ever smoked—one screening by ultrasound per Plan Year
Diabetes screening (fasting A1C)	Adults with high blood sugar
Routine immunizations	
Diphtheria, tetanus, pertussis (DTaP; Tdap; TD), haemophilus influenza (HIB), hepatitis A & B, human papillomavirus (HPV), influenza, measles, mumps, rubella (MMR), meningococcal, pneumococcal (pneumonia), poliovirus, rotavirus, varicella (smallpox); for age 50 and older: zoster (shingles)	

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.

Prescription Medication Highlights (\$1,800 individual/\$3,600 family Out-of-Pocket Maximum)			
Drug Tier	Deductible	Retail Rx 30 day supply What you pay	Mail Rx 90 day supply What you pay
A	\$0	\$0 copay	\$0 copay
B	\$0	\$15 copay	\$30 copay
C	\$0	\$50 copay	\$100 copay
D	\$0	50% coinsurance*	50% coinsurance*
F	\$0	100% coinsurance*	100% coinsurance*
Specialty	\$0	Diplomat-\$150 or \$250 copay Pharmacy other than Diplomat-50% coinsurance*	Not covered
Specialty NC		Not covered	Not covered

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

For complete details about the Plan, refer to the Summary Plan Document (SPD) available on the website www.benefits.mt.gov.

Mail Order & Specialty Pharmacy

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



Monthly Cost

	Premium Plan
Member Only	\$41.10
Member & Spouse	\$62.50
Member & Children	\$61
Member & Family	\$70

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- <ul style="list-style-type: none"> • \$50 per member • \$150 per family Deductible is waived for Type A services including Diagnostic & Preventive
Examples of Covered Services*	
Type A Services Sealants- children to age 16 Fluoride- children to age 19 Diagnostic & Preventive <ul style="list-style-type: none"> • 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. 20% Co-insurance on type B Services 50% Co-insurance on type C Services
Type B Services Endodontics (root canals) Oral Surgery Periodontics (gum treatment) Restorative (all fillings)	
Type C Services Crowns Prosthodontics (inlays, onlays, bridges, and dentures) Implants	
Implants	

*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.

Member Only	\$7.64
Member & Spouse*	\$14.42
Member & Children	\$15.18
Member & Family	\$22.26

Eligibility

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

More Details

For full details on the 2016 Vision Plan, visit www.benefits.mt.gov/vision.



Vision Hardware Plan Details



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

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!

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.******

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!

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.



Connect with a Health Coach

Non-Medicare Retirees

- Call or email one of the coaches found at www.healthcenter.mt.gov/Health-Coaching
- Call 1-855-200-6822 and ask for a health coaching appointment
- Follow the steps below:
 - 1) Have your state sponsored health screening.
 - 2) Have a follow-up appointment with a Health Center provider.
 - 3) Ask the provider about making an appointment with a coach.
- 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 lifelife@mt.gov or (800) 287-8266.

Medicare Retirees

- Contact HCBd at lifelife@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.



Life Insurance Plan Details

Fully insured and administered by TheStandard insurance company.

Basic Life Insurance

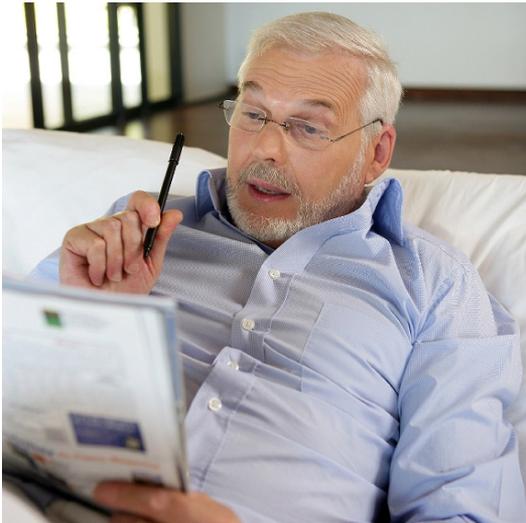
Core benefit for state employees and non-Medicare retirees.
\$1.90/month=\$14,000 of term-life coverage

Basic Life provides \$14,000 of term-life coverage. It is available to non-Medicare retirees under age 65 who keep their state benefits 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.



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



CLAIMS, BENEFITS, IN-NETWORK PROVIDERS, ETC.
(855)999-1057
www.allegiance.com/som
PO Box 3018 Missoula, MT 59806



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
