HCBD
HEALTH CARE
& BENEFITS DIVISION

State of Montana
2014 Retirees

www.benefits.mt.gov

Dear Retiree,

Enclosed is information about your options to continue with the State Employee Group Benefits Plan as a retiree in 2014. ***If you have already made your retiree elections, disregard this introductory letter.***

You may continue coverage with the State Employee Group Benefits Plan (State Plan) if you are eligible at the time you leave active State employment to receive a monthly retirement benefit under the applicable provisions of your retirement system. You may stay on the State Plan if you are on defined contribution whether you draw a monthly benefit, elect the lump sum distribution, or postpone withdrawal of your benefit.

If you do not continue State Employee Group Benefits, or if you let your coverage lapse, you may not reinstate coverage at a later date.

Transfer Coverage: A retiree may choose to become a dependent of an active or retired spouse/domestic partner on the State Plan while still keeping the right to return to coverage under his or her own name at a later date. A retiree who transfers onto another State Plan member's coverage does not have to begin a new deductible for the remainder of the plan year.

If you transfer to your spouse/domestic partner's coverage and your spouse/domestic partner is an active employee, you may be able to transfer some or all of your plan C elective life insurance. Contact Health Care and Benefits Division (HCBD) for more information. If you transfer to your retired spouse/domestic partner's coverage, you lose all life insurance coverage. If your retiree coverage is reinstated due to termination of your spouse/domestic partner's employment, death, or divorce, and you are not Medicare eligible, Plan A basic life coverage is reinstated.

Your options if you are NOT Medicare eligible: If you stay on the State Plan, are under age 65, and are not Medicare eligible, you must continue core benefits (medical, dental, basic life). Continuing existing medical and/or dental coverage on dependents is optional. You are not eligible for group coverage of elective life or accidental death and dismemberment (AD&D) benefits.

Your options if you are Medicare eligible: If you choose to continue State Plan benefits, and you are age 65 or over or otherwise eligible for Medicare, you must continue medical coverage. Continuing dental for yourself and any existing medical and/or dental coverage on dependents is optional. You are not eligible for group coverage of any life or accidental death and dismemberment (AD&D) benefits.

Medical Plan Choices: At the time you retire, you must decide which medical plan to choose. You can either continue your current medical plan or choose a medical plan with a higher deductible for the remainder of the plan year on the Retiree Election form. You may elect either plan offered during Annual Change. **Medicare retirees** may continue with their current dental, select the less expensive plan, or decline dental at retirement (and change again during Annual Change). **Non-Medicare retirees** may stay on their current dental plan or select the Basic plan if on Premium at retirement. They may change during Annual Change.

IMPORTANT NOTICE TO MEDICARE-ELIGIBLE MEMBERS: At age 65, or any time you or your spouse/domestic partner (if covered by the State Plan) become Medicare eligible and enroll in both Part A and Part B Medicare coverage, ***notify HCBD***. If you do not provide proof of enrollment in Part A and Part B coverage, your State coverage pays claims as the primary carrier. In that case, your rate will continue to be based on the higher non-Medicare benefits rate for you and/or your spouse/domestic partner, and will not drop until you provide proof of Medicare coverage to HCBD. You will receive a refund for overpayment of benefits for up to one year. To assure full coverage, contact your local Social Security Administration office to enroll in Part B, if you have not already done so, and to confirm Part A coverage.

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

MEDICARE PART D ENROLLMENT: Medicare Part D is prescription drug coverage available from Medicare. Most State of Montana retirees will have better prescription drug coverage at a lower cost by keeping the State of Montana plan and not enrolling in Medicare Part D. If you enroll in Medicare Part D, you may not stay on the State's health plan (nor can you return to the plan later). For more information, call HCBD.

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

Vision Coverage: Retirees who continue core benefits may also continue optional vision hardware coverage. Coverage benefits are described in detail on page 32.

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

The term SPD used in this book refers to the Summary Plan Document that is available on the benefits website at http://benefits.mt.gov/pages/1.files/spd.revision.2013.pdf

Dependent Coverage Options: Continuing existing medical and/or dental and/or vision hardware coverage on dependents is optional. If you want to continue existing medical coverage for your dependents, make this election within 60 days after your employee coverage terminates. To continue dependent dental and/or vision hardware coverage, the retiree must also continue dental and/or vision hardware coverage.

New dependents can only be added to medical and/or dental and/or vision mid-year if the request is made within 60 days of a qualifying event (marriage, birth, adoption, etc). Existing dependents can only be added to medical if they are losing eligibility for other group coverage and the request is made within 60 days of the termination date of the other coverage.

Flexible Spending Account Options: If you did not pre-pay the remainder of your annual flexible spending account election from your final paycheck, your account terminates the end of the month in which full or partial payment has been made. You have 120 days after the date your account terminates to submit receipts for eligible expenses incurred during the time your account was active (between January 1 and the date your employee coverage terminates in the year you retire).

If you submit receipts more than 120 days after your account terminates, you will not be eligible for reimbursement for those expenses.

Payment Options:

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

2) Monthly Self-Payment to HCBD: Benefits payments are due on the first of each month with a 10 day grace period. You will not receive a monthly bill. HCBD provides a payment book. VEBA reimbursement falls in this category. With VEBA you will be reimbursed directly for your out-of-pocket benefits payments.

3) Electronic Deduction of Benefits Payments from a Checking or Savings Account: Benefits payments are deducted from the designated account on the 6th of each month or the following working day if the 6th falls on a weekend or holiday. You must complete an Electronic Benefits Payments Deduction Authorization form (included in this packet).

4) Pre-payment Prior to Leaving: You may prepay benefits payments out of your final check. This option is only available if your final paycheck has not been received. To pre-pay, you must complete a Retiree

Pre-Payment Option form, a Retiree Statement of Current Coverage, and life forms if applicable (included in this packet if you have not yet retired). CONTINUED →

Mark your method of payment on the Retiree Election form. If you do not check an option, we will assume that you are self-paying monthly.

How to Continue Coverage: Complete the Retiree Election form and return the white copy to HCBD, PO Box 200130, Helena MT 59620-0130.

LIFE INSURANCE CONVERSION INFORMATION

Upon loss of eligibility for group life insurance coverage with the State of Montana, State Plan members are eligible for conversion to an individual policy with the carrier, OR the member may exercise the option of portability.

A member loses eligibility for group life coverage when:

1) The member retires from the State of Montana: If under age 65 and not Medicare eligible, Basic Life – Plan A, must be continued at the group rate. If over age 65 or otherwise Medicare eligible, Plan A may be converted to an individual policy. All remaining group life insurance is lost, and all except Accidental Death and Dismemberment (AD&D) are eligible for conversion.

2) The retiree becomes Medicare eligible after retirement from the State of Montana: The Basic Life Plan A may be converted to an individual policy.

NOTE: If you retired before age 60 and are permanently and totally disabled, you may qualify for a waiver of benefit payment through The Standard Life Insurance. Contact HCBD for more information.

All members who lose eligibility for the State Plan (described above) have life insurance coverage for an additional 60-day period following the termination date of their State Plan coverage. **This is the conversion period**. In order for life insurance coverage to be continued after the conversion period, the member must: 1) request conversion information before the end of their conversion period; and 2) complete and return all forms, along with payment, to The Standard Insurance Company.

If you are under age 65 and not receiving Medicare, complete and return the Life Insurance Enrollment/ Change form and the Life Insurance Beneficiary Designation form, which are included in this packet.

We strongly recommend that you contact The Standard Life Insurance Company at (800) 378-4668 ext 6785 or HCBD at (800) 287-8266 or TTY (406) 444-1421 to discuss the portability and conversion options.

Our Wellness Discount for 2014:

The Two Step Health Screening Process + Cigna Motivate*Me Program*®

Stay tuned for details about Motivate*Me*® starting in January 2014!

Beyond the two steps for our health screening discount, we will have the Cigna Motivate*Me* Program®

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

Being tobacco-free[1] 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 *or call CareHere (877) 423-1330*

Then...

Step 2: Fill out Cigna's online Health Assessment (HA) ***using the numbers from your health screening***[2] by going to 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[1] 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—then in 2015 you get a discount for your health screening and more if you are tobacco-free ***(the exact discount amounts have not been set).*** If your eligible dependent completes both steps, you get another discount + more if they are tobacco-free.

For details, go to www.benefits.mt.gov or contact Health Care and Benefits Division (HCBD) at (800) 287-8266, TTY (406) 444-1421, or benefitsquestions@mt.gov.

[1]*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.*

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

Cigna®

CareHere!

What's Inside

Motivate*Me*™ 3
Summary of Benefits and Coverage (SBC) –required by healthcare reform 5
Benefits at a Glance 21
Medical Plans 22
Worksheet 23
Rates 24
Plan Details (Schedule of Benefits) 25
Covered Preventive Services 28
URx Prescription Drug Plan 29
Dental 30
Vision Hardware Plan 32
Montana Health Center 33
Weight Management 34
Tobacco Cessation 35
Stress Management 36
Disease Management 37
Health Pregnancies, Healthy Babies® 38
HCBD Wellness 38
Life Insurance 39
Eligibility (Allowed Dependent Changes; Qualifying Events) 40
HIPAA Notice 41
Glossary 42
Notice of Marketplace Exchange—required by healthcare reform 43
Contact Information ..... Back cover

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 or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$500** person / **$1,000** family For out-of-network providers **$750** person / **$1,750** 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 **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$2,500** person / **$5,000** family / For out-of-network providers **$4,250** person / **$9,500** family	The **out-of-pocket limit** 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.
What is not included in the out-of-pocket limit?	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 **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see **www.myCigna.com or call 1-800-Cigna24**	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	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 **excluded services**.

- **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	
If you visit a health care provider's office or clinic	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
If you have a test	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.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://benefits.mt.gov/pages/urx.html	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

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	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.
If you need immediate medical attention	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
If you have a hospital stay	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.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Visits 1-4 in an Office Setting: No charge Visits 5 and beyod 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 beyod 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.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you are pregnant	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.
If you need help recovering or have other special health needs	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 3 0 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.
If your child needs dental or eye care	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.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children)	• Habilitation services • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Prescription drugs	• Private-duty nursing • Routine foot care • Weight loss programs

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.)		
• Chiropractic care		

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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. 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.

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, kwiijigo holne' 1-800-244-6224.

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

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:** $5,160
- **Patient pays:** $2,380

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
Total	**$7,540**

Patient pays:

Deductible	$500
Co-pays	$20
Co-insurance	$1,690
Limits or exclusions	$170
Total	**$2,380**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $820
- **Patient pays:** $4,580

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
Total	**$5,400**

Patient pays:

Deductible	$140
Co-pays	$120
Co-insurance	$0
Limits or exclusions	$810.78
Total	**$1,070.78**

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

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 or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$1,000** person / **$2,250** family For out-of-network providers **$1,000** person / **$2,250** family Does not apply to in-network preventive care , prescription drugs	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$5,000** person / **$11,250** family / For out-of-network providers **$5,000** person / **$11,250** family	The **out-of-pocket limit** 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.
What is not included in the out-of-pocket limit?	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 **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see **www.myCigna.com or call 1-800-Cigna24**	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	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 **excluded services**.

- **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	
If you visit a health care provider's office or clinic	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 7 ehabilitation 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 M
If you have a test	Diagnostic test (x-ray, blood work)	25% co-insurance	35% co-insurance	50% penalty for no precertification.
	Imaging (CT/PET scans, R7 ls)	25% co-insurance	35% co-insurance	50% penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition Rore information about **prescription drug coverage** is available at http://benefits.mt.gov.pages/urx.html	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
If you have outpatient surgery	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.
If you need immediate medical attention	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----------
If you have a hospital stay	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.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Rental/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.
	Rental/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.
If you are pregnant	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.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	25% co-insurance	35% co-insurance	50% penalty for no precertification. Coverage is limited to M0 days annual max. R aximums cross-accumulate.
	7 ehabilitation services	25% co-insurance	35% co-insurance	50% penalty for failure to precertify speech therapy services. Coverage for 7 ehabilitation, including Cardiac rehab and Chiropractic care, services is limited to 3 0 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 M0 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.
If your child needs dental or eye care	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.)		
• Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Habilitation services	• Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Prescription drugs • Private-duty nursing	• 7 outine foot care • Weight loss programs

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.)		
• Acupuncture • Chiropractic care		

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 1-866-444-32M2 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-8MM26M-2323 x61565 or 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 (32M2) or 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: Rontana Consumer Affairs Program at 800-332-6148. However, for information regarding your own state's consumer assistance program refer to 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, kwiijigo holne' 1-800-244-6224.

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

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:** $M540
- **Plan pays:** $4,810
- **Patient pays:** $2,M80

Sample care costs:

Hospital charges (mother)	$2,M00
7 outine Obstetric Care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
7 adiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductible	$1,000
Co-pays	$0
Co-insurance	$1,560
Limits or exclusions	$1M0
Total	**$2,730**

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
Redical equipment and supplies	$1,300
Office visits & procedures	$M00
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductible	$990
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$810.78
Total	**$1,800.78**

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 (H7 As) that help you pay out-of-pocket expenses.

Plan ID: 9M904
Plan Name: Open Access Plus Classic

2014 Retiree Benefits at a Glance

Payment Options:
- Automatic Deduction from MPERA benefit
- Monthly self-payment to HCBD (includes VEBA reimbursement)
- Electronic deduction from checking or savings
- Pre-pay out of final paycheck for the remainder of the benefit year ***(This option is only applicable if you have not yet received your final paycheck)***

Non-Medicare Retirees:

Required: **Core Benefits Plan**
- ⇒ Medical (on self)
- ⇒ Dental (on self)
- ⇒ Basic Life ($14,000 term life insurance)

Optional:
- Dependent Medical coverage
- Dependent Dental coverage
- Vision hardware coverage (self and/or dependents; *dependents must be on medical to be eligible for vision hardware*)

Cancelled:
- ∗ Optional Supplemental Life Insurance *(existing coverage is convertible to an individual policy within 60 days)*
- ∗ Flexible Spending Accounts (unless pre-paid out of the final check for the remainder of the benefit year)
- ∗ Long Term Disability
- ∗ Pre-tax Plan

Medical Plan Options:
Capitol
Classic

Dental Plan Options:
Basic
Premium

Medicare-Eligible Retirees:

Required:
- ⇒ Medical (on self)

Optional:
- Dependent Medical coverage
- Dental coverage (self & dependents)
- Vision hardware coverage (self & dependents; *dependents must be on medical to be eligible for vision hardware*)

Cancelled:
- ∗ All Life Insurance (existing optional life insurance is convertible to an individual policy within 60 days.)
- ∗ Flexible Spending Accounts (unless pre-paid out of the final check for the remainder of the benefit year)
- ∗ Long-Term Disability
- ∗ Pre-tax Plan

Medical Plan Options:
Capitol
Classic

Dental Plan Options:
Basic
Premium

Spouse/Domestic Partner Coverage Options

1. If you work for the state but your spouse/domestic partner does not, you may continue existing coverage for your spouse/domestic partner after you retire. If your spouse/domestic partner is not currently covered under your plan, you may only add your spouse/domestic partner to your coverage within 60 days after your spouse/domestic partner loses eligibility for other coverage.
2. If you and your spouse/domestic partner both work for the state, the working spouse/domestic partner may cover the retired spouse/domestic partner. The retired spouse/domestic partner retains the right to return to the State Plan as a retiree instead of being covered by the working spouse/domestic partner. You may not use VEBA for reimbursement for the retiree payments if the spouse/domestic partner is still working. Both spouses/domestic partners must be retired to use VEBA.

Note: Dependent medical or dental coverage can only be continued if the retiree continues coverage.

Medical coverage includes the prescription drug plan, an annual eye exam, health screenings, and the employee/retiree assistance program.

How to Elect: You must notify HCBD if you want to continue benefits coverage by completing the Retiree Election form ***within 60 days of your retirement.***

Capitol and Classic Plans

Who is Eligible?

Employees, legislators, retirees, COBRA members, and dependents (spouse, domestic partner, children) are eligible for the medical plan. For dependent eligibility, see page 41.

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 25 or visit our website www.benefits.mt.gov under RETIREES 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 https://cigna.vsp.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. 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 this example and assume this is your fourth visit this plan year to your in-network doctor's office for sinusitis. Let's assume **you have paid $600 this year and therefore met your deductible.**

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).

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.

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
			Your total cost:	**$37.50**

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
			Your total cost:	**$170**

There is a *third* option. All eligible members *(must not be eligible for Medicare to use the health centers for services other than health screenings and flu shots)* on the medical plan may use any of the health centers. See page 33 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
Your total cost:	**$0**

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

Monthly Out-of-Pocket Benefit Costs Worksheet

for Retirees

Primary Benefits

At age 65:

- Dental becomes optional and
- The Retiree is no longer eligible for Basic Life insurance

Medical Plans (See rates on page 24)	Choose Capitol or Classic	Cigna	$_____ (a)
Dental Plans (See rates on page 30)	Choose Basic or Premium	Delta Dental	$_____(b)
Basic Life Insurance of $14,000 Available to retirees under age 65 and not Medicare eligible (See page 39)	Non-Medicare retirees add $1.90 for Basic Life		$_____ (c)
Total Core Benefits Contribution		**Add lines a, b, and c =**	$_____(d)

Optional Benefits

Vision hardware (See rates on page 32)		$_____(e)
Optional Benefits Contribution Total	**Line e =**	$_____(f)

Totals

Primary Benefits	Enter amount from line d	$_____(g)
Optional Benefits	Enter amount from line f	$_____(h)
Total Benefits	Add lines g and h	$_____(i)
Health screening discount		$_____(k)
Tobacco-free discount		$_____(l)

Details about the health screening and wellness discounts through Cigna's MotivateMe® *program will be available to members starting in January 2014. Watch for information on www.benefits.mt.gov and in newsletters and emails.*

Total Monthly Out-of-Pocket Costs for 2014	Subtract lines k and l from line i	$_____

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

Retiree Rates—Monthly Benefits Payment

Non-Medicare Retirees	Capitol Plan	Classic Plan
Retiree only	$734	$772
Retiree & spouse/domestic partner	$1,037	$1,083
Retiree & children	$880	$923
Retiree & family	$1,061	$1,109
Retiree & Medicare spouse/domestic partner	$881	$923
Retiree, Medicare spouse/domestic partner, & children	$933	$976

Medicare Retirees	Capitol Plan	Classic Plan
Medicare only	$299	$314
Medicare & spouse/domestic partner	$594	$624
Medicare & children	$489	$513
Medicare & family	$622	$652
Medicare & Medicare spouse/domestic partner	$521	$546
Medicare, Medicare spouse/domestic partner, & children	$532	$559

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

	My Cost—**Select In-Network**	My Cost—**Select Out-of-Network**
Annual Deductible* Applies 1/1/14 — 12/31/14	$500/member $1,000/family	A separate $750/member A separate $1,750/family
Coinsurance Percentages for provider charges	25%	35% + balance billing
Coinsurance Percentages for facility charges	25%	35% + balance billing
Annual Out-of-Pocket Max*	$2,500/member $5,000/family	A separate $4,250/member A separate $9,500/family + balance billing

Classic Plan

	My Cost—**Classic In-Network**	My Cost—**Classic Out-of-Network**
Annual Deductible* 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
Coinsurance Percentages for provider charges	25%	35% + balance billing
Coinsurance Percentages for facility charges	25%	35% + balance billing
Annual Out-of-Pocket Max*	$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 Maximum

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

Plan Details—*What the Member Pays*

	Capitol Plan		Classic Plan	
Office/Routine Care				
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office visits	$15/visit (covers office visit charge only)	35% + balance billing D	25%[1] D	35% [1] + balance billing D
Professional outpatient physical, occupational, cardiac, pulmonary, & speech therapy (max 30 combined days/yr)	$15/visit[3] (copay applies to each visit)	35% + balance billing[3] (coinsurance applies to each visit) D	25% [3] (coinsurance applies to each visit) D	35% + balance billing[3] (coinsurance applies to each visit) D
Professional Lab/Diagnostic/ Injectables	25% (no deductible on injectables without an office visit) D	35% + balance billing D	25% D	35% + balance billing D
Durable medical equipment and prosthetics 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
Allergy shots	$15 for office visit + 25% coinsurance; (no deductible; 25% coinsurance if no office visit) D	35% + balance billing D	25%	35% + balance billing D
Hospital Care				
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient services	25% D	35% + balance billing D	25% D	35% + balance billing D
Outpatient services and Surgical Center Services	25% D	35% + balance billing D	25% D	35%+ balance billing D
Organ transplant—Prior authorization, pre-certification, case management are required.	25% D	Not covered	25% D	35% + balance billing D
Mental Health and Substance Abuse				
	In-Network	**Out-of-Network**		
Outpatient professional services[2] 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
Inpatient services[2]	25% D	35% + balance billing D	25% D	35% + balance billing D

[1] *No deductible for first two non-routine visits*
[2] *Residential programs for mental health and/or chemical dependency are not covered by this plan*
[3] *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 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**
Ambulance services for medical emergency	25% D	25% + balance billing D	25% D	25% + balance billing D
Emergency department and hospital charges—Capitol plan copay includes all services (no deductible or coinsurance); copay waived if admitted, then all inpatient benefits apply[1]	$250/visit for facility charges[1] + $100 for physician services	$250/visit for facility charges[1] + $100 for physician services + balance billing	25% D	25% + balance billing D
Emergency department Professional and ancillary charges	N/A	N/A	25% D	25% + balance billing D
Urgent care facility and professional charges	$35 (covers visit charge only)	$35 (covers visit charge only) + balance billing	25% D	25% + balance billing D
Urgent care ancillary—lab/ diagnostic/surgical charges	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**
Home health care	$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
Hospice	25% D	35% + balance billing D	25% D	35% + balance billing D
Skilled nursing	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
Inpatient rehabilitation (max 60 days per year total) See the SPD for details[2]	25% D	35% + balance billing D	25% D	35% + balance billing D
Maternity Services				
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital charges	25% D	35% + balance billing D	25% D	35% + balance billing D
Physician charges	25% D	35% + balance billing D	25% D	35% + balance billing D
Ultrasounds	25% D	35% + balance billing D	25% D	35% + balance billing D

[1] *If there is an admission from the emergency department, be sure to authorize follow up care*
[2] *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 under Forms/Publications

Plan Details—*What the Member Pays*

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

[1] 20 days maximum for chiropractic care on the Classic plan
[2] 10 days maximum for acupuncture care on the Classic plan
[3] 10 days maximum for naturopathic care on the Classic plan

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 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).

Periodic exams—Appropriate screening tests (see the SPD for a full list of tests)	
Well child care Infant through age 17	Age 0 months through 4 year—up to 14 visits Age 5 years through 17 years—one visit per plan year
Adult routine exam Exams may include screening/counseling and/or risk factor reduction interventions for depression, obesity, tobacco use, drug and/or alcohol abuse	Age 18 through 65+—one visit per plan year
Preventive screenings	
Anemia screening (CBC)	Pregnant women
Bacteruria screening (UA)	Pregnant women
Breast cancer screening (mammography)	Women age 40+—one per plan year
Cervical cancer screening (PAP)	Women age 21 through 65—one per plan year
Cholesterol screening (lipid profile)	Men age 35+ (age 20-35 if risk factors for coronary heart disease are present) Women age 45+ (age 20-45 if risk factors for coronary heart disease are present)
Colorectal cancer screening age 50+	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.
Prostate cancer screening (PSA) age 50+	One per plan year (age 40+ with risk factors)
Osteoporosis screening	Post menopausal women—65+ (60+ with risk factors)—one bone density x-ray (DXA) every two years
Abdominal aneurysm screening	Men 65-75 who have ever smoked: one ultrasound screening per plan year
Diabetes screening (fasting A1C)	Adults with high blood pressure
HIV screening **STD screening**	Pregnant women and others at risk Persons at risk
RH incompatibility screening	Pregnant women
Routine immunizations	
Diphtheria, tetanus, pertussis (DTaP; Tdap; TD), haemophilus influenza (HIB), hepatitis A & B, human papillomavirus (HPV), influenza, measles, mumps, rubella (MMR), meningococcal, pneumococcal (pneumonia), poliovirus, rotavirus, varicella (smallpox); for age 50 and older: zoster (shingles)	

Prescription Drug Plan

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
Excellent value based on medical evidence	A	$0	$0 copay	$0 copay
High value based on medical evidence	B	$0	$15 copay	$30 copay
Good value based on medical evidence	C	$0	$40 copay	$80 copay
Lower value based on medical evidence	D	$0	50% coinsurance[1]	50% coinsurance[1]
Lowest value based on medical evidence	F	$0	100% coinsurance[1]	100% coinsurance[1]
You may purchase **specialty drugs** 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[1]	Not covered

[1]*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? HCBD wants to help!

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

Administered by Delta Dental (866) 496-2370
www.deltadentalins.com/stateofmontana

Dental

DELTA DENTAL

	Monthly Cost Basic Plan	Monthly Cost Premium Plan
Member only	**$17.50**	**$35.00**
Member and spouse/domestic partner	**$27.00**	**$53.50**
Member and children	**$26.00**	**$52.00**
Member and family	**$30.00**	**$60.00**

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 31 for a list of Types A, B, and C services.

We have **two networks** with Delta Dental—PPO℠ and Premier®. 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.

Eligibility	Employees, Legislators, Retirees[1], spouses, & eligible dependent children up to age 26	
Deductibles	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
Maximums	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.	

[1]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.
- 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**
Type A Services[1] 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
Type B Services	Not a covered benefit	Not a covered benefit	Not a covered benefit
Type C Services	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**
Type A Services[1] 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
Type B Services[1,2] Endodontics, periodontics, extractions, oral surgery, composite fillings	80% of maximum contract allowance	80% of maximum contract allowance	80% of maximum contract allowance + balance billing
Type C Services[1,2] Crowns, bridges, initial dentures	50% of maximum contract allowance	50% of maximum contract allowance	50% of maximum contract allowance + balance billing

[1] *See the SPD on www.benefits.mt.gov for a full list of types A, B, and C services*
[2] *Deductible applies*

Find a dentist, view claims, check benefits, and manage your profile online and on your mobile phone
www.deltadentalins.com/stateofmontana

Benefits and Covered Services	Limitations / Maximums
Type A Services	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
Type B Services	See the HCBD website or the SPD for a full list of covered services and limitations
Type C Services	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 under Forms/Publications

Vision Hardware Plan *(Optional)*

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

Now all you have to decide is if you want to purchase vision hardware coverage—your eye exam is already 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.**

Another change is 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 new network is Cigna Vision Network. Check their website https://cigna.vsp.com to see all the in-network providers.

You must elect this plan. If you have vision now, you do not automatically get the Vision Hardware plan. You must select it during annual change.

Who is Eligible?

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

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

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

Vision Hardware	2014 Monthly Cost
Member only	$5.76
Member and spouse/domestic partner	$10.86
Member and children	$11.42
Member and family	$16.76

Members who choose the Vision Hardware plan in addition to the medical plan receive:		
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	**Plan Pays:** 100% after Copay 100% after Copay 100% after Copay 100% after Copay	**Plan pays:** Up to $45 Up to $55 Up to $65 Up to $80
Contact Lenses Allowances: (one pair–*one time benefit per plan year*—instead of lenses) Elective Therapeutic (must meet medically necessary criteria)	**Plan pays:** $130 Covered 100%	**Plan pays:** Up to $95 Up to $210
Frame Retail Allowance (one per frequency period)	**Plan pays:** Up to $130	**Plan pays:** Up to $52

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

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 eligible members can receive primary care, health screenings, health coaching, and more!

Non-Medicare retirees may receive all services at health centers. **Medicare retirees** may receive health screenings and flu shots at health centers.

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 in person with a registered dietitian or exercise or behavioral health coach for members who can travel to a health center.

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

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** covered on the plan
  - ⇒ ***Medicare retirees may use the health center for health screenings and flu shots***

To schedule or change an appointment *ONLINE*:

www.carehere.com or email CareHere at help.montana@carehere.com

The first time you go to www.carehere.com, you will need to register. The system will ask you for your code. The code is **MANA9**.

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
   (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. And you can always call (877) 423-1330 to make your appointment at the health center.

For directions to download your results, see the health center page on www.benefits.mt.gov and click the brochure.

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

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

Operated by CareHere
In Helena: 405 Saddle Dr; (406) 444-9930; (406) 502-1355
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

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

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** 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 who can travel to a health center for face to face support. See page 33 for eligibility to use the health centers.

Schedule your first appointment at:
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 Registerd Dieticians
- 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 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 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 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)
- 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)

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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.

To schedule your first appointment with a coach, log on to www.carehere.com, or call 406.444.9930 or 877.423.1330.

You can have your own personal Tobacco Cessation Coach work with you over the phone or online through the Montana Health Center in Helena or at the new health center in Billings.

The "Beat the Pack/Kick the Can" tobacco cessation program includes an initial consult in person, or via telephone or Skype, depending on where you live. 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. Medications will be available if deemed appropriate. Please contact CareHere for more information.

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 3 for details.

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

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

Cigna®

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STRESS MANAGEMENT with CareHere

Schedule your first appointment at:

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

To log into CareHere Connect, go to 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!®

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** 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

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CareHere's DISEASE MANAGEMENT

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

To learn more about CareHere's program, visit **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.

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.

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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 **Retiree 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 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!

TheStandard® Positively different.

Life Insurance

Who Is Eligible? The *Basic Life Insurance* plan is a core benefit for all active employees, legislators, and **non-Medicare retirees**.

	Plans	Monthly Contributions
Plan A:	Basic Life	$1.90 per month

BASIC LIFE INSURANCE

Life insurance gives a set amount of money to a designated beneficiary if the person insured dies while the policy is in effect.

At retirement, Plan A—Basic Life— can be continued **until age 65 or the retiree is Medicare eligible**.

Plan A – Basic Life

Provides $14,000 of term-life coverage, a core benefit for any member of the State's health insurance. It is available to retirees under age 65 who keep their state benefits into retirement.

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

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

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

However, without answering medical questions, both **conversion** (changing your group life to individual life) or **portability** (taking your group life insurance with you after separation) may be available if requested when the coverage ends.

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 with life insurance have this benefit!* Call (800) 527-0218 for more information.

Administered by The Standard Insurance Co
(800) 759-8702 • www.standard.com

Eligibility (Allowed Dependent Changes, Information, Qualifying Events)

Enrolling Dependents During Annual Change

During annual change you have some options for adding eligible dependents to benefits coverage.

- You may add your dependent child up to age 26, spouse, or domestic partner to dental.
- If your dependent child, spouse, or domestic partner is already covered on your medical plan, you may add them to vision.
- You may add dependent children up to age 26 to medical during annual change.
- You may only add a spouse or domestic partner to medical if the State offers open enrollment for spouses/domestic partners. *Contact HCBD for information on open enrollment. Open enrollment does not happen every year during annual change.*

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) 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 listed circumstances 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.

Deleting Dependents

You may delete a dependent at any time, but once a dependent is removed from the medical plan, they ***may not be re-enrolled*** without a qualifying event (described above on this page).

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

Eligible Dependents Defined

Eligible dependents include:

1. The eligible retiree's lawful spouse or declared domestic partner (you can find the form at www.benefits.mt.gov under FORMS);
2. The eligible retiree'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).

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.

STATE OF MONTANA
HIPAA NOTICE OF PRIVACY PRACTICES

An updated HIPAA notice is now available on our website www.benefits.mt.gov and is being 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
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. 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.

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

Health Care & Benefits Division

(800) 287-8266, (406) 444-7462;
Hearing impaired TTY (406) 444-1421
email: benefitsquestions@mt.gov
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; help.montana@carehere.com

Medical Plans Customer Service and Claims Processing Questions

Cigna
(855) 692-0131
stateofmontana@cigna.com
www.mycigna.com
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

Mail Order Prescription Drugs

MedVantx (877) 870-MONT (6668) or
Ridgeway Pharmacy (800) 630-3214

General Questions, Prescription Drug Refills, Customer Service

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

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

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

Life Insurance

The Standard Insurance Company
For questions about benefits, claims, status of applications call:
(800) 759-8702
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

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