

## Welcome, New State Employee!

The State of Montana is pleased to offer you a great package of health care benefits from which to choose. These benefits are a large part of your compensation, and **some benefits can only be guaranteed if you enroll within your initial enrollment period, the first 31 days of State employment or eligibility.** Your coverage is effective on your date of hire. You will receive medical, dental, and prescription drug identification cards within **six weeks of returning your forms.**

The State of Montana is a self-funded benefits group. That means the benefits are not purchased, but rather the State share and employee out-of-pocket contributions are pooled and used to pay claims. *Each member shares the responsibility of being a wise health care consumer to help control costs as much as possible.* You can reduce costs in a variety of ways such as using the wellness and care management programs and researching your health care options. These programs are outlined in detail within this booklet.

### Enrollment

If you choose to participate in the benefits package offered by the State of Montana, you will receive State share—\$806 per month—toward the cost of benefits. To participate you must enroll in the **Core Benefits** that include:

- ◆ The Capitol or Classic medical plan including prescription coverage and an annual eye exam;
- ◆ The Basic or Premium dental plan; and
- ◆ Basic life insurance (\$14,000).

There are **add-on benefits** you may choose in addition to the core benefits:

- Medical and/or dental coverage for dependents;
- Vision hardware coverage;
- Additional life insurance for you and/or your dependents;
- Long-term disability (LTD) coverage;
- Accidental Death & Dismemberment (AD&D) coverage; and
- Flexible spending accounts for medical and/or dependent care

### HOW TO ENROLL

Complete the forms (included in this packet) listed below:

1. For medical, dental, vision hardware, and the pre-tax plan – complete the **2014 State of Montana Employee Group Benefits Plan Enrollment/Change Form.**
2. For life insurance, AD&D, LTD – complete the **Standard Life Insurance Co. Enrollment/Change Form.**
3. For the Flexible Spending Accounts (FSA) – complete the **2014 Flexible Spending Account Enrollment/Change Form.**

We are your partners in improving your health. Working together we can help improve your quality of life and lower the amount we spend on healthcare. The staff at Health Care and Benefits Division (HCBD) is ready to help you make your choices. Contact us at (800) 287-8266; (406) 444-7462; hearing impaired (406) 444-1421; or [benefitsquestions@mt.gov](mailto:benefitsquestions@mt.gov).

In good health,

HCBD Staff

### Waiving Coverage

**If you choose to waive coverage and DO NOT wish to participate in the group health care benefits offered, please check the Waiver of Coverage box located toward the top of the 2014 Employee Group Benefits Plan Enrollment/Change Form.**

***You will also be waiving the \$806 monthly employer contribution.***

The updated Summary Plan Document (SPD) is published on [www.benefits.mt.gov](http://www.benefits.mt.gov). If you have specific questions about the SPD, contact HCBD at (800) 287-8266; hearing impaired (406) 444-1421; or [benefitsquestions@mt.gov](mailto:benefitsquestions@mt.gov). As benefits may change, always refer to the SPD and contact HCBD for the most current benefits information.

Be sure to check our website [www.benefits.mt.gov](http://www.benefits.mt.gov) to see the updated HIPAA Notice of Privacy Practices.

## TWO STEPS To Get Your Discount in 2015



Stay tuned for more details from HCBBD about the Cigna MotivateMe Program®

See page 33 for more information on the health screening discount.

To get your health screening discount in 2015, you have **TWO STEPS** to complete during 2014. If you have a dependent age 18 or older on your plan, their participation **increases** your discount!

Being tobacco-free<sup>1</sup> gives you even more of a discount.

Here's how it works:

**Step 1:** In 2014 complete a health screening with CareHere, the company that runs the Montana Health Centers.

To schedule go to [www.carehere.com](http://www.carehere.com) or call CareHere (877) 423-1330

**Then...**

**Step 2:** Fill out Cigna's online Health Assessment (HA) **using the numbers from your health screening**<sup>2</sup> by going to [www.myCigna.com](http://www.myCigna.com). When you fill out your assessment, you and your dependent age 18 or older covered on your plan will have to **register as new users**. Tell us here if you do or do not use tobacco.

Your dependent age 18 or older on your plan does the same. Being tobacco-free<sup>1</sup> increases your discount. Cigna (855) 692-0131

**You must complete BOTH steps to qualify for any discount!**

Once you have completed both steps in 2014—with CareHere and with Cigna—you are eligible for the discount in 2015.

**Dollar amounts of discounts have not been set yet.** Stay tuned! If your eligible dependent completes both steps, you increase your discount. Being tobacco-free bumps up the discount, too!

For details, go to [www.benefits.mt.gov](http://www.benefits.mt.gov) or contact Health Care and Benefits Division (HCBBD) at (800) 287-8266, TTY (406) 444-1421, or [benefitsquestions@mt.gov](mailto:benefitsquestions@mt.gov).

<sup>1</sup>Do you use tobacco? Ready to stop? You have options. Both Cigna (855) 692.0131 and CareHere (877) 423.1330 offer comprehensive tobacco cessation programs for members on the State plan. Both programs are no cost to you the member. Copays apply to any medications deemed appropriate by the clinic provider.

<sup>2</sup>Need help getting your health screening results? Go to [www.benefits.mt.gov](http://www.benefits.mt.gov) and click on Health Screenings for directions OR call CareHere at (877) 423-1330

Are you **JOINT CORE** (meaning you and your spouse are SOM employees and cover dependents on your plan)? Do you have one or two eligible dependents 18 or older covered on your plan? You may be eligible for even greater discounts. We'll have details once the discount amounts are set.

Remember... **eligible dependents** refers to children age 18 or older, your spouse, or your domestic partner covered on your plan.



CareHere!



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# State of Montana: Open Access Plus Capitol Plan

Coverage Period: 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Individual + Family | Plan Type: OAP



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.myCigna.com](http://www.myCigna.com) or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	For in-network providers <b>\$500</b> person / <b>\$1,000</b> family For out-of-network providers <b>\$750</b> person / <b>\$1,750</b> family Does not apply to in-network preventive care , in-network office visits , in-network allergy treatment and serum, emergency room visits, urgent care facility visits , prescription drugs Co-payments don't count toward the <b>deductible</b> .	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. For in-network providers <b>\$2,500</b> person / <b>\$5,000</b> family / For out-of-network providers <b>\$4,250</b> person / <b>\$9,500</b> family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. For a list of participating providers, see <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-Cigna24 to request a copy.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15 co-pay/visit	35% co-insurance	-----none-----
	Specialist visit	\$15 co-pay/visit	35% co-insurance	-----none-----
	Other practitioner office visit	\$15 co-pay/visit for chiropractor	35% co-insurance	Coverage for Chiropractic care is limited to 20 days annual max.
	Preventive care/screening/immunization	No charge	35% co-insurance	Out-of-network deductibles do not apply to preventive care or immunizations for children through age 7
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Imaging (CT/PET scans, MRIs)	25% co-insurance	35% co-insurance	50% penalty for no precertification.
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://benefits.mt.gov/pages/urx.html">http://benefits.mt.gov/pages/urx.html</a>	Generic drugs	Not Covered	Not Covered	Contact your employer for non-Cigna coverage that may be available
	Preferred brand drugs	Not Covered	Not Covered	Contact your employer for non-Cigna coverage that may be available
	Non-preferred brand drugs	Not Covered	Not Covered	Contact your employer for non-Cigna coverage that may be available
	Specialty drugs	Not Covered	Not Covered	Contact your employer for non-Cigna coverage that may be available

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Physician/surgeon fees	25% co-insurance	35% co-insurance	50% penalty for no precertification.
<b>If you need immediate medical attention</b>	Emergency room services	\$250 co-pay/visit	\$250 co-pay/visit	Per visit co-pay is waived if admitted
	Emergency medical transportation	25% co-insurance	25% co-insurance	-----none-----
	Urgent care	\$35 co-pay/visit	\$35 co-pay/visit	Per visit co-pay is waived if admitted
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Physician/surgeon fees	25% co-insurance	35% co-insurance	50% penalty for no precertification.
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Visits 1-4 in an Office Setting: No charge Visits 5 and beyond in an Office Setting: \$15 cop-pay/office visit  25% co-insurance/other outpatient services	35% co-insurance	50% penalty for no precertification.
	Mental/Behavioral health inpatient services	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Substance use disorder outpatient services	Visits 1-4 in an Office Setting: No charge Visits 5 and beyond in an Office Setting: \$15 cop-pay/office visit  25% co-insurance/other outpatient services	35% co-insurance	50% penalty for no precertification.
	Substance use disorder inpatient services	25% co-insurance	35% co-insurance	50% penalty for no precertification.

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you are pregnant</b>	Prenatal and postnatal care	25% co-insurance	35% co-insurance	-----none-----
	Delivery and all inpatient services	25% co-insurance	35% co-insurance	50% penalty for no precertification.
<b>If you need help recovering or have other special health needs</b>	Home health care	25% co-insurance	35% co-insurance	50% penalty for no precertification. Coverage is limited to 70 days annual max.
	Rehabilitation services	\$15 co-pay/visit	35% co-insurance	50% penalty for failure to precertify speech therapy services. Coverage for Rehabilitation, including Cardiac rehab, services is limited to 30 days annual max.
	Habilitation services	Not Covered	Not Covered	-----none-----
	Skilled nursing care	25% co-insurance	35% co-insurance	50% penalty for no precertification. Coverage is limited to 30 days annual max
	Durable medical equipment	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Hospice services	25% co-insurance	35% co-insurance	50% penalty for no precertification.
<b>If your child needs dental or eye care</b>	Eye Exam	Not Covered	Not Covered	-----none-----
	Glasses	Not Covered	Not Covered	-----none-----
	Dental check-up	Not Covered	Not Covered	-----none-----

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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## Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitation services</li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Prescription drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>		

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Montana Consumer Affairs Program at 800-332-6148. However, for information regarding your own state's consumer assistance program refer to [www.healthcare.gov](http://www.healthcare.gov).

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does/does not meet the minimum value standard for the benefits it provides.**

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-800-244-6224.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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## Coverage Examples

### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



#### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Note:** These numbers assume enrollment in individual-only coverage.

Having a baby (normal delivery)	
• <b>Amount owed to providers:</b>	\$7,540
• <b>Plan pays:</b>	\$5,160
• <b>Patient pays:</b>	\$2,380
<b>Sample care costs:</b>	
Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>
<b>Patient pays:</b>	
Deductible	\$500
Co-pays	\$20
Co-insurance	\$1,690
Limits or exclusions	\$170
<b>Total</b>	<b>\$2,380</b>

Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
• <b>Amount owed to providers:</b>	\$5,400
• <b>Plan pays:</b>	\$820
• <b>Patient pays:</b>	\$4,580
<b>Sample care costs:</b>	
Prescriptions	\$2,900
Medical equipment and supplies	\$1,300
Office visits & procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>
<b>Patient pays:</b>	
Deductible	\$140
Co-pays	\$120
Co-insurance	\$0
Limits or exclusions	\$810.78
<b>Total</b>	<b>\$1,070.78</b>

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 97791

Plan Name:Capitol Plan

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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## State of Montana: Open Access Plus Classic Plan

Coverage Period: 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Individual + Family | Plan Type: OAP



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.myCigna.com](http://www.myCigna.com) or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	For in-network providers <b>\$1,000</b> person / <b>\$2,250</b> family For out-of-network providers <b>\$1,000</b> person / <b>\$2,250</b> family Does not apply to in-network preventive care , prescription drugs	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. For in-network providers <b>\$5,000</b> person / <b>\$11,250</b> family / For out-of-network providers <b>\$5,000</b> person / <b>\$11,250</b> family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the out-of-pocket limit?</b>	Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. For a list of participating providers, see <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-Cigna24 to request a copy.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	25% co-insurance	35% co-insurance	Plan deductible is waived for the first 2 visits, In and Out-of-Network
	Specialist visit	25% co-insurance	35% co-insurance	Plan deductible is waived for the first 2 visits, In and Out-of-Network
	Other practitioner office visit	25% co-insurance for chiropractor	35% co-insurance	Coverage for Chiropractic care and Rehabilitation services (includes Cardiac rehab) is limited to 30 days annual max.
	Preventive care/screening/immunization	No charge	35% co-insurance	Out-of-Network deductibles do not apply to preventive care and immunizations for children through age 7
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Imaging (CT/PET scans, MRIs)	25% co-insurance	35% co-insurance	50% penalty for no precertification.

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Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://benefits.mt.gov/pages/urx.html">http://benefits.mt.gov/pages/urx.html</a>	Generic drugs	Not Covered	Not Covered	Contact your employer for non-Cigna coverage that may be available
	Preferred brand drugs	Not Covered	Not Covered	Contact your employer for non-Cigna coverage that may be available
	Non-preferred brand drugs	Not Covered	Not Covered	Contact your employer for non-Cigna coverage that may be available
	Specialty drugs	Not Covered	Not Covered	Contact your employer for non-Cigna coverage that may be available
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Physician/surgeon fees	25% co-insurance	35% co-insurance	50% penalty for no precertification.
<b>If you need immediate medical attention</b>	Emergency room services	25% co-insurance	25% co-insurance	-----none-----
	Emergency medical transportation	25% co-insurance	25% co-insurance	-----none-----
	Urgent care	25% co-insurance	25% co-insurance	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Physician/surgeon fees	25% co-insurance	35% co-insurance	50% penalty for no precertification.

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Visits 1-4 in an Office Setting: No charge Visits 5 and beyond in an Office Setting:25% co-insurance 25% co-insurance/other outpatient services	35% co-insurance	50% penalty for no precertification.
	Mental/Behavioral health inpatient services	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Substance use disorder outpatient services	Visits 1-4 in an Office Setting: No charge Visits 5 and beyond in an Office Setting:25% co-insurance 25% co-insurance/other outpatient services	35% co-insurance	50% penalty for no precertification.
	Substance use disorder inpatient services	25% co-insurance	35% co-insurance	50% penalty for no precertification.
<b>If you are pregnant</b>	Prenatal and postnatal care	25% co-insurance	35% co-insurance	-----none-----
	Delivery and all inpatient services	25% co-insurance	35% co-insurance	50% penalty for no precertification.

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	25% co-insurance	35% co-insurance	50% penalty for no precertification. Coverage is limited to 70 days annual max. Maximums cross-accumulate.
	Rehabilitation services	25% co-insurance	35% co-insurance	50% penalty for failure to precertify speech therapy services. Coverage for Rehabilitation, including Cardiac rehab and Chiropractic care, services is limited to 30 days annual max.
	Habilitation services	Not Covered	Not Covered	-----none-----
	Skilled nursing care	25% co-insurance	35% co-insurance	50% penalty for no precertification. Coverage is limited to 70 days annual max
	Durable medical equipment	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Hospice services	25% co-insurance	35% co-insurance	50% penalty for no precertification.
<b>If your child needs dental or eye care</b>	Eye Exam	Not Covered	Not Covered	-----none-----
	Glasses	Not Covered	Not Covered	-----none-----
	Dental check-up	Not Covered	Not Covered	-----none-----

**Excluded Services & Other Covered Services**

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Dental care (Children)</li> <li>Habilitation services</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Prescription drugs</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Chiropractic care</li> </ul>		

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-Cigna24 to request a copy.

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Montana Consumer Affairs Program at 800-332-6148. However, for information regarding your own state's consumer assistance program refer to [www.healthcare.gov](http://www.healthcare.gov).

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does/does not meet the minimum value standard for the benefits it provides.**

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-800-244-6224.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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## Coverage Examples

### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



#### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

**Note:** These numbers assume enrollment in individual-only coverage.

#### Having a baby

(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$4,810
- **Patient pays:** \$2,730

##### Sample care costs:

Hospital charges (mother)	\$2,700
Routine Obstetric Care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductible	\$1,000
Co-pays	\$0
Co-insurance	\$1,560
Limits or exclusions	\$170
<b>Total</b>	<b>\$2,730</b>

#### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$90
- **Patient pays:** \$5,310

##### Sample care costs:

Prescriptions	\$2,900
Medical equipment and supplies	\$1,300
Office visits & procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

##### Patient pays:

Deductible	\$990
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$810.78
<b>Total</b>	<b>\$1,800.78</b>

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 97904

Plan Name: Open Access Plus Classic

Questions: Call 1-800-Cigna24 or visit us at [www.myCigna.com](http://www.myCigna.com).

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# Capitol and Classic Plans

## Who is Eligible?

Employees, legislators, retirees, COBRA members, and dependents (spouse, domestic partner, children) are eligible for the medical plan. Employees are required to be enrolled in medical coverage unless they waive the entire benefit package. For dependent eligibility, see page 44.

## Decide Which Plan Is Right for You

1. Read about both plans below.
2. Carefully compare each plan's costs, deductibles, and services in the Plan Details starting on page 24 or visit our website [www.benefits.mt.gov](http://www.benefits.mt.gov) under EMPLOYEES and MEDICAL.
3. Compare your typical health care needs with how the plans work
4. Select the plan that works best for you and your family

Your options are the **Capitol Plan** or the **Classic Plan**.

Cigna administers both medical plans for the State and has a large nationwide network of providers. All members covered on the medical plan may have **one vision and eye health evaluation** each year. Check the Cigna website [www.cigna.com](http://www.cigna.com) to see if a provider is in-network.

## Capitol Plan

The Capitol plan starts cost sharing on office visits, urgent care visits, and emergency department visits immediately when the new plan year starts. You have an annual deductible that you pay toward services such as lab work and imaging. Once you have met your deductible, you pay coinsurance toward the services that do not have a copay.

To see how this works, let's look at the table below to see how much you would owe in this example. Assume this is your fourth visit this plan year to your in-network doctor's office for sinusitis. Let's also assume **you have paid \$600 this year and therefore met your \$500 deductible**.

Whether you choose the Capitol or Classic plan, age and gender appropriate preventive services with an in-network provider are always covered at 100% of the allowable amount so you have no out-of-pocket costs.

## Classic Plan

The Classic plan works like an indemnity plan. That means you pay all costs (*with a few exceptions*) until you meet your deductible. The deductible on the Classic plan is \$1,000 for an individual and \$2,250 for a family.

The Classic plan costs the State health plan more money, so the deductible and other associated costs are higher for the members who choose this plan. Let's compare your costs for the same office visit we looked at for the Capitol plan. And again in this example we're assuming **you have paid \$600 this year but have not met your deductible (higher deductible on the Classic plan)**.

Capitol Plan	Provider's Charge	Allowed Fee	The Plan Pays	Your Out-of-Pocket Cost
Office Visit	\$100	\$80	\$65	\$15 copay
Blood work	\$120	\$90	\$67.50	\$22.50 coinsurance
<b>Your total cost:</b>				<b>\$37.50</b>

Classic Plan	Provider's Charge	Allowed Fee	The Plan Pays	Your Out-of-Pocket Cost
Office Visit (4th for plan year)	\$100	\$80	\$0	\$80 toward your deductible
Blood work	\$120	\$90	\$0	\$90 toward your deductible
<b>Your total cost:</b>				<b>\$170</b>

There is a **third option**. All eligible members on the medical plan may use any of the health centers. See page 32 for details. If you receive these same services at a Montana Health Center, your out-of-pocket costs would be:

Montana Health Center	Your Out-of-Pocket Cost
Office Visit	\$0
Blood work	\$0
<b>Your total cost:</b>	<b>\$0</b>

# Monthly Out-of-Pocket Benefit Costs Worksheet

## for Employees and Legislators

<b>CORE Benefits</b>		
Medical Plan (See rates on page 23)	Choose Capitol or Classic	Cigna \$ _____ (a)
Dental Plan (See rates on page 29)		Delta Dental \$ _____ (b)
Basic Life Insurance of \$14,000 (See page 41)		\$ _____ 1.90 (c) ©
<b>Total Core Benefits Contribution</b>		<b>Add lines a, b, and c =</b> \$ _____ (d)
<b>Optional Benefits</b>		
Flexible Spending Accounts <sup>1</sup> (page 39) Remember! No monthly fee for FSA's	Medical FSA	\$ _____ (e)
<sup>1</sup> Legislators are not eligible for Flexible Spending Accounts	Dependent Care FSA	\$ _____ (f)
Vision hardware (See rates on page 31)		\$ _____ (g)
Life Insurance (See rates on page 41)	<b>Dependent Life for \$0.52</b> (\$2,000 / spouse; \$1,000 / child)	\$ _____ (h)
	<b>Optional Employee Life</b> (Age rate x every \$1,000 of coverage)	\$ _____ (i)
	<b>Supplemental Spouse</b> (Age rate x every \$1,000 of coverage)	\$ _____ (j)
	<b>Accidental Death &amp; Dismemberment</b> (\$0.020 x every \$1,000 of coverage or \$0.030 with dependents x every \$1,000 of coverage)	\$ _____ (k)
Long Term Disability (LTD) <sup>2</sup> (See info on page 43)		\$ _____ (l)
<sup>2</sup> Legislators are not eligible for LTD		
<b>Optional Benefits Contribution Total</b>	<b>Add lines e, f, g, h, i, j, k, and l =</b>	\$ _____ (m)
<b>Totals</b>		
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	Enter \$806 for active employees and legislators	\$ _____ 806(q)
<b>Total Monthly Out-of-Pocket Costs for 2014 Benefits</b>	Subtract line p from line q	\$ _____

**Watch for information about MotivateMe, the wellness program for 2014. By participating you may be able to save money on your benefits in 2015.**



## Active Employee and Legislator Rates



Employees receive 26 paychecks / year.  
Contributions come out of 24  
paychecks / year

### Monthly Benefits Payment

	Capitol Plan	Classic Plan
Employee	\$717	\$756
Employee and spouse	\$926	\$967
Employee and kids	\$809	\$849
Employee and family	\$981	\$1,023
Joint Core	\$755	\$793

### Costs to the Member

**NOTE:** \**Copays* on the Capitol plan, *Deductibles* and *Durable Medical Equipment* on both plans, and URx coinsurance **do not** apply toward the Out-of-Pocket Maximum

#### Capitol Plan

#### Classic Plan

	Member's Cost— Capitol In-Network	Member's Cost— Capitol Out-of-Network		Member's Cost— Classic In-Network	Member's Cost— Classic Out-of-Network
<b>Annual Deductible*</b> Applies 1/1/14 — 12/31/14	\$500/member \$1,000/family	A separate \$750/ member A separate \$1,750/ family	<b>Annual Deductible*</b> Applies 1/1/14 — 12/31/14	\$1,000/member \$2,250/family	\$1,000/member \$2,250/family (combined with in-network) + balance billing
<b>Coinsurance Percentages for provider charges</b>	25%	35% + balance billing	<b>Coinsurance Percentages for provider charges</b>	25%	35% + balance billing
<b>Coinsurance Percentages for facility charges</b>	25%	35% + balance billing	<b>Coinsurance Percentages for facility charges</b>	25%	35% + balance billing
<b>Annual Out-of-Pocket Max*</b>	\$2,500/member \$5,000/family	A separate \$4,250/ member A separate \$9,500/ family + balance billing	<b>Annual Out-of-Pocket Max*</b>	\$5,000/member \$11,250/family	\$5,000/member \$11,250/family (combined with in- network) + balance billing

\***Copays** on the Capitol plan, **Deductibles** and **Durable Medical Equipment** on both plans, and URx coinsurance **do not** apply toward the Out-of-Pocket Max

For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

# Plan Details—*What the Member Pays*

	Capitol Plan		Classic Plan	
<b>Office/Routine Care</b>				
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Office visits</b>	\$15/visit (covers office visit charge only)	35% + balance billing D	25% <sup>1</sup> D	35% <sup>1</sup> + balance billing D
<b>Professional outpatient physical, occupational, cardiac, pulmonary, &amp; speech therapy</b> (max 30 combined days/yr)	\$15/visit <sup>3</sup> (copay applies to each visit)	35% + balance billing <sup>3</sup> (coinsurance applies to each visit) D	25% <sup>3</sup> (coinsurance applies to each visit) D	35% + balance billing <sup>3</sup> (coinsurance applies to each visit) D
<b>Professional Lab/Diagnostic/Injectables</b>	25% (no deductible on injectables without an office visit) D	35% + balance billing D	25% D	35% + balance billing D
<b>Durable medical equipment and prosthetics</b> May require prior authorization	25% (not applied to out-of-pocket max) D	35% + balance billing (not applied to out-of-pocket max) D	25% (not applied to out-of-pocket max) D	35% + balance billing (not applied to out-of-pocket max) D
<b>Allergy shots</b>	\$15 for office visit + 25% coinsurance; (no deductible; 25% coinsurance if no office visit) D	35% + balance billing D	25% D	35% + balance billing D
<b>Hospital Care</b>				
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Inpatient services</b>	25% D	35% + balance billing D	25% D	35% + balance billing D
<b>Outpatient services and Surgical Center Services</b>	25% D	35% + balance billing D	25% D	35%+ balance billing D
<b>Organ transplant</b> —Prior authorization, pre-certification, case management are required.	25% D	Not covered	25% D	35% + balance billing D
<b>Mental Health and Substance Abuse</b>				
	In-Network	Out-of-Network		
<b>Outpatient professional services<sup>2</sup></b> EAP benefits apply for the first 4 visits in-network; see page 38	Visits 1 - 4 no charge; then \$15/visit (covers office visit charge only)	35% + balance billing D	Visits 1 - 4 no charge; then 25% D	35% + balance billing D
<b>Inpatient services<sup>2</sup></b>	25% D	35% + balance billing D	25% D	35% + balance billing D

<sup>1</sup>No deductible for first two non-routine visits

<sup>2</sup>Residential programs for mental health and/or chemical dependency are not covered by this plan

<sup>3</sup>Developmental delays are not covered

**D** = Deductible applies

For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

# Plan Details—What the Member Pays

	Capitol Plan		Classic Plan	
Emergency and Urgent Care Services				
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Ambulance services for medical emergency</b>	25% D	25% + balance billing D	25% D	25% + balance billing D
<b>Emergency department and hospital charges</b> —Capitol plan copay includes all services (no deductible or coinsurance); copay waived if admitted, then all inpatient benefits apply <sup>1</sup>	\$250/visit for facility charges <sup>1</sup> + \$100 for physician services	\$250/visit for facility charges <sup>1</sup> + \$100 for physician services + balance billing	25% D	25% + balance billing D
<b>Emergency department Professional and ancillary charges</b>	N/A	N/A	25% D	25% + balance billing D
<b>Urgent care facility and professional charges</b>	\$35 (covers visit charge only)	\$35 (covers visit charge only) + balance billing	25% D	25% + balance billing D
<b>Urgent care ancillary—lab/diagnostic/surgical charges</b>	25% D	25% + balance billing D	25% D	25% + balance billing D

Extended Care Services (prior authorization recommended)				
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Home health care</b>	\$15/day (max 30 days/year)	35% (max 30 days/year) + balance billing D	25% (max 70 days/year) D	35% (max 70 days/year) + balance billing D
<b>Hospice</b>	25% D	35% + balance billing D	25% D	35% + balance billing D
<b>Skilled nursing</b>	25% (max 70 days/year) D	35% + balance billing (max 70 days/year) D	25% (max 70 days/year) D	35% + balance billing (max 70 days/year) D
<b>Inpatient rehabilitation</b> (max 60 days per year total) See the SPD for details <sup>2</sup>	25% D	35% + balance billing D	25% D	35% + balance billing D

Maternity Services				
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Hospital charges</b>	25% D	35% + balance billing D	25% D	35% + balance billing D
<b>Physician charges</b>	25% D	35% + balance billing D	25% D	35% + balance billing D
<b>Ultrasounds</b>	25% D	35% + balance billing D	25% D	35% + balance billing D

<sup>1</sup>If there is an admission from the emergency department, be sure to authorize follow up care

<sup>2</sup>Residential services are not covered

D = Deductible applies

For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

# Plan Details—*What the Member Pays*

	Capitol Plan		Classic Plan	
<b>Routine Newborn Care</b>				
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Inpatient hospital and physician charges</b> for routine newborn care	25%	35% + balance billing <sup>D</sup>	25%	35% + balance billing
<b>Preventive Services</b>				
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Adult preventive services</b> See SPD for covered benefits; includes contraception	\$0	35% + balance billing No deductible for mammograms <sup>D</sup>	\$0	35% + balance billing No deductible for mammograms <sup>D</sup>
<b>Adult Immunizations</b> (such as flu and pneumonia)	\$0	35% + balance billing <sup>D</sup>	\$0	35% + balance billing (no deductible)
<b>Well child checkups and immunizations</b> See the schedule listed in the SPD	\$0	35% + balance billing	\$0	35% + balance billing (no deductible)
<b>Alternative Care</b>				
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Chiropractic</b>	\$15/day (max 20 days/year)	35% + balance billing (max 20 days/year) <sup>D</sup>	25% <sup>1</sup> <sup>D</sup>	35% + balance billing <sup>1</sup> <sup>D</sup>
<b>Acupuncture</b>	Not covered	Not covered	25% <sup>2</sup> <sup>D</sup>	35% + balance billing <sup>2</sup> <sup>D</sup>
<b>Naturopathic</b>	Not covered	Not covered	25% <sup>3</sup> <sup>D</sup>	35% + balance billing <sup>3</sup> <sup>D</sup>
<b>Miscellaneous Services</b>				
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Dietary/Nutritional counseling</b>	\$0 (no deductible, no coinsurance) Max 3 days/year	35% + balance billing Max 3 days/year <sup>D</sup>	25% Max 3 days/year <sup>D</sup>	35% + balance billing Max 3 days/year <sup>D</sup>
<b>PKU supplies</b>	25%	35% + balance billing <sup>D</sup>	25% <sup>D</sup>	35% + balance billing <sup>D</sup>
<b>TMJ treatment</b> —Requires prior authorization	25% Surgical only <sup>D</sup>	Not covered	25% Surgical only <sup>D</sup>	Surgical only 35% + balance billing <sup>D</sup>

<sup>1</sup> 20 days maximum for chiropractic care on the Classic plan

<sup>2</sup> 10 days maximum for acupuncture care on the Classic plan

<sup>3</sup> 10 days maximum for naturopathic care on the Classic plan

<sup>D</sup> = **Deductible applies**

For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

## Covered Preventive Services

When members on the Capitol and Classic plans receive age and gender appropriate preventive care from an **in-network** provider, the care is covered at 100% of the allowed amount without any deductible, coinsurance, or copay.

This complies with the Patient Protection and Affordable Care Act (PPACA).



<b>Periodic exams</b> —Appropriate screening tests (see the SPD for a full list of tests)	
<b>Well child care</b> 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
<b>Adult routine exam</b> 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
<b>Preventive screenings</b>	
<b>Anemia screening (CBC)</b>	Pregnant women
<b>Bacteruria screening (UA)</b>	Pregnant women
<b>Breast cancer screening (mammography)</b>	Women age 40+—one per plan year
<b>Cervical cancer screening (PAP)</b>	Women age 21 through 65—one per plan year
<b>Cholesterol screening (lipid profile)</b>	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)
<b>Colorectal cancer screening age 50+</b>	Fecal occult blood testing once per plan year; OR Sigmoidoscopy every 5 years; OR Colonoscopy every 10 years - Members age 50 years old or older may receive one colonoscopy per 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 age 50 or older. Preventive colonoscopies for members under age 50 are not covered unless the member meets the medical policy criteria established by the Third Party Administrator.
<b>Prostate cancer screening (PSA) age 50+</b>	One per plan year (age 40+ with risk factors)
<b>Osteoporosis screening</b>	Post menopausal women—65+ (60+ with risk factors)—one bone density x-ray (DXA) every two years
<b>Abdominal aneurysm screening</b>	Men age 65-75 who have ever smoked—one screening by ultrasound per plan year
<b>Diabetes screening (fasting A1C)</b>	Adults with high blood pressure
<b>HIV screening</b> <b>STD screening</b>	Pregnant women and others at risk Persons at risk
<b>RH incompatibility screening</b>	Pregnant women
<b>Routine immunizations</b>	
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)	

For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications



# Prescription Drug Plan

Administered by MedImpact (888) 648-6764  
<https://mp.medimpact.com/mtn>

## Prescription Medication Highlights

URx Drug Classification	Drug Tier	Deductible	Retail Rx 30 day supply What you pay	Mail Rx 90 day supply What you pay
<b>Excellent value</b> based on medical evidence	A	\$0	\$0 copay	\$0 copay
<b>High value</b> based on medical evidence	B	\$0	\$15 copay	\$30 copay
<b>Good value</b> based on medical evidence	C	\$0	\$40 copay	\$80 copay
<b>Lower value</b> based on medical evidence	D	\$0	50% coinsurance <sup>1</sup>	50% coinsurance <sup>1</sup>
<b>Lowest value</b> based on medical evidence	F	\$0	100% coinsurance <sup>1</sup>	100% coinsurance <sup>1</sup>
You may purchase <b>specialty drugs</b> through Diplomat Pharmacy for a copay. If you buy through a retail pharmacy, you pay 50%.	S	\$0 deductible then \$150 or \$250 copay though Diplomat	50% coinsurance <sup>1</sup>	Not covered

<sup>1</sup>Does not count toward your out-of-pocket maximum.

### What is URx?

**URx** focuses on producing better clinical outcomes by making sure members get the **best** drug for the best price to treat their condition. **You get URx with either medical plan.**

### How Does URx Work?

**URx** has the Pharmacy & Therapeutics Committee (PTAC) that evaluates drugs based on the proven clinical results. PTAC places drugs in tiers within the URx formulary. The tiers are based on a combination of clinical and financial value to the plan and the member.

MedImpact is the pharmacy benefit administrator. MedVantx and Ridgeway are our mail order pharmacies. Diplomat Specialty Pharmacy handles the specialty medications (drugs that require special administration).

### What Tier Are You In?

What grade do your prescription drugs get in the **URx** program? Does your medication get an A, B, C, D, or F? Most people don't realize that just because a drug costs more, does **NOT** mean the drug is **better**.

Drug companies spend billions of dollars each year on advertising—so if you see six commercials for a particular drug, that drug may cost a lot more than a comparable drug. *Our health plan spends more on drugs than on doctor visits for our members.*

### How Do I Determine What Tier My Drug Is?

You can look up the class of your drug at: <https://mp.medimpact.com/mtn> and then talk to your doctor about the options for your medication.

We encourage you to take this information to your health care

provider to see if you are able to use the therapeutically equivalent drug.

### What Does 'Most Drugs Are Covered' Really Mean?

MedImpact negotiates discounts with pharmaceutical companies. These discounts will be passed on to you regardless of the class of your drug. The vast majority of drugs, including those that were not formerly covered, have a substantial discount.

### Out-of-Pocket Maximum for 2014

⇒ **Individual: \$1,650/year**

⇒ **Family: \$3,300**

Once you meet your out-of-pocket max, your drugs in tiers A, B, C, and specialty drugs through Diplomat Pharmacy are covered at **100%**. Drugs in tiers D, F, and specialty through retail pharmacies never apply to the out-of-pocket maximum.

You might be able to save using a mail order pharmacy. Here's an example:

Advair Diskus 100 — 50mcg

Your charge for a one month supply from a retail pharmacy: \$40 = **\$1.33 per day**

Your charge for a three month supply from a mail order pharmacy: \$80 = **\$0.88 per day**

The plan pays less for many medications through the mail order pharmacies, and we pass those savings on to you. Call MedVantx or Ridgeway today to see if you can save money buying your prescriptions by mail.

Diplomat Specialty Pharmacy (877) 319-6337  
 MedVantx (877) 870-MONT (6668)  
 Ridgeway (800) 630-3214

Having trouble with your specialty medication copayments? HCBP wants to help!

Contact (800) 287-8266, (406) 444-7462; TTY (406) 444-1421, or [benefitsquestions@mt.gov](mailto:benefitsquestions@mt.gov). A Benefits Specialist can tell you about options that may be available.



	<u>Monthly Cost Basic Plan</u>	<u>Monthly Cost Premium Plan</u>
<b>Member only</b>	<b>\$17.50</b>	<b>\$35.00</b>
<b>Member and spouse</b>	<b>\$27.00</b>	<b>\$53.50</b>
<b>Member and children</b>	<b>\$26.00</b>	<b>\$52.00</b>
<b>Member and family</b>	<b>\$30.00</b>	<b>\$60.00</b>
<b>Joint Core</b>	<b>\$20.50</b>	<b>\$41.00</b>

**Basic or Premium—Which plan is best for you?**

The **Basic plan** covers Type A services (Diagnostic and Preventive or D&P such as exams, cleanings, and x-rays; amalgam fillings are now also Type A). The Basic plan costs about half what the Premium plan costs.

The **Premium plan** includes the Basic plan Type A services **plus** Types B and C services. See the table on page 30 for a list of Types A, B, and C services.

We have **two networks** with Delta Dental—PPO<sup>SM</sup> and Premier<sup>®</sup>. The difference between seeing a dentist in the **PPO** and **Premier** networks is the level of the discount.

- **PPO** dentists accept reduced fees so you will usually pay the least when you visit a PPO dentist .
- **Premier** dentists agree to a discount, just not as low as PPO fees. So you pay a percentage of a slightly higher fee.

You have access to dentists in both networks at any time. You do not have to pre-select a dentist or a network. The difference in selecting a dentist is your out-of-pocket cost. The allowed fees and your out-of-pocket costs will depend on whether you choose a dentist from the PPO or Premier network.

If you see a non-Delta Dental dentist, you will be balance billed the difference between the allowed amount and that dentist's charged fee.

<b>Eligibility</b>	Employees, Legislators, Retirees <sup>1</sup> , spouses, & eligible dependent children up to age 26	
<b>Deductibles</b>	Basic Plan	Deductible does not apply
	Premium Plan	\$50 per person / \$150 per family each calendar year- waived for Type A services; applies towards Type B and Type C services
<b>Maximums</b>	Basic Plan	\$600 per person each calendar year- Type A services
	Premium Plan	\$1,200 per person each calendar year for Type B and C services; \$600 for Type A services; Lifetime implant maximum—\$1,500
Do Diagnostic & Preventive services count toward maximum?	No, your plan includes D&P Maximum Waiver benefit, allowing you to obtain diagnostic and preventive dental services without those benefits reducing the plan year maximum.	

<sup>1</sup>Retirees under age 65 are required to have dental unless they waive the entire benefits package; once Medicare eligible, dental coverage is optional.

**Website Directions:** To see if your dentist is in the PPO or Premier network,

- Go to [www.deltadentalins.com/stateofmontana](http://www.deltadentalins.com/stateofmontana).
- Go to the **Find a Dentist** box on the right of the page.
- Select the distance from your zip code to search
- Select the network—to see all dentists, select **Any Plan**
- Click search

If you selected **Any Plan**, two tabs open on the new page. One tab is for PPO dentists and one is for Premier dentists. Be sure to check both tabs for your dentist.

## What the Dental Plans Pay

### Basic Plan—the Plan Pays:

Benefits and Covered Services	PPO dentist	Premier dentist	Non-participating dentist
<b>Type A Services<sup>1</sup></b> Diagnostic & Preventive (D&P), Exams, cleanings, sealants, x-rays, amalgam fillings, and composite fillings up to the amalgam allowable	100% of maximum contract allowance	100% of maximum contract allowance	100% of maximum contract allowance + balance billing
<b>Type B Services</b>	Not a covered benefit	Not a covered benefit	Not a covered benefit
<b>Type C Services</b>	Not a covered benefit	Not a covered benefit	Not a covered benefit

### Premium Plan—the Plan Pays:

Benefits and Covered Services	PPO dentist	Premier dentist	Non-participating dentist
<b>Type A Services<sup>1</sup></b> Diagnostic & Preventive (D&P), Exams, cleanings, sealants, x-rays, amalgam fillings	100% of maximum contract allowance	100% of maximum contract allowance	100% of maximum contract allowance + balance billing
<b>Type B Services<sup>1,2</sup></b> Endodontics, periodontics, extractions, oral surgery, composite fillings	80% of maximum contract allowance	80% of maximum contract allowance	80% of maximum contract allowance + balance billing
<b>Type C Services<sup>1,2</sup></b> Crowns, bridges, initial dentures	50% of maximum contract allowance	50% of maximum contract allowance	50% of maximum contract allowance + balance billing

<sup>1</sup> See the SPD on [www.benefits.mt.gov](http://www.benefits.mt.gov) for a full list of types A, B, and C services

<sup>2</sup> Deductible applies

Find a dentist, view claims, check benefits, and manage your profile online and on your mobile phone  
[www.deltadentalins.com/stateofmontana](http://www.deltadentalins.com/stateofmontana)

Benefits and Covered Services	Limitations / Maximums
<b>Type A Services</b>	One full mouth x-ray and series in any 60 month period
	Two sets of supplementary bitewing x-rays in the 12 month benefit period
	Two exams &/or cleanings in any benefit year (fluoride application through age 19)
	No deductible; \$600 yearly maximum for Basic and Premium plans
	Sealants limited to covered dependents through age 15; may be applied to molars once per tooth per lifetime
<b>Type B Services</b>	See the HCBD website or the SPD for a full list of covered services and limitations
<b>Type C Services</b>	See the HCBD website or the SPD for a full list of covered services and limitations



For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

## Vision Hardware Plan (Optional)

### Who is Eligible?

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

All members covered on the medical plan may have **one vision and eye health evaluation** each year.

Decide if you want to purchase vision hardware coverage—your eye exam is included with your medical!

What this means for members is that **whether or not you choose the vision hardware plan, you may have one in-network eye exam each year.**

*You must be on the medical plan to select the vision hardware plan.*

Cigna's Vision Network offers one of the largest national routine vision networks, with 54,800+ optometrists and ophthalmologists at over 28,000 locations nationwide.

Our network is the Cigna Vision Network. Check their website <https://cigna.vsp.com> to see all the in-network providers.

You must select vision hardware to receive it. If you have vision hardware now, you **do not** automatically get the vision hardware plan. You must select it during annual change.

<b>All Members who are on the Capitol or Classic Medical Plan Receive:</b>		
Coverage	In-Network Benefit	Out-of-Network Benefit
Eye Exam (one per plan year)	Member pays \$10; <b>Plan pays 100%</b> after Copay	<b>Plan Pays Up to \$45</b>
<b><u>In-Network Coverage Includes:</u></b> One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses		

**Cigna's Vision Hardware Plan**  
(877) 478-7557  
<https://cigna.vsp.com>

*Note: The Cigna Vision Hardware phone number will be effective for plan members 1/1/14*



**Members *MUST* be on the medical plan to select the vision hardware plan**

Vision Hardware	2014 Monthly Cost
<b>Member only</b>	\$5.76
<b>Member and spouse</b>	\$10.86
<b>Member and children</b>	\$11.42
<b>Member and family</b>	\$16.76

<b>Members who choose the <u>Vision Hardware plan</u> in addition to the medical plan receive:</b>		
Coverage	In-Network Benefit	Out-of-Network Benefit
Materials Copay	Member pays \$20 copay	N/A
Eyeglass Lenses Allowances: (one pair per plan year) Single Vision Bifocal Trifocal Lenticular	<b>Plan Pays:</b> 100% after Copay 100% after Copay 100% after Copay 100% after Copay	<b>Plan pays:</b> Up to \$45 Up to \$55 Up to \$65 Up to \$80
Contact Lenses Allowances: (one pair— <i>one time benefit per plan year</i> —instead of lenses) Elective Therapeutic (must meet medically necessary criteria)	<b>Plan pays:</b> \$130 Covered 100%	<b>Plan pays:</b> Up to \$95 Up to \$210
Frame Retail Allowance (one per frequency period)	<b>Plan pays:</b> Up to \$130	<b>Plan pays:</b> Up to \$52

# The Montana Health Center

Now open in Helena, Billings, and Miles City!

*All eligible members may use the health centers, but they are responsible for their travel expenses.*

## CareHere!



### Montana Health Center

At the Montana Health Center you can receive primary care, health screenings, sports physicals, CDL exams, health coaching, and more!

The CareHere wellness team provides support as you set goals to improve and maintain a healthier lifestyle, at no additional cost to you.

Coaching is available to eligible members who can visit a health center.

Our health care team includes experienced physicians, physician assistants, nurse practitioners, RNs, LPNs, medical assistants, phlebotomists, registered dietitians, exercise physiologists and behavioral health experts, to meet all your health care needs.

*Stay tuned for details on more health centers opening in 2014!*

#### Who is **ELIGIBLE** to use the health centers?

- Active employees covered by the State plan and their dependents age two and older covered on the plan;
- Employees injured at work; and
- Non-Medicare retirees

#### To schedule or change an appointment **ONLINE**:

**[www.carehere.com](http://www.carehere.com)**

The first time you go to [www.carehere.com](http://www.carehere.com), you will need to register. The code you use to register is **MANA9**.

1. Go to member login and log in
2. Click APPOINTMENTS (on the left under GENERAL)
3. Click a day on the calendar
4. Scroll down and select the **provider** and **time** of your choice
5. Type in your reasons for the appointment; make health screening appointments on the lab or health screening schedule  
(*Note: Make 2 back-to-back appointments when you have 3+ medicines needed or if you are getting a full physical*)
6. Click CONFIRM YOUR APPOINTMENT

You may edit or delete your appointment at *any time* prior to the appointment time. You can also call (877) 423-1330 to make your appointment at the health center.

**This information is confidential and may not be viewed by anyone else other than the health center team.**



#### **Operated by CareHere**

*In Helena: 405 Saddle Dr; (406) 444-9930*

*In Billings: 1501 14th St West, Suite 230; (406) 969-5115*

*In Miles City: 515 Main St; (406) 234-0123*

*For live support 24/7 for all health centers call (877) 423-1330*

*[help.montana@carehere.com](mailto:help.montana@carehere.com)*



For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

# Health Screening Discount

**Q: What do I need to do to get the discount on my benefits payments in 2015?**

A: Getting your discount is a two-step process.

**Step 1:** In 2014, complete a health screening with CareHere, the company that runs the Montana Health Centers. To schedule go to <http://carehere.com>. (See "How do I sign up for a health screening" below.)

*Then...*

**Step 2:** In 2014, fill out the Cigna online Health Assessment *using the results from your health screening* by going to [www.myCigna.com](http://www.myCigna.com). When you fill out your assessment, you and your dependent age 18 or older covered on your plan will have to register as new users if you have never logged in to [www.myCigna.com](http://www.myCigna.com). To earn the tobacco-free discount, you will let us know here if you do or do not use tobacco. Your dependent age 18 or older on your plan does the same. You and **one dependent** are the maximum number of people who can get the discount.

**You must complete BOTH steps to qualify for any discount!**



**Q: How much is the discount for 2015?**

A: The amount of our discount has not been decided yet. Look for emails and newsletters from Health Care and Benefits Division (HCBD) for details as they become available.

**Q: How do I know if my dependent is eligible?**

A: An "eligible" dependent is a dependent child, spouse, or domestic partner who is covered on the State of Montana medical benefit plan and is age 18 or older.

**Q: When will I receive my discount?**

A: The discount off the monthly contributions will begin with the first full pay period in January. The discount will be given for each month for one (1) benefit year FOLLOWING the year that you attended a screening. So if you attend a screening in 2014 and complete Cigna's online assessment, then you will receive the discount off each month's contribution in 2015.

**Q: How do I sign up for a health screening?**

A: Go to [www.carehere.com](http://www.carehere.com). Once you are registered (**first-time** registration instructions can be found at: [www.benefits.mt.gov](http://www.benefits.mt.gov) under Health Screenings), make a note of the date and location that you'd like for your health screening when you log in, then click "Appointments." Select the date from the calendar on the top right, and then the time and location from the list. The active link for the screening does NOT show up until you use the calendar to navigate to the appropriate date. For assistance, contact CareHere at 877-423-1330.

**Q: How do you define tobacco-free? I don't actually smoke...**

A: Tobacco-free means you have not used ANY tobacco products for at least six months.

Still have questions? Check out the full FAQ at [www.benefits.mt.gov](http://www.benefits.mt.gov) under Health Screenings.

**Wellness incentives will only GET BIGGER for 2016.** And these incentives will build throughout 2015. Your actions from January through December 2015 can increase your discounts in 2016. So pay attention to newsletters, emails, and any communications from HCBD to learn how you can **save even more money in 2016**. You can't participate if you don't know, and *you won't know if you don't read your updates from HCBD.*

**Questions? Need help?**

Health Care and Benefits Division

[www.benefits.mt.gov](http://www.benefits.mt.gov) [benefitsquestions@mt.gov](mailto:benefitsquestions@mt.gov)

(800) 287-8266; (406) 444-7462;

Hearing impaired TTY (406) 444-1421

Employees receive 26 paychecks per year.

Contributions come out of 24 paychecks per year.

# Weight Management

These weight management programs are easy to use, available where and when you need it, and are always no cost to you.



## WEIGHT MANAGEMENT with CIGNA

Cigna's weight management program is great for all members throughout the state of Montana. Get support to help build your confidence, become more active, eat healthier and change your habits using a non-diet approach. Use the program online, over the phone – or both.

Log into [www.myCigna.com](http://www.myCigna.com) or call **855.246.1873** to get signed up today!

### On the phone

- Personal healthy-living plan
- Individual telephone coaching
- Dedicated wellness coach
- Convenient evening and weekend coaching hours
- Program workbook and toolkit
- Healthy Rewards® discounts\*
- Join 24/7/365
- Optional telephone group support

### Online

- Personal health assessment and healthy-living plan
- 12-step self-paced program
- Weekly educational emails
- Interactive tools and resources
- Healthy Rewards®\* discounts
- Secure, convenient support

## WEIGHT MANAGEMENT through CareHere

The Montana Health Centers operated by CareHere offer individualized and personal wellness services at established health centers for those able to visit a health center. See page 32 for eligibility to use the health centers.

Schedule your first appointment at: [www.carehere.com](http://www.carehere.com) or call **877.423.1330**

Benefits include:

- Behavioral health support for stress management and lifestyle changes.
- Nutrition and mindful eating support with experienced Registered Dietitians
- Cholesterol and weight management to reduce risk for heart and vascular disease.
- Increasing nourishment in diet
- Exercise and fitness support with experienced Exercise Physiologists.
- Ongoing, confidential support for challenges with stress management, tobacco or alcohol cessation, family support services, and maintaining lifestyle changes.

To log into CareHere Connect, go to [www.carehere.com](http://www.carehere.com) and sign in, then click on CareHere Connect in the lower left corner of your screen. CareHere Connect is a great option for progressing at your own pace. CareHere Connect helps you track your eating, build a healthy eating plan, and meet your goals.



\* Some Healthy Rewards programs are not available in all states. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge. "Cigna", "Cigna Healthy Rewards," "myCigna.com" are registered service marks, and the "Tree of Life" logo and "GO YOU" are service marks, of Cigna Intellectual Property, Inc, licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Health Management, Inc., Cigna Behavioral Health, Inc., vielife Limited, and HMO or service company subsidiaries of Cigna Health Corporation. All models are used for illustrative purposes only. 848442 a 06/12 © 2012 Cigna. Some content provided under license.

Additional resources are the [Healthy for Life Self-Study Option](#) and [Weight Watchers](#). Details about both are available at [www.benefits.mt.gov](http://www.benefits.mt.gov) under Live Life Well.

# Tobacco Cessation

Is now your time to quit? You have options!



## CIGNA'S TOBACCO CESSATION

Our tobacco cessation program helps you get and stay tobacco free. Develop a personal quit plan that's right for you. Use the program online, over the phone – or both. You may qualify for Chantix or other tobacco cessation needs under the pharmacy benefit with participation.

Contact Cigna at (855) 246-1873 or log on to [www.myCigna.com](http://www.myCigna.com) for details.

### On the phone

- Personal quit plan
- Individual telephone coaching
- Dedicated wellness coach
- Convenient evening and weekend coaching hours
- Program workbook and toolkit
- Healthy Rewards® discounts\*
- Optional telephone group support
- No cost over-the-counter nicotine replacement therapy (patch or gum)
- Other medications through URx pharmacy
- Join 24/7/365

### Online

- Personal quit plan
- Six-step self-paced program
- Weekly educational emails
- Healthy Rewards® discounts\*
- Secure, convenient support
- Interactive tools and resources
- No cost over-the-counter nicotine replacement therapy (patch or gum)



## TOBACCO CESSATION AT THE MONTANA HEALTH CENTERS

The Montana Health Centers operated by CareHere offer great tobacco cessation program for members able to visit a health center. You may qualify for Chantix or other tobacco cessation medications with participation.

To schedule your first appointment with a coach, log on to [www.carehere.com](http://www.carehere.com), or call 406.444.9930 or 877.423.1330.

The "Beat the Pack/Kick the Can" tobacco cessation program includes an initial consult with a health coach. It also includes:

- 8 week online, self-paced cessation program with coaching
- Build an individualized Quit Plan
- Set your own Quit Date
- Access to tobacco cessation medications if deemed appropriate by a health care provider
- One full year of coaching support
- Access to dietitian and exercise physiologist
- Nutritional support
- Manage weight gain

Eight week group workshops also take place depending on demand in health center areas.

The **tobacco-free discount**—Being tobacco-free or participating and completing a tobacco cessation program in 2014 will make you eligible for the tobacco-free discount **in 2015**. See page 33 for details.

\* Some Healthy Rewards programs are not available in all states. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge. "Cigna", "Cigna Healthy Rewards," "myCigna.com" are registered service marks, and the "Tree of Life" logo and "GO YOU" are service marks, of Cigna Intellectual Property, Inc, licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Health Management, Inc., Cigna Behavioral Health, Inc., vieliflife Limited, and HMO or service company subsidiaries of Cigna Health Corporation. All models are used for illustrative purposes only. 848442 a 06/12 © 2012 Cigna. Some content provided under license.

# Stress Management

Stress is a real part of our lives. Managing stress well can have a huge impact on our overall health. Cigna and CareHere give us great choices to find the program that works best to manage stress in our lives.



## CIGNA'S STRESS MANAGEMENT

Our stress management program helps you understand the sources of your stress and learn coping techniques to manage stress both on and off the job. Use the program online, over the phone – or both.

Call or go online for easy enrollment:

**1.855.246.1873**

[myCigna.com](http://myCigna.com)

### On the phone

- Personal stress management plan
- Individual telephone coaching
- Dedicated wellness coach
- Convenient evening and weekend coaching hours
- Program workbook and toolkit
- Healthy Rewards® discounts\*
- Join 24/7/365
- Optional telephone group support

### Online

- 8-week program
- Weekly educational emails
- Healthy Rewards® discounts\*
- Secure, convenient support



## STRESS MANAGEMENT with CareHere

Schedule your first appointment at:

[www.carehere.com](http://www.carehere.com) or call **877.423.1330 (24/7)**;

(406) 444.9930 Helena; (406) 969-5115 Billings

CareHere offers a Behavioral Health Coach to work with members able to visit a health center.

Your Behavioral Health Coach offers consults in person and may follow up via Skype, or by phone for established patients and can assist with the following:

- Development of Problem solving skills
- Communication skills
- Life balance
- Parental support
- Goals identification
- Life Transitions
- Marriage
- Divorce
- Birth of child
- Caring for Aging Parents
- Education
- Addictions
- Personal advocacy
- Identifying local resources
- Mental Health Issues
- Depression
- Anxiety

If you are not near a Montana Health Center, you may use the CareHere Connect option for online stress management support.

To log into CareHere Connect, go to [www.carehere.com](http://www.carehere.com) and sign in, then click on CareHere Connect in the lower left corner of your screen. CareHere Connect is a great option for progressing at your own pace. CareHere Connect helps you recognize stressors and teaches you tips to manage stress.

**CareHere!**

\* Some Healthy Rewards programs are not available in all states. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge. "Cigna", "Cigna Healthy Rewards," "myCigna.com" are registered service marks, and the "Tree of Life" logo and "GO YOU" are service marks, of Cigna Intellectual Property, Inc, licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Health Management, Inc., Cigna Behavioral Health, Inc., vieliflife Limited, and HMO or service company subsidiaries of Cigna Health Corporation. All models are used for illustrative purposes only. 848442 a 06/12 © 2012 Cigna. Some content provided under license.

# Disease Management

Do you have a chronic health condition? Have you recently been diagnosed with a new condition? We can help!



## YOUR HEALTH FIRST

Cigna's disease management is great for members throughout the state. Use the program online, over the phone – or both.

Call **855.246.1873** for live support from your health advocate or log on to [www.myCIGNA.com](http://www.myCIGNA.com) for self-service resources.

A health advocate may be calling you to get things started, or you can call someone at any time to:

- Manage a chronic health condition;
- Create a personal care plan;
- Understand medications or your doctor's orders;
- Identify triggers that affect your condition;
- Make educated decisions on your treatment options; and
- Know what to expect for a hospital stay.

### Take charge of your health using online tools.

When you're doing well on your own, you can use a variety of self-service resources to help you better understand your condition and overcome barriers to better health.

Get support TODAY for:

- Asthma
- Heart Disease
- Coronary Artery Disease
- Metabolic Syndrome
- Peripheral Arterial Disease
- Congestive Heart Failure
- Acute Myocardial Infarction
- COPD
- Diabetes
- Angina
- Low Back Pain
- Osteoarthritis
- Depression
- Anxiety
- Bipolar Disorder



## CareHere's DISEASE MANAGEMENT

For members able to visit a Montana Health Center, advanced disease management focuses on proactive health care.

To learn more about CareHere's program, visit [www.carehere.com](http://www.carehere.com) or call **(877) 423-1330**.

Incentive plans benefit you. For example, full participation in the CareHere diabetes management program rewards you with diabetes supplies at no cost to you and cash rewards. Talk with a CareHere provider for a full list of incentives for conditions such as:

- Cancer
- Peripheral artery disease
- High blood pressure
- Cardiovascular disease (including heart disease, arteriosclerosis, atherosclerosis, and stroke)
- Diabetes
- Chronic respiratory diseases (asthma, COPD, emphysema)
- Rheumatoid arthritis, osteoarthritis, gout
- Joint and back pain

Your CareHere health care team will work with you to:

- Reduce risk for chronic and infectious diseases
- Achieve and maintain good mental and emotional health through stress management;
- Improve health by setting specific goals;
- Provide ongoing support to maintain healthy lifestyles; and
- Customize educational materials based on clinical values, learning styles, and the member's personal desire for change.

The CareHere Wellness team includes healthcare professionals such as physicians, mental health care providers, physician assistants, nurse practitioners, nurses, dietitians, fitness experts and other wellness personnel to give you the best overall care. These services can help reduce future high-cost health care expenditures.

**CareHere!**



## Healthy Pregnancies, Healthy Babies®

Call **1.800.615.2906**  
to enroll as soon as you  
know you are pregnant.

### Get rewarded for a good decision

When you participate and complete the program, you'll be eligible to receive:

- \$250 if you enroll during your 1st trimester; or
- \$125 if you enroll during your 2nd trimester.

When you're pregnant your body undergoes major changes. The Cigna Healthy Pregnancies, Healthy Babies® program supports you in managing your pregnancy and keeping you and your baby healthy.

You're expecting. That means you're going to be choosing a name. Looking for a pediatrician. And seeing big changes – to your body and your lifestyle.

- Find support early and often -- get preconception information, tell us about your pregnancy, or get infertility coaching so we can meet your needs.
- Learn as much as you want -- talk to a nurse who can help you with everything from morning sickness to you maternity benefits, 24/7.
- Sign up for text messages -- text 511411 to get started: BABY for English, BEBE for Spanish.

**You can get prenatal vitamins at no cost through the URx pharmacy plan!** There are also benefits for breast pumps and lactation consultation. See the breastfeeding page at [www.benefits.mt.gov](http://www.benefits.mt.gov).



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## LIVE LIFE WELL



Health Care and Benefits Division (HCBD) coordinates all the wellness programs available to members of the State of Montana health plan. Members can pick and choose as many wellness programs to participate in as they like.

Not sure where to start? If you don't know if you want to go with an HCBD program, one offered by Cigna, or one through CareHere, call HCBD (contact information below) for details and directions. We can help you figure out which way will help you get the best results for your needs and lifestyle.

We can also give you the latest details on the discount and our fun nutrition and physical activity opportunities.

Counseling services for the **Employee Assistance Program** are automatically processed through Cigna. Members can get **four counseling sessions** with no copay when using an in-network provider.

Do you love **Weight Watchers**? Members and dependents 18 and over on the plan can still get reimbursed up to \$75 every two years if they meet all the requirements found on the HCBD website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Live Life Well.

### Onsite Presentations

The health coach comes to you! Great for conferences, staff meetings, or sessions to address work life wellness issues. Popular presentations include stress management, nutrition, safety, and much more.

HCBD is looking at ways to reward members who participate in healthy programs. *Read your newsletters* for more details!



For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

# Flexible Spending Accounts

Flexible Spending Accounts (FSAs) give you a tax advantage that can help you pay qualified medical and dependent care expenses on a pre-tax basis. By anticipating your family's costs for 2014, you can lower your taxable income. For a complete list of **qualified medical expenses** visit [www.allegianceflexadvantage.com](http://www.allegianceflexadvantage.com) and look in 'What is Eligible?' under the 'Participants' section.

For 2014, the annual maximum contribution per employee to the medical FSA is **\$2,500**.

The annual maximum amount you may contribute to the Dependent Care FSA per plan year is **\$5,000** or **\$2,500** if married but filing taxes separately.

The Internal Revenue Service (IRS) allows FSAs as a tax break to employees and for qualified expenses for their qualified dependents.

The taxes you pay each paycheck and collectively each plan year are reduced. Without an FSA medical expenses are only deductible if they exceed 10% of your adjusted gross income.

**Keep in mind that gross earnings for determining Social Security benefits may be reduced by pre-tax deductions.** Talk with your tax advisor.

## How do FSAs work?

If you enroll in the Medical FSA or Dependent Care FSA, your contributions are taken out of each paycheck—before taxes—in equal installments throughout the plan year. These dollars are placed into your FSA into two separate accounts (medical / dependent care). When you have an eligible health care expense, you file a claim with Allegiance unless you select during Annual Change to have your claims filed automatically.

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

## Is an FSA right for me?

FSAs are beneficial for anyone who has out-of-pocket medical, dental, vision, hearing, or dependent care expenses beyond what one's health plan covers. It's easy to determine if an FSA will save you money. At enrollment time, determine your plan year contribution amount. Estimate the expenses that you **know** will occur during the year. These include out-of-pocket expenses for yourself and anyone claimed as a dependent on your taxes.

If you have \$100 or more in recurring or predictable expenses, an FSA can help you stretch your dollars. *Talk with a tax advisor to see if an FSA is right for you.*

## 2014 Options

When you sign up for medical flex, you have options!

1. File claims online, on the website, in person, by fax, or by mail
2. Sign up for [joint processing](#)
3. Use a [debit card](#) for qualified medical expenses

Joint processing means the amount of **medical claims** processed by Cigna that you are responsible for will be automatically forwarded to Allegiance for processing.

This eliminates the paperwork of filing a claim or the time spent online submitting a claim.

The key here is every claim is automatically forwarded until your flex funds are gone. So 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.

Debit cards can be used just like a regular debit card for any qualified medical expense. The catch here is you are responsible for keeping all receipts in case you are audited.

There are a few points to remember about these options. One, if you select the debit card for medical or dependent flex, you must use the debit card if you also have the other type of flexible spending account. If you do select the debit card option, you can always still file paper forms.

Second, if you select joint processing on medical flex, your only option for dependent flex is filing paper forms.

If you prefer, you may file claims with Allegiance by fax, mail, or securely through the Allegiance website.



See the flex calculators on the Allegiance website:

Administered by Allegiance Benefit Plan Management • (866) 339-4310  
(406) 523-3149 or FAX (877) 424-3539  
[www.allegianceflexadvantage.com](http://www.allegianceflexadvantage.com)

For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

# Flexible Spending Accounts

## An FSA Example

Mary is a single mother of two earning \$42,000 per year (\$3,500 gross per month). Her older child has braces, and Mary is paying the orthodontist \$150 per month. Mary takes a prescribed maintenance drug that costs \$50 per month. Her younger child attends preschool while Mary is at work, and Mary pays \$300 per month to the daycare provider. Mary's total qualified medical and dependent care expenses come to \$500 per month.

	No FSA	With FSA
Gross pay	\$3,500	\$3,500
FSA election	\$0	\$500
<b>Taxable pay</b>	<b>\$3,500</b>	<b>\$3,000</b>
Fed Tax*	\$314	\$242
State Tax*	\$154	\$124
FICA	\$268	\$230
<b>Net pay</b>	<b>\$2,764</b>	<b>\$2,404</b>
Prescription	\$50	\$0
Braces	\$150	\$0
Day care	\$300	\$0
<b>\$ in Mary's pocket</b>	<b>\$2,264</b>	<b>\$2,404</b>

This table is a comparison of Mary's monthly take-home pay without FSAs versus her take-home pay if she enrolls in FSAs. Participation in FSAs puts an extra \$140 in Mary's pocket each month (\$1,680 per year).



\*tax based on 2013 Federal and Montana payroll tax withholding tables, claiming 3 allowances, and the current 7.65% FICA/Medicare rate.

## Medical/Dependent Care FSA(s) Worksheets

These worksheets can help you decide how much to select for Medical & Dependent Care FSAs. Review your Explanation of Benefits (EOB) to get an idea of how much you spent in the last 12 months on health care.

The amount you select is taken from your paychecks in 24 installments—*first from any unused state share*, and then from your gross pay (before taxes)—and deposited into your FSA.

### Medical FSA Worksheet Up to \$2,500/yr

<u>Common Medical Expenses</u>	<u>2014 Estimates</u>
Estimated Medical Costs (deductibles, copays, coinsurance)	\$ _____
Estimated Dental Costs	\$ _____
Estimated Vision Costs	\$ _____
Estimated Prescription Costs	\$ _____
<b>Total Estimated 2014 Health FSA</b>	<b>\$ _____</b>

### Dependent Care FSA Worksheet to \$5K

<u>Monthly Care Expenses</u>	
Infant Expenses	\$ _____
Preschool Expenses	\$ _____
Before and After School Care	\$ _____
School Vacations	\$ _____
Total Monthly Expenses	\$ _____
	x 12
<b>Total Estimated 2014 Care</b>	<b>\$ _____</b>

### Important!

Be sure your total estimated amounts for Medical or Dependent Care FSAs can be divided evenly by 24 (the number of deductions in the plan year)



For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications



# Life Insurance

**Who Is Eligible?** The *Basic Life Insurance* plan 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.

**During Annual Change:**

- You may **delete** plans B, C, D, and E.
- You may **decrease** coverage in Plan C down to your annual salary, rounded to the next highest \$5,000 increment.
- You may **apply for, increase, or decrease** coverage under plans C and D.
- You may **add, increase, or decrease** Plan E.

**Choose from Five Plans**

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

A member may carry all life plans until separation. At separation, no life plans may be continued through COBRA.

At retirement, only Plan A—Basic Life—can be continued until age 65 or Medicare eligible.

*\*Evidence of Insurability (EOI) is the proof of good health.*

Administered by The Standard Insurance Co • (800) 759-8702 • [www.standard.com](http://www.standard.com)

**Plan A – Basic Life**

Provides \$14,000 of term-life coverage, a core benefit for state employees (also available to retirees under age 65 who keep state benefits into retirement).

**Plan B – Dependent Life**

Available during your initial 31-day enrollment period, or within the first 60 days of marrying or having your first child. Plan B offers \$2,000 of coverage for a spouse and \$1,000 of coverage for each dependent child.

**Plan C – Optional Employee Life**

Available during your initial 31-day enrollment period without *EOI* up to the member’s annual salary. Enrollment after the 31 day period requires *EOI*. Offers a minimum of your annual salary rounded to the next highest \$5,000 up to \$500,000 with *EOI*.

During Annual Change, current Plan C enrollees—those employees with existing 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**

Offers insurance on your spouse’s life. During your 31-day enrollment period and annual change, you may make a new election of Plan D coverage of up to \$10,000 without *EOI*. The employee must be enrolled in Plan C for the spouse to be eligible for Plan D.

The 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.

**Plan E—Optional Accidental Death & Dismemberment**

This plan is available without *EOI*.

**Employee Only:** Coverage is available between \$25,000 and \$500,000 in increments of \$25,000. The coverage may be up to 10 times your annual salary rounded down to the next \$25,000.

**Employee and Dependents:** The employee receives the coverage described above. 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.

**Making a Change**

**Evidence of Insurability:** As we described under options C and D, there are times you may need to provide *EOI*.\*

**For more on MEDEX Travel Assist see page 43 under Long-Term Disability**

Plans		Monthly Contributions
<b>Plan A:</b>	Basic Life	\$1.90 per month
<b>Plan B:</b>	Dependent Life	\$0.52 per month
<b>Plan C:</b>	Optional Employee Life	(every \$1,000 of coverage) x (Age Rate)
<b>Plan D:</b>	Optional Spouse Life	(every \$1,000 of coverage) x (Age Rate)
<b>Plan E:</b>	AD&D—Employee only	\$0.020 / \$1,000 of coverage
	AD&D—Employee plus dependents	\$0.030 / \$1,000 of coverage

**Age Rates for Plans C & D**  
Based on employee’s age on the last day of the month that contributions are paid\*

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

\*The first payment after the employee’s birthday will reflect the new rate.

# Life Insurance Examples



Plan	Person Insured	Rate		Amount of Coverage	Monthly Out-of-Pocket Cost	Evidence of Insurability Required?	
<b>A—Basic Life</b>	Employee	\$1.90 per month		\$14,000	\$1.90	No	
Plan	Number of Dependents	Rate		Amount of Coverage	Monthly Out-of-Pocket Cost	Evidence of Insurability Required?	
<b>B—Dependent Life</b>	3	\$0.52 per month		\$1,000 per child \$2,000 per spouse	\$0.52	No	
Plan	Person Insured	Rate	Age Rate	Amount of Coverage selected by employee	Monthly Out-of-Pocket Cost	Evidence of Insurability Required?	
<b>C—Optional Employee Life</b>	Employee	(every \$1,000 of coverage) x (Age Rate)	\$0.067	\$40,000 (annual salary is \$38,000)	\$2.68	Yes—outside 31 day enrollment period	
Plan	Person Insured	Rate	Age of Employee	Age Rate	Amount of Coverage	Monthly Out-of-Pocket Cost	Evidence of Insurability Required?
<b>D—Optional Spouse Life</b>	Spouse of Employee	(every \$1,000 of coverage) x (Age Rate)	32	\$0.042	\$30,000	\$1.26	Yes—more than \$10,000
Plan	Person Insured	Amount of Coverage	Rate		Monthly Out-of-Pocket Cost	Evidence of Insurability Required?	
<b>E—AD&amp;D Employee only</b>	Employee	\$350,000	\$0.020 / \$1,000 of coverage		\$7.00	No	
Plan	Persons Insured	Amount of Coverage	Rate		Monthly Out-of-Pocket Cost	Evidence of Insurability Required?	
<b>E—AD&amp;D Employee + Dependent</b>	Spouse & 3 Dependents	Employee—\$350,000 Spouse—\$140,000 (40% of \$350,000) Each Dependent <u>\$35,000</u> (10% of \$350,000) <b>Total coverage: \$595,000</b> ( $\$350,000 + \$140,000 + \$35,000 + \$35,000 + \$35,000$ )	\$0.030 / \$1,000 of coverage (premium based on amount elected, not total coverage)		\$10.50	No	



For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications



**The Standard**<sup>®</sup>  
Positively different.

## Long Term Disability

\$9.90 per member  
per month

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.

### Who Is Eligible?

LTD coverage is a voluntary benefit 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. **\*Evidence of Insurability (EOI) is proof of good health.**

### 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.

### 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.

If you become disabled at age 60 or older, the benefit duration is determined by your age when disability begins.

If you are age 60-64 when disability begins, your maximum benefit period is five years.

For ages 65-68, the maximum is to age 70.

For ages 69 and over, the maximum is one year.

### More Information

For more information visit The Standard Insurance Company's website at [www.standard.com](http://www.standard.com). Also LTD brochures are available to provide more information on the plan. These brochures can be found on the HCBP website [www.benefits.mt.gov](http://www.benefits.mt.gov) and click on Long Term Disability under the EMPLOYEES tab or by contacting Health Care and Benefits Division at (800) 287-8266, TTY (406) 444-1421, or [benefitsquestions@mt.gov](mailto:benefitsquestions@mt.gov).

### Advantages of Long-Term Disability Coverage

- LTD covers your inability to work in your own occupation for the first 24 months you are disabled (once you meet the benefit waiting period). Many other policies require you to be totally disabled from all occupations.
- If you are disabled from all occupations after 24 months (once you meet the benefit waiting period), benefits may continue until you are Social Security Normal Retirement Age.
- LTD provides benefits for covered illnesses or injuries that may occur 24 hours a day, both on and off the job.
- If the group policy terminates, LTD benefits will continue as long as you are eligible to receive them.

### MEDEX Travel Assist—also from The Standard

MEDEX Travel Assist provides pre-trip, medical, travel, and legal assistance—and more!  
They can even fly you home if you have a medical emergency!  
*All Plan members who have life insurance have this benefit!*

Call (800) 527-0218 for more information or check out the Travel Assistance brochure at [www.benefits.mt.gov](http://www.benefits.mt.gov) on our forms page .

Administered by The Standard Insurance Co • (800) 759-8702 • [www.standard.com](http://www.standard.com)

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

For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

# Eligibility (Allowed Dependent Changes, Information, Qualifying Events)



## During the First 31 Days of Employment

Employees have several opportunities during their initial hiring period that are not available later or that require applications.

### Plan B Dependent Life

An employee may elect Plan B only during their initial 31 days of employment or in the event of marriage or birth.

### Long Term Disability

An employee is guaranteed approval during their first 31 days of employment; otherwise this benefit requires an application.

## Allowed Dependent Changes During Annual Change

During annual change, members can add dependents to the dental plan using the online benefits enrollment available through the MINE site. Members may also purchase Optional Accidental Death & Dismemberment (AD&D) during annual change. *Members cannot add spouses or domestic partners to medical unless there is a qualifying event.*

Annual change typically lasts five weeks from mid-September through the third week in October.

## Declaring Dependent's Tax Status

All employees who add a spouse or domestic partner during annual change will receive a Declaration of Tax Status form to return to HCBD.

If you do not return the form, your spouse or domestic partner will default to a non-qualified tax status. You can find the [Declaration of Tax Status form](#) on the HCBD website on the [Forms and Publications page](#).

## Deleting Dependents

You may delete dependent coverage during annual change or any time throughout the year, but once a dependent is removed from the medical plan, they *may not be re-enrolled* without a qualifying event (described on this page).

Mid-year additions or other changes are not allowed without a qualifying event.

## Enrolling Dependents After Annual Change

After annual change, dependent coverage enrollment is only allowed during [qualifying events](#):

- within 60 days of becoming a dependent (through marriage or court-ordered support/custody/legal guardianship);
- within 60 days of losing eligibility (not voluntary cancellation or cancellation for failure to pay) for other group coverage;
- within 60 days of losing an employer's contribution toward other group coverage, sustaining a major increase in out-of-pocket costs, or losing benefits;
- within 60 days after the 31-day automatic coverage period (91 days from birth) after birth or adoption.

**Notify Health Care and Benefits Division** when one of the qualifying events occurs (*within the specified time frames*) to enroll dependents.

If you have questions regarding your specific situation, call HCBD or see the plan rules described in the [Summary Plan Document](#) available on the Forms and Publications page at [www.benefits.mt.gov](http://www.benefits.mt.gov).

## Eligible Dependents Defined

Eligible dependents include:

1. The eligible employee's lawful spouse or declared domestic partner (you can find the form at [www.benefits.mt.gov](http://www.benefits.mt.gov) under FORMS);
2. The eligible employee's dependent children who are under age 26 and not in full-time active military service (the dependent may be married and still be eligible);
3. Disabled dependents (refer to SPD for the definition of disabled dependents).

*The member is responsible for removing any dependents who cease to be eligible. Failure to do so will result in the member being held responsible for repayment of any claims dollars paid out for ineligible dependents. Additionally the member will not be refunded benefits payments paid for ineligible dependents.*



# Pre-Tax Plan

IRS regulations do not permit refunds of contributions paid pre-tax. Notify Health Care & Benefits Division of any changes as soon as possible to avoid overpayment.

The pre-tax plan allows you to pay for your portion of most of your benefits payments on a pre-tax basis. If the state contribution covers your benefits payment entirely, you do not need to participate in the pre-tax plan, *unless you have a Flexible Spending Account (FSA)*. Enrollment in an FSA requires participation in the pre-tax plan.

The tax status you select for 2014 will continue into the 2015 benefit year *unless* you indicate otherwise.

## Who Is Eligible?

All employees enrolled in the State Employee Benefit Plan are eligible to participate in the pre-tax plan.

## Eligible Benefits

Payments for the member's medical, dental, vision, accidental death & dismemberment (AD&D), employee term life (*only plans A and C up to \$50,000 of coverage*), long term disability, and flexible spending elections may be paid pre-tax through the pre-tax plan. Payments for the member's tax qualified dependents are also eligible for this plan.

## Ineligible Benefits

Dependent life insurance coverage, supplemental spouse life insurance coverage, and employee life coverage over \$50,000 are defined by IRS code as taxable benefits and are excluded from the pre-tax plan.

## Retirees & COBRA Members

Retirees and COBRA members can elect to prepay contributions through the end of the year in which their employee coverage terminates. These contributions will be taken on a pre-tax basis if you are currently enrolled in the pre-tax plan.

If you are thinking about leaving State employment and either taking COBRA or retiring, consult your tax advisor.

If you have mid-year coverage changes that reduce the amount of your contribution, you **will not be refunded** any of the pre-paid contributions.

The majority of benefits payments, whether paid with pre-tax or post-tax dollars, cannot be refunded. In the event of automatic coverage termination due to death or Medicaid/SCHIP eligibility, contributions subsequently collected will be returned as regular taxable compensation.

Consult your tax advisor to determine the specific effect the pre-tax plan will have on your taxes.

## Loss of Eligibility

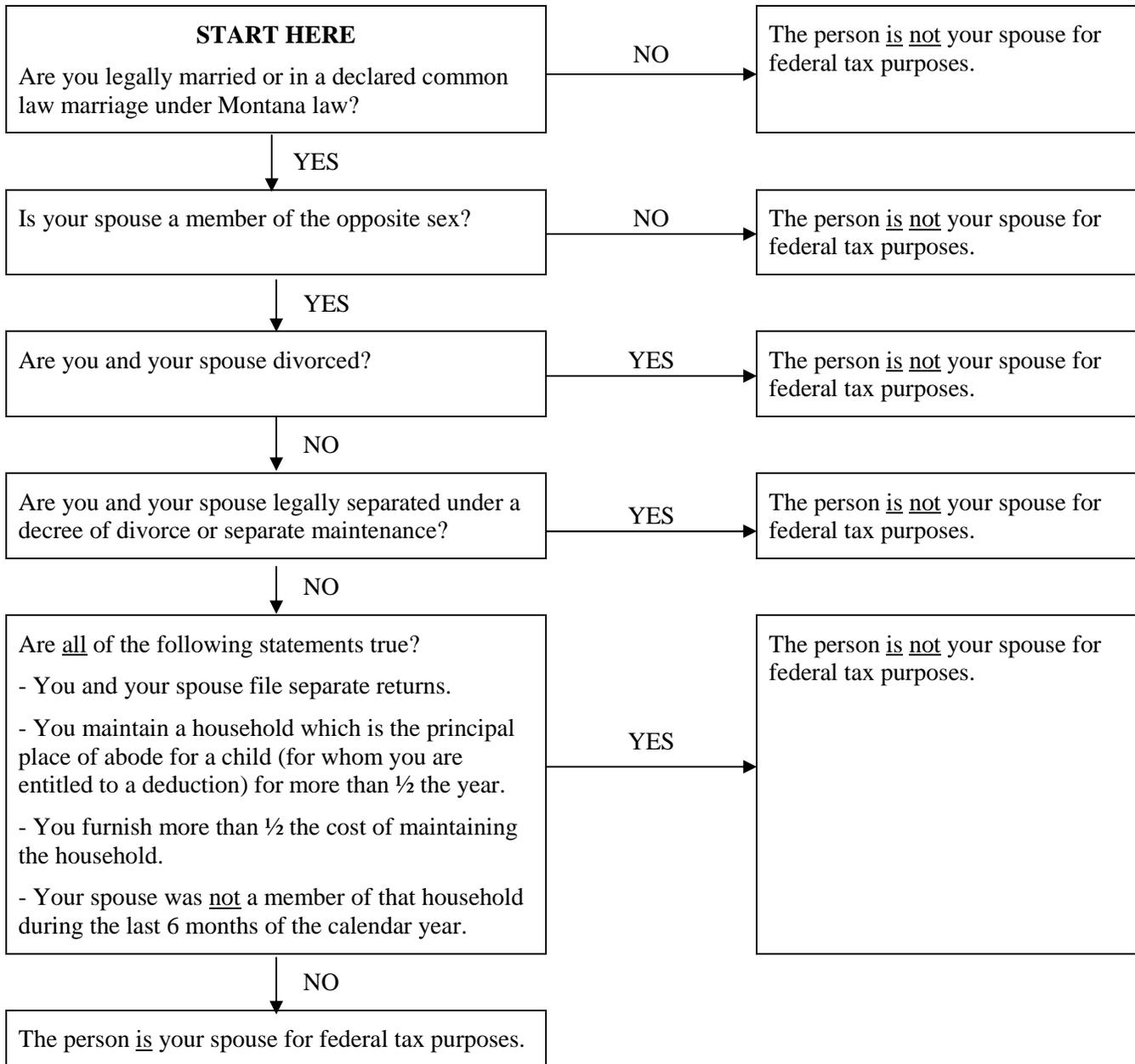
Remember—if your dependent loses eligibility, you must notify HCBP. You will continue to make benefits payments until you notify HCBP. **Those payments are not refundable.**

## What's the Catch?

According to IRS rules, a drawback of the Pre-tax Plan is that no refund is allowed. This means you must notify HCBP right away if a dependent spouse, domestic partner, or child loses eligibility for coverage. If you do not notify HCBP of a loss of eligibility and more contributions are taken out of your check than you owe, **no refund is available**.

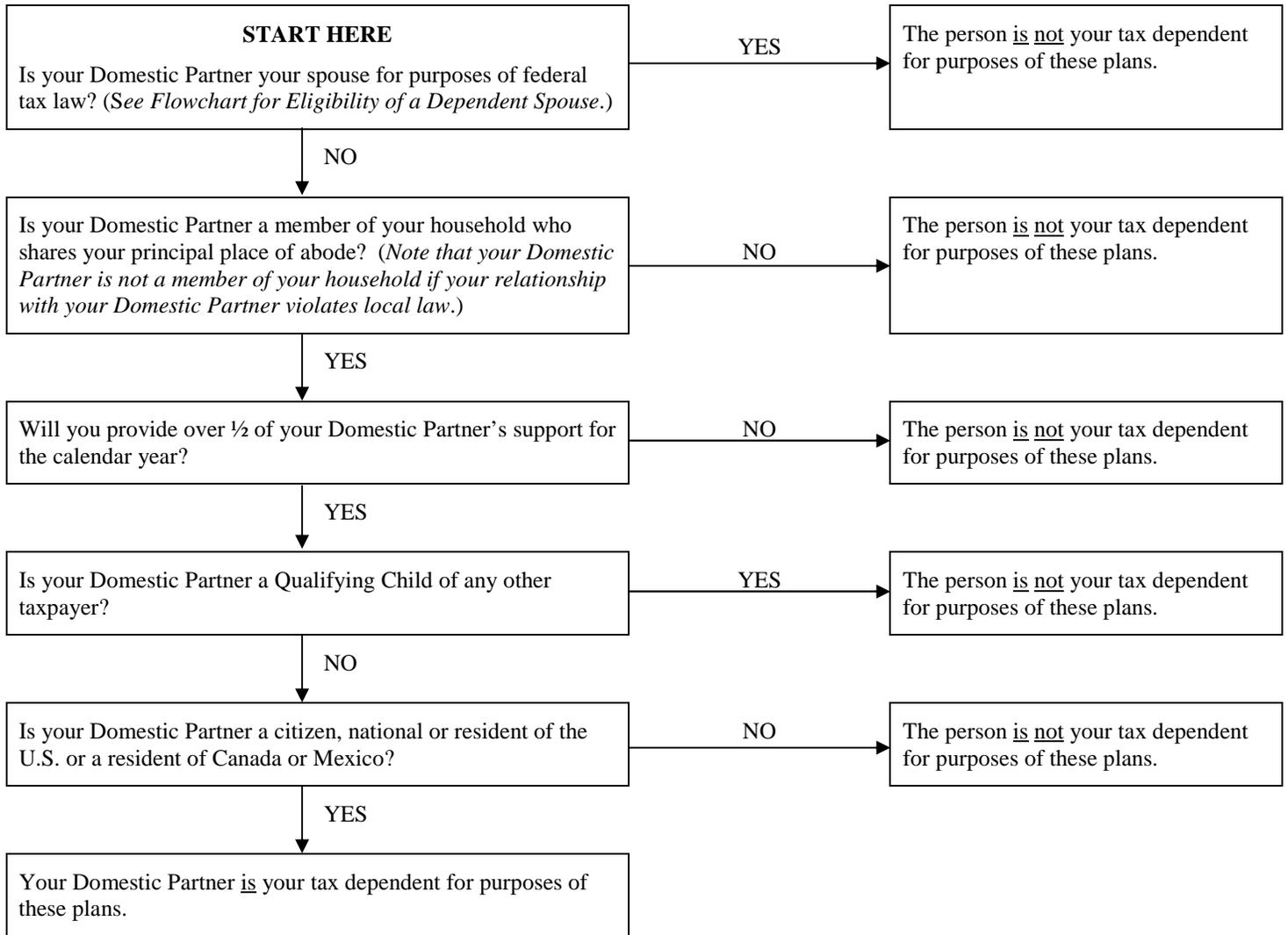
In the event of automatic coverage termination due to death or Medicaid/SCHIP eligibility, contributions subsequently collected will be returned as regular taxable compensation.

Also, remember that gross earnings for purposes of determining social security benefits may be reduced by pre-tax deductions. Talk with your tax consultant for details.



- *If the person is your spouse, then you should put a check in the box next to "Yes" on the Declaration of Tax Status form.*
- *If the person is not your spouse, then you should put a check in the box next to "No" on the Declaration of Tax Status form.*

## FLOWCHART FOR DEPENDENT STATUS OF A DOMESTIC PARTNER



- *If your Domestic Partner is your tax dependent for purposes of these plans, then you should put a check in the box next to "Yes" on the Declaration of Tax Status form.*
- *If your Domestic Partner is not your tax dependent for purposes of these plans, then you should put a check in the box next to "No" on the Declaration of Tax Status form.*

# Workers' Compensation Management Bureau

## Program Description

The Workers' Compensation Management Bureau develops programs to enhance the safety of work environments, assist our injured workers in their healing process, and make sure that all injured State of Montana employees are returned to work as soon as medically appropriate following work-related injuries or occupational diseases.

## Who Is Eligible?

All active State employees are eligible for these programs.

## Safety

### Working Safely—Getting Started

The first step toward keeping yourself and others injury-free is awareness of safety tools available.

1. **Be aware** of your environment and head off problems before an injury occurs. Participate in safety training and programs when available to learn how to keep yourself, your work environment, and your coworkers safe.
2. **Use proper safety equipment** and follow recommended safety instructions. Get the right equipment for the job to avoid injury (that includes office work—repetitive motion injuries are a significant portion of our work-related injuries and occupational diseases).
3. **Take safety seriously.** A moment of distraction or carelessness is all it takes to cause a lifetime of disability.
4. **Take responsibility** for keeping yourself and others safe.

Did you know that a recent disability guideline study found workplace injuries increase where there are other health conditions such as obesity and diabetes? Wellness programs focus on prevention, and preventing injuries from happening in the first place is always best!

### Safety Resources

Safety is an integral part of the Workers' Compensation Management programs for State employees. Department of Administration, Department of Labor, and Montana State Fund are cooperating to make sure workers have access to safety management services to reduce the number of work-related injuries and occupational diseases.

## Return to Work

### Reporting an Injury

Work-related injuries and occupational diseases must be reported to our workers' compensation insurance carrier, the Montana State Fund, within 24 hours. The employee and supervisor fill out and send in the First Report of Injury (FROI). Report occupational diseases as quickly as possible. The FROI link can be found online at <http://benefits.mt.gov/pages/wcmb.html>.

If you have any questions about filing a claim, contact your Human Resources staff for assistance.

### Fraud Finders

What is fraud? It is more than an employee faking an injury. It includes medical providers billing excessive or uncompleted medical services or employers falsifying payroll records to lower premiums. When fraud occurs, it costs all of us, and it is **AGAINST THE LAW!**

To report suspicious activity, you can fill out Montana State Fund's online reporting form or call their Fraud Hotline: 888-MTCRIME (888-682-7463). All contacts will remain strictly confidential.

For more information, contact:  
Lance Zanto, Bureau Chief (406) 444-5689  
Stephanie Grover, Safety and Loss Control (406) 444-0122  
Joe Hamilton, Return to Work (406) 444-7016  
<http://benefits.mt.gov/pages/wcmb.html>



**WORKERS' COMPENSATION**  
MANAGEMENT BUREAU



For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications

# Glossary

- Allowable Charges**—A set dollar amount for procedures/services that are covered by the plan
- Annual Deductible**—Applies to all services unless noted or a copayment is indicated
- Balance Billing**—The amount over the plan's allowable fee that may be billed to the member by an out-of-network provider
- Benefit Plan**—Employer sponsored health care coverage
- Benefit Year/Plan Year**—The period starting January 1 and ending December 31 of each year
- Benefits Payment**—Formerly called *Contribution*: The amount an employee, retiree, or legislator pays to participate or for their dependent(s) to participate in a benefit plan
- Capitol Medical Plan**—Plan that offers first-dollar coverage for services such as office visits that are exempt from deductible. This plan also provides differing levels of benefits for in-network and out-of-network providers.
- Certification/Pre-certification**—A determination by the medical plan administrator that a specific service—such as an inpatient hospital stay—is medically necessary. Pre-certification is done in advance of non-emergency admissions by contacting your plan administrator.
- Classic Medical Plan**—Indemnity plan that applies deductible and coinsurance prior to paying benefits. Some services have a higher coinsurance.
- Coinsurance**—A percentage of allowable and covered charges that a member is responsible for paying, *after* paying any applicable deductible. The medical plan pays the remaining allowable charges.
- Copayment**—A fixed dollar amount for allowable and covered charges that a member is responsible for paying. The medical plan pays the remaining allowable charges. This type of cost-sharing method is typically used by managed care medical plans.
- Covered Charges**—Charges for medical services that are determined to be medically necessary and are eligible for payment under a medical benefit plan
- Deductible**—A set dollar amount that a member and family must pay before the medical plan begins to share the costs. The deductible applies to the plan year January 1 to December 31, regardless of hire date.
- Evidence of Insurability**—Proof of good health provided to an insurer to qualify for insurance
- First-Dollar Coverage**—Claim payments start immediately without first applying towards the deductible.
- In-Network Providers**—Providers who contract with the plan administrator to accept a set allowable fee on charges and who agree not to balance bill the member; participating provider
- Joint Core**—An option that is available when both spouses are eligible state employees and have eligible dependents on their coverage. Spouses and children have only one family deductible and one family out-of-pocket maximum, and they may have a slightly lower benefits payment than enrolling separately.
- Open Access Plus**—Cigna's network of providers that State members may use
- Out-of-Network Provider**—Any provider who renders services to a managed care member but is not a participant in the plan's network
- Out-of-Pocket Maximum**—The maximum dollar amount of any coinsurance that a member or family might pay in a plan year. Once the out-of-pocket maximum has been paid, the member or family is not responsible for paying any further allowable charges for the remainder of the benefit year. The out-of-pocket maximum does not include deductibles or copayments. The out-of-pocket maximum applies to the plan year January 1 to December 31, regardless of hire date.
- Participating Provider**—Providers who contract with the plan administrator to accept a set allowable fee on charges and who agree not to balance bill the member; in-network provider
- Prior Authorization**—A process that determines whether a proposed service, medication, supply, or ongoing treatment is covered
- Qualifying Events**—Circumstances in which dependent coverage changes are allowed after the initial hiring period
- 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).
- URx**—A prescription drug management program developed by the State of Montana for all plan members

# STATE OF MONTANA

## HIPAA NOTICE OF PRIVACY PRACTICES

An updated HIPAA notice is now available on our website [www.benefits.mt.gov](http://www.benefits.mt.gov) and was mailed to all members of the State of Montana plan in October 2013. This notice that explains your rights and protections under HIPAA.

To view the full HIPAA Notice of Privacy Practices or 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](mailto:agodbout@mt.gov)  
 Address: Health Care and Benefits Division  
 PO Box 200130  
 Helena, MT 59620-0130

Copies of the Notice are available at 100 North Park Avenue, Suite 320, Helena, MT 59601 and on our web site [www.benefits.mt.gov](http://www.benefits.mt.gov). You may request the Notice by calling the Health Plan or sending a request by email to the above address.

### DISCLAIMER

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.



For complete details about the health care plan, refer to the Summary Plan Document (SPD) available on the website [www.benefits.mt.gov](http://www.benefits.mt.gov) under Forms/Publications



# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved  
OMB No. 1210-0149  
(expires 11-30-2013)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.<sup>1</sup>

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact \_\_\_\_\_.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

<sup>1</sup> An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)	
5. Employer address		6. Employer phone number	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)		12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:  
All employees.

Some employees. Eligible employees are:

- With respect to dependents:  
We do offer coverage. Eligible dependents are:

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

\*\* Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

# ATTACHMENT 1

## ELIGIBLE EMPLOYEE

If you are an employee of a participating department or agency of the State of Montana (State) and are in one of the following classifications, you are eligible to enroll in the State Employee Benefit Plan (State Plan):

- a. Permanent full-time employee;
- b. Permanent part-time or job-share employee regularly scheduled to work 20 hours or more a week and more than six months in any 12-month period;
- c. Seasonal full-time employee:
  - 1) regularly scheduled to work 40 hours or more a week for six months or more a year; or
  - 2) who works 40 hours or more a week for a continuous period of more than six months a year, although not regularly scheduled to do so.
- d. Seasonal part-time employee:
  - 1) regularly scheduled to work 20 hours or more a week for six months or more a year; or
  - 2) who works 20 hours or more a week for a continuous period of more than six months a year, although not regularly scheduled to do so;
- e. Elected official;
- f. Officer or permanent employee of the legislative branch;
- g. Judge or permanent employee of the judicial branch;
- h. Temporary full-time employee:
  - 1) regularly scheduled to work 40 hours or more per pay period for more than six months within a year; or
  - 2) who works for 40 hours or more per pay period for a continuous period of six months or more, although not regularly scheduled to do so; or
  - 3) who is covered under a labor union contract that provides for eligibility.
- i. Temporary part-time employee:
  - 1) Regularly scheduled to work 20 hours or more a week for six months or more within a year; or
  - 2) Who works for 20 hours or more a week for a continuous period of more than six months, although not regularly scheduled to do so; or
  - 3) Whose temporary status is defined under a labor union contract that provides for eligibility.
- j. A part-time or full-time employee of the Montana State Fund; or
- k. Member of the Legislature.

## ATTACHMENT 2

Eligible dependents include:

- a. The eligible employee's lawful spouse or declared domestic partner. Declaration of Domestic Partnership forms may be obtained from Health Care and Benefits Division (HCBP).
- b. The eligible employee's dependent children who are under age 26 and not in full-time active military service. Dependent children are:
  - 1) natural or legally adopted children of the eligible employee or the employee's lawful or declared domestic partner; or
  - 2) any other child with whom the eligible employee maintains a parent-child relationship.
- c. A parent-child relationship means:
  - 1) court-ordered custody of the child by the employee or the employee's lawful or declared domestic partner; or
  - 2) legal guardianship of the child by the employee or the employee's lawful or declared domestic partner.

Eligible disabled dependents:

An employee's dependent children who are incapable of self-sustaining employment by reason of mental or physical disability will continue to be eligible for medical, dental, and life benefits after they turn 26 provided all of the following conditions are met:

- a. The eligible employee continues dependent coverage;
- b. The incapacity commenced before the date the dependent child's coverage would otherwise terminate; and
- c. The child is dependent upon the eligible employee for support and maintenance within the current meaning of the Internal Revenue Code.

**Health Care & Benefits Division**

(800) 287-8266, (406) 444-7462;  
Hearing impaired TTY (406) 444-1421  
email: [benefitsquestions@mt.gov](mailto:benefitsquestions@mt.gov)  
[www.benefits.mt.gov](http://www.benefits.mt.gov)  
100 N Park Ave #320  
PO Box 200130  
Helena, MT 59620-0130



**Montana Health Centers  
Operated by CareHere**



**Helena:** 405 Saddle Dr; (406) 444-9930; (406) 502-1355; Fax (406) 206-0304  
**Billings:** 1501 14th St West, Suite 230;  
(406) 969-5115; Fax (406) 969-5118  
**Miles City:** 515 Main St; (406) 234-0123;  
Fax (406) 234-0278

For live support 24/7 for all health centers call  
(877) 423-1330  
[www.carehere.com](http://www.carehere.com); [help.montana@carehere.com](mailto:help.montana@carehere.com)

**Medical Plans Customer Service and Claims Processing Questions**



**Cigna**  
(855) 692-0131  
[stateofmontana@cigna.com](mailto:stateofmontana@cigna.com)  
[www.mycigna.com](http://www.mycigna.com)  
[www.cigna.com](http://www.cigna.com)

**Cigna's Vision Hardware Plan**



(877) 478-7557  
<https://cigna.vsp.com>

Note: The Cigna Vision Hardware phone number will be effective for State of Montana plan members 1/1/14

**URx Prescription Drug Program Information**

<http://benefits.mt.gov/pages/urx.html>  
Email: [ASKURx@mt.gov](mailto:ASKURx@mt.gov)



**General Questions, Prescription Drug Refills, Customer Service**



**MedImpact**  
(888) 648-6764  
<https://mp.medimpact.com/mtn>

**Mail Order Prescription Drugs**  
MedVantx (877) 870-MONT (6668) or  
Ridgeway Pharmacy (800) 630-3214

**Specialty Meds**  
Diplomat Specialty Pharmacy (877) 319-6337

**Dental Benefits Customer Service and Claims Processing Questions**



**Delta Dental**  
(866) 496-2370  
[www.deltadentalins.com/stateofmontana](http://www.deltadentalins.com/stateofmontana)

**Flexible Spending Accounts, Claims, Eligible Expenses, Account Status, and IRS Rules**



**Allegiance Flex Advantage**  
(866) 339-4310  
FAX: (406) 523-3149 or (877) 424-3539  
[www.allegianceflexadvantage.com](http://www.allegianceflexadvantage.com)

**Life Insurance The Standard Insurance Company**



For questions about benefits, claims, status of applications call:  
(800) 759-8702  
[www.standard.com](http://www.standard.com)

For all other questions call HCBD: (800) 287-8266

**Long Term Disability The Standard Insurance Company**



For questions about benefits, claims, status of applications call:  
(800) 759-8702  
[www.standard.com](http://www.standard.com)

For all other questions call HCBD: (800) 287-8266

The State's health plan no longer offers optional Long Term Care coverage (see page 30).  
For more information contact Unum Life Insurance Company at (800) 227-4165; [www.unum.com](http://www.unum.com)

