

**2015 State of Montana
NEWLY RETIRING
Benefit Book**



Introduction

Dear State of Montana Retiree,

Congratulations on your upcoming retirement! At Health Care and Benefits, we know this can be a busy and sometimes confusing time.

Enclosed in this book you should find good information to help guide you in making decisions about your health benefits in retirement. Please be sure to read this book thoroughly and refer any questions to Health Care and Benefits Division or a certified insurance agent.

Keep in mind that as a retiree, you no longer receive a State Share contribution as this was part of your employment benefits. You may, however, elect to stay on the State Health Plan and pay the retiree rate for your benefits. These rates are listed on p. 14.

Because of the increased options available through the Affordable Care Act and Medicare, many retirees may find it beneficial to consider switching from the State Health Plan to a plan available on the Health Insurance Marketplace (under 65) or a Medicare Supplement Plan (over 65). While making changes to your health coverage can be scary, here are a few things to keep in mind:

- If you are under 65, Federal premium assistance may be available to significantly reduce your monthly premium if you purchase a plan through the Health Insurance Marketplace at www.healthcare.gov.
- You have the right to return to the State of Montana Plan one time if you try a new plan and don't like it. (See the "retreat rights" language on pg. 6)
- You have free access to an expert who can answer your questions about health coverage options, and even get you signed up for a new plan. You should seek professional advice from a certified exchange agent or other qualified assister, particularly concerning the timing of changing your coverage.

Unfortunately, there is no "silver bullet" to solve the problem of rising health care costs, but Health Care and Benefits is committed to seeking new and innovative ways to keep costs down while providing the top level benefits State of Montana employees and retirees deserve.

Your partners in good health,

The HCBD Staff



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Retiree Benefit Details

This book contains information about your options to continue with the State Employee Group Benefits Plan as a retiree in 2015.

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.

Keep in mind that if you discontinue your enrollment in the State Health Plan in order to enroll in a Health Insurance Marketplace plan or Medicare supplement plan, you may be eligible for Retreat Rights. See page 6 for more details. If you discontinue your enrollment or let your coverage lapse for any other reason, you may not reinstate coverage in the State Health Plan 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). You may stay on your current dental plan or select the Basic plan if on Premium at retirement. 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 may continue with your current dental, select the less expensive plan, or decline dental at retirement (and change again during

Annual Change). You are not eligible for group coverage of any life or accidental death and dismemberment (AD&D) benefits.

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 retirement, you must act promptly to **avoid penalties by Medicare** for late enrollment. Contact HCBD for a letter verifying your State Plan coverage for Medicare purposes.

MEDICARE PART D ENROLLMENT: Medicare Part D is prescription drug coverage available through insurance providers who are licensed to sell Medicare supplements and Part D coverage. State of Montana retirees may have better prescription drug coverage at a lower cost by keeping the State of Montana plan and not enrolling in Medicare Part D. Please visit with a licensed insurance representative to compare programs. If you enroll in Medicare Part D, you may not stay on the State's health plan and may not return to the plan. However, if you enroll in Medicare Part D in addition to a Medicare supplement plan, you may be entitled to Retreat Rights. Please see page 6 or contact HCBD for more information.

DISABILITY WAIVER OF LIFE INSURANCE

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

VISION COVERAGE: Retirees who continue core benefits may also continue optional vision hardware coverage. Coverage benefits are described in detail on page 21.

LONG TERM DISABILITY COVERAGE: If enrolled in long term disability, your coverage ends the date you retire.

Retiree Benefit Details Cont.

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 may 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 may 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. If you did pre-pay the remainder in your final paycheck, your FSA will continue until the end of the year in which you retire. 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:

Mark your method of payment on the Retiree Election form. If you do not check an option, we will assume that you are self-paying monthly. You must send first month's payment with your forms.

1) Automatic Deduction from MPERA Benefit

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

2) Monthly Self-Payment to HCBBD: Benefits payments are due on the first of each month with a 10 day grace period. You will not receive a monthly bill. HCBBD 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).

HOW TO CONTINUE COVERAGE: Complete the Retiree Election form and return the white copy to HCBBD, 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.

All members who lose eligibility for the State Plan (described above) have life insurance coverage for an additional 31-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 or HCBBD at (800) 287-8266 or TTY (406) 444-1421 to discuss the portability and conversion options.

2015 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 in which you retire.)
- * Long Term Disability
- * Pre-tax Plan

Medical Plan Option:

Capitol

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 in which you retire.)
- * Long-Term Disability
- * Pre-tax Plan

Medical Plan Option:

Capitol

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 may only be continued if the retiree continues coverage.

Medical coverage includes the prescription drug plan, an annual eye exam, and health screening.

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.*

Retiree Alternative Coverage Options

What factors should I consider when choosing coverage options?

- **Premiums:** The State of Montana retiree premiums for coverage have increased. Coverage sold through the online Health Insurance Marketplace may be less expensive, however, the cost sharing may be significantly higher.
- **Guaranteed Issue:** Non-Medicare retirees cannot be denied coverage or charged more for coverage because of pre-existing conditions for plans on the health insurance marketplace.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You should see if your current health care providers participate in a network as you consider options for health coverage.
- **Service Areas:** Some plans do not have extensive out of state healthcare provider networks. You should check out of state network access if you travel for extended periods of time. If you move permanently to another area of the country, you will need to inform your insurer immediately and you may need to change your health plan or Medicare supplement coverage. Some health plans for sale in the Health Insurance Marketplace have narrower networks, but those plans are often cheaper.
- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You should check to see if your current medications are listed in the drug formularies for other health coverage.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, if you purchase coverage in the Health Insurance Marketplace, you will pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. The cost sharing varies significantly among the different plans offered in the Health Insurance Marketplace, so you should shop carefully for a plan that fits your health and financial needs. For example, one option may have much lower monthly premiums, but a much higher deductible, coinsurance and maximum out of pocket.
- **Out-of-network:** Healthcare services from out-of-network providers have very high cost-sharing in all individual health insurance plans.



When can I enroll in Marketplace coverage:

It is recommended that you investigate Marketplace options at least 30 days prior to retirement.

Retirement is considered a qualifying event that triggers a special 60 day enrollment opportunity outside of the Marketplace's normal Open Enrollment period. Visit www.healthcare.gov or talk to a navigator, Certified Application Counselor (CAC), or certified exchange agent to learn more about enrollment and to shop for plans.

Retreat Rights for Retirees

Retirees choosing to leave the State of Montana Health Plan for a Marketplace plan or a Medicare Supplement plan will have a one-time opportunity to return to the State of Montana retiree plan during an annual change enrollment period. Retirees must notify the Health Care and Benefits Division within two years of their benefit coverage termination date, and they will be allowed to re-enroll in the next annual change period, typically held in September and October of each year. Your coverage will be effective January 1 of the next plan year.

WARNING to VEBA Participants

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

Retiree Alternative Coverage Options UNDER 65

Under 65

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

Health Insurance Marketplace

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

Through the Marketplace you:

- Could be eligible for a new kind of tax credit that lowers your monthly premiums and offers cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away.
- Can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.
- Can learn if you qualify for free or low-cost coverage from Medicaid.



Being offered State of Montana retiree coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace. However, you must plan to disenroll from your retiree plan before you begin to receive premium tax credits. You should consult with a professional assister (see below) or insurance agent about this process.

Contact a Certified Assister for FREE

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

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

Navigators are public advisors who help people compare the health insurance options in the new Marketplace website. Navigators have taken federal and state training and have been fingerprinted and undergone a Montana background check.

Note: You should consult only with agents and assisters who are certified by the Montana Insurance Commissioner.

A list of these experts can be found at:

Web: www.montanahealthanswers.com/talk-to-a-human/ Scroll down to see contact lists for Navigators, CACs, and agents in your area.

Call: The Office of the Commissioner of Securities and Insurance 1-800-332-6148



Health Insurance Marketplace Cost Examples

The examples below are *estimates only* based on 2015 health plans.

Cost Examples	Stan	Joe and Irene
Age(s)	61	62/64
Location	Lewis & Clark County	Yellowstone County
Household Income	\$29,000/year	\$39,000/year
State of Montana Plan Cost	\$931/month	\$1314/month
Gold Plan Cost BEFORE subsidy	\$660/month	\$1,407/month
Gold Plan Cost AFTER federal tax subsidy	\$305.25/month	\$484/month

- The estimate above for the individual describes the cost of a Gold level plan with a \$750 deductible/70% coinsurance/\$4,500 out-of-pocket maximum.
- The estimate above for the couple describes the cost of the same 2015 Gold level plan with a \$1,500 deductible/70% coinsurance/\$9,000 out-of-pocket maximum.



For More Information

Please make an appointment with a Marketplace Navigator, Certified Application Counselor (CAC), or Certified Exchange Agent to learn if there are plans and prices that might be a good fit for you.

*****Note: Although based on an actual 2015 plans, the scenarios above are only estimates and you must go to www.healthcare.gov to get an eligibility determination for advanced premium tax credits.*****

Retiree Alternative Coverage Options OVER 65

Over 65

If you're over 65 and eligible for Medicare, you do not qualify for a plan on the Health Insurance Marketplace, but might consider looking into Medicare Supplemental insurance, including Medicare Advantage plans.

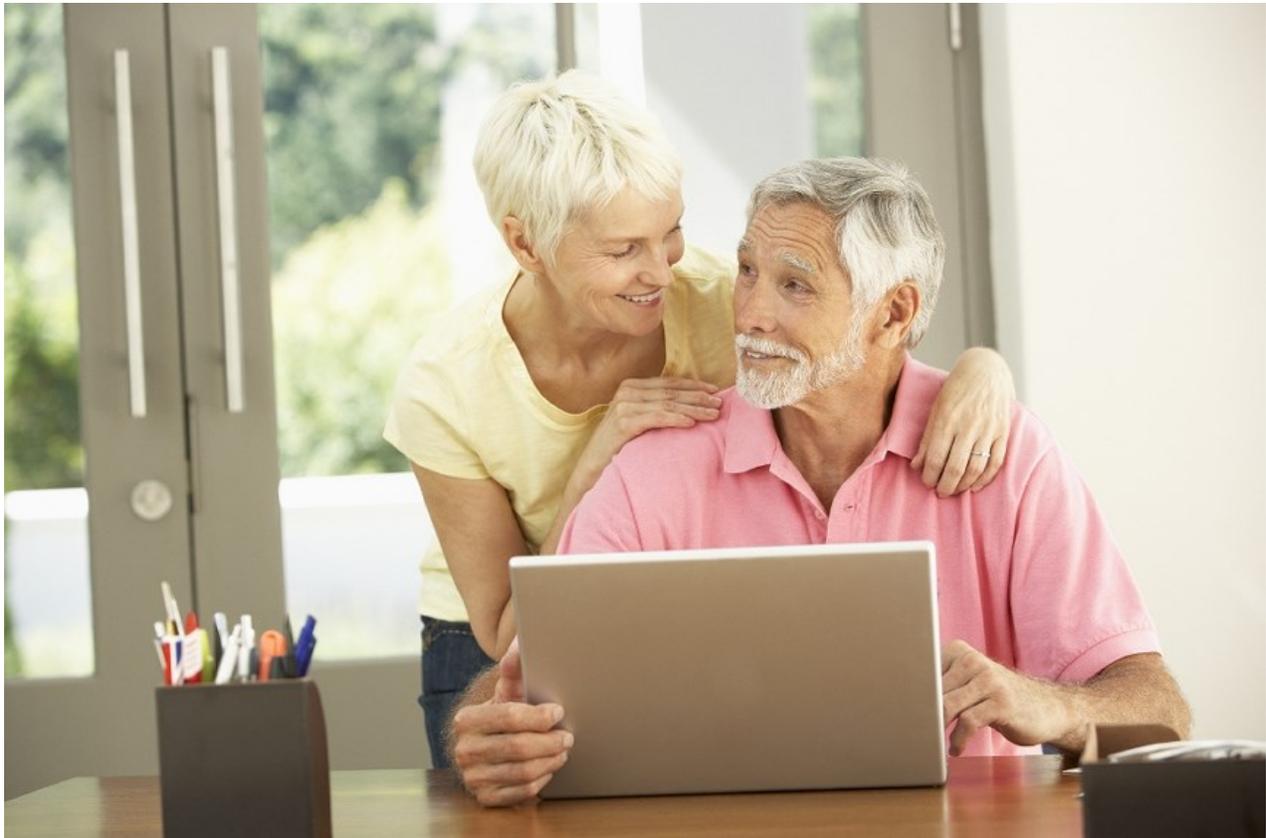
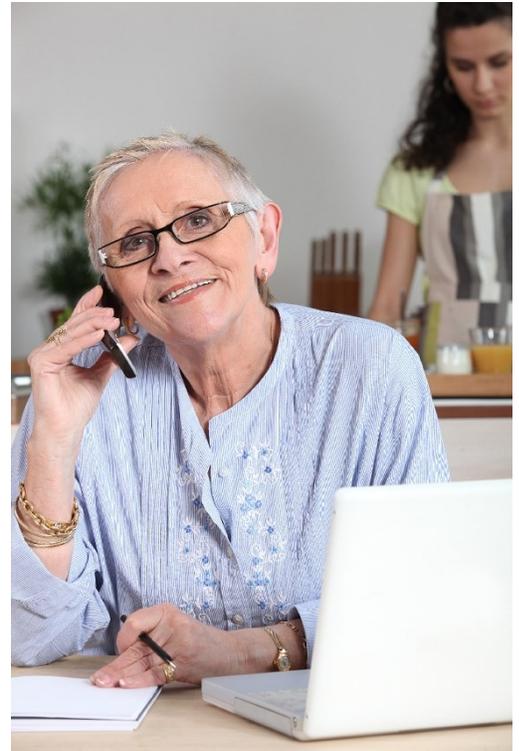
Contact SHIP for FREE

The Montana State Health Insurance Assistance Program (SHIP) is a FREE health-benefits counseling and advocacy service for Medicare beneficiaries and their families or caregivers.

Its mission is to educate, advocate FOR, counsel and empower people to make informed benefit decisions. You may also consult with an insurance agent who is trained in Medicare supplement or Medicare advantage plans.

Call: 1-800-551-3191

Web: <http://www.dphhs.mt.gov/SLTC/aging/SHIP.aspx>



Termination Instructions

If you decide to terminate your State of Montana Health Plan:

- A newly retiring employee **MUST** notify HCBD within 60 days of retiring.
- Existing retired members who decide to terminate their State of Montana Plan coverage must let HCBD know by December 31 of the current plan year.

Notify HCBD of your decision to terminate your coverage by:

- Marking the “Option to Terminate Benefits” box on your benefit statement (mailed mid-September) or confirmation statement (mailed mid-November) and returning it (postmarked) to Health Care and Benefits Division *P.O. Box 200130 Helena, MT 59620-0130* by December 31 of the current plan year.

Or

- Fill out and return (postmarked) the “Retiree Benefit Termination” form to HCBD by December 31 of the current plan year. This form can be found by calling HCBD at 1-800-287-8266.

Be aware that if you terminate your State of Montana Benefits in order to move to a Health Insurance Marketplace or Medicare Supplement Plan, you have a one time right to return to the State of Montana Plan within the designated time period. See the “Retreat Rights” language on p. 6 for more details.

If you terminate your State of Montana Benefits coverage for any other reason, you will not have the opportunity to return to the State of Montana Plan.



State of Montana Plan Eligibility

Dependent Changes, Information, Qualifying Events

Eligible Dependents Defined

Eligible dependents include:

- A. The eligible employee's lawful spouse or declared domestic partner. Declaration of Domestic Partnership forms may be obtained from Health Care and Benefits Division (HCBD).
- B. The eligible employee's dependent children who are under age 26 and not in full-time active military service. Dependent children are:
 - 1) natural or legally adopted children of the eligible employee or the employee's lawful spouse or declared domestic partner; or
 - 2) any other child with whom the eligible employee maintains a legal parent-child relationship.
- C. An employee's dependent children who are incapable of self-sustaining employment by reason of mental or physical disability may be eligible for medical, dental, and life benefits after they turn 26.

See the [Summary Plan Document](#) for more details on Eligible Dependents.

The member is responsible for removing any dependents who cease to be eligible. Failure to do so will result in the member being held responsible for repayment of any claims paid for ineligible dependents.

Annual Change Elections

Members will have the opportunity to use online benefits enrollment in September and October to make changes to Plan options for themselves and/or their eligible dependents. These changes take effect January 1 of the following year.

Adding/Deleting Dependents

You may delete dependent coverage during annual change, but once a dependent is removed from the medical Plan, they *may not be re-enrolled outside of an open enrollment period* without a documented qualifying event discussed below and described in detail in the Summary Plan Document.

Enrolling Dependents After Annual Change

After Annual Change, dependent coverage enrollment is only allowed during [qualifying events](#). Some examples include:

- 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 or losing benefits
- Within 91 days after birth or adoption¹

¹The newborn child of a qualified dependent child (your grandchild) will automatically have coverage for the first 31 days after birth, but cannot be added permanently after that time.

Notify Health Care and Benefits Division when one of the above circumstances occurs within the specified time frames to enroll dependents after Annual Change.

For more details regarding qualifying events, call HCBD or see the [Summary Plan Document](#) available on the FORMS page at www.benefits.mt.gov.

State of Montana Benefit Cost Worksheet

for Retirees

Primary Benefits

At age 65:

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

Medical Plan (See rates on page 14)	Capitol Plan	Cigna	\$ _____ (a)
Dental Plan (See rates on page 19)		Delta Dental	\$ _____ (b)
Basic Life Insurance of \$14,000 Available to retirees under age 65 and not Medicare eligible (See page 24)	<i>Medicare retirees cross out the \$1.90 for Basic Life</i>		\$ <u>1.90</u> (c)
Total Core Benefits Contribution		Add lines a, b, and c =	\$ _____ (d)

Optional Benefits

Vision hardware (See rates on page 21)			\$ _____ (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)
Live Life Well Incentive total ¹		\$ _____ (k)

¹ Enter \$10 for each of the following complete by yourself and/or one dependent:

- You attended a 2014 State sponsored health screening AND filled out Cigna's online health assessment (\$10)
- You are tobacco-free or completed a qualifying tobacco cessation program. (\$10)
- You completed three Next Step activities. (\$10)

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

Total Monthly Out-of-Pocket Costs for 2015 Benefits	Subtract lines k from line i	\$ _____
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State of Montana Medical Plan

One Plan for all!

The Capitol Plan now combines Cigna's vast group of in-network providers, low co-pays and deductibles, and additional services like naturopathic care from last year's Classic Plan to create the right plan for you.

Who is Eligible?

Employees, legislators, retirees, COBRA members, and dependents (spouse, domestic partner, children) are eligible for the medical plan. Members are required to be enrolled in medical coverage unless they waive the entire benefit package. For dependent eligibility, see page 12.

Plan Includes:

- One vision and eye health evaluation per Plan member each year for \$10 at an in-network provider
- URx Prescription Drug Coverage (this benefit is administered by Medimpact—NOT CIGNA)
- Under 65—Use of Montana Health Centers at no cost
- Over 65—Use of Montana Health Centers ONLY for health screening and flu shots at no cost



Non-Medicare Retiree Plan Cost

	Capitol Plan
Retiree Only	\$931
Retiree and spouse	\$1,314
Retiree and kids	\$1,117
Retiree and family	\$1,345
Retiree and Medicare Spouse	\$1,114
Retiree and Medicare Spouse & Children	\$1,184

Medicare Retiree Plan Cost

	Capitol Plan
Retiree Only	\$371
Retiree and spouse	\$738
Retiree and kids	\$607
Retiree and family	\$771
Retiree and Medicare Spouse	\$646
Retiree and Medicare Spouse & Children	\$662

Member Cost:

	In-Network	Out-of-Network
Office Visit	\$20 copayment	35% + balance billing
Annual Deductible (Counts towards Annual Max Out-of-Pocket) Applies 1/1/15 – 12/31/15	\$750/member \$1,750/family	A separate \$1,250/member A separate \$2,750/family
Coinsurance %	25%	35% + balance billing
Annual Max Out-of-Pocket (Includes Annual Deductible)	\$3,300/member \$6,600/family	A separate \$4,950/member A separate \$10,900/family + balance billing
Annual URx Max Out-of-Pocket	\$1,650/member	\$3,300/Family

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

State of Montana Plan Details—What the Member Pays

Office/Routine Care	In-Network	Out-of-Network
Office visits —Includes specialists and naturopathic	\$20—Covers office visit charge only	35% + balance billing D
Professional outpatient physical, occupational, cardiac, pulmonary, & speech therapy (max 30 combined days/yr)	\$20/visit ¹ (copayment applies to each visit)	35% + balance billing ¹ (coinsurance applies to each visit) D
Professional Lab/Diagnostic/Injectables	25% (no deductible on injectables without an office visit) D	35% + balance billing D
Durable medical equipment and prosthetics —May require prior authorization	25% D	35% + balance billing D
Allergy shots	\$20 for office visit + 25% coinsurance (no deductible; if no office visit) D	35% + balance billing D
Routine Vision Exam (One per member per Plan Year)-If exam is medical, deductible and coinsurance apply. Talk to your provider to find out if your exam is considered routine.	\$10	Balance billing for cost over \$45
Preventive Services		
Adult preventive services —See P. 17 for more details	\$0	35% + balance billing (No deductible for mammograms) D
Adult Immunizations (such as flu and pneumonia)	\$0	35% + balance billing D
Well child checkups and immunizations —See the schedule listed in the Summary Plan Document	\$0	35% + balance billing D
Emergency and Urgent Care Services		
Ambulance services for medical emergency	25% D	25% + balance billing D
Emergency department and hospital charges —Copayment includes all services (no deductible or coinsurance); copayment waived if admitted, then all inpatient benefits apply.	\$250/visit for facility charges+\$100 for physician services	\$250/visit for facility charges +\$100 for physician services + balance billing
Emergency department professional and ancillary charges	N/A	Balance billing
Urgent care facility and professional charges	\$35 (covers visit charge only)	\$35 (covers visit charge only) + balance billing
Urgent care ancillary (lab/diagnostic/surgical charges)	25% D	25% + balance billing D
Hospital Care		
Inpatient services	25% D	35% + balance billing D
Outpatient services and Surgical Center Services	25% D	35% + balance billing D
Organ transplant —Prior authorization, pre-certification, case management are required. Services must be rendered at a Life Source network facility	25% D	Not covered

¹ Developmental delays are not covered

D =Must meet deductible before coinsurance applies.

State of Montana Plan Details—What the Member Pays Continued

	In-Network	Out-of-Network
Mental Health and Substance Abuse		
Outpatient professional services —The first 4 visits in-network are no charge.	Visits 1 - 4 no charge; then \$20/visit (covers office visit charge only)	35% + balance billing D
Inpatient services ³	25% D	35% + balance billing D
Maternity Services		
Hospital charges	25% D	35% + balance billing D
Physician charges	25% D	35%+ balance billing D
Ultrasounds	25% D	35% + balance billing D
Routine Newborn Care		
Inpatient hospital and physician charges for routine newborn care	25%	35% + balance billing
Extended Care Services (prior authorization recommended)		
Home health care (Max 70 Days/Plan Year)	25% D	35% D
Hospice	25% D	35% + balance billing D
Skilled nursing (Max 70 Days/Plan Year)	25% D	35% + balance billing D
Inpatient rehabilitation (max 60 days per Plan Year total) See the SPD for details ³	25% D	35% + balance billing D
Miscellaneous Services		
Dietary/Nutritional counseling Max 3 days/Plan Year	\$0 (no deductible, no coinsurance)	35% + balance billing D
Chiropractic/Acupuncture (combined maximum of 20 days/Plan Year)	\$20/day	35% + balance billing D
PKU supplies	25% D	35% + balance billing D
TMJ treatment—Requires prior authorization	25% Surgical only D	Not covered

³ Residential services are not covered

D =Must meet deductible before coinsurance applies.

STATE OF MONTANA HIPAA NOTICE OF PRIVACY PRACTICES

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

If you have any questions about your privacy rights, please contact the Health Plan at the following address:

Contact Office or Person: Amber Godbout, Privacy Official
 Health Plan Name: State of Montana Employee Benefit Plan
 Telephone: (406) 444-7462 (in Helena) or (800) 287-8266; TTY (406) 444-1421
 email: agodbout@mt.gov
 Address: Health Care and Benefits Division
 PO Box 200130
 Helena, MT 59620-0130

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

DISCLAIMER

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

Covered Preventive Services

Age and gender appropriate preventive care from an **in-network** provider is covered at 100% of the allowed amount without any deductible, coinsurance, or copayment for Plan members.

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



Periodic exams —Appropriate screening tests (see the Summary Plan Document for a full list of tests)	
Well child care Infant through age 17	Age 0 months through 4 year—up to 14 visits Age 5 years through 17 years—one visit per Plan Year
Adult routine exam Exams may include screening/counseling and/or risk factor reduction interventions for depression, obesity, tobacco use, drug and/or alcohol abuse	Age 18 through 65+—one visit per Plan Year
Preventive screenings	
Anemia screening (CBC)	Pregnant women
Bacteruria screening (UA)	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 members age 50 years old or older may receive one colonoscopy per Plan Year regardless of diagnosis at zero cost if provided by an in-network provider. Any additional services related to the colonoscopy (i.e. laboratory, surgical, radiology) services are subject to deductible and coinsurance. Out-of-network services are subject to regular benefits and colonoscopies billed as preventive will only be allowed every 10 years for age 50 or older. Preventive colonoscopies for members under age 50 are not covered unless the member 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 age 65-75 who have ever smoked—one screening by ultrasound 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)	



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

What is URx?

URx is your prescription drug benefit. It is administered by MedImpact, NOT CIGNA. You are enrolled in URx when you enroll in the medical plan.

How Does URx Work?

URx aims to make sure members get the best drug for them at the best price. Just because a drug costs more, does NOT mean the drug is better.

The Pharmacy & Therapeutics Committee (PTAC) evaluates drugs based on proven clinical results and financial value to the Plan and member and places drugs in tiers.

Drug Tiers

Look up the tier of your drug at: <https://mp.medimpact.com/mtn>. Then, talk to your doctor about the options for your medication.

If your drug falls into the D or F tiers, consider asking your doctor for an alternative from the A, B, or C tiers. If no alternative is available, you can apply for an exception by filling out the URx Plan Exception form found at www.benefits.mt.gov.

Most Drugs Are Covered

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 discount.

SAVE BIG with Mail Order Pharmacies

You can get a three month supply of some medication for the price of two months!

The Plan pays less for many medications through mail order pharmacies MedVantx and Ridgeway. We pass those savings on to you.

MedVantx (877) 870-MONT (6668)

Ridgeway (800) 630-3214

Specialty Pharmacy

Diplomat Specialty Pharmacy is the Plan's preferred pharmacy to handle specialty medications (drugs that require special administration). Using a pharmacy other than Diplomat for specialty medications could cost significantly more.

Diplomat Specialty Pharmacy (877) 319-6337

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

Prescription Medication Highlights (\$1,650 individual/\$3,300 family Out-of-Pocket Maximum)

URx Drug Classification Value based on medical evidence	Drug Tier	Deductible	Retail Rx 30 day supply What you pay	Mail Rx 90 day supply What you pay
Excellent	A	\$0	\$0 copayment	\$0 copayment
High	B	\$0	\$15 copayment	\$30 copayment
Good	C	\$0	\$40 copayment	\$80 copayment
Lower	D	\$0	50% coinsurance ¹	50% coinsurance ¹
Lowest	F	\$0	100% coinsurance ¹	100% coinsurance ¹
Specialty drugs	S	\$0	Diplomat—\$150 or \$250 copayment Pharmacy other than Diplomat — 50% coinsurance ¹	Not covered
Specialty F	SF	Not Covered	Not Covered	Not Covered

¹Does not count toward your out-of-pocket maximum.

State of Montana Dental



(866) 496-2370

www.deltadentalins.com/stateofmontana

Dental Plan Options

There are two dental plan options. Both dental plans cover two cleanings and exams per member per Plan Year at 100% of the allowable charge at an in-network provider. Cleanings and exams do not count toward the Type A maximum.

Basic Plan

Yearly maximums¹ per Plan member:

- Type A—\$600 (No Deductible)
- Type B & C and Implants—Not covered

Premium Plan

Annual maximums¹ per Plan member:

- Type A—\$600 (No Deductible)
- Type B & C—\$1,200 (\$50 deductible per Plan member/\$150 per family per calendar year).
- Implants—\$1,500 Lifetime Limit

¹After the plan pays the annual maximum, you are responsible for 100% of the cost of services.

Plan Cost

	Basic Plan	Premium Plan
Member only	\$22	\$40
Member and spouse	\$34	\$61
Member and children	\$32.50	\$59.50
Member and family	\$37.50	\$68.50
Joint Core	\$26	\$47

Find an in-network dentist, view claims, check benefits, and manage your profile online and on your mobile phone

www.deltadentalins.com/stateofmontana

Eligibility: Employees, Legislators, Retirees², and eligible dependents.

²Retirees under age 65 are required to elect a dental plan unless they waive the entire benefits package; once Medicare eligible, dental coverage is optional.

Delta Dental Networks

Preferred Provider (PPO) \$

You usually pay the least when you visit a PPO dentist because they agree to accept the allowable charge.

Premier \$\$

Premier dentists accept a slightly higher allowable charge than PPO dentists. You pay a percentage of this higher fee.

Non-Network \$\$\$

If you see a non-Delta Dental dentist, you will be responsible for the difference between the allowable charge and what that dentist billed.

Benefits and Covered Services	Limitations / Maximums
Type A—Diagnostic & Preventive (D&P)³	One full mouth x-ray and series in any 5 year period
These services are not subject to the annual maximum.	Two sets of supplementary bitewing x-rays in a benefit period
	Two exams and/or cleanings in any Plan Year (fluoride application through age 19)
Type A Services	No deductible; \$600 annual maximum for Basic and Premium Plans
Sealants, amalgam fillings, etc. ³	Sealants limited to covered dependents through age 15; may be applied to molars once per tooth per lifetime.
Type B Services Endodontics, periodontics, extractions, oral surgery, composite fillings, etc. ³	Type B Services are only covered under the Premium Plan.
Type C Services Crowns, bridges, initial dentures, etc. ³	Type C Services are only covered under the Premium Plan.
Type C—Implants³	Implants are only covered under the Premium Plan. Implants have a separate \$1,500 lifetime maximum for those on the premium Plan.

³See the Summary Plan Document (SPD) for a full list of covered services and limitations.

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

State of Montana Dental Continued

What You Pay

Basic Plan

Benefits and Covered Services	PPO dentist	Premier dentist	Non-participating dentist
Type A Diagnostic & Preventive ¹ (D&P)—Does not count toward type A maximum	2 cleanings and exams per plan year at no cost	2 cleanings and exams per plan year at no cost	2 cleanings and exams per plan year at no cost + Balance billing
Type A Services ¹	0% + any costs incurred after annual maximum is met ²	0% + any costs incurred after annual maximum is met ²	0% + any costs incurred after annual maximum is met ² + Balance billing
Type B & C Services ¹ —NOT COVERED (You pay full charged amount)	100%	100%	100%

Premium Plan

Benefits and Covered Services	PPO dentist	Premier dentist	Non-participating dentist
Type A Diagnostic & Preventive ¹ (D&P)—Does not count toward type A maximum	2 cleanings and exams per plan year at no cost	2 cleanings and exams per plan year at no cost	2 cleanings and exams per plan year at no cost + balance billing
Type A Services ¹	0% + any costs incurred after annual maximum is met ²	0% + any costs incurred after annual maximum is met ²	0% + any costs incurred after annual maximum is met ² + Balance billing
Type B Services ¹	20% + any costs incurred after annual maximum is met ² D	20% + any costs incurred after annual maximum is met ² D	20% up to annual maximum ² + balance billing D
Type C Services ¹	50% + any costs incurred after annual maximum is met ² D	50% + any costs incurred after annual maximum is met ² D	50% + any costs incurred after annual maximum is met ² + balance billing D

¹ See the SPD on www.benefits.mt.gov for a full list of types A, B, and C services

² See p. 17 for annual maximum amounts and limitations. After the plan pays the annual maximum, you are responsible for 100% of the cost of services.

D =Must meet deductible before coinsurance applies.

Why Preventive Care Makes Sense!

Take advantage of your two no cost cleanings and exams per year at an in-network dentist!



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

State of Montana Vision Hardware Plan (*Optional*)

All members covered on the medical plan get **one routine vision and eye health evaluation** each year for \$10 at an in-network provider.

Members must re-enroll each year for the Vision Hardware Plan.

Network:

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

Note: Cigna's vision provider network is slightly different from its network of labs that make vision hardware (VSP). Be sure to check that both your eye doctor and lab are in-network.

Who is Eligible?

Employees, retirees, legislators, COBRA members, and dependents covered on the medical plan. You must re-enroll in vision hardware each year!

All or None

If you choose vision hardware coverage, it will apply to everyone covered on your medical Plan. For example, if your plan covers "Member and spouse", but your spouse doesn't wear glass, you will still pay \$10.86/month if you elect the Vision Hardware Plan.

More Details

For full details on the 2015 Vision Plan, visit www.benefits.mt.gov and click on Vision under the Employees tab.



Make sure your doctor and your LAB are in network! It's important to check both by calling (877) 478-7557 or going online <https://cigna.vsp.com>.

Coverage	In-Network	Out-of-Network
Materials Copayment	Member pays \$20	N/A
Frame Retail Allowance— <i>one every two Plan Years</i> instead of contact lenses	Plan Pays: Up to \$130	Plan Pays: Up to \$52
Lenses Allowance		
Plastic or glass eyeglass lenses — <i>one pair per Plan Year</i> instead of contact lenses	Plan Pays: 100% after Copayment	Plan Pays: Up to \$45
Standard Polycarbonate lenses (covered for under 18)— <i>one pair per Plan Year</i> instead of contact lenses	100% after Copayment	Up to \$65
Single Vision ,Bifocal, Trifocal, Lenticular — <i>one pair per Plan Year</i> instead of contact lenses	100% after Copayment	Up to \$80
Contact Lenses Allowances— <i>one time benefit per Plan Year</i> instead of lenses or lenses and frames	Plan Pays: \$130	Plan Pays: Up to \$95
Elective Therapeutic (must meet medically necessary criteria)	100%	Up to \$210

The Montana Health Centers

Billings, Butte, Helena, Miles City, Missoula



The Montana Health Centers operated by CareHere offer no cost primary care services and health coaching to help you on your journey to a healthier lifestyle.

Who Can Use Montana Health Centers

Active employees and non-Medicare retirees and their dependents age two and older who are covered on the Plan may receive all available services at any Montana Health Center location.

Medicare retirees may only use the Health Center for flu shots and health screenings.

Employees injured at work may also go to the Montana Health Center.

Services

- Primary care
- Same day services with appointment
- Flu shots and other vaccinations
- Health screenings
- Lab services
- Diagnostic service referral
- Health coaching
- Much more

Wellness Coaching

- Registered Nurse-Blood pressure, asthma, and medication management, etc.
- Registered Dietitian-Diabetes, weight loss, and cholesterol management, etc.
- Exercise Physiologist-Exercise, including getting started
- Tobacco Cessation Coach
- Behavioral Health Coach-Stress and Employee Assistance Program

To schedule or change an appointment *ONLINE*:

www.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**.

You may edit or delete your appointment at any time prior to the appointment time.

And you can always call (855) 200-6822 to make your appointment at the health center.

ALL Montana Health Centers

Call: (855) 200-6822 or E-mail: help.montana@carehere.com

Billings

billings.montana@carehere.com
1501 14th St West, Suite 230 Billings, MT 59102
Fax (406) 969-5118
Mon - Fri 7am-6 pm

Butte

butte.montana@carehere.com
3703 Harrison Ave. Butte, MT 59702
Fax (406) 565-5734
Mon - Fri 7am-6 pm

Helena

helena.montana@carehere.com
405 Saddle Dr Helena, MT 59601
Fax (406) 206-0304
Mon - Fri 7am-6 pm
Sat 7:30 am-4:30 pm

Miles City

milescity.montana@carehere.com
515 Main St Miles City, MT 59301
Fax (406) 234-0278
Mon 8 am-5 pm, Tues 7 am-11 am, Wed 8 am- 5 pm
Thurs 7am-6 pm, Fri 7 am- 6pm
Sat 8 am-12 pm and 1 pm-5 pm

Missoula

missoula.mt@carehere.com
1211 S Reserve, Suite 202, Missoula, MT 59801
Fax (406) 206-0317
Mon - Thurs 7 am-6 pm, Fri 9 am-6 pm, Sat 8 am-1 pm

**More info online at
www.healthcenters.mt.gov**

2015 Live Life Well Incentive



Earn up to \$30/month* off your 2016 monthly benefits payment by completing these activities before October 31, 2015!

Visit www.benefits.mt.gov/discount for full details.

Discount	Check List
 <p>\$10 Health Screening/Assessment Discount</p>	<input type="checkbox"/> Complete a State-sponsored health screening with CareHere by Oct. 31, 2015 <input type="checkbox"/> Complete the Cigna Online Health Assessment by October 31.
<p><i>You must complete the Health Screening/Assessment Discount requirements to qualify for the Tobacco Free and/or Next Steps Discounts!</i></p>	
 <p>\$10 Tobacco Free Discount</p>	<input type="checkbox"/> Be tobacco free <input type="checkbox"/> Report it on the Cigna Online Health Assessment <p style="text-align: center;">OR</p> <input type="checkbox"/> Complete a tobacco cessation program <input type="checkbox"/> Return the form to HCBDB by October 31, 2015.
 <p>\$10 Next Steps Discount</p>	<input type="checkbox"/> Complete 4 of the activities listed below. <ul style="list-style-type: none"> <input type="checkbox"/> Engage in a wellness program through Cigna, CareHere or HCBDB. <input type="checkbox"/> Exercise an average of three days a week, 15 minutes a day. <input type="checkbox"/> Get a dental exam. <input type="checkbox"/> Get an eye exam. <input type="checkbox"/> Update a vaccine (flu shot, tetanus, etc.). <input type="checkbox"/> Get a routine annual physical exam. <input type="checkbox"/> Report your activities in the MINE site. <ol style="list-style-type: none"> 1. Log in to the MINE site. 2. Click "Employee Self Service" 3. Click "Next Steps Discount" under "Benefits" 4. Follow instructions on the Next Steps Discount Page.

***Double your money!** If you have a dependent age 18 or older or spouse/domestic partner on your Plan and he/she completes the activities above and the required certification steps, it could double your discount—to a potential maximum of \$60/month off per policy holder (up to \$120 maximum for Joint Core members).

Life Insurance



Fully insured and administered by

The Standard® (800) 759-8702 • www.standard.com
Positively different.

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. Contact The Standard 1-800-759-8702 for more information.



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.

Fully insured and administered by The Standard Insurance Co • (800) 759-8702 • www.standard.com

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

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

Live Life Well



Health Care and Benefits Division (HCBD) coordinates all of the wellness programs available to members of the State of Montana health Plan. Members can pick and choose as many Live Life Well programs to participate in as they like at no cost.

Visit www.benefits.mt.gov and click on the Live Life Well tab for more information about wellness programs.

Lifestyle Management Programs



Live Life Well offers many lifestyle and condition management programs to State of Montana Plan members. Completing any of the programs listed below could save you money in 2016 with the Live Life Well Discount. Completing a tobacco cessation program qualifies as both a Next Step activity and qualifies you for the Tobacco Free Discount. See p. 23 for more details.



	 <p>1-855-246-1873 To sign up for a Cigna program, log into www.myCigna.com or call.</p>	 <p>For non-Medicare members only. 1-855-200-6822 To make an appointment with a health coach:</p> <ol style="list-style-type: none"> 1. Have your state sponsored health screening. 2. Have a follow-up appointment with a Health Center provider. 3. Talk to the provider about scheduling an appointment with a health coach.
<p>Weight Management</p> 	<p>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.</p>	<p>One on one coaching to create a personalized program including nutrition and mindful eating support with experienced Registered Dietitians and exercise and fitness support with experienced Exercise Physiologists.</p>
<p>Stress Management</p> 	<p>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.</p>	<p>Work one on one with a coach to learn critical coping skills and get support with life transitions, parental support, addiction, and more.</p>
<p>Tobacco Cessation</p> 	<p>Get and stay tobacco free. Develop a personal quit plan that's right for you. Use the program online, over the phone – or both.</p>	<p>Individualized quit plan that includes access to tobacco cessation medications if deemed appropriate by a health care provider and one full year of coaching support.</p>
<p>Disease Management</p> 	<p>Make educated decisions on your treatment options and more. A health advocate may be calling you to get things started, or you can call someone at any time. The programs also offer a variety of self-service resources to help you better understand your condition and overcome barriers to better health.</p>	<p>Teams of healthcare professionals including physicians, mental health care providers, physician assistants, nurse practitioners, nurses, dietitians, fitness experts to give you the best overall care. Incentive Plans reward you with medical supplies at no cost to you and cash rewards. Talk with a Montana Health Center provider for a full list of incentives for conditions.</p>

Live Life Well Continued

Cigna Healthy Pregnancies, Healthy Babies®

1-855-246-1873

Supports you in managing your pregnancy and keeping you and your baby healthy. Get rewarded for a good decision.

- \$250 after delivery if you enroll during your 1st trimester
- \$125 after delivery if you enroll during your 2nd trimester
- 24/7 over the phone nursing support
- Preconception information, pregnancy support, infertility coaching
- Text 511411 to get more! BABY for English, BEBE for Spanish.

You can get prenatal vitamins at no cost through the URx pharmacy Plan!



Weight Watchers

Members and dependents 18 and over on the Plan get reimbursed up to \$75 every two years if they meet all the requirements found on the HCBP website www.benefits.mt.gov.



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!

Case Management

1-855-246-1873

If you have a new or complicated diagnosis, Cigna can help you navigate the system.

A Nurse Case Manager can:

- Help you understand your current condition or diagnosis, treatment Plan, and treatment options
- Serve as a patient advocate as questions of care or coverage come up
- Act as a point of contact to help coordinate care
- SAVE YOU MONEY by
 - * Helping you make the best use of your health Plan and URx pharmacy benefits
 - * Providing referrals and information about wellness programs and other no cost resources
 - * Helping you get cost effective durable medical equipment and supplies



Notes

Glossary

Allowable Charges—Charges that are both: a. For services covered by the Plan, in which you are enrolled, and b. Within the allowable fee established by the Plan Administrator.

Balance Billing—The amount over the plan's allowable fee that may be billed to the member by an out-of-network provider

Benefits Payment/Contribution— The amount an employee, retiree, or legislator contributes out-of-pocket to participate or for their dependent(s) to participate in a benefit plan

Certification/Pre-certification—Certification is a determination by the plan administrator that a hospital inpatient stay meets medical necessity criteria for inpatient benefits. Additionally, a determination that the inpatient hospital stay also meets (or fails to meet) the criteria for the in-network level of benefits. Pre-certification is certification in advance of a non-emergency admission.

Coinsurance—Coinsurance is a means of cost sharing. The Plan pays a percentage of allowed charges (after any applicable deductible has been met) and the member pays a percentage - the coinsurance.

Copayment—Copayment, like coinsurance, is also a type of cost sharing. You pay a fixed dollar amount, the copayment, for a covered service and the Plan pays remaining allowable charges.

Deductible—Allowed charges a member and family must pay before a medical plan makes payment. The deductible applies to the Plan Year, regardless of hire date.

In-Network Provider—A covered health care provider who has (or group of providers who have) contractually agreed to provide medical services to members of a health plan according to the fees and other terms of a plan contract. Benefits for services provided in-network (by an in-network provider) are typically higher level benefits (the in-network level of benefits) than benefits for services out-of-network (by another 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.

Member

An individual who, by virtue of being a state employee, retiree, surviving dependent, or COBRA member, who:

- Has met the State Plan's requirements to enroll in the State Plan or independently continue State Plan coverage under the provisions of Chapter I.E;
- Is enrolled in the State Plan and any insurance plan offered by the State Plan to which the term is applied; and
- Is named as the member by the HCBP and by the insurance company as shown on its identification card.

Out-of-Network Provider—Any covered provider who is not an in-network provider designated by the plan administrator. Out-of-network providers include providers who are participating only to the extent that they accept a plan's allowable fees, but who have not agreed to other terms of a network contract.

Out-of-Pocket Maximum—The maximum amount of any coinsurance which is credited toward a plan's out-of-pocket maximum that you must pay in a benefit year for:

- An individual member (the individual out-of-pocket maximum); or
- Enrolled family members (the family out-of-pocket maximum).

Once a member meets the plan's individual out-of-pocket maximum, no more coinsurance which is credited toward the out-of-pocket maximum must be made for that member for the remainder of the benefit year. Once an enrolled family has met the plan's family out-of-pocket maximum, no more coinsurance which is credited toward the out-of-pocket maximum, must be made for any enrolled family member for the remainder of the benefit year.

Participating Provider—A provider who has agreed to accept allowable charges as payment in full and not bill State Plan members extra amounts. Lists of in-network providers for the medical and dental plans, as well as participating pharmacy providers for the prescription drug plan, are available at the website of the plan administrator or by calling the customer service number on the identification card for the plan.

Plan Year—The period starting January 1 and ending December 31 of each year

Prior Authorization—A process to inform you whether a proposed service, medication, supply, or ongoing treatment meets the following criteria for coverage by your selected medical, prescription drug, or dental plans:

- Is medically necessary;
- Complies with applicable medical policy;
- Is a benefit of the plan; and
- In the case of prior authorization, whether it meets criteria for the in-network level of benefits.

See the Summary Plan Document for more information on obtaining a prior authorization.

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

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

Contact Information



Health Care & Benefits
Division

Phone: (800) 287-8266, (406) 444-7462;
Hearing impaired TTY (406) 444-1421
Email: benefitsquestions@mt.gov
Web: www.benefits.mt.gov
Mail: 100 N Park Ave Suite 320
PO Box 200130
Helena, MT 59620-0130



Montana Health Centers

Live support for **ALL** MT Health Centers:
Phone: (855) 200-6822
Email: help.montana@carehere.com
Web: Make an appointment www.carehere.com
Code: MANA9
See P. 18 for local addresses and hours of operation.



Cigna Medical Plans,
Customer Service, and
Claims Processing
Questions

Phone: (855) 692-0131
Email: stateofmontana@cigna.com
Web: www.mycigna.com
www.cigna.com

Vision Hardware Plan

Vision Hardware Plan:
Phone: (877) 478-7557
Email: stateofmontana@cigna.com
Web: <https://cigna.vsp.com>



URx Customer Service

Phone: (888) 648-6764
Email: askurx@mt.gov
Web: www.mp.medimpact.com/mtn
www.benefits.mt.gov/pages/urx.html

Mail Order and Specialty
Pharmacy

Mail Order Prescription Drugs:
MedVantx (877) 870-MONT (6668)
Ridgeway Pharmacy (800) 630-3214
Specialty Meds
Diplomat Specialty Pharmacy (877) 319-6337



Delta Benefits Customer
Service and Claims
Processing Questions

Phone: (866) 496-2370
Web: www.deltadentalins.com/stateofmontana



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

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



Life and Long Term
Disability Insurance

For questions about benefits, claims, status of
application:

Phone: (800) 759-8702
Web: www.standard.com

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