

State of Montana



Employee Benefits Summary Plan Document

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CHAPTER I: ELIGIBILITY, ENROLLMENT, DATES OF COVERAGE AND ELIGIBILITY DECISIONS/APPEALS

A. WHO IS ELIGIBLE

1. ELIGIBLE EMPLOYEE

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

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

2. ELIGIBLE DEPENDENT

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 or declared domestic partner; or
 - 2) any other child with whom the eligible employee maintains a parent-child relationship.
- c. A parent-child relationship means:
 - 1) court-ordered custody of the child by the employee or the employee's lawful or declared domestic partner; or
 - 2) legal guardianship of the child by the employee or the employee's lawful or declared domestic partner.For an eligible spouse or a declared domestic partner, the employee must declare the tax status as required by the Internal Revenue Service in order to apply the proper tax treatment (before or after tax) to benefits. The

qualification of these individuals as your spouse or domestic partner for tax purposes does not affect their eligibility but does impact the tax treatment of that coverage.

If a question arises regarding the eligibility of a dependent as described in this provision, proof of the parent-child relationship and dependent status must be submitted upon request to the HCBP for approval.

A child may not be covered by the State Plan as an eligible dependent of more than one eligible employee, under the same coverage (medical, dental and/or vision— see I.B.4).

3. ELIGIBLE DISABLED DEPENDENT

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

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

Notification and proof of such incapacity must be submitted to the Plan Administrator within 31 days of the date the dependent child's coverage would otherwise terminate. Recertification of the disability will be required annually.

4. IMPORTANT NOTICE – RESPONSIBILITY TO REMOVE INELIGIBLE DEPENDENTS

It is the member's responsibility (employee, retiree, COBRA enrollee, or surviving spouse) to remove any dependents that cease to be eligible, as defined in I.A.2 or I.A.3, from coverage within 60 days of the date eligibility is lost. The subscribing employee, retiree, COBRA enrollee, or surviving spouse is responsible for repayment of any claims dollars paid out for an ineligible dependent. All benefits payments, paid pre-tax or post-tax, cannot be refunded.

5. REVIEW OF ELIGIBILITY DENIED IN WHOLE OR IN PART

If you believe that you or your dependent(s) have been inappropriately denied eligibility for benefits described in this Summary Plan Document, you are encouraged to call HCBP customer service number for an explanation and decision.

This number is:

(406) 444-7462 / (800) 287-8266 / TTY (406) 444-1421

If unsatisfied with the response, send a written appeal to HCBP within 30 days of the date of the original decision, including an explanation of the reason the decision was made in error along with any relevant documentation. Appeals should be sent to:

Health Care and Benefits Division

Attn: Eligibility Appeals

PO Box 200130

Helena MT 59620-0130

A second and final decision will be issued within 45 days of the original appeal date.

B. HOW TO ENROLL

1. ENROLLMENT OF NEWLY ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS DURING THE FIRST 31-DAY INITIAL ENROLLMENT PERIOD

a. WHETHER TO ENROLL IN CORE BENEFITS FOR YOURSELF

A new employee who is eligible for benefits or an existing employee who becomes eligible for benefits must, within 31 days from the first day of eligibility, notify their agency payroll personnel and either:

- 1) enroll and receive State contribution toward the cost of benefits; or
- 2) sign a waiver of benefits and forego State contribution.

b. CORE BENEFITS ARE:

- 1) employee medical benefits – you choose one of the available medical plans for the remainder of the benefit year and automatically receive the Employee Assistance Program and Prescription Drug Plan;
- 2) employee dental benefits; and

3) basic (Plan A) employee life insurance.

A current New Employee and/or annual change booklet for benefits costs and State contribution is available from agency payroll personnel or the HCBd website at www.benefits.mt.gov.

c. ENROLLMENT OPTIONS FOR LEGISLATORS

Legislators may:

- 1) enroll and receive State contribution toward the cost of benefits; or
- 2) sign an Option 2 Authorization waiving State Plan coverage and applying State contribution toward any out-of-pocket benefits payments for health benefits (option 2 materials and forms are included in your initial benefit enrollment materials); or
- 3) sign a waiver of benefits and forego State contribution.

d. WHETHER TO ENROLL IN OPTIONAL BENEFITS

1) Optional benefits that face restrictions after the initial enrollment period

A newly eligible employee who wants any of the following optional benefits must enroll in these benefits within 31 days of the first day of eligibility for coverage to be automatic. Enrollment in optional benefits must occur at the time of enrollment in core benefits to avoid Pre-tax Plan and Flexible Spending Account restrictions (see I.B.5 and I.B.6).

Affected Optional Benefits Are:

i. Medical (including the Prescription Drug Plan) and dental coverage for existing dependents.

After the initial enrollment period, you can only enroll dependents for medical coverage under certain circumstances (see I.B.3).

Dependents may be enrolled for dental coverage during any annual change period.

ii. Optional vision insurance. This is available only during the initial enrollment period and during an annual change period for any benefit year(s) the coverage is offered.

iii. Plan B – basic dependent life insurance on existing dependents. This is only available later if you marry, declare domestic partnership, or have a first child.

iv. Plan C – optional employee life insurance on self, in the amount of one times your annual salary rounded to the next highest \$5,000. Later enrollment requires an application showing evidence of insurability, which must be accepted by the underwriting department of the State Plan's life insurance company.

v. Long-term care insurance on self (monthly benefit amounts of \$1,000 – \$4,000). A separate application is required, but during the initial enrollment period, this application does not require approval. Later enrollment (or enrollment for monthly benefit amounts of \$5,000 or \$6,000) requires an application showing evidence of insurability, which must be accepted by the underwriting department of the State Plan's long-term care insurance company.

vi. Flexible Spending Accounts (available to active and eligible employees who receive paychecks through Central Payroll — see I.B.6). This is not available again until the next annual change period unless there is a qualifying event as described in I.B.6.

vii. Long-term disability (available to active and eligible employees who receive paychecks through Central Payroll excluding legislators). This coverage may require application and approval by the State Plan's long-term disability company and is available during the initial enrollment period. After this initial enrollment period, enrollment is not available again until the next annual change period.

2) Optional benefits that are not affected by time of enrollment.

The following optional benefits may be obtained even if you do not enroll during the first 31-day initial enrollment period. However, once you have enrolled, you must wait until an annual change period to add or change benefits whose benefits payments are paid pre-tax through the Pre-tax Plan (see I.B.5).

i. Plan C – optional employee life insurance on yourself in excess of one times your annual salary rounded to a \$5,000 increment. This coverage always requires application to and approval by the State Plan's life insurance company.

- ii. Plan D – supplemental spouse or declared domestic partner life insurance. This coverage always requires application to and approval by the State Plan’s life insurance company.
 - iii. Plan E – accidental death and dismemberment insurance. This coverage never requires application to and approval by the State Plan’s life insurance company.
 - iv. Long-term care insurance on your spouse (or parents) or coverage on yourself for monthly benefit amounts of \$5,000 or \$6,000. This coverage always requires application to and approval by the State Plan’s long-term care insurance company.
 - v. Long-term disability – This coverage may require application to and approval by the State Plan’s long-term disability insurance company.
- e. IF YOU ENROLL – On the first day you meet eligibility requirements and are employed in active pay status, you may enroll with your agency payroll personnel in core benefits for yourself, the member (and the optional benefits listed below). When you sign the enrollment form, you authorize any contribution or payment for benefits for core and any optional benefits you elect that exceed the State contribution to be deducted from your pay. See a current New Employee/ annual change booklet for benefits costs and the applicable State contribution.
- 1) When you enroll, you must:
 - i. choose a medical plan for the remainder of the benefit year; and
 - ii. either accept automatic participation in the Pre-tax Plan or decline participation for the remainder of the benefit year (see I.B.5).
 - 2) At that time, you may also elect any of the following optional benefits:
 - i. medical and/or dental coverage for dependents (dependents shall be on same medical plan as the member);
 - ii. optional vision coverage;
 - iii. any optional life insurance on yourself and dependents not requiring approval of the State Plan’s life insurance company;
 - iv. accidental death and dismemberment insurance; or
 - v. flexible Spending Accounts.

The State is required by the Internal Revenue Service (IRS) to apply the proper tax treatment (before or after tax) to benefits for spouses/domestic partners enrolled in medical, dental, or vision benefits. Therefore, it is important that you provide the tax status of each person enrolled. The qualification of these individuals as your spouse/domestic partner for tax purposes does not affect their eligibility but does impact the tax treatment of that coverage.

You may also apply for additional life insurance coverage on yourself (additional Plan C coverage), long-term disability coverage for yourself (excluding legislators), life insurance on your spouse (Plan D – supplemental spouse), and you, your spouse, parents, and parents-in-law may apply for long-term care benefits.

You should elect any optional benefits and apply for additional Plan C life insurance at the same time you enroll in core benefits to avoid Pre-tax Plan and Flexible Spending Account restrictions (see I.B.5 and I.B.6).

Elected officials become eligible to enroll on the first day they take the oath of office or the day the term begins, whichever comes first.

f. IF YOU WAIVE BENEFITS

If you waive State Plan coverage, you do not give up your rights as an eligible State employee to automatic enrollment in core benefits at a later date. This automatic enrollment does not apply to dependents. In order to add dependents outside the initial enrollment period, you must experience a qualifying event as described in I.B.3. The waiting period for coverage of a pre-existing medical condition may apply as described in I.C.4 unless you receive a previous coverage credit described in I.C.5.

g. RE-ENROLLMENT FOLLOWING TERMINATION

If a State employee who has terminated employment and State Plan benefits is rehired and re-enrolled in the State Plan within 30 days of last day worked, any prior coverage is reinstated. Contact HCBD for questions relating to reinstatement of coverage.

A former employee who is re-hired after 30 days may make new plan elections and enroll any eligible dependents, the same as any newly hired employee (within 31 days of re-hire).

Any expenses incurred during a lapse in coverage are not covered regardless of whether the rehire is within 30 days of termination or later.

2. ENROLLMENT OF NEWLY ACQUIRED DEPENDENTS DURING A 60-DAY SPECIAL ENROLLMENT PERIOD TRIGGERED BY A NEW-DEPENDENT QUALIFYING EVENT

New dependents (a new spouse/domestic partner or child) must be enrolled (through your agency payroll personnel) within 60 days of the qualifying event. In the case of a birth/adoption, the 60 days begins after the 31-day automatic coverage period. See I.C.2 for special newborn coverage. Documentation of the qualifying event (for example, a copy of the marriage license or birth certificate) is required at the time of enrollment.

Legally adopted children must be enrolled (through your agency payroll personnel) by providing copies of the court-ordered adoption to the payroll person within 60 days of the date on which they first became eligible (date of adoption court order).

Pre-adoptive children must be enrolled (through your agency payroll personnel) by completing an affidavit of intent to adopt (a court document) or providing placement agreement documents within 60 days of the date on which they first became eligible (date of pre-adoption placement agreement). Interim coverage for the pre-adoption placement period will be provided for a maximum of 14 months from the date of placement. (See I.C.2 for pre-adoptive coverage.)

In the case of a birth, adoption, or pre-adoptive placement, the spouse and other dependents of an employee may be enrolled along with the new dependent child during the child's 60-day special enrollment period.

New dependents not enrolled for medical coverage within their first 60-day special enrollment period may only be added later under certain circumstances (see I.B.3).

3. OTHER QUALIFYING EVENTS TRIGGERING 60-DAY SPECIAL ENROLLMENT PERIODS FOR DEPENDENTS

An employee may elect not to enroll a dependent for medical and/or dental coverage within the employee's initial enrollment period (described in I.B.1) or within a newly-acquired dependent's special enrollment period (described in I.B.2) because the dependent has comparable coverage with another group plan or government program. In this case, the dependent may be enrolled for medical and/or dental benefits at a later date during a 60-day special enrollment period beginning on one of the following qualifying events:

- a. Loss of other coverage due to loss of eligibility (**not cancellation or failure to pay benefits payments**) as a result of events such as spouse's or partner's termination or loss of employment; spouse's reduction in hours resulting in loss of eligibility for benefits; loss of eligibility for Medicaid, Medicare, Healthy Montana Kids, or other governmental health benefits; or, in the case of a dependent child, divorce resulting in loss of eligibility under the ex-spouse's or ex-partner's plan.
- b. A significant adverse change (benefits cuts and/or benefits payments increase) in a health care plan as approved by HCBD.
The waiting period for coverage of a pre-existing medical condition (described in I.C.4) may apply to the above — just as it may apply to dependents enrolled in their first 31 days of eligibility — unless the eligible dependent receives a previous coverage credit described in I.C.5.
- c. A child support order or change in a child support order making a State Plan member responsible for a dependent child's medical benefits.

4. ENROLLMENT OF INDIVIDUALS WHO ARE ELIGIBLE BOTH AS EMPLOYEES AND DEPENDENTS OR WHO ARE ELIGIBLE DEPENDENTS OF MORE THAN ONE STATE EMPLOYEE

Two spouses or a parent and child who are both employed by the State and who are both eligible employees must each enroll (or waive) core benefit coverage. One may not be enrolled as a dependent of the other, with the following exceptions in the case of spouses: Plan B – dependent life; Plan D – supplemental spouse coverage; and Plan E – accidental death and dismemberment (AD&D) insurance.

RELATED INFORMATION – FLEXIBLE SPENDING ACCOUNTS (FSA)

Qualified medical expenses of any FSA-eligible dependent (whether they have their own FSA or not) can be paid through a Medical FSA.

JOINT CORE COVERAGE

If two spouses who are both eligible employees have eligible dependents they wish to enroll, they may enroll for joint core coverage under the same medical plan. The children will be enrolled as dependents of one of the parent spouses, but with joint core coverage. Joint core coverage means that the spouses and children will have only one family deductible and one family out-of-pocket maximum to meet and may have a slightly lower benefits payment than enrolling separately. If employees do not initially enroll in Joint Core coverage, they must have a qualifying event to opt into Joint Core coverage at a later date.

If the spouses choose to enroll separately, one spouse will have employee-only coverage and the other spouse will have employee and children coverage with separate deductibles and out-of-pocket maximums. The dependent children can only be covered as dependents of one of the spouses.

5. PRE-TAX PLAN ENROLLMENT AND RESTRICTIONS ON CHANGES AFFECTING CONTRIBUTION

PAYMENTS FOR BENEFITS

a. PRE-TAX PLAN

This is a Pre-Tax Plan for paying your share of benefits payments with pre-tax dollars, rather than with after-tax dollars. The plan is offered in accordance with the Internal Revenue Code Section 125 and applicable federal regulations. Note – You must participate in this program in order to participate in the FSA program (see I.B.6). Payments paid through the Pre-tax Plan cannot be claimed as medical expenses when calculating itemized deductions on your income tax return or when calculating the federal Earned Income Tax Credit. This credit is available to low-income families who make benefits payments to provide coverage for one or more dependent children. Tax savings achieved by paying your benefits payment through the Pre-tax Plan may be more favorable than those achieved by claiming them as a medical expense deduction because of limitations on medical expenses that can be deducted.

Employee contributions that are eligible for pre-tax payment (deduction from gross wages), include contributions to:

- 1) medical, dental, and optional vision insurance (including dependent coverage);
- 2) up to \$50,000 of term life insurance (plans A and C);
- 3) accidental death and dismemberment (AD&D) insurance; and
- 4) long-term disability insurance.

b. WHO MAY PARTICIPATE IN THE PRE-TAX PLAN AND HOW TO ENROLL

All employees who enroll in the State Plan are automatically covered by the Pre-tax Plan, unless they decline participation in writing at the beginning of employment/eligibility or during the annual change period.

c. ANNUAL ELECTION

Once a year, during a designated annual change period, enrolled employees are asked to make the following elections for the upcoming benefit year:

- 1) which health plan they want for themselves and family members currently enrolled for medical benefits;
- 2) which available optional benefits they wish to elect, change, or apply for; and
- 3) whether their previous election related to the pre-tax plan will continue.

This opportunity is provided in the fall of each year for the following benefit year beginning January 1. See current annual change materials for the deadline for elections.

d. MID-YEAR RESTRICTIONS ON CHANGES

Once a benefit year begins and the first contribution has been taken, IRS regulations prohibit enrolled employees from joining or dropping out of the Pre-tax Plan or making benefit changes that affect the amount of benefits payments made with pre-tax dollars until the beginning of the next benefit year, with a few exceptions.

Pre-tax benefits payments may be changed mid-year under the following circumstances:

- 1) The employee elected to make the change during the annual change period before the benefit year started, but had to await application approval;
- 2) The change is automatically triggered by a change in age (age-based life insurance rates), salary (amount of Plan C life insurance coverage), or a general benefits payment change authorized by HCBD; or
- 3) A change in coverage and benefits payment is needed (or enrollment in the Pre-tax Plan is needed) because of a qualifying event (a qualifying change in family/employment status).

e. QUALIFYING EVENTS INCLUDE:

- 1) marriage or declaration of domestic partnership;
- 2) divorce, legal separation, dissolution of domestic partnership, or a change in a custody/support order;
- 3) death of a spouse/domestic partner or child;
- 4) birth or adoption of a child;
- 5) employment change of a spouse, which affects their eligibility for benefits, such as termination, reduction or increase in hours, going on unpaid leave, etc.;
- 6) a major change, as determined by HCBD upon review of the circumstances, in a spouse's or partner's benefits: an adverse change (such as major increases in out-of-pocket benefits costs, deductible, or copayment maximums) prompting dependent additions to your plan; or a positive change (such as added benefits or cost reductions) prompting dependents to be deleted from your State Plan and moved to your spouse's plan;
- 7) a dependent child's loss of eligibility under your plan (due to age, military service, etc.) or loss of a dependent child's eligibility under your spouse's plan necessitating an addition to your plan; or
- 8) loss of other primary health benefits such as Medicaid, Medicare (does not apply to Medicare supplement plans), or Health Montana Kids (HMK) by a dependent.

Changes in coverage must be consistent with the qualifying event and requested within 60 days of the qualifying event. In the case of birth/adoption, the 60 days begins after the 31-day automatic coverage period. Permissible changes do not include a change in medical plans, unless you move out of the plan's service area or retire. Requests for permissible coverage changes and documentation of the qualifying event must be received (date stamped) at HCBD, PO Box 200130, Helena, MT 59620-0130; or received by fax at (406) 444-0080 by the 60th day after the event. Changes involving a reduction in benefits payments should be requested as soon as possible to avoid loss of benefits dollars (see refund restrictions below) and liability for claims paid on an ineligible dependent (see I.A.4).

f. REFUND RESTRICTIONS

The Internal Revenue Code prohibits refunds when changes are made to coverage paid with pre-tax dollars. Employees on the Pre-tax Plan must remove ineligible dependents as soon as they become ineligible to avoid losing benefits dollars by contacting HCBD at the above address or fax number. All benefits payments, whether paid with pre-tax or post-tax dollars, cannot be refunded. If a dependent on your plan loses eligibility, you are responsible for notifying HCBD.

g. CHANGES NOT SUBJECT TO MID-YEAR RESTRICTIONS

Allowable changes in coverage that do not change the amount of benefits payments made with employee pre-tax dollars can be made at any time. These include:

- 1) changes that do not affect benefits payments (such as the addition of a second child to the Dental or Vision Plans); and
- 2) any changes in life insurance (plans A and C) from an amount over \$50,000 to another amount over \$50,000 (benefits payments for life insurance amounts in excess of \$50,000 must be paid after taxes).

h. RE-ENROLLMENT FOLLOWING TERMINATION

If a State employee who has terminated employment and State Plan benefits is rehired and re-enrolled in the State Plan within 30 days of termination, any prior coverage is reinstated as described in I.B.1, provision e. Coverage paid pre-tax can only be changed during a benefit year if one of the qualifying events listed in I.B.5 provision d, above has occurred. A former employee who is re-hired after 30 days may make new plan elections and enroll any eligible dependents, the same as any newly hired employee. Any expenses incurred during a lapse in coverage are not covered, regardless of whether the rehire is within 30 days of termination or later.

6. FLEXIBLE SPENDING ACCOUNTS (FSA) ENROLLMENT AND CHANGES

a. FLEXIBLE SPENDING ACCOUNTS

- 1) **Medical FSA** – A medical FSA is an IRS- approved way for enrolled employees to pay, on a pre-tax basis, for their own or a family member's eligible medical expenses that are not covered by a benefit plan. (Eligible expenses of family members who are not on the State Plan may be paid through an FSA. See Chapter VI for eligible medical expenses.)
- 2) **Dependent Care FSA** – A dependent care FSA is an IRS- approved way to pay for qualified dependent care (day care) expenses on a pre-tax basis. See Chapter VI for a listing of eligible dependent care expenses. FSAs are offered in accordance with Internal Revenue Code Sections 125 and 129 and applicable federal regulations and save you tax dollars on eligible expenses.
- 3) **Relationship to Tax Deductions & Credits** – Medical expenses submitted for reimbursement through a Medical FSA may not be claimed as medical expenses when calculating itemized deductions on your income tax return. Tax savings achieved by paying your medical expenses through an FSA may be more favorable than those achieved by claiming them as a medical expense deduction, because of limitations on medical expenses that can be deducted.
Dependent care expenses submitted for reimbursement from a Dependent Care FSA cannot be used to calculate the dependent care credit on your federal income tax return. The amount eligible for the tax credit is directly reduced by the amount placed in a Dependent Care FSA. Tax savings from an FSA may be greater or less than taxes saved by using the Child Care Tax Credit. Call or visit the web site of the FSA Administrator to assist you in deciding between these two options.

b. WHO MAY PARTICIPATE IN AN FSA AND HOW TO ENROLL

Employees who are enrolled or are in the process of enrolling in the State Plan, who are paid through the Central State Payroll System (excluding legislators), and who are in the Pre-Tax plan are eligible to enroll in both the Medical and Dependent Care FSAs.

New employees who want an FSA must enroll in the FSA program within their first 31 days as described in I.B.1. All employees in the State Plan may enroll in one or both FSAs each year as described in I.B.6, provision e.

c. HOW MUCH CAN BE PUT INTO EACH ACCOUNT?

You may put up to \$2,500 of pre-tax dollars into your Medical FSA per benefit year, and in most instances up to \$5,000 of pre-tax dollars into your Dependent Care FSA. IRS regulations change this \$5,000 dependent care maximum if any of the following apply:

- 1) if your spouse is also enrolled in a Dependent Care FSA, your total annual family contribution cannot exceed \$5,000;
- 2) if either you or your spouse earns less than \$5,000 a year, you can contribute up to the lower of the two incomes;
- 3) if your spouse is either a full-time student or incapable of self-care, you may contribute up to \$3,000 a year for one dependent or \$5,000 a year for two or more dependents;
- 4) if you are married but file a separate federal income tax return, you may put a maximum of \$2,500 into your Dependent Care FSA or

The minimum you may put into each account is \$120 a year, or \$10 a month.

d. PLACING UNUSED MONTHLY STATE CONTRIBUTION INTO AN FSA

Any portion of the State contribution in excess of the amount needed for core benefits and any elected optional benefits will be placed in an FSA, provided you are enrolled in an FSA and specifically designate the amount.

e. ANNUAL ELECTIONS

Once a year, during the annual change period, you must decide whether you wish to participate in one or both FSAs and elect the amount of pre-tax dollars you wish to put into the account(s) for the next benefit year. This annual amount is then divided into equal pay-period amounts, which are deducted first from any unused State contribution and then from gross pay. An administrative fee for FSA administration services, if applicable, is also deducted from your gross pay.

An expense must be incurred (services received or products ordered) during the benefit year in which an FSA is in effect to be reimbursable from that FSA (as described I.B.6, provision e). This may or may not be the same time you are billed for and pay for the services or products. If you are planning to pay for services that are received over the course of more than one benefit year through an FSA (especially orthodontia), contact the FSA program administrator in advance of making your FSA election for assistance.

f. MID-YEAR RESTRICTIONS ON CHANGES

Once the annual change election deadline has passed, you may not change or discontinue your election for the remainder of the benefit year, unless a change is due to a qualifying change in family or employment status. Qualifying events are the same as for the Pre-tax Plan (see I.B.5, provision e).

To make a change, you must submit a change form (available from your agency payroll personnel or the HCBd website) to HCBd within 60 days of the qualifying event. Mid-year reductions in Medical FSAs are not allowed if you have already received more in reimbursements than you have contributed.

NOTICE - USE IT OR LOSE IT REQUIREMENT

IF, AT THE END OF THE BENEFIT YEAR, YOU HAVE NOT HAD ENOUGH ELIGIBLE EXPENSES TO USE UP YOUR FSA AMOUNT, YOU FORFEIT THE UNUSED BALANCE. IT IS IMPORTANT TO PUT NO MORE OF YOUR GROSS SALARY DOLLARS INTO AN FSA THAN YOU ARE SURE YOU WILL USE DURING THE YEAR.

g. RE-ENROLLMENT FOLLOWING TERMINATION

If a State employee who has terminated employment and State Plan benefits is rehired and re-enrolled in the State Plan within 30 days of termination, any prior FSA enrollment is reinstated at prior monthly contribution rates. The annual FSA election will be reduced by the amount of any missing contributions, and no expenses incurred during the lapsed period of coverage are eligible for FSA reimbursement. The FSA annual election and monthly contribution can only be changed if one of the qualifying events listed in I.B.5, provision e, has occurred. A terminated employee who is re-hired after 30 days may make a new FSA election, the same as any newly hired employee, and only expenses incurred after the effective date of the newly-elected FSA are eligible for reimbursement from that account.

C. WHEN COVERAGE BEGINS

1. FOR NEWLY-HIRED AND NEWLY-ELIGIBLE EMPLOYEES (AND THEIR DEPENDENTS) ENROLLED WITHIN THE 31-DAY INITIAL ENROLLMENT PERIOD

a. CORE EMPLOYEE MEDICAL AND DENTAL BENEFIT COVERAGE IS EFFECTIVE ON:

- 1) the first day of the pay period following receipt of enrollment forms by the HCBd; or
- 2) retroactive to the first day of employment for new hires and the first day of eligibility for newly-eligible employees, provided:
 - i. an enrollment form is submitted within the 31-day initial enrollment period; and
 - ii. the enrollment form authorizes a payroll deduction of any retroactive benefits payments due. Retroactive payments must be taken after taxes, regardless of whether you will be on the Pre-tax Plan, to comply with Internal Revenue Service requirements.

To make sure you receive the most favorable benefits for early medical expenses, select your medical plan early and follow any plan rules regarding eligible covered providers, referrals, etc. (See I.C.4 for coverage effective dates on pre-existing medical and dental conditions.)

b. OPTIONAL DEPENDENT MEDICAL AND DENTAL BENEFITS

Optional dependent medical and dental benefit coverage is effective on the same date as employee medical and dental benefits. Coverage of pre-existing conditions may be delayed as described in I.C.4 and I.C.5.

c. **OPTIONAL VISION INSURANCE**

Optional vision insurance coverage is also effective on the same date as employee medical and dental insurance.

d. **FLEXIBLE SPENDING ACCOUNTS**

FSA coverage is effective the first day of the first month following enrollment in which a full month of FSA payroll deductions can be taken.

e. **LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE**

Life and AD&D insurance coverage, which do not require application and approval by the State Plan's life insurance company, are effective on the same day as employee medical and dental coverage as described above. Elected optional life insurance benefits requiring approval are effective on the first of the month following approval.

f. **LONG-TERM CARE INSURANCE**

Long-term care insurance benefits that do not require approval are generally effective on the first day of the month following receipt of the application by the State Plan's long-term care insurance company if the application is received by the 15th of a month. Benefits are effective on the first day of the second month following receipt of the application, if it is received after the 15th of a month. Long-term care insurance benefits that require approval are effective on the effective date specified by the State Plan's long term care insurance company.

g. **LONG-TERM DISABILITY INSURANCE**

Long-term disability insurance benefits that do not require approval are effective on the same day as employee medical and dental coverage as described above. Long-term disability insurance benefits that require approval are effective on the effective date specified by the State Plan's long-term disability insurance company.

2. FOR LATER DEPENDENT ENROLLMENTS TRIGGERED BY A QUALIFYING EVENT

The effective date of medical and dental benefits is the beginning of the first day of the first pay period following HCBD receipt of the enrollment form and all required documentation of the qualifying event — except in the case of birth, adoption, placement for adoption, and court ordered coverage described below. See I.C.4 and I.C.5 for any applicable waiting periods for coverage of pre-existing conditions.

Since enrollment forms and any required documentation must be received before coverage can begin, it is important to enroll dependents as soon as they become eligible or a qualifying event occurs. Waiting until the end of the 60-day special enrollment period delays coverage.

a. **BIRTHS**

Automatic medical coverage of an infant born to a plan member begins at birth for a 31-day period. You must submit an Enrollment/Change Form (no later than 91 days after the birth) and make any required employee contributions to continue medical coverage on an eligible newborn dependent beyond the first 31 days. You may also enroll the newborn for dental and/or vision coverage at that time or wait until later. Retroactive medical coverage to the date of birth may be obtained for an eligible newborn dependent (as well as the spouse and other eligible dependents) if:

- 1) enrollment occurs within the 60-day special enrollment period (after the 31-day automatic coverage); and
- 2) the enrollment form authorizes a payroll deduction of any retroactive benefits payments due, which will be taken pre-tax for Pre-tax Plan members, as allowed by IRS rules.

b. **ADOPTION AND PRE-ADOPTIVE PLACEMENT**

Medical, dental, and/or vision coverage of a child adopted by (or placed for adoption with) a member or member's spouse can begin on the date of the adoption or pre-adoptive placement agreement, if:

- 1) the adoption court order or Affidavit of Intent to Adopt has been completed;
- 2) enrollment occurs within the 60-day special enrollment period (after the 31-day automatic coverage); and
- 3) the enrollment form authorizes a payroll deduction of any retroactive benefits payments due, which will be taken pre-tax for Pre-tax Plan members as allowed by IRS rules.

Copies of the adoption court order or pre-adoptive placement agreement are required. Coverage for pre-adoptive placement will be provided for a maximum of 14 months from the date of placement.

c. COURT-ORDERED COVERAGE

Medical, dental, and/or vision coverage of a child subject to a court order can begin on the date of the order, if:

- 1) enrollment occurs within the 60-day special enrollment period (60 days of the effective date of the order); and
- 2) the enrollment form authorizes a payroll deduction of any retroactive benefits payments due.

In the case of court-ordered coverage, enrollments will be accepted after the 60-day special enrollment period, but coverage is effective the first day of the first pay period following HCBD receipt of the enrollment form and documentation of the qualifying event (court order).

d. THE EFFECTIVE DATE FOR OTHER HEALTH CARE BENEFITS

The effective date for benefits coverage that does not require application and approval is the beginning of the first day of the first pay period following HCBD receipt of the enrollment form and required documentation of the qualifying event. The effective date for a Flexible Spending Account is always the first day of the month following enrollment in which a full month of FSA payroll deductions can be taken. The effective date for optional benefits, which require application and approval, is the first of the month following approval, or in the case of long term care or long term disability insurance, the effective date is set by the long term care or long term disability insurance companies.

3. FOR LATER ENROLLMENT IN EMPLOYEE-ONLY COVERAGE BY EMPLOYEES WHO INITIALLY WAIVED COVERAGE

The effective date is the beginning of the first day of the first pay period following HCBD receipt of the enrollment form. Note this refers to new employees who initially waive coverage. If an existing employee declines benefits during annual change, that employee has to wait until the following annual change to select benefits. See I.C.4 and I.C.5 for any applicable waiting periods for coverage of pre-existing conditions. Dependents may not be added without a qualifying event outlined in I.B.1, I.B.2, and I.B.3.

4. WAITING PERIODS FOR PRE-EXISTING CONDITIONS FOR MEMBERS AND DEPENDENTS AGE 19 OR OLDER

Medical and Dental Plan coverage (excluding prescription drug coverage) of any pre-existing medical or dental condition is available only after a new member has been continuously covered for a period of 12 consecutive months, except as provided in I.C.5.

A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment (including prescription drugs) was recommended or received within the six-month period before the enrollment date. Pregnancy is not considered a pre-existing condition.

If an employee or dependent is already hospitalized on the date the employee becomes eligible for coverage, enrollment will be deferred until the day following the day of termination of such hospital confinement (unless a previous coverage credit is granted as provided in I.C.5).

RELATED INFORMATION

Long-Term Care Insurance – Long-term care insurance excludes coverage of a pre-existing condition when coverage was obtained without submitting evidence of insurability. See the pre-existing condition exclusion in the long-term care insurance outline of coverage.

5. CREDITABLE COVERAGE

Any period of up to 12 months of prior comprehensive medical coverage on a new State Plan enrollee, defined as creditable coverage in Chapter I, will be credited toward any applicable 12-month waiting period on a pre-existing medical condition described in I.C.4.

Only prior coverage since the last 60-day break in coverage, which satisfies the definition of creditable coverage, will be credited toward waiting periods. A certificate of creditable coverage from the prior plan must be submitted to the HCBD and approved.

EXAMPLE

If a newly enrolled employee or dependent was previously covered by another comprehensive group health plan for a year or more, and did not have a lapse of more than 60 days between the prior and State Plan coverage, 12 months of creditable coverage is applied, eliminating any waiting period on a pre-existing medical condition. If the employee or dependent was only previously covered for five months, five months of the 12-month waiting period would be eliminated, leaving a seven-month waiting period.

If the former plan did not include a significant benefit (such as an organ transplant benefit) or only included a limited benefit, credit may be denied for the missing benefit or portion of benefit. In the case of a limited benefit under the former plan, State Plan coverage for the first 12 months of membership would be limited to the benefit of the prior plan.

D. WHEN COVERAGE ENDS

1. MEDICAL AND DENTAL BENEFITS

EMPLOYEE COVERAGE ENDING DATE

Coverage of an enrolled employee (and their dependents) ends (except as provided in I.D) at 12:00 midnight on the last day of the month or pay period (as established by HCBD) in which one of the following occurs:

- a. The employee's State employment terminates, or the employee otherwise ceases to be eligible under the State Plan;
- b. Employee contribution or payment for benefits that is due is not paid; or
- c. The State Plan terminates.

Terminating employees who have been continuously covered by the State Employee Plan since August 1, 1998 (when advance contribution or payment for benefits collection ended), are entitled to an additional month or two additional pay periods of coverage for themselves and their dependents (as established by HCBD) provided any required employee contribution is paid.

DEPENDENT COVERAGE ENDING DATE

Coverage of an enrolled dependent also ends (except as provided in I.D) at 12:00 midnight on the last day of the month or pay period (as established by HCBD), in which the dependent ceases to meet State Plan eligibility requirements and/or employee contribution or payment for benefits are not paid.

It is the employee's/member's obligation to notify agency payroll personnel within 31 days when a dependent becomes ineligible for benefits. Members should provide notification as early as possible to avoid making unusable and nonrefundable payments. Coverage of dependents turning age 26 should automatically terminate. However, if it does not, the employee is responsible for notifying HCBD of the dependent's loss of eligibility.

2. OTHER BENEFITS

Group life insurance, accidental death and dismemberment (AD&D) insurance, long-term care, long-term disability insurance, and optional vision insurance end when medical and dental benefits end (except as provided in I.E). Optional vision, life, and AD&D insurance coverage also cease when the group policies providing this coverage cease, although similar benefits may be continued through another insurance company or self-insurance by the State. FSA coverage ends (except as provided in I.E) at the end of the month in which the last employee contribution is taken.

E. COVERAGE CONTINUATION RIGHTS

1. EMPLOYEE AND DEPENDENT PLAN MEMBERS LOSING ELIGIBILITY – COBRA AND STATE

EMPLOYEE PROTECTION ACT RIGHTS

This provision summarizes your rights and obligations under the Consolidated Omnibus Budget Reconciliation Act of 1986, commonly referred to as COBRA (Public Law 99-272, Title X), and the State Employee Protection Act (2-18-1201-1206, MCA). See I.E.1, provisions b and c, and I.E.3 for rights during a leave without pay and leave involving Workers' Compensation benefits. See I.E.9 through I.E.11 for additional rights to convert some group benefits to an individual or conversion policy.

- a. LAID OFF EMPLOYEES — STATE EMPLOYEE PROTECTION ACT COVERAGE

Under the State Employee Protection Act, an employee who is laid off as part of a reduction in force covered by the Act may continue existing State Plan coverage for six months from the effective date of the layoff, or until the employee becomes employed in a job that provides comparable benefits, whichever comes first. During this time, the employee receives State share toward the contribution or payment for benefits and must only self-pay the employee contribution.

b. EMPLOYEE RIGHTS TO COBRA COVERAGE

1) Under COBRA, an employee covered by the State Plan may continue existing State Plan medical, optional dental, and optional vision coverage on him or herself and/or dependents (see I.E.1, provision c) if coverage would otherwise be lost due to any of the following qualifying events:

- i. layoff or reduction-in-force (COBRA coverage starts after any period of State Employee Protection Act coverage ends);
- ii. voluntary termination of employment for reasons other than gross misconduct; or
- iii. voluntary or involuntary reduction in scheduled hours below 20 a week.

To continue coverage under COBRA, you must self-pay the entire applicable monthly contribution or payment for benefits.

Employees covered by the State Plan whose hours are reduced as a result of leave of absence or any injury for which Workers' Compensation benefits are being received have other rights to continue coverage which must be exhausted before COBRA rights are available (see I.E.2 and I.E.3).

2) FSA Coverage Continuation

An employee with any of the above events may continue a Flexible Spending Account (FSA) through the remainder of the benefit year using one of two payment options:

- i. by making as many of the remaining monthly FSA contributions for the benefit year as can be taken out of the final pay check on a pre-tax basis (to receive the tax benefit) and self-paying for any remaining months with after-tax dollars at the beginning of each remaining month; or
- ii. by self-paying the FSA contribution for all post-employment months with after-tax dollars at the beginning of each month.

3) Continuation Period

COBRA medical, dental, and optional vision coverage may be continued for up to 18 months. Flexible Spending Account participation may be continued through the remainder of the current benefit year.

4) Disability Continuation Period

COBRA coverage may be continued for up to 29 months if an employee enrolled in the State Plan is determined to have been disabled under the Old Age, Survivors, and Disability Insurance (OASDI) or Supplemental Security Insurance (SSI) of the Social Security Act at the time of, or within 60 days after, the pertinent qualifying event described above. The employee must apply to the HCBD (406) 444-7462, (800) 287-8266, or TTY (406) 444-1421 for the extended coverage during the first 18 months of COBRA coverage, and within 60 days after the date of the disability determination by the Social Security Administration. Flexible Spending Accounts may also be continued through the remainder of the current benefit year (see I.E.1, provision b).

c. DEPENDENT RIGHTS TO COBRA COVERAGE

1) Independently of the employee, the spouse or other dependent of a State employee enrolled in the State Plan who self-pays the entire applicable monthly benefits payment, may continue existing medical, dental, and optional vision coverage (see I.E.1, provision d) if coverage would otherwise be lost due to any of the following events:

- i. the death of the employee *and* the spouse or dependent is not eligible for, or does not exercise rights outlined in I.E.1, provision f.
- ii. the lay-off, reduction-in-force, voluntary or involuntary termination (for reasons other than gross misconduct), or reduction in hours of employment of the employee.
- iii. divorce, legal separation, or removal of a spouse from the plan in anticipation of divorce.
- iv. attainment of age 26 by a dependent child or some other event resulting in loss of dependent status.

2) Continuation Period

Except where coverage is lost as result of the employee's loss of eligibility due to layoff, termination, reduction in hours, etc., COBRA medical, dental, and optional vision coverage may be continued for up to 36 months. (Surviving dependents eligible to continue coverage under I.E.1, provision f, must exhaust their rights under that provision before COBRA rights are available.) Coverage lost due to layoff, termination, reduction-in-hours, etc., may be continued for only up to 18 months, absent a qualifying disability described below. Flexible Spending Account participation may be continued through the remainder of the current benefit year.

3) Disability Continuation Period

Coverage may be continued for up to 29 months for a covered dependent with a qualifying disability at the time of, or within 60 days after the employee's layoff, reduction-in-force, or voluntary/involuntary termination. The disability must qualify under the (OASDI) or Supplemental Security Income (SSI) sections of the Social Security Act as determined by the Social Security Administration. To receive the COBRA extension, a copy of your SSI determination must be filed with HCBF within the first 18 months of COBRA coverage and within 60 days after the date of the disability determination by the Social Security Administration. Flexible Spending Account participation may be continued through the remainder of the current benefit year.

4) Impact of a Second Qualifying Event on the Continuation Period

If a dependent on a COBRA member's coverage or a newly acquired dependent added to a COBRA member's coverage loses eligibility due to another qualifying event (such as a child turning age 26), the dependent has an independent right to continue coverage for 36 months from the date of the original qualifying event. If an employee who has continued State Plan benefits under COBRA for up to 18 months becomes entitled to Medicare during that time, COBRA coverage for qualified covered dependents may be extended for up to 36 months from the original qualifying event.

d. COBRA CONTINUATION OPTIONS – COBRA-eligible employees may continue the following existing benefit coverage combinations on themselves and covered dependents:

- 1) medical benefits only;
- 2) medical, plus dental benefits;
- 3) medical, plus optional vision insurance; or
- 4) medical, plus dental, plus optional vision insurance.

Dependents may also independently continue any one of the above coverage combinations, provided the coverage was in effect before the event resulting in loss of eligibility (and provided they are not covered as a dependent of a COBRA-eligible employee). Only those dependents with dental and/or optional vision coverage — but no medical coverage — before the event resulting in loss of eligibility, may continue dental and/or optional vision coverage without continuing medical coverage. Dental and/or optional vision can only be added at annual change for any benefit year it is offered.

Flexible Spending Accounts can also be continued through the end of the benefit year. No life, accidental death and dismemberment, or long term care insurance benefits may be continued under this provision. New dependents may be added for the same coverage as the employee or COBRA-continuing dependent, provided they are enrolled as specified in I.B.1, provision b.

e. COBRA CONTINUATION PROCEDURES

For loss of dependent eligibility due to divorce, reaching age 26, or other event, the dependent must notify HCBF of the event within 60 days of the event, or the date on which coverage terminates due to the event, whichever is later. *The right to continue coverage is forfeited if HCBF is not notified within the 60-day time period.*

When HCBF receives notice of loss of dependent status, a Second Notice of COBRA Rights is sent (employees and enrolled dependents receive the first notice within three months when they first enroll). In the case of dependents turning age 26, the Plan Administrator normally sends an automatic notice of COBRA rights. However, it is your or your dependent's responsibility to notify HCBF of loss of dependent eligibility if you do not receive a notice.

An automatic second notice of COBRA rights is also sent when covered employees terminate employment with the State or otherwise lose eligibility for State Plan benefits.

You and/or your dependents must elect to continue coverage under COBRA within 60 days of the later of:

- 1) the date you receive your COBRA Rights Notice; or
- 2) the date active employee coverage ends.

The right to continue coverage is forfeited if not exercised within this 60-day period. All back payment for benefits (payment for benefits for intervening months since coverage was lost) must be paid within 45 days of the date you elect to continue coverage.

f. TERMINATION OF COBRA COVERAGE

COBRA coverage terminates before the end of the normal continuation period if any of the following occurs:

- 1) the monthly benefits payment is not paid by the first of the month of coverage or within the following 30-day grace period;
- 2) the COBRA member becomes eligible for Medicare; or
- 3) the COBRA member, through employment, marriage, or some other means, becomes covered under another group plan. If the other group plan has a pre-existing condition waiting period, COBRA coverage terminates when that waiting period ends.

2. EMPLOYEES TAKING LEAVE OF ABSENCE

a. COVERAGE CONTINUATION OPTIONS

An employee enrolled in the State Plan who is on an approved leave of absence without pay may continue core benefits only or has the option of also continuing any or all optional benefits in effect before the leave for a period of up to 12 months. The employee will be responsible for paying the entire monthly benefits payment, except for months of leave for which State contribution is required by:

- 1) union contract; or
- 2) the Federal Family Medical Leave Act (FMLA), which provides up to 12 weeks of State contribution for eligible family and medical leave.

All coverage ends when contribution or payment for benefits due is not paid, except that employees on FMLA leave may continue coverage for the period of FMLA leave by self-paying while on leave or by pre-paying prior to going on leave.

When coverage under this leave of absence provision ends, the employee and/or covered dependents may elect to continue medical and dental coverage under COBRA (see I.E.1, provisions b. and c.)

An employee enrolled in a Flexible Spending Account may continue the account by paying elected FSA amounts in advance out of final pay check(s) (to receive a tax advantage) for a leave of known duration, by paying on an after-tax basis at the beginning of each month, or through a combination of these methods. If payments cease, the account becomes inactive, allowing only those funds accumulated before payment ended to be used for reimbursement of eligible expenses incurred before payment ended.

b. RE-ENROLLMENT FOLLOWING A LAPSE

If an employee allows State Plan coverage to lapse while on leave of absence and later returns to active employment, re-enrollment is as follows:

1) Medical, Dental, and Optional Vision Benefits

If the employee returns to work and re-enrolls in State Plan coverage within the same benefit year, any prior coverage is reinstated. A mid-year change in medical plans is not allowed (unless you move out of your elected plan's service area or retire), and no dependents may be added unless a qualifying event described in I.B.3 and I.B.5, provision e., has occurred during the lapse that would have triggered a special enrollment period. Other mid-year changes may be made for employees previously in the Pre-tax Plan only if one of the qualifying events listed in I.B.5, provision e., has occurred.

If coverage lapses for more than 60 days, a new waiting period will be required for a pre-existing condition (medical and dental) for dependents age 19 and older unless eliminated or reduced by creditable coverage as described in I.C.5.

Note: Deductibles start over if a lapse occurs, even if the lapse is only one day.

2) Flexible Spending Accounts

If the employee returns to work and re-enrolls in the State Plan within the same benefit year, any prior FSA enrollment is reinstated under one of two employee options:

- i. coverage is resumed at the original annual amount and any missing contributions are made up by increasing the remaining monthly contributions; or
- ii. coverage is resumed at an annual amount reduced by the amount of the missing contributions.

No expenses incurred during the lapsed period of coverage are eligible for FSA reimbursement. The FSA annual election and monthly contribution may only be changed if one of the qualifying events listed in I.B.5, provision e., has occurred.

3) Life Insurance

Upon return to work, enrollment in basic Plan A (core life insurance) is required and Plan B (dependent life) is not available regardless of the period of time coverage has lapsed. Plans C (optional employee life) and D (optional dependent life) require application and approval if coverage has lapsed for a period of four months or more. Plan E (AD&D) may be elected without application.

Life Insurance for an Employee Who Returns from an FMLA Leave

If the return is within FMLA time frames, any life insurance in effect at the time of the FMLA leave may be reinstated.

4) Long-Term Care insurance

Re-enrollment requires application and approval by the State Plan's long-term care insurance company and rates are set at your or a re-enrolling spouse's age at time of re-enrollment.

5) Reinstatement of Long-Term Disability (LTD) insurance

If your insurance ends, you may become insured again as a new member; however, the following will apply:

- i. If you cease to be a member because of a covered disability, your insurance will end; however, if you become a member again immediately after long-term disability benefits end, the eligibility waiting period will be waived and with respect to the condition(s) for which LTD benefits were payable, the pre-existing condition exclusion will be applied as if your insurance had remained in effect during that period of disability.
- ii. If your insurance ends because you cease to become a member for any reason other than a covered disability, and if you become a member again within 90 days, the eligibility waiting period will be waived.
- iii. If your insurance ends because you fail to make a required benefits contribution, you must provide evidence of insurability to become insured again.
- iv. If your insurance ends because you are on a federal or state-mandated family or medical leave of absence and you become a member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.
- v. The pre-existing condition exclusion will be applied as if insurance had remained in effect in the following instances:
 - a) if you become insured again within 90 days; or
 - b) if required by federal or state-mandated family or medical leave act or law and you become insured again immediately following the period allowed pursuant to the federal or state-mandated family or medical leave act or law.
- vi. In no event will coverage be retroactive.

3. EMPLOYEES RECEIVING WORKERS' COMPENSATION

An employee on the State Plan receiving Workers' Compensation benefits for any work-related injury or occupational disease sustained during State employment may continue core benefits and has the option of continuing any optional benefits in effect before the injury by self-paying the entire monthly benefits payment. Coverage may be continued for as long as Workers' Compensation benefits are received and the individual's employment has not been terminated, but not to exceed 12 months. When coverage under this provision ends, the employee and/or covered dependents may

elect to continue medical and dental coverage under COBRA (see I.E.1, provision b). Flexible Spending Accounts are continued as described in I.E.1, provision b.

If the employee allows coverage to lapse while on leave due to a work-related injury and later returns to active employment, re-enrollment is as described in I.E.2, provision b.

4. EMPLOYEES WHO BECOME TOTALLY DISABLED

a. CONTINUATION OF LIFE INSURANCE AND BENEFITS PAYMENT WAIVER

An employee enrolled in the State Plan who becomes totally and permanently disabled before the age of 60 may be eligible to continue some life insurance coverage under the State Plan to age 65 without further payment for benefits. A waiver of payment for benefits claim must be filed and required documentation submitted to the State Plan's life insurance company within 12 months of the date you stopped active work. If you become totally and permanently disabled, contact HCBD for more information.

b. CONTINUATION OF LONG-TERM CARE INSURANCE AND BENEFITS PAYMENT WAIVER

When Long-Term Care Insurance benefits become payable to a covered individual, the contribution or payment for benefits is waived for as long as the individual continues to be eligible for a monthly benefit. Benefits payments are not waived while receiving payment for respite care. Respite care is formal care provided for a short period of time to allow the primary care giver a break from their care-giving responsibilities. For additional guidance on respite care, contact the State Plan's long-term care insurance company.

5. EMPLOYEES AND THEIR DEPENDENTS WHO BECOME MEDICARE ELIGIBLE

Covered employees and their dependents who become Medicare eligible because they are turning age 65, or because of a disability other than End Stage Renal Disease, have the following options:

- a. You or a dependent enrolled in the State Plan who becomes Medicare eligible may continue State Plan coverage only and not enroll for Medicare until you retire or terminate employment. Please note that there are Medicare penalties if you or your dependent fails to enroll in Part B Medicare during a short enrollment window at the time of retirement or termination of employment.
- b. You may cancel State Plan coverage for you (which would cancel your State contribution toward benefits) and/or your dependent and rely on Medicare coverage. If your dependent is eligible for Medicare because of a disability and loses Medicare eligibility in the future, that loss is a qualifying event allowing you to put your dependent back on the State Plan within 60 days of the loss.
- c. You may continue State Plan benefits and enroll in Medicare benefits. In this case, the State Plan will be primary payer until you retire (see VIII.A.3).

END STAGE RENAL DISEASE

A State Plan member who is eligible to enroll in Medicare due to End Stage Renal Disease should enroll in Medicare (both parts) when first eligible (select option 2 or 3 above). The State Plan will cover End Stage Renal Disease as the primary payer for 30 – 33 months (depending on circumstances as required by Medicare's coordination of benefits rules). After that time, Medicare becomes the primary payer and the State Plan becomes the secondary payer.

6. RETIREES

a. ELIGIBILITY, ENROLLMENT, AND PAYMENT

- 1) An employee enrolled in the State Plan who:
 - i. at least meets the early retirement criteria defined by MPERA; and
 - ii. makes arrangements with HCBD within 60 days of the date active employee coverage ends to continue post-retirement coverage, may continue with the State Plan on a self-pay basis, retroactive back to the date active employee coverage was lost, as provided below.
- 2) Employees enrolled in the Pre-tax Plan may pre-pay eligible retiree payment for benefits for up to the remainder of the benefit year from their final check on a pre-tax basis, provided a pre-payment request is timely submitted. Contact your agency payroll staff or HCBD. All information must be submitted by the end of the final pay period. Payment options for those who choose not to pre-pay, or when pre-payment ends, include:
 - i. automatic deduction from State retirement benefits (preferred);

- ii. electronic benefits payment deduction from a checking or savings account;
- iii. monthly self-payment; or
- iv. VEBA account (if eligible).

The State contribution ends when active employee coverage ends. Payments for benefits for converted coverage, described in I.E.9, are always self-paid directly to the applicable insurance company. *If State Plan coverage is allowed to lapse or is cancelled at the time of or after retirement, no reinstatement of coverage is allowed.*

b. OPTIONS OF RETIREES WHO ARE UNDER AGE 65 AND NOT MEDICARE ELIGIBLE

At retirement, you are eligible to continue core benefits – medical, dental, and Plan A life insurance – on yourself. (See a current retiree packet for medical plan options. The medical plan may be changed at retirement provided the change is to a plan with the same or higher deductible.)

Retirees who continue core benefits may also continue:

- 1) existing medical and dental benefits on dependents (dependents must be on the same plan as the retiree); and
- 2) existing optional vision benefits.

You may also add eligible dependents to your Dental Plan each annual change period. Newly acquired dependents may be added in the same manner as newly acquired dependents of employees described in I.B.2 and I.B.3.

Dependents may be enrolled in optional vision benefits during the annual change period for any benefit year(s) in which optional vision is offered.

You are not eligible for optional group life or accidental death and dismemberment benefits. See I.E.9 through I.E.11 for rights to convert life insurance to an individual policy at higher rates and to convert any long-term care insurance to an individual policy at the same rates.

c. OPTIONS OF RETIREES WHO ARE OVER AGE 65 OR OTHERWISE MEDICARE ELIGIBLE

1) If you are over age 65 or already receiving Medicare benefits at retirement (or at the time you turn age 65 or become eligible for Medicare after retirement), you are eligible to continue:

- i. medical benefits only on yourself; or
- ii. medical and dental coverage on yourself. (See a current retiree packet for medical plan options. The medical plan can be changed at retirement. The new medical plan must have the same or a higher deductible.)

2) Retirees who continue medical coverage on themselves may continue:

- i. existing medical and dental benefits coverage on dependents (dependents must be on the same plan as the retiree); and
- ii. existing optional vision coverage.

You are not eligible for any group life or accidental death and dismemberment insurance benefits. See I.E.9 through I.E.11 for rights to convert life insurance to an individual policy at higher rates and to convert any long-term care coverage to an individual policy at the same rates.

At age 65, you are eligible for a lower medical benefits payment, provided you show proof of enrollment in both parts A and B of Medicare. To avoid a Medicare benefits payment penalty, it is important to enroll yourself (if Medicare eligible) and/or a covered Medicare-eligible spouse in Part B Medicare as soon as you retire. If you, or a covered spouse, become Medicare eligible after you retire, enroll as soon as you/your spouse become Medicare eligible to avoid the benefits payment penalty (and a Medicare late enrollment penalty).

d. TRANSFER OPTIONS

A retiree may transfer coverage and become a dependent of an actively employed or retired spouse on the State Plan or University System Plan, while still retaining the right to return to coverage under their own name in the case of an event resulting in loss of eligibility for spousal coverage (divorce, death of the spouse, etc.). A retiree who transfers onto the coverage of an employee or retiree spouse does not have to begin a new deductible or out-of-pocket maximum calculation, unless the dependent was on a different medical plan from the spouse.

7. SURVIVING DEPENDENTS

a. SURVIVING SPOUSE AND SURVIVING CHILDREN

A surviving spouse (or surviving child) of a deceased State Plan member may continue:

- 1) existing medical only on self;
- 2) medical and dental coverage on self; (The medical plan can be changed when surviving dependent coverage is elected. The new medical plan must have the same or a higher deductible.)
- 3) existing vision coverage on self

Surviving spouses who continue medical coverage on themselves, may also continue:

- 4) existing medical and/or existing dental coverage on dependents (dependents must be on the same medical plan as the surviving spouse member); and
- 5) existing optional vision coverage.

A spouse may elect to continue coverage for as long as the spouse is not remarried, in active military service, or employed, and by virtue of that event becomes eligible to participate in another group plan with equivalent benefits and costs.

Surviving children may continue coverage for as long as they have no equivalent medical coverage and are not eligible for medical benefits by virtue of the employment of a surviving parent, legal guardian, or spouse until age 26.

A surviving dependent must elect to continue coverage within 60 days of loss of coverage under the deceased member and pay any retroactive payment for benefits required for continuous coverage in order to receive continued benefits under this provision.

Only those dependents of a member covered by the State Plan at the time of the member's death are eligible for continuation with the State Plan. Newly acquired dependents of a surviving spouse or another surviving dependent are not eligible for State Plan coverage.

Surviving dependents are eligible to continue coverage under I.E.7 when this benefit is exhausted. A surviving spouse on the Long-Term Care Plan may convert to an individual policy at the same rates (see I.E.11).

8. LEGISLATORS AND JUDGES

a. LEAVING OFFICE

A legislator or judge leaving office, who does not qualify for continuation with the State Plan as a retiree under I.E.6, may continue core benefits (medical, dental, and core life) plus any existing dependent medical and dental coverage and any existing optional vision coverage until Medicare eligible as provided by 2-18-704, MCA.

1) To be eligible, the legislator or judge must:

- i. terminate legislative/judicial service;
- ii. be a vested member of a legally constituted state retirement system; and
- iii. notify HCBD in writing within 90 days of the end of service.

The entire monthly payment for benefits must be paid by the legislator or judge.

2) A former legislator or judge may not continue State Plan coverage under this provision if the legislator or judge:

- i. is a member of another plan with substantially the same or greater benefits at an equivalent cost;
- ii. is employed, and by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost; or
- iii. is receiving Medicare benefits at retirement.

A former legislator or judge who continues on the State Plan under these provisions and subsequently terminates coverage may not rejoin the plan unless he/she again serves as a legislator or becomes eligible through active State employment.

b. TERM LIMITED

A legislator who is involuntarily terminated because of term limits may continue existing State Plan coverage for six months from the last day of the legislator's final term of office as provided by 2-18-820, MCA (except that any optional life insurance benefits end at age 65 or when the legislator becomes Medicare eligible). During this time, the legislator will receive State contribution toward payment for benefits and will only need to self-pay the employee

contribution. At the end of this six-month period, a legislator may continue core benefits (employee medical, dental, and basic life insurance coverage) plus any existing optional vision and dependent medical and dental benefits, until the legislator becomes Medicare eligible. When coverage ends, legislators who meet the terms of I.E.8, provision a., may continue coverage under that provision.

CONVERSION RIGHTS

9. MEDICAL BENEFITS

An enrolled employee or dependent who loses eligibility for State Plan coverage and who does not elect to continue medical coverage under provisions of I.E, or who has exhausted or is ineligible for continuation rights under I.E, is entitled to convert indemnity medical plan coverage to a medical conversion plan provided by the Plan Administrator. Requests must be submitted to the Plan Administrator within 31 days of termination of State Plan coverage, and benefits payments must be paid directly to the company.

10. LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

An individual enrolled in life insurance under the State Plan who loses eligibility for State Plan coverage is entitled to convert to a life insurance plan provided by the State Plan's life insurance company. The conversion plan is a higher-cost plan, does not provide waiver of benefits payments, and does not provide accidental death and dismemberment insurance. Requests must be submitted to the State Plan's life insurance company within 31 days of termination of State Plan coverage, and benefits payments must be paid directly to the company.

11. LONG-TERM CARE INSURANCE

An individual enrolled in the long-term care insurance under the State Plan who loses eligibility for State Plan coverage is entitled to convert to an individual policy at the same rate. Although rates will not increase due to conversion or age, they can be increased by the long-term care insurance company on a class basis according to underwriting risk studies. Conversion requests must be submitted to the long-term care insurance company within 31 days of termination of State Plan coverage, and benefits payments must be paid directly to the company.

Additional information, forms, and assistance with requests are available from your agency payroll or personnel office and the HCBD.

CHAPTER II: HOW TO OBTAIN BENEFITS AND CLAIM APPEALS

Payment of benefits provided by the State Plan will be made on the basis of your submission of required information. You must also be eligible for benefits as discussed in this document.

A. OBTAINING MEDICAL BENEFITS ON THE CHOICE AND CLASSIC PLAN (IDENTICAL FOR BOTH PLANS)

1. STEPS TO TAKE IN ADVANCE OF RECEIVING SERVICES

(See II.A.7 for organ transplant services.)

- a. Make sure you have a current identification card from the Plan Administrator for use in obtaining dental benefits, and, if on a medical plan, for use in obtaining medical benefits. Make sure it has your identification number, correct name(s), and dependent information. If you need services before you receive your card or have lost it, ask your covered provider to verify your coverage by calling the Plan Administrator or Health Care and Benefits Division (HCBD). Replacement cards can also be ordered by calling the Plan Administrator.
- b. In advance of receiving non-emergency services, know and optimize your benefits:
 - 1) Obtain prior authorization of inpatient hospital stays (all non-emergency inpatient hospital stays should be certified before admission to make sure they meet medical necessity requirements for inpatient benefits as described in II.A.4; emergency inpatient stays should be certified within 24 hours or the next business day). Services for which prior authorization is recommended include but are not limited to the following (retrospective review will be done if services are not prior authorized):
 - i. cardiac and/or pulmonary rehabilitation;
 - ii. chronic pain programs;
 - iii. home health services;
 - iv. hospice;
 - v. TMJ surgery;
 - vi. Magnetic Resonance Imaging (MRI), Computer Axis Tomography (CAT scan, CT scan), and Positron Emission Tomography (PET Scans); and
 - vii. non-emergency surgery.
 - 2) Benefits that may only be used if prior authorized include but are not limited to:
 - i. reconstructive surgery;
 - ii. transplants; and
 - iii. travel benefit.
 - 3) Obtain the in-network level of benefits (the highest level of benefits described in the current annual change book's Schedule of Benefits) by
 - i. obtaining covered medical services from an in-network covered provider. In certain instances in-network benefits may be available for services provided by an out-of-network covered provider when an in-network covered provider is not available. You may still be balanced billed for the difference between the covered provider's charge and the allowance even when an exception has been made. Contact the Plan Administrator concerning network exceptions; or
 - ii. obtaining covered medical services for an emergency medical condition or obtaining covered facility/professional services for urgent care (care for an urgent medical condition) from any licensed covered provider. In the case of a medical emergency, plan members are encouraged to obtain services from the closest appropriate covered provider. You will receive the in-network level of benefits for immediate treatment of an emergency medical condition by any eligible covered provider including an out-of-network covered provider. However, you will only receive the in-network level of benefits for any out-of-network follow up care (after the medical emergency has ended) if the above pre-certification

requirements are met. You may still be balanced billed for the difference between the covered provider's charge and the allowance even when an exception has been made.

Non-emergency care received from a covered provider who is not in-network will be covered at the out-of-network level of benefits (described in the current Schedule of Benefits). However, note that the medical services identified in III.B.38 are not available as an out-of-network benefit.

- 4) Determine if you need prior authorization (described in II.A.6) for specific proposed medical or dental procedures, equipment, or supplies. (Some services require prior authorization in advance of services for benefits). Others should be prior authorized if they are new or outside standard medical or dental practice (and may be excluded as an Experimental Procedure or Service, as defined in Chapter IX) or if they are only covered under some circumstances. See II.A.6 for a listing of services that must be prior authorized (also specified for each service in Chapter III) and see the current annual change booklet for updates.
- 5) Determine if there are frequency, duration, or dollar limits on services you plan to receive so you can plan accordingly (see II.A.2 and the current Schedule of Benefits). Contact Case Management with HCBD for assistance.
- 6) For the lowest out-of-pocket costs, see an in-network covered provider (in-network covered providers are those who accept allowable charges and will not bill you for amounts over allowances). For the most current in-network covered provider listing, go to the website of the Plan Administrator shown on your identification card, or to the HCBD website and click on the link Administrator Contacts to view the Plan Administrator's covered provider network.
- 7) Determine if there is a Care Management option if you have a chronic health condition. Care Management options may include services for, but are not limited to, diabetes and infusion services. You may qualify to participate in focused care management to increase your benefits. (See the current annual change booklet or the HCBD website www.benefits.mt.gov for current Care Management options, if any.)
- 8) Obtain a pre-determination of what your out-of-pocket costs will be if you are considering using a covered provider who is not an in-network covered provider. You will be responsible for all charges over the allowed charges (see II.A.4).
- 9) Call the State Plan's case management staff for assistance in optimizing your benefits if you are diagnosed with a serious illness or suffer major injury (see III.B.41).

2. STEPS TO TAKE TO MAKE SURE YOUR COVERED PROVIDER RECEIVES PAYMENT

(See II.A.7 for organ transplant benefits.)

- a. Present your current identification card to your physician, dentist, hospital, or other covered health care provider when you and covered dependents receive services. Most covered providers will submit a claim to your Plan Administrator for you.
- b. Make sure your covered provider has your current identification number and address. If you change your address, notify your agency payroll staff.
- c. Most covered providers will file a claim for you; however, you are responsible for making sure a claim has been filed. If your covered provider will not submit a claim to the Plan Administrator, complete a standard claim form which should be available from the covered provider. Have the covered provider complete its portion and send the completed form, and all itemized bills to the Plan Administrator at the address on your identification card.
- d. Payment will be sent directly to in-network covered providers who have agreed to accept allowable fees. You will receive payment directly for services of out-of-network covered providers. For in-network covered providers, you will be responsible for deductible, coinsurance, and charges for non-covered services only, not for amounts above allowable charges.
- e. Respond to requests for information on accidents, health care coverage, or any other information requests from the Plan Administrator. Your claim will not be paid until required information is received.
- f. Monitor invoices from the covered provider and explanations of benefits from the State Plan to make sure the State Plan received and adjudicated a claim for services and that the covered provider received the appropriate payment due.

OUT-OF-STATE SERVICES

If you are receiving services out-of-state, check with the Plan Administrator to identify in-network covered providers or other covered providers who offer favorable fees and procedures for obtaining benefits.

EMERGENCY OUT-OF-COUNTRY SERVICES

Emergency out-of-country services are available at the in-network level. You will need to pay for services up front. You may wish to check with the Plan Administrator regarding requirements for documentation format to ensure proper claims processing.

CLAIMS FILING DEADLINE – Claims must be received (by the State’s Plan Administrator) within one year from the date expenses were first incurred to receive benefits. CLAIMS WILL NOT BE DEEMED FILED UNTIL RECEIVED BY THE PLAN ADMINISTRATOR. Claims received after the filing deadline will be denied.

3. MEMBER SELF-AUDIT AWARD

Check bills from your covered medical providers for errors such as duplicate charges or being billed for services you have not received, and you may be eligible to receive an award of 50 percent of identified overcharges up to \$1,000.

a. Plan members who identify over-charge errors in medical bills which:

- 1) have not already been detected by the Plan Administrator or reported by the covered provider;
- 2) involve charges which are allowable and covered by the State Employee Benefit Plan; and
- 3) amount to \$50 or more in over charges may be eligible to receive a self-audit award of one-half of the savings obtained from billing adjustments, up to a maximum of \$1,000.

b. To receive this self-audit award, the member must:

- 1) notify the Plan Administrator of the error before it is detected by the Plan Administrator or by the health care provider;
- 2) contact the covered provider to verify the error and determine or work out a correct billing; and
- 3) have copies of the corrected billing sent to the Plan Administrator for verification, claims adjustment, and calculation of the self-audit award.

EXPLANATION OF BENEFITS

Check the Explanation of Benefits (EOBs) from the Plan Administrator to determine if you have received the benefits described in this document and to determine the amount owed to the covered provider (the amount you owe in deductible, copayment, coinsurance, charges for uncovered services, and in the case of covered providers who are not in-network covered providers, charges in excess of allowable charges).

CLAIMS ASSISTANCE

If you need assistance with filing a claim or an explanation of how a claim was paid, call your Plan Administrator at the customer service number on your identification card or listed in your current annual change materials.

4. PRE-DETERMINATION

If you are considering using a covered provider who is not an in-network covered provider, you may wish to know in advance of receiving non-emergency medical or dental services what your out-of-pocket costs will be. This includes charges in excess of allowable fees, plus any deductible, copayment, or coinsurance obligation. You may determine this by calling the Plan Administrator at the number on your identification card, or by sending a written request for a pre-determination. Your pre-determination request must include specific procedure codes and charges, which you will need to obtain from your covered health care provider. The final services rendered and coding for those services may differ and would not necessarily be the same as the pre-determination amount.

You will receive a determination of the allowable fee for each submitted procedure, which is a benefit of the State Plan. Note that the allowable fee is not necessarily the same as the plan reimbursement, which is reduced by any deductible, copayment, and coinsurance and may be affected by waiting periods, coordination of benefits, and other State Plan provisions. The Plan Administrator can only advise you of your deductible and/or copayment or coinsurance obligation at the present time, which may not be the same as when claims for services are processed. If you obtain a pre-determination by phone, you should record the date and time. That will allow the Plan Administrator to access their recording of your phone conversation at a later date, if documentation is needed.

5. CERTIFICATION OF HOSPITAL STAYS

All hospital inpatient days must be certified as medically necessary by the Plan Administrator to be eligible for benefits. See III.B.3 for benefit reductions for non-certified days.

a. CALL-IN PRE-CERTIFICATION PROCEDURES

1) Non-Emergency Hospital* Admissions

Non-emergency hospital* admissions should be called in to the state's Plan Administrator for pre-certification (in advance of admission) to determine whether the admission meets medical necessity criteria for inpatient benefits before services are received. You are responsible for any charges that are not benefits of the State Plan. Pre-certification is strongly encouraged. Pre-certification is especially critical for *hospital admissions/stays for: organ transplant, treatment of mental illness, chemical dependency, and rehabilitation or recovery, as indicated in Chapter III.

You should record the date and time of the call so that the Plan Administrator can access their recording of your phone conversation at a later date, if documentation is needed. Calling also allows you to take advantage of assistance in obtaining appropriate care that maximizes your benefits.

2) Emergency Hospital* Admissions

Emergency hospital* admissions should be called in to the Plan Administrator for certification within 24 hours of the admission, or the first working day after the admission if it occurs over a weekend or a holiday, to determine if the stay meets medical necessity criteria for benefits. Calling also allows you to take advantage of assistance in arranging follow-up care that maximizes your benefits.

**The term hospital, for purposes of certification, includes any facility that provides inpatient medical, psychiatric, or chemical dependency services, not just facilities licensed as hospitals.*

3) How to Call and Who May Call

You, a family member, a friend, the hospital, or covered provider may call. The telephone number is listed on the back of your identification card. As indicated above, you may want to record the date and time of the call so that the recording can be retrieved at a later date if needed for documentation. Please note, the Plan Administrator will not be able to provide any information to a family member or friend unless you have provided a signed release of private information to the Plan Administrator.

4) When Making the Call

When you call, a Plan Administrator staff member will request information such as your name, phone number, identification card number, diagnosis, date of admission to the hospital, name and phone number of your physician, and other information needed to certify your hospital stay. If information is needed that you or a representative calling for you cannot provide, the staff member will attempt to contact your covered provider. If a family member or friend contacts the Plan Administrator and you have not provided a signed release of private information, the Plan Administrator will start the precertification process and follow-up with your physician. The Plan Administrator is unable to provide any information to a family member or friend without the signed release of private information.

If there is any question about whether your case meets medical necessity or meets the appropriate level of care, the nurse will refer your case to the physician advisor employed by the Plan Administrator. That physician may consult with your physician, and, if need be, may consult with specialist physicians.

You will receive written notification of the determination. At the end of any certified days, the Plan Administrator staff will contact the hospital to confirm your discharge. If you are not being discharged, the Plan Administrator staff member will contact your physician for additional information, and may certify any additional days which meet medical necessity criteria or appropriate level of care.

Any time hospital days are denied certification, the Plan Administrator staff member will notify the facility or the covered provider within 24 hours of the decision. See II.D.1 for appeal rights. Assistance with arranging continuing outpatient care is available upon request as described in III.B.41.

b. IF NO ONE CALLS FOR CERTIFICATION

If you do not pre-certify your hospital stay, the Plan Administrator will do a retrospective review when claims are submitted, and any eligible inpatient days certified at that time. However, with a post-hospitalization review, you run the risk that all, or a portion of the stay, may be found ineligible for standard benefits when it is too late to consider alternatives. **The call-in certification process was established to give you advance notice that the services are eligible or ineligible for benefits.**

6. PRIOR AUTHORIZATION

a. REQUIRED PRIOR AUTHORIZATION

Some medical services, equipment, and supplies require prior authorization in order to receive benefits. There are no benefits for services, equipment, and supplies requiring prior authorization unless they are approved in advance of receipt. See your current annual change booklet or the HCBD website (www.benefits.mt.gov) for updates.

At the time of this document's publication, some of these are:

- 1) durable medical equipment and prosthesis expenses over \$1,000 (III.B.21);
- 2) intensive out-patient rehabilitation;
- 3) surgical treatment of temporomandibular joint (TMJ) Dysfunction (III.B.42.a.20);
- 4) skilled nursing facility care (III.B.30);
- 5) transplants (III.B.26);
- 6) autism services (III.B.40);
- 7) home health services (III.B.28); and
- 8) travel benefits (III.B.27);

Check with the Plan Administrator for recommended prior authorizations. You should obtain prior authorization for any proposed procedures, equipment, or supplies that are not clearly a benefit of the State's indemnity medical plan, are only a benefit under some circumstances, or that may not meet medical necessity criteria because they are new, extraordinary, an Experimental Procedure or Service (as defined in Chapter IX) or possibly contrary to accepted medical policy.

- b. To check if procedure or service requires prior authorization, call the Plan Administrator. Some prescription drugs require prior authorization. Since these change more frequently than other medical services, please see the prescription drug benefits administration company website <https://mp.medimpact.com/mtn> for a current listing, or call the customer service number on your prescription drug identification card concerning a particular prescription. Dental implants may also require prior authorization in order to receive benefits. Contact the current dental Plan Administrator for prior authorization.

c. PROCEDURE

To obtain a prior authorization, you and/or your covered health care provider may send a written request to the Plan Administrator. Your prior authorization request must include information by your covered health care provider explaining the proposed services, equipment or supplies, the functional aspects of treatment, the projected outcome, treatment plan, and any other supporting documentation, study models, photographs, x-rays, etc. Once all required documentation has been received, allow 10 days for a prior authorization determination.

7. TRANSPLANT BENEFITS

To receive transplant benefits, take the following steps:

- a. Prior authorize the planned transplant by calling the customer service number listed on your identification card. You will be assigned a transplant coordinator who will work with your physician to obtain the necessary documentation for prior authorization. It is your responsibility to verify which covered transplant providers are in the Plan Administrators national transplant network;
- b. Make sure the covered transplant providers are in the Plan Administrators national transplant network to avoid a large out-of-pocket expense; and
- c. See II.A.2 for information about filing claims.

8. APPEAL OF PRIOR AUTHORIZATION AND CERTIFICATION ACTIONS

If you or your physician disagrees with a certification denial of inpatient services under the Classic medical plan (described in II.A.4) or a prior authorization decision (described in II.A.6 of this chapter), you may appeal the decision. You have 60 days from the date you are notified of the decision to submit an appeal request. You can do this by calling the customer service number on your identification card or directly calling the Plan Administrator. The Plan Administrator will send you the necessary forms to initiate the process. The decision on the review will be provided within 60 days after receipt of all relevant medical records. If you are informed that requested services will be denied as not medically necessary or not a benefit of the plan, you may initiate a first level and second level review before receipt of services.

NOTICE: FAILURE TO APPEAL THE ADVERSE BENEFIT DETERMINATION IN WRITING WITHIN THE TIME PERIOD SPECIFIED WILL RENDER THE DETERMINATION FINAL. ANY APPEAL RECEIVED AFTER THE END OF THE TIME PERIOD SPECIFIED WILL NOT BE CONSIDERED.

B. PRESCRIPTION DRUG BENEFITS – IDENTICAL FOR THE CHOICE AND CLASSIC PLANS

1. STEPS TO TAKE IN ADVANCE OF OBTAINING PRESCRIPTION DRUG BENEFITS

- a. Make sure you have a current State Plan prescription drug identification card from the State Plan's prescription drug benefits administration company and that it contains the correct name(s) and number. If you need services before you receive your card or have lost it, ask your covered provider to verify your coverage by calling the prescription drug benefits administrator or HCBDB.
- b. In advance of obtaining prescription drugs, know and optimize your benefits by accessing the drug formulary listing and, if necessary, talking with your physician about whether the medication you need is included in the highest formulary tier possible since your copayments are based on a five tier structure. The higher formulary tiers are your lowest-cost option and are the best value based on medical evidence and outcomes. You can also obtain clinical advice regarding your prescription by calling the Ask-A-Pharmacist service. (See the current annual change booklet for your tier formulary copayment and/or coinsurance and contact information for Ask-A-Pharmacist). If you are prescribed a high-cost drug that may require special handling and/or administration to treat a chronic or complex condition, please contact HCBDB to see if you qualify for a specialty drug program which, if eligible, would reduce your out-of-pocket costs. Specialty drugs may include but are not limited to medications for treatment of hemophilia, hepatitis C, arthritis, multiple sclerosis, RSV, osteoporosis, Parkinson's disease, pulmonary arterial hypertension, transplants, and cancer.

Go to the website of the State Plan's prescription drug benefits administration company (on your prescription drug identification card) for a current formulary listing. The formulary listing changes from time to time and the website listing is kept current. You may also call the customer service number on your identification card. Hard copies of formulary updates are also sent to members when there are significant changes.

Determine if the prescription drug you need is a covered benefit of your State Plan and/or requires prior authorization or step therapy (trying lower-cost alternatives before moving to a higher-cost alternative) by calling the customer service number on your prescription drug identification number. Prior authorization is primarily required to ensure clinical appropriateness of a specific therapy. Step therapy may be required for coverage of some higher-cost prescriptions that have good lower-cost alternatives.

2. PRESCRIPTIONS FROM A PHARMACY

- a. To receive prescription drug benefits from a participating pharmacy, take your prescription drug identification card along with your prescription to any participating pharmacy. The pharmacist will process your prescription claims electronically for up to a 30-day supply and collect only your portion of the cost (copayment). You will not need to file a claim. To locate participating pharmacies, call the prescription drug benefits administration company at the customer service number on your prescription drug identification card or visit the website shown on your prescription drug identification card.
- b. To receive prescription drug benefits from a non-participating pharmacy, you pay the entire cost of the prescription and file a claim with the prescription drug benefits administration company for reimbursement of plan allowances.

Claim forms are available on the HCBD website or from the prescription drug benefits administration company. Allowances may not cover the entire cost.

3. MAIL ORDER PRESCRIPTIONS FOR MAINTENANCE DRUGS

The mail order program can save you money on prescriptions for ongoing medications while conveniently delivering medications directly to your home. Contact the vendors for enrollment forms and information.

For maintenance drugs you don't need immediately (make sure to have a two to three week supply on hand), call or send your prescription(s) for up to a 90-day supply, along with your copayment, to the mail service provided by the State Plan's mail order vendors. The amount of the copayment you should send can be obtained from the current annual change booklet. If you are uncertain, call the customer service number on your prescription drug identification card for assistance.

4. IF A MEMBER IS COVERED BY ANOTHER PRIMARY PRESCRIPTION DRUG PLAN

If another prescription drug plan is responsible for primary payment of a member's prescription drug expenses (described in Chapter VII), that plan must pay first.

To receive a secondary payment from the State Plan at a participating pharmacy, provide the State Plan's coverage information to the pharmacist for immediate coordination of benefits.

To receive a secondary payment from the State Plan at a non-participating pharmacy, submit a receipt and claim form showing your out-of-pocket costs (that the other plan did not pay) after the primary payment to the State Plan's prescription drug administration company at the address indicated on your prescription drug card to receive a reimbursement. See III.A.2, provision e, for information on secondary benefits. If you have difficulties with coordination of care with your primary and secondary benefits, contact HCBD for assistance.

C. MISCELLANEOUS BENEFITS – IDENTICAL FOR THE CHOICE AND CLASSIC PLANS

Optional Vision Insurance, Employee Assistance Program, Wellness Benefits, Flexible Spending Account, Life Insurance, Accidental Death and Dismemberment Insurance, Long-Term Care Insurance, and Long-Term Disability Insurance

1. OPTIONAL VISION BENEFITS

To receive vision exam and eye ware benefits, you must have enrolled in a separate optional vision plan during the annual change enrollment period preceding the benefit year.

To assure that you or another enrolled family member pays no more than the copayment specified in the current annual change materials for an eye exam and fully-covered lenses, select an in-network covered provider of the State's vision benefits plan, and schedule your eye exam and/or eye ware purchase according to the annual change booklet. In-network covered providers have agreed to accept plan payments plus your copayment as full compensation for routine exams and fully covered lenses. Some other covered providers may also accept plan payments plus your copayment as full compensation.

To obtain a list of in-network covered providers, call the customer service number or visit the website of the State's vision benefits plan.

- a. To receive benefits from an in-network covered provider, make an appointment, mention that you (or an enrolled family member) are an enrolled member of the State's vision benefits plan, and provide any information the covered provider needs to verify your eligibility for benefits. The covered provider will collect any copayments and uncovered costs from you and obtain payment for covered costs directly from the vision benefits plan.
- b. To receive benefits from an out-of-network covered provider, you pay the entire cost of the eye exam and/or eye ware, complete a reimbursement form, and send an itemized receipt to the State's vision benefits plan **within six months** from the date of service. Included with the receipt should be the member's name, phone number, address, member I.D., the name of the group (State of Montana), the patient's name, date of birth, phone number, address, and the patient's relationship to the member. The vision benefits plan will reimburse you for costs (less your copayment) up to allowable fees. For current allowable fees, see the current annual change booklet or the HCBD website.

2. EMPLOYEE ASSISTANCE PROGRAM BENEFITS

To receive Employee Assistance Program (EAP) benefits – four counseling sessions with no out-of-pocket cost to the member – make an appointment with a licensed in-network counselor near you. The covered provider will submit the claim to the Plan Administrator and reimbursement will be sent directly to them. All State Plan members — regardless of their selected medical plan — are eligible for EAP benefits, and there is no separate benefits payment for this coverage. You may obtain information on EAP benefits from HCBD at (800) 287-8266, TTY (406) 444-1421, or www.benefits.mt.gov. EAP counseling benefits are not available if services are rendered by an out-of-network provider.

3. WELLNESS BENEFITS

All State Plan members, regardless of their selected medical plan, are eligible for Wellness benefits, and there is no separate contribution payment for these benefits. You may obtain information on enrollment criteria and any deadlines for each Wellness benefit (Health Screenings, Lunch 'N' Learn, Spring Fitness, Hunter's Challenge, Prenatal Benefits, Tobacco Cessation, Diabetes Management Program, and Weight Watchers reimbursement) from the HCBD website.

4. FLEXIBLE SPENDING ACCOUNT (FSA) BENEFITS

In any benefit year, you may receive Flexible Spending Account benefits, only if you:

- a. Have enrolled in an FSA during the annual change enrollment period preceding the benefit year ;
- b. Incur qualified expenses during the year (while still enrolled); and
- c. File a timely claim for reimbursement or payment.

Any money in an FSA not used for qualified expenses incurred during the benefit year is forfeited at the end of the benefit year. Expenses are incurred when the services are received or a product ordered. This may or may not be the same time that you are billed, so it is important to work with the FSA program administrator in setting up an FSA and submitting claims for services that span more than one benefit year, such as orthodontia services. (See Chapter I for information on enrolling in FSAs, restrictions on making changes to FSAs, and continuing or reinstating an FSA after you terminate employment or take a leave of absence.)

To receive reimbursement from a medical FSA for an incurred eligible medical expense that is not covered by a health plan, submit a claim form and expense receipt to the State Plan's Flexible Spending Account program administrator (specified in the current annual change materials). For an incurred eligible medical expense that is covered by a health plan, submit a claim form and a copy of the Explanation of Benefits from the State Plan showing the portion of the expense you must pay. The FSA program administrator processes routine claims and sends reimbursement due within five business days following receipt. IRS regulations require Medical FSAs to reimburse a claim up to the elected annual amount minus any reimbursements already received, regardless of the account balance at the time the claim is submitted. See Chapter VI for eligible medical expenses.

To receive reimbursement from a Dependent Care FSA for an incurred eligible day care expense, submit a claim form and expense receipt to the FSA program administrator. Only amounts up to the current balance of a Dependent Care FSA are reimbursable. Due to the State's payroll deduction schedule, a full month of FSA contribution is typically not available until the middle of the following month. You should consequently plan on paying the first month of day care expenses from other sources, unless the covered day care provider is willing to wait for payment.

Claim forms are available on the website of the State Plan's FSA program administrator or HCBD. See the address in the current annual change materials.

5. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

You or your beneficiary (in the case of your death) may file a benefits claim for any life insurance or accidental death and dismemberment insurance in which you or dependents are enrolled, by contacting HCBD. A certified death certificate or attending physician's statement to verify the loss will be required.

6. LONG-TERM CARE INSURANCE BENEFITS

To file a long-term care insurance claim, contact the State Plan's long-term care insurance company with which you enrolled at the number in your long-term care insurance enrollment kit. You may also obtain the number from the HCBD website at (benefits.mt.gov) or by calling HCBD at (406) 444-7462, (800) 287-8266, or TTY (406) 444-1421.

7. LONG-TERM DISABILITY INSURANCE BENEFITS

To file a long-term disability insurance claim, contact the State Plan's long-term disability insurance company or contact HCBD. You may obtain the number from your current annual change materials.

D. CLAIMS APPEALS – IDENTICAL FOR THE CHOICE AND CLASSIC PLANS

1. APPEALING A DENIED MEDICAL, DENTAL, OR PRESCRIPTION DRUG CLAIM

a. If a claim is denied in whole or in part, the member will receive written notice of the adverse benefit determination. A claim Explanation of Benefits (EOB) will be provided by the Plan Administrator showing:

- 1) the reason the claim was denied;
- 2) reference(s) to the specific State Plan provision(s) or rule(s) upon which the claims decision was based which resulted in the denial or partial denial;
- 3) a list of any additional information needed to appeal the claim and why such information is needed; and
- 4) an explanation of the member's right to appeal the adverse benefit determination for a full and fair review.

If the member does not understand the reason for any adverse benefit determination, he or she should contact the Plan Administrator at the address or telephone number shown on the EOB form.

To initiate the first level of review on an adverse benefit determination, the member shall submit a written appeal or a request for review to the Plan Administrator within ninety (90) days after the adverse determination. The member should include any additional information supporting the appeal and send this information to the Plan Administrator by the end of the 90-day period. Failure to appeal the adverse benefit determination within the 90-day period will render the determination final. Any appeal received after the end of this 90-day period will not be considered.

Appeals or requests for review of adverse benefit determinations must be submitted to the Plan Administrator in writing, and supporting materials may be submitted via mail, the electronic claims submission process, facsimile (fax), or electronic mail (email – if secure, HIPAA-compliant email is available).

b. FIRST LEVEL OF BENEFIT DETERMINATION REVIEW

The first level of benefit determination review is conducted by the Plan Administrator. The Plan Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the State Plan and other relevant information. Notice of the decision on the first level of review will be sent to the member within 60 days following the date of receipt of the written appeal by the Plan Administrator.

c. SECOND LEVEL OF BENEFIT DETERMINATION REVIEW

If, based on the Plan Administrator's review, the initial adverse benefit determination remains the same, and the member does not agree with that benefit determination, the member may initiate the second level of benefit review. The member must request the second review in writing and send it to HCBD no later than ninety (90) days after receipt of the Plan Administrator's decision from the first level of review.

Failure to initiate the second level of benefit review within the appropriate time period will render the determination final.

The State Plan will review the claim in question along with any additional information (e.g., physician's letters, operative reports, bills, and medical records) submitted by the member. The State Plan will conduct a full and fair review of the benefit determination made by the Plan Administrator. While the State Plan cannot give deference to the initial benefit determination, the State Plan relies in part upon the Plan Administrator's judgment, expertise, and medical coverage policy. The State Plan may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental Procedures or Services, the State Plan will consult with an appropriately trained health care professional who was neither the medical professional consulted in the initial determination nor his or her subordinate.

After a full and fair review of the member's appeal, the State Plan will provide written or electronic notice of the final internal benefit determination, within a reasonable time, but no later than 60 days from the date the appeal is received by the State Plan. Such notice will contain the same information as notices for the initial determination.

All claim payments are based upon the terms contained in the Summary Plan Description (SPD). The member may also request, free of charge, more detailed information, names of any medical professionals consulted, and copies of relevant documents, as defined and required by law, which were used by the State Plan to adjudicate the claim.

d. EXPEDITED INTERNAL APPEAL

- 1) An expedited internal appeal process is available for review of an adverse determination involving an emergency or life-threatening situation.
- 2) The expedited appeals process is not applicable to retrospective reviews, i.e., after the services have already been performed. This process is only applicable to those emergency situations where treatment has not yet been rendered.
- 3) A request for an expedited internal review shall be made by fax (406) 444-0080, telephone (800) 287-8266, or TTY (406) 444-1421.
- 4) The appeal will be reviewed by a licensed covered provider and a decision concerning the review will be completed within 48 hours or two business days of receiving notice of the request for expedited review and the receipt of all necessary information.

e. EXTERNAL REVIEW

If you are not satisfied with your State Plan's decision after completing the State Plan's internal review process, you may appeal the denial to the State Plan for a decision by an external Independent Review Organization (IRO).

- 1) You may file a request for external review within 4 months after the date of receiving a notice of a final internal adverse benefit determination.
- 2) The State Plan shall complete, within 5 business days of receiving the request for external review, a preliminary review of the request, to determine if:
 - i. the claimant is or was covered under the plan;
 - ii. the denial was based on the claimant's ineligibility under the terms of the plan, thus making the claim not eligible for federal external review;
 - iii. claimant exhausted internal process, if required; and
 - iv. claimant provided all necessary information to process the review.
- 3) Within 1 business day after completion of the above, the State Plan must notify the claimant in writing if the request is not eligible or if it is incomplete.
 - i. If the claim is complete but not eligible for external review, the written notice must include reasons for its ineligibility and contact information for the Department of Labor's Employee Benefits Security Administration (including its toll-free number).
 - ii. If the claim is incomplete, written notice must describe what information is needed to complete the request, and also give the claimant the remainder of the four-month filing period or the 48-hour period following the claimant's receipt of the notice, to correct the problem.
- 4) If the claim is eligible for external review, the plan must assign the request to an IRO (Independent Review Organization). The IRO must notify the claimant of the request's eligibility and acceptance for external review and that the claimant can submit in writing, within 10 business days, additional information which the IRO must consider during its review. The State Plan must provide to the IRO within 5 business days after the IRO's assignment the documents and information considered in the State Plan's denial of the claim.
- 5) If the State Plan does not provide documents and information, the IRO may terminate its review and reverse the claim denial. If this happens, the IRO must notify the claimant and the State Plan within 1 business day of its decision to reverse; the State Plan must carry out the IRO's decision.
- 6) The IRO reviews the claim de novo (brand new), and will not be bound by any decisions or conclusions reached during the State Plan's internal claims and appeals process. It can consider additional information and documents to the extent available and appropriate, beyond what was provided as part of any earlier review. This includes materials outside of the State Plan's claims file.
- 7) The IRO must complete its review and provide notice of the decision to the State Plan and the claimant within 45 days of its receipt of the external review request.

f. EXPEDITED FEDERAL EXTERNAL REVIEW PROCESS

- 1) Procedures are available for expedited review in the following situations:
 - i. following an adverse benefit determination involving a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or
 - ii. an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not been discharged from a facility.
- 2) If the State Plan gets one of these appeals, it must conduct the preliminary review previously described above within 24 hours of the business day on which the appeal is received, and then, within 24 hours of the preliminary review or on the next business day, provide a written notice to the claimant detailing whether the claim is eligible for external review and, if not eligible, why not and what materials are needed to complete the request.
- 3) If the appeal meets the criteria for an external review, the State Plan will assign it to an IRO which must, in turn, decide the external review request as expeditiously as the claimant's medical condition requires but in no event more than 72 business hours after the IRO receives the request for expedited review.

2. VISION INSURANCE, LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, LONG-TERM DISABILITY, LONG-TERM CARE INSURANCE, AND FLEXIBLE SPENDING CLAIMS APPEALS

a. FIRST LEVEL APPEALS

- 1) Vision Insurance claims appeals: If you are denied vision insurance benefits, you or your covered vision provider may call the State Plan's vision insurance plan company for an explanation. If unsatisfied with the response, send a written request for a review to the vision insurance plan company within 60 days of receipt of the denial.
- 2) Life Insurance, Accidental Death and Dismemberment, Long-term Disability and Long-term Care Insurance Claims: If you receive a notice that a life or AD&D insurance claim has been denied, you may call the State Plan's life and accidental death and dismemberment company for an explanation and send a written request for review, along with supporting documentation within 60 days of receipt of the denial. If you receive a notice that a long-term disability insurance claim has been denied, you may call the State Plan's long-term disability insurance company with which you enrolled for an explanation, and send a written request for a review along with supporting documentation within 180 days of receipt of the denial. If you receive a notice that a long-term care insurance claim has been denied, you may call the State Plan's long-term care insurance company with which you enrolled for an explanation. You may send a written request for a review along with supporting documentation within 60 days of receipt of the denial.
- 3) Flexible Spending Claims: If you are denied flexible spending benefits, call the State Plan's flexible spending administration company for an explanation. If you are unsatisfied with the response, send a written request for a review to the flexible spending administration company within 180 days of the receipt of the denial.

Failure to appeal the adverse benefit determination in writing within the time period specified will render the determination final. Any appeal received after the end of the time period specified will not be considered.

b. SECOND LEVEL APPEALS

- 1) Vision benefits, Life Insurance, Accidental Death and Dismemberment, Long-Term Disability, and Long-Term Care Insurance Claims: Since vision, life, accidental death and dismemberment, long-term disability, and long-term care plans are not self-insured by the State, final claims decisions are made by the relevant benefits company. Request information from the relevant company about the policy, contract terms, and appeals.
- 2) Flexible Spending Accounts: If you are not satisfied with the response to the first level review of a flexible spending claim, you may submit a second appeal to the flexible spending administration company within 60 days of receipt of the level one decision. The claim will be reviewed and a written decision explaining the basis of the decision will be issued within 60 days or within 90 days if additional information or an external review is necessary.

Failure to initiate the second level claims review within the appropriate time period will render the determination final.

CHAPTER III: MEDICAL BENEFITS

A. PRESCRIPTION DRUG PLAN BENEFITS & EXCLUSIONS - IDENTICAL FOR THE CLASSIC AND CHOICE PLANS

1. SEPARATE PRESCRIPTION DRUG PLAN

Prescription drugs are covered by a separate Prescription Drug Plan, which is administered by the State Plan's prescription drug benefits Plan Administrator for all State Plan members. There is no separate contribution. Any deductible, copayments, or coinsurance you are required to make are separate from medical plan deductible, copayments and coinsurances, and are accumulated toward a separate annual out-of-pocket maximum.

2. COVERED PRESCRIPTION DRUG EXPENSES AND PLAN PAYMENT

a. COVERED PRESCRIPTION DRUG EXPENSES

Expenses, within allowable fees of the State Plan's prescription drug benefits administrator, for plan-allowed quantities of federal legend drugs (any drug that requires a prescription) and compound medications that contain at least one federal legend drug in a therapeutic amount are covered, provided the drug meets the following requirements:

- 1) is prescribed by a covered provider licensed to prescribe legend drugs for approved use in the treatment of an injury or illness;
- 2) is dispensed by a licensed pharmacist or licensed physician or surgeon;
- 3) is listed in the American Medical Association Drug Evaluation, Physician's Desk Reference, or Drug Facts and Comparisons ;
- 4) is not a specific exclusion of the State Plan's Prescription Drug Plan as described in III.A.3, as updated on the Health Care and Benefits Division (HCBD) website;
- 5) meets the prior authorization requirements of the State Employee Benefit Plan's Prescription Drug Plan; and
- 6) meets any other requirements of this Summary Plan Description.

b. OTHER COVERED EXPENSES

The Prescription Drug Plan also covers expenses, within allowable fees, of the following drugs and supplies (provided requirements described in III.A.2, provisions a.5 and a.6 are met):

- 1) diabetic drugs and supplies, including injectable insulin, diagnostic testing agents, hypoglycemia rescue agents (glucose tablets), lancets, Lancet auto-injectors, insulin syringes, and insulin auto-injectors and their needles;
- 2) syringes and needles for other medical conditions;
- 3) prenatal vitamins at zero copayment when prior-authorized for expectant mothers participating in the Prenatal Program; and
- 4) contraceptives, oral and injectable, except emergency "morning after" contraceptives such as Plan B and Preven.

c. COVERED PRESCRIPTION DRUG EXPENSES YOU PAY

You pay a designated copayment (dollar amount) or coinsurance (percentage) for each prescription for yourself or an enrolled family member until you reach your individual out-of-pocket maximum for the benefit year, or until your family reaches the family out-of-pocket maximum for the benefit year. The State Plan pays remaining covered prescription drug expenses, defined above.

See the current annual change booklet or the HCBD website for the following:

- 1) The copayment or coinsurance you pay for a prescription drug and the annual out-of-pocket maximum per member and per family. Co-payment and/or coinsurance amounts vary depending on:
 - i. where the prescription is filled; and
 - ii. where your medication falls in the five tier formulary structure - Tier A - F and Tier S for specialty medications (III.A.5)
 - (a) Tier A prescription drugs are the best value and the lowest cost (copayment) option;

- (b) Tier B prescription drugs are a high level of value and includes generic and brand drugs;
- (c) Tier C prescription drugs are a good level of value but have a higher overall net cost;
- (d) Tier D prescription drugs are a lower level of value that generally have much higher overall net costs and lower cost alternatives are available;
- (e) Tier F prescription drugs are the lowest level of value on clinical evidence or the highest overall net cost in relation to generic or other brand alternatives, or new FDA approved medications that have not yet been reviewed by Pharmacy and Therapeutics Advisory Committee (PTAC); or
- (f) Tier S prescription drugs for specialty drugs (additional information found in III.A.5).

Tier D and F copayments and copayments for Specialty prescription drugs filled at retail pharmacies do not apply to the out-of-pocket maximum.

The formulary tiers are reviewed by a Montana-based Pharmacy and Therapeutics Advisory Committee (PTAC). The drugs in each tier are based on safety, efficacy, approved indications, ease of use, potential for adverse effects and cost-effectiveness.

A current listing of the formulary prescriptions in each tier may be obtained by going to the website at www.urx.mt.gov or by calling HCBD. **Before filling a new prescription**, it is important to access the formulary list to determine the tier and corresponding copayment for your medication.

For assistance locating an alternative for a Tier D or F medication, call the Ask-A-Pharmacist program at (888) 527-5879.

d. PARTICIPATING PHARMACIES

If you obtain prescriptions from mail-order services or one of its many participating retail pharmacies that accept allowable fees, you will pay your copayment and/or coinsurance only. If you use a non-participating pharmacy, you pay the entire cost of the prescription and submit a claim for reimbursement, but you will only be reimbursed up to the allowable fee less any deductible, copayment, and/or coinsurance. Go to the HCBD website or the current annual change materials for a listing of participating pharmacies and information on mail order services. You may also call the customer service number on your prescription drug identification card to find a participating pharmacy near you, or ask a pharmacy if it is a participating pharmacy with the State Plan's prescription drug benefits administration company.

e. WHEN A PLAN MEMBER HAS OTHER PRIMARY PRESCRIPTION DRUG INSURANCE COVERAGE

When another medical or prescription drug insurance plan is responsible for primary payment of prescription drug costs, the State Plan's Prescription Drug Plan coordinates benefits as described in II.H.4 with the benefits provided by the primary plan. As the secondary plan, the State Plan pays for any out-of-pocket costs (costs not paid by the other plan) less any deductible and/or copay and/or coinsurance that is due under the State Plan (subject to plan limitations and exclusions).

3. EXCLUDED PRESCRIPTION DRUG EXPENSES

Expenses for the following drugs are exclusions of the Prescription Drug Plan:

- a. Experimental or investigational drugs or drugs prescribed for experimental (non-FDA-approved/unlabeled) indications or in dosages above recommended levels, unless such dosages are approved by HCBD;
- b. Charges for the administration of the injection of any prescription drug; and
- c. Drugs for a treatment excluded under general medical exclusions in III.B for the Classic plan, III.C for the Choice plan of this document, or the current annual change booklet.

4. PRESCRIPTION DRUG BENEFITS WITH PRIOR AUTHORIZATION OR OTHER REQUIREMENTS

A number of prescription drugs require prior authorization by the State Plan's prescription drug benefits administration company for coverage. Call the customer service number on your prescription drug identification card to determine if a particular prescription drug requires prior authorization.

The following drugs may be covered if prior-authorized by the company that administers your medical plan:

- a. Weight-loss medication as part of a prior-authorized weight-loss program.

Some high-cost prescriptions with good lower-cost alternatives may require step therapy (trial of a less costly drug first). See the prescription drug company website for updates, or call the customer service number on your prescription drug identification card.

Some drugs are only available through a retail pharmacy, not the mail services. See the website or call HCBD for information on drugs restricted to a retail pharmacy.

5. SPECIALTY DRUG PROGRAM

Specialty drugs are high cost prescription drugs that may require special handling and/or administration to treat chronic complex conditions. These drugs may be taken orally but often are injectibles with a complex manufacturing process or may have limited distribution. The specialty drug program includes but is not limited to medications to treat hemophilia, hepatitis C, arthritis, multiple sclerosis, RSV, osteoporosis, Parkinson's disease, pulmonary arterial hypertension, as well as medications for oncology and transplant patients.

Because of the complexity of the medical condition, many of these drugs require prior authorization to ensure appropriate use and to maximize the effectiveness of the drug by encouraging careful adherence to treatment protocols. Contact HCBD or URx for information.

B. MEDICAL PLAN BENEFITS AND EXCLUSIONS FOR THE CHOICE PLAN

1. COVERED MEDICAL EXPENSES AND PLAN PAYMENT (CHOICE)

a. COVERED MEDICAL EXPENSES

Expenses covered by the state-sponsored Choice plan are:

- 1) expenses within allowable charges (you are responsible for expenses over allowable charges unless you use an in-network covered provider — see II.A.1 and II.A.2);
- 2) expenses within specified benefit limitations contained in this chapter and which meet other requirements of this Summary Plan Description; and
- 3) expenses for covered medical services.

b. COVERED MEDICAL SERVICES

Covered medical services are services, procedures, and supplies:

- 1) listed in this section and not excluded in III.B.40;
- 2) determined by the Plan Administrator to be medically necessary for the diagnosis or treatment of:
 - i. injury;
 - ii. illness; or
 - iii. maternity or preventive services specified in III.B.34 for the Choice plan. (Expenses associated with inpatient hospital days only meet medical necessity criteria if they are certified as described in III.B.2 for the Choice plan.)
- 3) provided to a member by a licensed covered provider; and
- 4) provided and coded in accordance with applicable medical policy, as defined in Chapter IX; and
- 5) provided in accordance with the terms of this State Plan including any prior authorization requirements and within any time and service limits.

c. COVERED MEDICAL EXPENSES YOU PAY

Deductible

You pay your (and each enrolled dependent's) first covered medical expenses in a benefit year that are subject to deductible, until you have met the individual or family deductible requirement for your plan. See your current annual change booklet for the individual and family deductible amounts for covered medical services that are subject to deductible for your medical plan

IMPORTANT: A BENEFIT YEAR MEANS THE PERIOD COMMENCING JANUARY 1 AND ENDING DECEMBER 31 OF EACH YEAR. A BENEFIT YEAR DOES NOT START ON THE DATE YOU ARE HIRED. BENEFITS, CO-PAY MAXIMUMS, AND DEDUCTIBLES ARE NOT PRO-RATED WHEN AN EMPLOYEE IS NOT EMPLOYED FOR THE ENTIRE BENEFIT YEAR. FOR EXAMPLE, IF A MEMBER STARTS EMPLOYMENT ON SEPTEMBER 1 AND MEETS THE DEDUCTIBLE BY DECEMBER 31 OF THAT SAME YEAR, THE DEDUCTIBLE REQUIREMENT STARTS AGAIN ON JANUARY 1 OF THE FOLLOWING YEAR.

Coinsurance

After you have met deductible requirements, you pay a coinsurance percentage on any of your (and each enrolled dependent's) covered medical expenses that require coinsurance, until you have met your individual or family out-of-pocket maximum for the benefit year. The plan then pays 100 percent of covered medical expenses for the

remainder of the benefit year - with the exception of those that do not accumulate toward the out-of-pocket maximum (refer to the annual change booklet). To determine the coinsurance percentage you pay, the covered medical services to which it applies, and the benefit year's out-of-pocket maximum for your plan, see the current annual change booklet.

d. **COVERED MEDICAL EXPENSES DEFINED**

Covered medical services are services, procedures, and supplies:

- 1) determined by the State Plan to be medically necessary as preventive services specified in this section.

Covered medical expenses are paid or credited to the member's deductible, copayment, and coinsurance obligations for the applicable level of benefits as described below.

e. **IN-NETWORK LEVEL OF BENEFITS**

You receive the in-network level of benefits (described in this document and the current Schedule of Benefits) for covered medical services that are:

- 1) services provided by an in-network covered provider (in certain instances in-network benefits may be available for services provided by an out-of-network covered provider when an in-network covered provider is not available. Contact HCBD concerning network exceptions);
- 2) treatment of an emergency medical condition or facility/professional services for urgent care (care of an urgent medical condition) by any licensed covered provider.

You will be responsible for any deductible, copayment, and coinsurance amounts that the current Schedule of Benefits specifies for the in-network level of benefits.

f. **OUT-OF-NETWORK LEVEL OF BENEFITS**

You will receive the reduced out-of-network level of benefits (described in the current Schedule of Benefits) for all other covered medical services obtained out-of-network, with some exceptions. There are no out-of-network benefits for the following services:

- 1) organ transplant services.*

*Note that the above require prior authorization for *any* benefits, and then can only be used in-network.

For covered medical services eligible for the out-of-network level of benefits, you will be responsible for any applicable copayment, deductible, and coinsurance amounts described in the current Schedule of Benefits. You will also be responsible for any charges in excess of the State Plan's allowable fee by out-of-network covered providers who do not accept the State Plan's allowable fees as full compensation as well as any applicable out-of-network differential.

g. **RELATED INFORMATION**

Some medical services contain limits on the duration or frequency of services covered by the plan. These are contained in the descriptions of the specific covered medical expenses in this section and are updated in the annual change booklet for the current benefit year.

If you are currently being treated for a major illness or serious injury, you are encouraged to use the care management services described in III.B.41. These services help you get the most out of your benefits and help control your out-of-pocket costs.

2. CERTIFICATION REQUIREMENT FOR INPATIENT HOSPITAL COVERAGE (CHOICE)

Inpatient hospital stays (hospital confinement of 24 hours or more) are reviewed by the State Plan's utilization review company to determine if inpatient hospitalization is medically necessary (as defined in Chapter IX). Only charges for hospital days certified as medically necessary are eligible for standard inpatient benefits described in this section. Plan members can determine whether medical necessity criteria are met by calling the customer service number on their identification card in advance of a non-emergency hospital admission and within 24 hours (or the first working day) after an emergency hospital admission as described in II.A.4.

Assistance in finding appropriate outpatient treatment is available upon request when inpatient days are denied certification (see III.B.40).

3. COVERAGE OF MEDICAL EXPENSES FOR CERTIFIED AND NON-CERTIFIED HOSPITAL STAYS (CHOICE)

- a. Medical services received during a hospital stay certified as medically necessary are covered as described in this chapter.
- b. When all or part of the hospital stay fails to be certified as medically necessary, either through the call-in process (described in II.A.4) or after the fact when claims are processed, coverage is as follows:
Only expenses that would have been incurred for outpatient treatment are covered for any hospital days that are not certified. Hospital room and board charges are not covered, and other hospital expenses may not be eligible for coverage.

4. INPATIENT HOSPITAL SERVICES (CHOICE)

Certification requirement applies. See III.B.3 for coverage of non-certified days. Pre-certification of all non-emergency hospital admissions is strongly recommended. See III.B.6 for emergency admissions.

The following inpatient hospital services are covered for days that the member is confined to a licensed hospital, provided the inpatient days are certified as inpatient level of care as required in II.A.4:

(To be eligible under this provision, the services must not be primarily for rehabilitation care, which is covered under III.B.30.)

- a. Bed, board, and general nursing services in semiprivate (two or more beds) accommodations. The plan will allow the hospital's average semiprivate room charge as the allowance toward a private room.
- b. Bed, board, and both general and concentrated nursing services provided by nurses who are hospital employees in intensive care and cardiac care units.
- c. Miscellaneous hospital services and services provided by covered providers on the hospital's staff as described below:
 - 1) operating room, recovery room, and delivery room;
 - 2) surgical and anesthetic supplies;
 - 3) Splints, casts, and dressings;
 - 4) drugs and medicines that:
 - i. are approved for use in humans by the U.S. Food and Drug Administration (approved label indications only);
 - ii. are listed in the American Medical Association Drug Evaluation, Physician's Desk Reference, or Drug Facts and Comparisons; and
 - iii. require a physician's written prescription.
 - 5) oxygen and use of equipment for its administration;
 - 6) intravenous injections, and setups for intravenous solutions including the solution, if included in III.B.4.c, above;
 - 7) physical therapy; occupational therapy; speech therapy, if administered by or under the supervision of a registered therapist employed by the hospital (provision III.B.30);
 - 8) chemotherapy, radiation therapy, and dialysis therapy;
 - 9) respiratory therapy if administered by or under the supervision of a registered respiratory therapist employed by the hospital;
 - 10) administration of blood and blood products (blood donor's fee is excluded);
 - 11) laboratory services;
 - 12) x-rays and other medically necessary diagnostic services; and
 - 13) other medically necessary inpatient hospital services.

5. OUTPATIENT HOSPITAL SERVICES (CHOICE)

Hospital services and supplies described above in provision III.B.4 are covered if a member is treated at a licensed hospital, but not admitted for bed patient care, with the exception of physical, occupational, and speech therapy (covered under III.B.30).

Charges for observation beds/rooms are covered when medically necessary and in accordance with medical policy for services of less than 24 hours and for charges not exceeding the room rate that would be charged for an inpatient stay of one day.

6. EMERGENCY ROOM SERVICES (CHOICE)

(Certification requirement applies if admitted for inpatient care.)

Benefits for services and supplies rendered in the emergency room of a hospital are covered for emergency medical conditions defined in Chapter IX.

a. EMERGENCY ROOM COPAYMENT

The emergency room copayment (as identified in the current Schedule of Benefits in the annual change book) only includes the facility charges. Any lab fees, diagnostic fees, or professional service charges are subject to deductible and coinsurance.

b. SPECIAL REQUIREMENT TO RECEIVE THE IN-NETWORK LEVEL OF BENEFITS FOR OUT-OF-NETWORK SERVICES

The in-network level of benefits is provided for out-of-network emergency services immediately required to diagnose and treat an emergency medical condition at the nearest appropriate medical facility. You may still be balanced billed for the difference between the provider charge and the allowance for any service rendered by an out-of-network covered provider. If an emergency medical condition is determined to exist that requires hospital admission or any follow-up services, you must notify the State Plan within 24 hours of (or the next business day after) the initial emergency care so the State Plan can coordinate the subsequent follow-up care and assure continued in-network benefits. If you are incapable of calling or having a representative call the State Plan within 24 hours (or on the next business day), you should contact the State Plan as soon as medically possible. Once medical stabilization is achieved, the Plan Administrator may require transfer to an in-network hospital for the in-network level of benefits to continue.

7. LICENSED AMBULANCE SERVICE (CHOICE)

Coverage only includes emergency ground or air transportation to the nearest hospital or medical facility that is equipped to furnish the services, unless otherwise approved by the State Plan. The emergency transportation must be medically necessary. Medical necessity is established when the patient's condition is such that other means of transportation would endanger the health of the member. Transportation is not covered if not medically necessary or if transport is to a lateral or lower level of care. See the current Schedule of Benefits for the ambulance transportation benefits.

The in-network level of benefits is provided for out-of-network emergency services immediately required to diagnose and treat an emergency medical condition at the nearest appropriate medical facility.

8. SURGICAL SERVICES (CHOICE)

(Certification requirement applies if performed inpatient. See III.B.3 for coverage of non-certified hospital days.)

Medically necessary (See Chapter IX for definition of medically necessary) surgical services are covered, including normal pre- and post-operative care, for the surgical treatment of injuries and illnesses rendered by a licensed surgeon/physician. Payment for these services is subject to the following conditions:

- a. When two or more surgical procedures are performed, payment will be made for the allowable charge of the procedure with the highest allowance, plus one half of the allowable charge for the procedure with the lowest allowance. No additional payment will be made for incidental surgery. Incidental surgery is a procedure that is an integral part of, or incidental to, the primary surgical service and performed at the same operative session. Surgery is not incidental if:
 - 1) it involves a major body system different from the primary surgical services; or
 - 2) it adds significant time or complexity to the operating session and patient care.
- b. If an operation or procedure is performed in two or more steps, total payment will be limited to the allowable charge for the initial procedure.
- c. If two or more surgeons perform operations or procedures together, other than as an assistant at surgery or anesthesiologist, the allowable charge will be divided among them. (This condition is subject to the conditions in III.B.8, provisions a. and b.)
- d. Assistant-at-surgery charges for actively assisting the operating physician in the performance of covered surgery, will be paid as follows depending on whether the assistant-at-surgery is a physician or non-physician assistant:
 - 1) assistant-at-surgery performed by a physician will be paid at 20 percent of the allowable charge for the surgical procedure, or the assistant's charge, whichever is less.

- 2) Assistant-at-surgery performed by a non-physician assistant or surgical technician will be paid at 10 percent of the allowable charge for the surgical procedure, or the assistant's charge, whichever is less.
 - 3) Benefits are not available when an assistant-at-surgery is present only because the facility provider requires such services — for teaching purposes, for example.
 - 4) Benefits for an assistant-at-surgery will be paid only if the State Plan determines that such services were necessary.
 - 5) If two physicians are paid as primary surgeons or co-surgeons for their multiple surgeries, no allowance as an assistant-at-surgery will be made to either of the surgeons. Any charges for an additional assistant-at-surgery will be subject to review.
- e. The charge for a surgical suite outside a hospital is included in the allowable fee for the surgery.

9. SURGICAL FACILITIES / SURGICENTERS (CHOICE)

Prior authorization of all non-emergency surgery is strongly recommended.

Medically necessary services of a surgicenter are covered, including recovery care beds, defined in Chapter IX, if the following criteria are met:

- a. The center is licensed or certified by Medicare by the state in which it is located, and
- b. The surgical procedure performed is recognized as a procedure that can be safely and effectively performed in an outpatient setting.

See III.B.8 for coverage of inpatient surgery, and see information on specific surgeries below.

c. MASTECTOMY

Coverage is provided for mastectomies due to malignancy, and as a result of disease, illness, or injury.

d. RECONSTRUCTIVE BREAST SURGERY

Coverage provides reconstructive surgery after a mastectomy, which resulted from disease, illness, or injury.

Coverage is provided for:

- 1) reconstruction of the breast on which the mastectomy was performed;
- 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 3) prostheses and treatment of any physical complications resulting from the mastectomy, including lymphedemas.

e. ORAL SURGERY

- 1) Coverage includes non-cosmetic surgical treatment for the excision of lesions of the oral cavity, tongue, cheek, and maxillary/mandibular fracture, or for the treatment of degenerative joint disease that is associated with rheumatoid arthritis or osteoarthritis of the TMJ. Surgical treatment of TMJ pain, dysfunction, or disease is covered when medically necessary. Non-surgical treatment is not covered.

- 2) ORTHOGNATHIC SURGERY (RECONSTRUCTIVE JAW SURGERY)

Prior authorization is strongly recommended.

Coverage is provided only for the treatment of congenital conditions of the jaw that may be demonstrated to cause actual significant deterioration of the member's physical condition because of inadequate nutrition.

Dental appliances, splints, orthodontia, or other services associated with covered jaw surgery are considered dental services and are not covered under the medical benefit.

f. RECONSTRUCTIVE SURGERY

Coverage is provided in order to restore bodily function or correct deformity resulting from a disease, trauma, or congenital or developmental abnormality. Coverage includes any consequences or complications that may arise from a covered surgery or related service.

10. INPATIENT COVERED PROVIDER SERVICES — EXCLUDING SURGICAL SERVICES COVERED UNDER III.B.8 (CHOICE)

Certification requirement applies. See III.B.3 for coverage of non-certified days. Pre-certification of all non-emergency hospital admissions is strongly recommended. See III.B.6 for emergency admissions.

In-hospital services by a covered provider are covered for days that a member is confined to a licensed hospital as a registered bed patient under the care of a licensed physician or surgeon, provided the inpatient days are certified as medically necessary according to II.A.4. Coverage includes health care services performed, prescribed, or supervised by

a professional covered provider, including diagnostic, therapeutic, medical, surgical preventive, referral, and consultative health care services. See III.B.3 for coverage of charges for non-certified hospital days. Benefits for medical care visits are limited to one visit per day per covered provider, unless the member's condition requires intensive medical care (a physician's constant attendance and treatment for a prolonged period of time).

11. ANESTHESIA SERVICES (CHOICE)

(Certification requirement applies to inpatient services. See III.B.3 for coverage of services for non-certified hospital days.)

Coverage includes anesthesia services rendered and billed by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist for medically necessary care (see Chapter IX for definition of Medical necessity) of a condition covered under this document.

Benefits will **not** be provided for the following:

- a. Hypnosis;
- b. Local anesthesia (paid as part of a global procedure charge);
- c. Anesthesia consultations before surgery (paid as part of the anesthesia charge); or
- d. Anesthesia for dental services or extraction of teeth (except those covered by III.B.14).

12. OFFICE VISIT SERVICES (CHOICE)

Covered office visit services are health care services provided by a physician, mid-level practitioner in a physician's office or clinic, or other covered providers in the office/clinic staff under physician direction. This includes but is not limited to diagnostic services, treatment services, allergy shots, laboratory services, x-ray and radiation services, and referral services.

Benefits will not be provided for the following:

- a. Routine physical examinations (including those required for school, athletics or employment, except those listed in III.B.34);
- b. Screening examinations, except those listed in III.B.34;
- c. Pre- or post-surgical visits considered to be inclusive services; or
- d. Conditions for which maternity benefits are payable (covered under provision III.B.15).
- e. Outpatient office visit benefits are limited to payment for one visit per day per covered provider specialty.

The in-network office visit copayment only covers the office visit allowable fee. Any laboratory, x-ray, radiation, tests, or ancillary procedures are subject to deductible and coinsurance unless covered under preventive benefits described in III.C.36.

13. URGENT CARE SERVICES (CHOICE)

- a. Coverage includes care for an acute illness or injury that requires immediate treatment (such as high fever; ear, nose, and throat infections; and minor sprains and lacerations).
- b. The copayment (as identified in the Schedule of Benefits in the annual change book) applies to allowable facility and professional fees for urgent care from any licensed covered provider. Any lab and/or diagnostic fees are subject to deductible and coinsurance.

14. MEDICAL/DENTAL SERVICES FOR ACCIDENTAL INJURY TO TEETH (CHOICE)

(Certification requirement applies to inpatient services. See III.B.3 for coverage of non-certified hospital days.)

a. PROFESSIONAL SERVICES

Coverage includes professional services rendered by a physician, surgeon, or doctor of dental surgery for the treatment of a fractured jaw or other accidental injury to sound natural teeth, provided that:

- 1) the injury occurs while the patient is covered under the State Plan; or
- 2) the injury occurs while the patient is covered under creditable coverage as defined in Chapter IX. Such services shall be covered only during the 12-month period immediately following the date of injury.

Services for the treatment of accidental injury to teeth caused by biting or chewing are exclusions of this provision (they are covered under the Dental Plan, if enrolled).

Services and supplies provided by a hospital in conjunction with dental treatment will be covered only when a non-dental physical illness or injury exists, which makes hospital care necessary to safeguard the member's health.

Dental factors, such as complexity of dental treatment and length of anesthesia, do not make a dental treatment eligible for hospital benefits.

15. MATERNITY AND NEWBORN SERVICES (CHOICE)

(Certification requirement applies to inpatient hospital stays. See III.B.3 for coverage of non-certified hospital days.) Refer to the current Schedule of Benefits in the annual change book for more information.

a. MATERNITY CARE

Coverage includes hospital, physician, and certified licensed RN nurse midwife services for the delivery or attempted delivery of one or more newborns, including prenatal and postpartum outpatient care and hospital services for conditions directly related to the pregnancy including ultrasounds. Inpatient hospital care following delivery will be covered for the length of time medically necessary and will be at least 48 hours following a vaginal delivery and at least 96 hours following a cesarean section. The decision to shorten the length of inpatient stay to less than the above must be made by the attending covered provider and the mother.

Payment for any maternity services provided by a physician or licensed registered nurse midwife is limited to the allowable fee for total maternity care, which includes delivery, prenatal, and postpartum care.

Coverage includes medically necessary obstetrical and gynecological services.

b. ROUTINE NEWBORN CARE

Coverage includes routine physician and laboratory care of a newborn at birth, standby care provided by a pediatrician at a cesarean section, and hospital nursery care of a newborn infant born in the hospital. The routine newborn care benefit is limited to three days of inpatient care. Additional hospital care required by a medical condition is covered under provision III.C.4.

16. DIAGNOSTIC / LABORATORY SERVICES (CHOICE)

Prior authorization is strongly recommended for MRIs, CT/CAT Scans, and PET Scans.

Coverage includes x-ray, laboratory and tissue diagnostic examinations, and diagnostic machine tests (such as EKGs) made for the purpose of diagnosing accident or illness when hospital confinement is not required and benefits are not provided elsewhere in this Summary Plan Description.

X-ray and laboratory benefits shall not be provided for the following:

- a. Dental examinations or treatments, except for dental x-rays resulting from injuries sustained in an accident covered under III.B.14;
- b. Visual examinations (covered under II.D.1); or
- c. Premarital examinations and routine physical checkups, including examinations made as a requirement of employment or governmental authority, except as provided in III.B.34.

17. RADIATION THERAPY (CHOICE)

Coverage includes x-ray, radium, or radioactive isotope therapy ordered by the attending physician and performed by a covered provider for the treatment of disease.

18. CHEMOTHERAPY (CHOICE)

Coverage includes the use of chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration (FDA), ordered by the attending physician, and administered by a covered provider for the treatment of the FDA approved diagnosis.

19. BLOOD TRANSFUSIONS (CHOICE)

Coverage includes blood transfusions, including the cost of blood and blood products. Storage charges for blood are covered when you have blood drawn and stored for your own use for a planned surgery.

20. MEDICAL SUPPLIES (CHOICE)

Coverage includes but is not limited to the following medically necessary supplies for which benefits are payable prescribed by a covered provider, all for use outside a hospital:

- a. Sterile dressings for conditions such as cancer or burns;
- b. Catheters;
- c. Splints and casts;
- d. Colostomy bags and related supplies;

- e. Supplies for renal dialysis equipment or machines
- f. Orthopedic braces, corsets, and trusses;
- g. Syringes and diabetic supplies (may also be covered under prescription drug plan); and
- h. Oxygen supplies; and
- i. Syringes and diabetic supplies are also covered under the Prescription Drug Plan described in III.A.

21. DURABLE MEDICAL EQUIPMENT (DME), IMPLANTS, AND PROSTHESES (CHOICE)

Prior authorization is required for the initial purchase, repair, or replacement of DME or prostheses over \$1,000. No benefit is available for expenses over \$1,000 unless prior-authorized.

Prior authorization is recommended for the initial purchase, repair, or replacement of DME or prosthetics under \$1,000 to assure coverage. See Chapter IX for a definition of durable medical equipment and examples of equipment that are not covered. Coinsurance for DME does not count toward the individual or family annual out of pocket maximum (coinsurance maximum).

Coverage applies to the least expensive appropriate prosthetic device used to replace a body part missing due to accident, injury, or illness (such as artificial limbs or eyes), and the least expensive appropriate type of durable medical equipment necessary for therapeutic purposes in your home (such as oxygen equipment, CPAP machines, crutches, a wheelchair, or a hospital-type bed). Rental (up to the purchase price) of a hospital-type bed, oxygen equipment, CPAP machine, wheelchair, or other durable therapeutic equipment (provided the equipment is designed for prolonged use over a period of years, serves a specific therapeutic purpose in the treatment of an injury or illness, is primarily and customarily used for a medical purpose, is appropriate for use in the home, and is not generally useful to a person in the absence or illness or injury) or the purchase of this equipment if economically justified, whichever is less. For DME for which purchase is not feasible, reasonable rental charges will be paid. The Case Manager shall determine the reasonable rate.

The State Plan will be responsible for determining rental versus purchase agreements. Requests for computerized and "deluxe" equipment, like motor-driven wheelchairs, are reviewed on an individual basis. The State Plan will have the right to decide when standard equipment is adequate. Coverage does not include maintenance, replacement due to loss, or duplication. Replacement can occur when equipment or prosthetics are no longer repairable or when DME has been out-grown, but no sooner than 5 years from the original received dated.

a. DURABLE MEDICAL EQUIPMENT REQUIREMENTS

Durable medical equipment must meet the following criteria:

- 1) able to withstand repeated use (consumables are not covered);
- 2) primarily used to serve a medical purpose rather than comfort or convenience;
- 3) generally not useful to a person who is not ill or injured; and
- 4) prescribed by a professional covered provider.

These devices and equipment are limited to those reasonably required by standard treatment practices as a result of injury or illness. Replacement of such devices and equipment shall be made only if the existing appliance cannot be made satisfactory by standard repair practices. To ensure coverage, contact the State's Plan Administrator regarding buying or rental agreements.

b. PRIOR AUTHORIZATION

You must obtain prior authorization from the indemnity medical plan's Plan Administrator for repair or replacement of durable medical equipment or a prosthesis that is over \$1000 (as well as initial purchase). Prior authorization may be obtained by submitting to the claims administration company the following:

- 1) a professional covered provider's prescription;
- 2) a written explanation by the professional covered provider as to why replacement is necessary or
- 3) an itemized repair and replacement cost statement from the covered provider.

c. Coverage is provided for the following services and supplies for medical purposes *only in a hospital or for therapeutic use in a member's home*:

- 1) oxygen services and supplies; and
- 2) prosthetic appliances including the purchase and fitting of breast prostheses and the purchase and fitting of artificial limbs, larynx, eyes, other prosthetic appliances or permanent internally implanted devices that are

not experimental. Repair, maintenance, replacement due to loss, and duplication are not covered. Replacement can occur when the item is no longer repairable; and

- 3) cochlear implants are covered if the Plan Administrator medical policy criteria are met and prior authorization is approved. Replacement batteries and any equipment upgrades are not covered. Prior authorization is required.

d. THE FOLLOWING ARE NOT COVERED:

- 1) durable medical equipment, orthopedic devices, or prosthetics required primarily for use in athletic activities;
- 2) replacement of lost or stolen durable medical equipment, orthopedic devices, or prosthetics;
- 3) repair to rental equipment;
- 4) continuous passive motion devices, except in the case of surgery involving the knee joint, which begins within two days following surgery and is limited to:
 - i. total knee replacement;
 - ii. repair of plateau fractures; and
 - iii. anterior cruciate ligament (ACL) repairs.
- 5) duplicate equipment purchased primarily for patient convenience when the need for duplicate equipment is not medical in nature; or
- 6) expenses over \$1,000 that are not prior authorized.

22. CHEMICAL DEPENDENCY TREATMENT (CHOICE)

(Certification requirement applies to inpatient services. See III.B.3 for coverage of services for non-certified hospital days. Pre-certification of non-emergency hospital admissions is strongly recommended. See III.B.6 for emergency admissions.)

Coverage includes outpatient visits and inpatient treatment. Residential care is not covered. Coverage is provided for inpatient and outpatient treatment for alcoholism and drug addiction (excluding costs for medical detoxification, which is covered under III.B.4). The State Plan offers a limited number of confidential counseling sessions at no cost to the State Plan member, as described in the current annual change booklet.

a. MEDICAL DETOXIFICATION

Treatment is covered the same as any other illness under the terms of this Summary Plan Description.

b. COVERED PROVIDERS

Covered providers for the treatment of chemical dependency are state-licensed facilities in which services are provided, such as a hospital or as a freestanding inpatient facility specializing in the treatment of chemical dependency; physicians; licensed social workers; and licensed addiction counselors.

Covered medical services do not include treatment of the following conditions:

- 1) developmental and learning disorders;
- 2) speech disorders;
- 3) eating disorders (except bulimia and anorexia nervosa);
- 4) impulse control conduct disorders (except intermittent explosive disorder and trichotillomania);
- 5) mental retardation;
- 6) inpatient confinement for environmental change;
- 7) gambling addiction; or
- 8) tobacco addiction.

c. PARTIAL HOSPITALIZATION BENEFITS

Prior authorization (prior to treatment) is strongly recommended.

Partial hospitalization (intensive outpatient services defined in Chapter IX) for the treatment of chemical dependency is covered when medically necessary. A partial hospitalization program offers four to eight hours of therapy, five days a week. The hours of therapy per day and the frequency of visits per week will vary with each individual, depending on the clinical symptoms and progress being made.

23. MENTAL ILLNESS TREATMENT (CHOICE)

(Certification requirement applies to inpatient services. See III.B.3 for coverage of services for non-certified hospital days. Pre-certification of non-emergency hospital admissions is strongly recommended. See III.B.6 for emergency admissions.)

a. INPATIENT BENEFITS

Pre-certification (prior to admission) is strongly recommended. Costs for inpatient services can be expensive. Calling the Plan Administrator (at the number on your medical identification card) in advance of admission lets you know whether you meet plan criteria for inpatient coverage, and whether the intended mental health care facility's charges are within plan allowances. If you do not meet inpatient criteria, the Plan Administrator can assist you with finding suitable alternatives such as partial hospitalization described below. If you do meet criteria, they can assist you in finding a mental health facility whose charges are covered by the State Plan.

Coverage includes medically necessary inpatient treatment of mental illness (as defined in Chapter IX).

Coverage is provided for medically necessary inpatient and outpatient treatment of mental illness. Residential treatment is not covered. However, services provided by a covered licensed professional health care provider during residential admission may be covered if billed under the individual professional health care provider's licensure (not billed as part of residential treatment). All residential facilities services are not covered regardless of their licensing.

1) Covered medical services do not include treatment of the following conditions:

- i. developmental and learning disorders;
- ii. speech disorders;
- iii. psychoactive substance abuse disorders;
- iv. eating disorders (except bulimia and anorexia nervosa);
- v. impulse control conduct disorders (except intermittent explosive disorder and trichotillomania);
- vi. mental retardation; or
- vii. inpatient confinement for environmental change.

b. SEVERE MENTAL ILLNESS CARE

Pre-certification of all non-emergency hospital admissions is strongly recommended. See III.B.6 for emergency admissions.

1) Coverage includes medically necessary care and treatment of severe mental illness as defined in 33-22-706

MCA. Severe mental illness is:

- i. schizophrenia;
- ii. schizo-affective disorder;
- iii. bipolar disorder;
- iv. major depression;
- v. panic disorder;
- vi. obsessive-compulsive disorder; or
- vii. autism.

c. PARTIAL HOSPITALIZATION BENEFITS

Prior authorization (prior to treatment) is strongly recommended.

Partial hospitalization (intensive outpatient services defined in Chapter IX) for the treatment of mental illness is covered when medically necessary. A partial hospitalization program offers four to eight hours of therapy, five days a week. The hours of therapy per day and the frequency of visits per week will vary with each individual, depending on the clinical symptoms and progress being made.

d. OUTPATIENT BENEFITS

Coverage includes outpatient treatment of mental illness, reimbursed (after deductible) at the percentages specified in the current annual change booklet.

The State Plan offers a limited number of confidential counseling sessions at no cost to the State Plan member, as described in the current annual change booklet.

e. COVERED PROVIDERS AND BENEFIT LIMITATIONS

Covered providers for the treatment of mental illness are state-licensed facilities in which services are provided, such as a hospital specializing in the treatment of mental illness; licensed mental health treatment facilities; physicians/psychiatrists; licensed psychologists; licensed professional counselors; and licensed psychiatric social workers. Residential treatment is not covered. However, services provided by a covered licensed professional health care provider during residential admission may be covered if billed under the individual professional health

care provider's licensure (not billed as part of residential treatment). All residential facilities services are not covered regardless of their licensing.

- f. Medical detoxification treatment is covered the same as any other illness under the terms of this document. Benefits do not include services rendered for learning disabilities; marital, family, or sexual problems; or for services excluded under the definition of mental illness in Chapter IX (except for limited EAP benefits). Benefits also do not include custodial care, residential care, or training.

24. INFUSION THERAPY SERVICES (CHOICE)

Coverage includes but is not limited to: antibiotic therapy, enteral nutrition, total parenteral nutrition, pain management, and specialized disease state therapy.

- a. Coverage includes medically necessary infusion therapy services provided they are both:
- 1) ordered by a professional covered provider, and
 - 2) provided by a licensed infusion therapy agency.
- b. Home infusion therapy services include:
- 1) pharmaceuticals and supplies,
 - 2) equipment, and
 - 3) skilled nursing services when billed by an infusion agency. Services billed by a home health agency will be covered under your home health benefit in III.B.29.

See the current annual change booklet or the HCBF website for information about the Infusion Program.

25. TRANSPLANTS (CHOICE)

(Certification requirement applies to inpatient services. See III.B.3 for coverage of services for non-certified hospital days.)

Prior authorization (prior to admission) and care management are required.

Benefits are only available through the designated transplant network (contact the Plan Administrator to locate the designated transplant network facilities). No out-of-network benefits are available. The State Plan has designated certain hospitals to perform covered transplants. These hospitals have been selected for their experience and outcomes in performing transplants and no benefits are available from other hospitals (except under rare circumstances approved in advance by the State Plan) In some instances, the designated hospital may not be located in the State Plan's service area, therefore requiring travel.

Transplants are one of the most costly medical procedures, and State Plan members need to make sure they are covered. Also, the Plan Administrator will assist you in maximizing your benefits through the use of a hospital in the designated transplant network (as defined in Chapter IX).

a. CORNEA AND KIDNEY TRANSPLANTS

Coverage includes cornea and kidney transplants, including eye bank charges and initial allowable expenses associated with removing the organ from the donor, which are chargeable to the recipient State Plan member and are not covered by the donor's health plan.

Expenses for a State Plan member to donate a kidney or cornea to an individual who is not a State Plan member are not covered.

b. BONE MARROW, HEART, LIVER, LUNG, AND PANCREAS

Organ or tissue transplant services for a member who receives human-to-human organ transplants of bone marrow, heart, heart/lung, liver, lung, and pancreas are covered as specified in the current annual change booklet. These allowances apply to charges related to the transplant for a period of 30 days before the transplant and extending for 18 months.

- 1) Bone marrow transplants are covered, when medically necessary, under the following circumstances:
 - i. allogenic and Syngeneic Bone Marrow Transplants (requires HLA typing match on at least five out of six loci);
 - (a) acute lymphocytic leukemia and non-acute lymphocytic leukemia;
 - (b) chronic myelogenous leukemia;
 - (c) aplastic anemia ;
 - (d) Fanconi's Anemia;
 - (e) infantile malignant osteopetrosis;

- (f) large-cell lymphoma;
- (g) lymphoma;
- (h) Severe Combined Immodeficiency Disease (SCIDS) ; and
- (i) Wiscott Aldrich Syndrome

c. Autologous Bone Marrow Transplants

- 1) acute lymphocytic leukemia and non-acute lymphocytic;
- 2) leukemia;
- 3) Burkitts Lymphoma;
- 4) large-cell lymphoma ;
- 5) non-Hodgkin’s lymphoma;
- 6) Hodgkin’s Disease; and
- 7) neuroblastoma

d. MEDICAL NECESSITY

Stem cell transplants in conjunction with high-dose chemotherapy are covered, when medically necessary. Prior authorization is recommended (a retrospective review will be done if services are not prior authorized). High-dose chemotherapy with either allogenic or autologous stem-cell transplant will be considered on an individual case basis.

e. INCLUDED SERVICES

The following transplant-related services are covered under this provision (not under other provisions of this Summary Plan Description):

- 1) organ procurement, including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ, and transportation of the donor or donor organ to the location of the transplant operation;
- 2) inpatient hospital services including room, board, and ancillaries;
- 3) surgical services including a surgical assistant;
- 4) anesthesia;
- 5) outpatient services, including professional and diagnostic services; and
- 6) medically necessary licensed ambulance travel or commercial air travel for the recipient to the location of the transplant, or in the case of a medical emergency to the nearest hospital with appropriate facilities.

f. BENEFITS ARE NOT PROVIDED FOR THE FOLLOWING:

- 1) services ordered by a single board certified specialist;
- 2) transplants of a non-human organ or artificial organ implant;
- 3) charges for lodging and meals (III.B.26);
- 4) Experimental Procedures (as defined in Chapter IX);
- 5) transplants that are not currently approved under Medicare transplant guidelines;
- 6) expenses for a State Plan member to donate an organ or portion of an organ to an individual who is not a State Plan member eligible for a transplant;
- 7) charges that are not routinely made to all patients receiving similar human organ or tissue transplants; or
- 8) benefits for a human organ or tissue transplant donor who has coverage for services related to the organ/tissue donation elsewhere. If the donor does not have coverage elsewhere and the recipient is a member, then the donor will be covered under State Plan, but only for health services related to the organ/tissue donation.

Benefits are only available through the designated transplant network. No out-of-network benefits are available.

Prior authorization is required. The State Plan has designated certain hospitals to perform covered transplants. These hospitals have been selected for their experience in performing transplants and no benefits are available from other hospitals (except under rare circumstances approved in advance by the State Plan) In some instances, the designated hospital may not be located in the State Plan’s service area, therefore requiring travel. Contact the State Plan for a list of designated organ transplant facilities.

26. NON-EMERGENCY TRAVEL BENEFIT (CHOICE)

Prior authorization by Health Care and Benefits Division (HCBD) is required prior to travel.

The non-emergency travel benefit is only available to members in conjunction with case management. Coverage includes one-way out-of-state transportation by regularly scheduled passenger aircraft, railroad, bus, or round-trip mileage at the current lowest state reimbursement rate for travel by personal automobile inside the United States and Canada to (or from) the nearest medical facility (or facility approved by HCBD) equipped to provide the necessary treatment not available in a Montana facility. Transportation benefits may only be used for services with an in-network provider.

- a. Transportation benefits are limited to medically necessary treatment that cannot be performed in-state as determined by the State's Plan Administrator. If services can be performed in state and the health care provider or patient prefers an out of state provider, travel benefits are not available.
- b. Transportation benefits in any one benefit year shall be limited to one-way transportation (except round-trip mileage at the current lowest state reimbursement rate for travel by personal automobile), or half of a round trip air fare ticket price for:
 - 1) non-transplant related services – One visit for treatment or surgery and one preparatory or follow-up visit for a condition which cannot be treated in state;
- c. Travel reimbursement is only covered for the patient, family members are not covered unless the patient is a child under 18 years of age. Then the transportation charges of a parent or legal guardian may be allowed if the attending physician certifies the need for such attendance.

TRAVEL PRIOR AUTHORIZATION

Travel will only be authorized if the above criteria, including active case management, are met. Prior authorization is required prior to travel, and retro-active authorization requests will be denied.

Plan members must submit a Travel Prior Authorization form available at:

http://benefits.mt.gov/content/docs/forms/Travel_Prior_Auth.pdf and return it to HCBD for a determination.

27. HOME HEALTH SERVICES (CHOICE)

Prior authorization (prior to services) through the State Plan's claims administration company is *strongly* recommended to assure coverage.

- a. Coverage includes the following services and supplies furnished by a licensed home health agency in a member's home in accordance with a professional covered provider's written home health care treatment plan for the treatment of a medically necessary injury or illness:
 - 1) part-time or intermittent nursing care by an RN or LPN;
 - 2) part-time or intermittent home health aide services;
 - 3) physical, occupational, speech, respiratory, and home infusion therapy (up to the home health visit maximum described in the current Schedule of Benefits); and
 - 4) medical supplies suitable for use in the home, prescribed medications, and lab services provided at home.Home health services are limited to the number of days specified in the current annual change booklet. Home health aide services in excess of four hours in any one day shall be considered an additional day. A day with any home health service is counted toward the maximum home health services
- b. Home health expenses are not payable for:
 - 1) services or supplies not included in the home health care plan of treatment;
 - 2) domestic or housekeeping services, including such programs as Meals-on-Wheels;
 - 3) services received in a nursing home or skilled nursing facility (covered under III.B.29);
 - 4) services for mental or nervous conditions;
 - 5) services of a social worker;
 - 6) transportation services; or
 - 7) durable medical equipment and prostheses (covered under III.B.21).

28. HOSPICE SERVICES (CHOICE)

Prior authorization is recommended.

Coverage includes services of a hospice facility, agency, or service.

- a. Services are subject to the following conditions:
 - 1) the services are medically necessary;
 - 2) they are ordered by a physician; and

- 3) the member is terminally ill and the physician has certified that the patient is not expected to live more than six months.
- b. Covered hospice services are:
- 1) home health care services listed above billed by hospice agency;
 - 2) facility expenses of a hospice facility, hospital, or skilled nursing facility for board, room, and other services and supplies furnished to a person while inpatient for pain control and other acute and chronic symptom management. Expenses for a private room are covered only up to the regular daily expense for a semi-private room unless a private room is medically necessary or a semi-private room is unavailable.
 - 3) hospice expenses for:
 - i. nursing care provided by a registered nurse or licensed practical nurse, and services of a home health aide;
 - ii. medical social services provided under the direction of a physician;
 - iii. psychological and dietary counseling;
 - iv. medically necessary physical and occupational therapy;
 - v. medical supplies, drugs, and medicines prescribed by a physician; and
 - vi. expenses for consultant or case and disease management services, or physical or occupational therapy by covered health care providers who are not employees of the hospice - but only when the hospice retains responsibility for the care.
 - 4) services of a social worker (M.S.W.); and
 - 5) bereavement follow-up care provided by a licensed social worker employed by the home health agency, limited to two visits per family following the member's death.
- c. Hospice benefits are not provided for the following:
- 1) care for which no charge would customarily be made if insurance coverage did not exist;
 - 2) patient expenses incurred more than six months after the first charge for hospice care is incurred;
 - 3) transportation services; or
 - 4) durable medical equipment and prostheses (covered under III.B.21).

29. SKILLED NURSING FACILITY CARE (CHOICE)

(Certification requirement applies. See III.B.3 for coverage of non-certified days.)

Prior authorization (prior to services) is required. Refer to the current annual change booklet for the maximum days covered.

Coverage includes medically necessary skilled nursing facility care, as defined in Chapter IX (for up to the maximum days stated in the annual change book) during convalescence or recovery from an acute illness or injury. Confinements must be ordered by the attending physician. Benefits will no longer be provided when confinement ceases to be rehabilitative and becomes custodial in nature.

30. REHABILITATION THERAPY (CHOICE)

Certification requirement applies. See III.C.3 for coverage of non-certified days. Prior authorization is strongly recommended. Refer to your current Schedule of Benefits for inpatient and outpatient maximums.

a. INPATIENT REHABILITATION THERAPY

Coverage includes inpatient rehabilitation therapy (physical, occupational, cardiac, pulmonary, and speech therapy as defined in Chapter IX) for up to the number of days specified in the current annual change booklet, which meets the appropriate level of care determined by the Plan Administrator and meets the following criteria:

- 1) provided by a multi-disciplinarian team under the direction of a physician;
- 2) medically necessary to improve or restore bodily function;
- 3) producing measurable progress;
- 4) required because the nature of the treatment (frequency, duration and/or variety) or the physical condition of the patient makes outpatient treatment or skilled nursing facility care an unrealistic alternative; and
- 5) rendered in a licensed rehabilitation care facility.

b. OUTPATIENT REHABILITATION THERAPY

- 1) Coverage includes outpatient physical, occupational, cardiac, pulmonary, and speech rehabilitation therapy services that meet the following criteria:

- i. prescribed by a licensed physician or mid-level practitioner within the last six months (after six months a new order or referral is required), and
- ii. provided by a licensed physical, occupational, cardiac, pulmonary, or speech therapist.

Benefits for all rehabilitation therapy are limited to the combined visit limit shown in the current annual change booklet — unless the therapy qualifies as Intensive Outpatient Rehabilitation, described below:

- 2) To be eligible for speech therapy coverage, the member must meet one or more of the following criteria:
 - i. has suffered an acute injury or serious illness which debilitates muscles or speech, or hinders the activities of daily living;
 - ii. is receiving treatment for medically diagnosed congenital defects or birth abnormalities; or
 - iii. is suffering exacerbation of an illness/injury, causing further debilitation.

c. INTENSIVE OUTPATIENT REHABILITATION THERAPY

Prior authorization (prior to services) is required for intensive outpatient rehabilitation therapy benefits exceeding the visit limit on standard outpatient rehabilitation benefits (specified in the current annual change booklet).

Coverage includes intense treatment involving at least two modalities, two or three hours per day, three to five times per week for an extended duration of three to six months for a severe injury or medical condition (such as brain injury) requiring extended rehabilitation following hospitalization or meeting criteria for inpatient rehabilitation therapy. Benefits for intensive outpatient therapy are limited to the number of visits pre-authorized through the State Plan's claims administration company. Services not prior authorized may be denied.

d. No rehabilitative therapy benefits are provided for the following:

- 1) custodial care;
- 2) diagnostic admissions;
- 3) maintenance, non-medical self-help, or vocational education therapy;
- 4) learning or developmental disabilities;
- 5) social or cultural rehabilitation;
- 6) visual, speech, or auditory disorders;
- 7) treatment for chemical dependency or mental illness (covered under III.B.22 and III.B.23); or
- 8) sports conditioning.

31. ALTERNATIVE HEALTH CARE (CHOICE)

a. CHIROPRACTIC SERVICES

Refer to the current Schedule of Benefits for visit limitations. The in-network office visit copayment covers allowable professional fees. Deductible and coinsurance apply to x-rays, ultrasounds, and other ancillary procedures.

32. INBORN ERRORS OF METABOLISM (INCLUDING PKU) (CHOICE)

Coverage includes treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist. Treatment includes diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment including, but not limited to: clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

In-network supplies, including medical foods, are exempt from deductible.

33. MEDICAL EYE CARE (CHOICE)

(Certification requirement applies. See III.B.3 for coverage of non-certified days.) Coverage includes services of a licensed physician and those services of an optometrist that are within the scope of their licensure, for the medical treatment of disease or injury to the eye.

Routine vision exams, glasses, and laser surgery to correct vision are not benefits of this medical plan (see II.D.1).

34. PREVENTIVE SERVICES (CHOICE)

Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of

recommendations and guidelines can be viewed at www.HealthCare.gov/center/regulations/prevention.html. Some of the most common periodic exams are listed in the table below:

Periodic exams —Appropriate screening tests	Applicable for members:
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
Prostate cancer screening (PSA) age 50+	1 per plan year (age 40+ with risk factors)
Osteoporosis screening	Post-menopausal women—65+ (60+ with risk factors)—one bone density x-ray (DXA)
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), zoster (shingles)	

35. DISEASE EDUCATION & DIETARY/NUTRITIONAL COUNSELING (CHOICE)

See the current annual change book for the annual benefit maximum booklet.

Coverage includes limited services of a registered dietician or other covered provider licensed to provide disease education and/or dietary/nutritional counseling services, when ordered by a physician. The services must be needed for reasons other than obesity (unless part of the treatment plan described below for morbid obesity) or routine vitamin supplementation. See the current annual change booklet for the dollar limit on this benefit.

The program must be a certified educational program administered by an in-network facility or in-network professional covered provider. Covered programs/clinics include but are not limited to: diabetes, multiple sclerosis, respiratory, polio, and cardiac clinics. Educational services are otherwise excluded.

36. BIRTH CONTROL (CHOICE)

The guidelines for benefits coverage published by the U.S. Department of Public Health and Human Services regarding what contraceptives a benefits plan must provide state:

All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

Coverage on the Choice plan includes birth control medications and supplies, other than oral contraceptives (covered under III.A), when a prescription is required including: Norplant, Depoprovera, diaphragms, IUDs and the fitting or administration of such.

37. AUTISM (CHOICE)

Prior authorization is required for autism services.

Coverage includes diagnosis and treatment of autism spectrum disorders for a covered child 18 years of age or younger.

- a. Coverage under this section must be provided to a child who is diagnosed with one of the following disorders:
 - 1) autistic disorder;
 - 2) Asperger's disorder; or
 - 3) pervasive developmental disorder not otherwise specified.
- b. Coverage may include:
 - 1) habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
 - 2) medications prescribed by a licensed physician;
 - 3) psychiatric or psychological care; and
 - 4) therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

38. MEDICAL CARE MANAGEMENT SERVICES (CHOICE)

Case management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility.

Should the need for case management arise, a case management professional will work closely with the patient, his or her family, and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation, or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager may recommend alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

- a. You, your dependent, or an attending physician can request case management services by calling the phone number shown on your ID card during normal business hours Monday through Friday. In addition, your employer, or a claim office may refer an individual for case management.
- b. A case management professional or team of professionals assesses each case to determine whether case management is appropriate.
- c. You or your dependent is contacted by an assigned case manager who explains in detail how the program works. Participation in the program is voluntary – no penalty or benefit reduction is imposed if you do not wish to participate in case management.
- d. Following an initial assessment, the case manager works with you, your family, and the attending physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- e. The case manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a hospital bed and other durable medical equipment for the home).
- f. The case manager also acts as a liaison among the insurer, the patient, his or her family, and the attending physician as needed (for example, by helping you understand a complex medical diagnosis or treatment plan).
- g. Once the alternate treatment program is in place, the case manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs. While participation in case management is strictly voluntary, case management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources.

39. ADDITIONAL BENEFITS (CHOICE)

a. CONGENITAL ANOMALY

Coverage includes the treatment only of medically diagnosed congenital defects and birth abnormalities.

b. DIALYSIS

Coverage is provided for renal disease, including the equipment, training, and medical supplies required for effective home dialysis.

c. INJECTABLE BENEFIT

Coverage includes injectable medications administered at the covered provider's office or facility, when not able to be self-injected including but not limited to: contraception, pain control, and administration of antibiotics.

Injectables billed without an office visit are exempt from deductible and are only subject to coinsurance.

40. EXCLUSIONS AND LIMITATIONS (CHOICE)

a. The following services and expenses are not covered:

- 1) hospitalization for days that are not certified as medically necessary for the therapeutic treatment of an injury or illness, except as specified in III.B.3. This includes the following:
 - i. hospitalization for diagnostic tests, observation, or examinations when treatment does not require bed patient care;
 - ii. hospitalization for physical therapy or inhalation therapy when treatment does not require bed patient care;
 - iii. hospitalization including any services furnished by an institution which is primarily a place for rest, a place for the aged, a nursing home, or any similar institution; or
 - iv. Any other hospitalization that is not medically necessary as described in Chapter IX.
- 2) services for which the member is not legally required to make payment or for which charges are made only because the member has benefits under the State Plan. Benefits are not provided for expenses dismissed by professional or courtesy discounts.
- 3) services and supplies that you or a dependent member are entitled to receive or do receive from the United States or any city, county, state, or country. This exclusion applies to any programs of any agency or department of any government.

- 4) under certain circumstances, the law allows certain governmental agencies to recover expenses for services rendered to you from your State Plan. When such a circumstance occurs, you will receive an Explanation of Benefits.
- 5) all services and supplies that are provided to treat any illness or injury arising out of employment when your employer has elected or is required by law to obtain coverage for such under state or federal workers' compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This exclusion applies to all services and supplies provided to treat such illness or injury even though the following apply:
 - i. Coverage under the government legislation provides benefits for only a portion of the services incurred;
 - ii. Your employer has failed to obtain such coverage as required by law. This exclusion does not apply if your employer was not required and did not elect to be covered under any workers' compensation, occupational disease laws, or employer's liability acts of any state, country, or the United States;
 - iii. the member waives their rights to such coverage or benefits;
 - iv. the member fails to file a claim within the filing period allowed by law for such benefits;
 - v. the member fails to comply with any other provision of the law to obtain such coverage or benefits; or
 - vi. the member was permitted to elect not to be covered by the workers' compensation laws, but failed to properly make such election effective. This exclusion will not apply if you are permitted by statute not to be covered and you elect not to be covered by the workers' compensation laws, occupational disease laws, or liability laws.
- 6) expenses that are or will be paid by another responsible party as described in Chapter VII.
- 7) services or procedures that are:
 - i. not medically necessary to treat active illness or injury, or specifically listed as a benefit;
 - ii. not generally accepted by the medical profession; or
 - iii. Experimental Procedures or Services, as defined in Chapter IX.
- 8) treatment of mental, psychoneurotic and personality disorders, chemical dependency disorders, adolescent behavior problems, learning disabilities, and family, marital or sexual problems — except as provided in III.B.22 and III.B.23.
- 9) routine physical examinations and immunizations including premarital, insurance, athletic, school entrance and employment physicals or immunizations, except services specifically covered under III.B.34.
- 10) treatment of a condition caused by or arising out of an act of war (declared or undeclared), insurrection, rebellion, or armed invasion.
- 11) any expense for which a contributing cause was commission by the member of a criminal act, attempt to commit a criminal act, or to which the contributing cause was the member's being engaged in an illegal occupation.
- 12) vision examinations (may be covered under a separate vision exam plan described in II.D.1), orthoptics, vision trainings, hearing examinations, corrective appliances, and laser eye surgery. Corrective appliances include glasses, contact lenses, and hearing aids.
- 13) infertility treatments.
- 14) dental care, including dental services listed as exclusions of the Dental Plan, with the following exceptions:
 - i. treatment required due to injury to sound natural teeth described in III.B.14; and
 - ii. treatment required due to a dependent child's congenital abnormality, provided the child was born and enrolled while the employee was a member of the State Plan or covered under creditable coverage as defined in Chapter IX.
- 15) speech therapy, except as provided in III.B.30.
- 16) elective or therapeutic abortion as defined in Chapter IX.
- 17) cosmetic surgery, services, or supplies except treatment or surgery due to a dependent child's congenital abnormality, provided the child was born and enrolled while the employee was a member of the State Plan. Cosmetic surgery is surgery that improves appearance or corrects a deformity without restoring a physical function of the body. Some procedures are usually cosmetic but may not always be. In these cases prior authorization described in III.A.6 is strongly recommended to assure coverage.
- 18) any foot orthotic and foot care, including the following:
 - i. removal or treatment of corns or callosities;

- ii. hypertrophy, hyperplasia of the skin, or subcutaneous tissues;
 - iii. cutting or trimming of nails;
 - iv. treatment of flat feet, fallen arches, or chronic foot strain;
 - v. orthotic appliances and casting for orthotic appliances, except as provided in III.C.22;
 - vi. padding and strapping; or
 - vii. fabrication.
- 19) medical or surgical reversal of elective sterilization and experimental fertility procedures.
 - 20) treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction (TMJ), anterior or internal dislocations, derangements and myofascial pain syndrome, or orthodontics (dentofacial orthopedics) or related appliances. Surgical treatment for these conditions will be allowed only if prior authorized by the Plan Administrator.
 - 21) organ or tissue transplants, except as provided in III.C.26.
 - 22) humidifiers, air conditioners, exercise equipment, home traction units, whirlpools, health spas or swimming pools, whether or not prescribed by a licensed covered provider.
 - 23) implantable and/or inflatable prosthesis.
 - 24) services and supplies related to sexual inadequacy or dysfunction, or sexual transformations and reversals of such procedures.
 - 25) personal services such as radio, television, and phone service.
 - 26) sanitarium care, custodial care, rest cures, or convalescent care to help you with daily living tasks such as: walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparing special diets, and supervising medications which are usually self-administered.
 - 27) health clubs, health spas, and exercise programs, whether or not approved or prescribed by a licensed provider.
 - 28) any expense incurred after group coverage terminates.
 - 29) education or tutoring services, except as specifically included as a benefit of state indemnity medical plans in this Summary Plan Description.
 - 30) any facility charges for chronic pain management services provided by an inpatient pain center.
 - 31) services and supplies related to any of the following treatments or related procedures:
 - i. self-help programs;
 - ii. religious counseling;
 - iii. marriage counseling;
 - iv. holistic medicine;
 - v. rolfing;
 - vi. stress management;
 - vii. hypnotherapy;
 - viii. homeopathy;
 - ix. massage or massage therapy; and
 - x. naturopathic services not otherwise covered in this Summary Plan Description.
 - 33) services and supplies primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature.
 - 34) travel for a member or provider, unless specifically covered as a benefit of this Summary Plan Description.
 - 35) private duty nursing, except as specifically included as a benefit of this Summary Plan Description.
 - 36) any additional charge for inclusive procedures or services as defined in Chapter IX and as determined by the Plan Administrator.
 - 37) services or supplies for complications resulting from services that are not covered.
 - 38) any service provided in conjunction with a non-covered service.
 - 39) services and supplies not provided by a licensed provider or which are not listed as a benefit of state medical plans in this Summary Plan Description.
 - 40) residential care services, boot camps, or rehabilitative schools.
 - 41) autism- related services provided in a public school setting.
 - 42) no payment will be made for duplicate services with respect to any scheduled visit.
 - 43) food or nutritional supplements.

- 44) treatment for obesity (surgical or non-surgical).
- 45) NON-AUTHORIZED SERVICES
Exclusions include services not performed, arranged, authorized, or approved as specified in this document.
- 46) PRESCRIPTION DRUGS
Exclusions include outpatient prescription drugs, which are covered by a separate prescription drug plan.
- 47) PRE-EXISTING CONDITIONS
Pre-existing conditions are excluded for up to one year from a member's coverage effective date. However, the period of exclusion may be reduced by creditable coverage as described in I.C.4.
- 48) NON-STANDARD OR SELF-PRESCRIBED SERVICES AND SUPPLIES
Except as specifically provided in this Supplement, plan exclusions include all services for non-standard or self-prescribed therapies. Exclusions include, but are not limited to:
- i. orthomolecular therapy, including nutrients, vitamins, and food supplements;
 - ii. acupuncture or acupressure;
 - iii. biofeedback; and
 - iv. chelating therapy (except for mineral or metal poisoning)
- 49) INJURY OR SICKNESS RELATED TO A RIOT
Exclusions include the care and treatment of injuries or sickness due to voluntary participation in a riot.
- 50) LEGALLY-ORDERED SERVICES
Exclusions include services which are required by a court order, or as a condition of parole or probation.
- 51) ADMINISTRATIVE CHARGES
Exclusions include charges for missed appointments or other administrative sanctions.
- 52) INJURY OR SICKNESS RELATED TO MILITARY SERVICE
Exclusions include services for (or related to) any sickness or injury suffered as a result of (or while in) military service.
- 53) CERTAIN PRIVATE ROOM CHARGES
Exclusions include private room accommodations that are in excess of the State Plan's allowable for the most common semi-private room charge, unless a private room is deemed medically necessary by the State Plan.
- 54) UNUSUAL CIRCUMSTANCES
Neither the State Plan nor any network or in-network providers shall have any liability or obligation because of a delay or failure to provide covered medical services or benefits under the following circumstances:
- i. complete or partial destruction of facilities;
 - ii. war;
 - iii. riot;
 - iv. civil insurrection;
 - v. major disaster;
 - vi. disability of a significant part of the in-network hospital and/or provider network;
 - vii. epidemic; or
 - viii. labor dispute not involving the State Plan, in-network hospitals, and/or other in-network providers.
- In-network providers will make their best efforts to provide services and benefits within the limitations of available facilities and personnel. If the rendering of covered medical services or benefits is delayed due to a labor dispute involving the State Plan or in-network providers, non-emergency care may be deferred until after the resolution of the labor dispute.
- 55) VOCATIONAL REHABILITATION
- 56) CHARGES RESULTING FROM LEAVING A HOSPITAL OR FACILITY CONTRARY TO MEDICAL ADVICE

B. MEDICAL PLAN BENEFITS AND EXCLUSIONS FOR THE CLASSIC PLAN

1. COVERED MEDICAL EXPENSES AND PLAN PAYMENT (CLASSIC)

a. COVERED MEDICAL EXPENSES

Expenses covered by the state-sponsored indemnity medical plan are:

- 1) expenses within allowable charges (you are responsible for expenses over allowable charges unless you use an in-network provider — see II.A.1 and II.A.2);

- 2) expenses within specified benefit limitations contained in this chapter and which meet other requirements of this Summary Plan Description; and
- 3) expenses for covered medical services.

b. COVERED MEDICAL SERVICES

Covered medical services are services, procedures, and supplies:

- 1) listed in this section and not excluded in III.C.39;
- 2) determined by the Plan Administrator to be medically necessary for the diagnosis or treatment of:
 - i. injury;
 - ii. illness; or
 - iii. maternity or preventive services specified in III.C.34 and III.C.14. (Expenses associated with inpatient hospital days only meet medical necessity criteria if they are certified as described in III.C.2.)
- 3) provided to a member by a licensed covered provider;
- 4) provided and coded in accordance with applicable medical policy, as defined in Chapter IX; and
- 5) provided in accordance with the terms of the State Plan including any prior authorization requirements and within any time and service limits.

c. COVERED MEDICAL EXPENSES YOU PAY

Deductible

You pay your (and each enrolled dependent's) first covered medical expenses in a benefit year that are subject to deductible, until you have met the individual or family deductible requirement for your plan. See your current annual change booklet for the individual and family deductible amounts for covered medical services that are subject to deductible for your medical plan

IMPORTANT: A BENEFIT YEAR MEANS THE PERIOD COMMENCING JANUARY 1 AND ENDING DECEMBER 31 OF EACH YEAR. A BENEFIT YEAR DOES NOT START ON THE DATE YOU ARE HIRED. BENEFITS, CO-PAY MAXIMUMS, AND DEDUCTIBLES ARE NOT PRO-RATED WHEN AN EMPLOYEE IS NOT EMPLOYED FOR THE ENTIRE BENEFIT YEAR. FOR EXAMPLE, IF A MEMBER STARTS EMPLOYMENT ON SEPTEMBER 1 AND MEETS THE DEDUCTIBLE BY DECEMBER 31 OF THAT SAME YEAR, THE DEDUCTIBLE REQUIREMENT STARTS AGAIN ON JANUARY 1 OF THE FOLLOWING YEAR.

Coinsurance

After you have met deductible requirements, you pay a coinsurance percentage on any of your (and each enrolled dependent's) covered medical expenses that require coinsurance, until you have met your individual or family out-of-pocket maximum for the benefit year. The plan then pays 100 % of covered medical expenses for the remainder of the benefit year - with the exception of those that do not accumulate toward the out of pocket maximum (refer to the annual change booklet). To determine the coinsurance percentage you pay, the covered medical services to which it applies, and the benefit year's out-of-pocket maximum for your plan, see the current annual change booklet.

d. RELATED INFORMATION

Some medical services contain limits on the duration or frequency of services covered by the plan. These are contained in the descriptions of the specific covered medical expenses in this section and are updated in the annual change booklet for the current benefit year.

If you are currently being treated for a major illness or serious injury, you are encouraged to use the care management services described in III.C.38. These services help you get the most out of your benefits and help control your out-of-pocket costs.

2. CERTIFICATION REQUIREMENT FOR INPATIENT HOSPITAL COVERAGE (CLASSIC)

Inpatient hospital stays (hospital confinement of 24 hours or more) are reviewed by the State Plan's utilization review company to determine if inpatient hospitalization is medically necessary (as defined in Chapter IX). Only charges for hospital days certified as medically necessary are eligible for standard inpatient benefits described in this section. Plan members can determine whether medical necessity criteria are met by calling the customer service number on their identification card in advance of a non-emergency hospital admission and within 24 hours (or the first working day) after an emergency hospital admission as described in II.A.4.

Assistance in finding appropriate outpatient treatment is available upon request when inpatient days are denied certification (see III.C.39).

3. COVERAGE OF MEDICAL EXPENSES FOR CERTIFIED AND NON-CERTIFIED HOSPITAL STAYS (CLASSIC)

- a. Medical services received during a hospital stay certified as medically necessary are covered as described in this chapter.
- b. When all or part of the hospital stay fails to be certified as medically necessary, either through the call-in process (described in II.A.6) or after the fact when claims are processed, coverage is as follows:
Only expenses that would have been incurred for outpatient treatment are covered for any hospital days that are not certified. Hospital room and board charges are not covered, and other hospital expenses may not be eligible for coverage.

4. INPATIENT HOSPITAL SERVICES (CLASSIC)

Certification requirement applies. See III.C.3 for coverage of non-certified days. Pre-certification of all non-emergency hospital admissions is strongly recommended. See III.C.6 for emergency admissions.

The following inpatient hospital services are covered for days that the member is confined to a licensed hospital, provided the inpatient days are certified as inpatient level of care as required in II.A.4:

(To be eligible under this provision, the services must not be primarily for rehabilitation care, which is covered under III.C.30.)

- a. Bed, board, and general nursing services in semiprivate (two or more beds) accommodations. The plan will allow the hospital's average semiprivate room charge as the allowance toward a private room.
- b. Bed, board, and both general and concentrated nursing services provided by nurses who are hospital employees in intensive care and cardiac care units.
- c. Miscellaneous hospital services and services provided by covered providers on the hospital's staff as described below:
 - 1) operating room, recovery room, and delivery room;
 - 2) surgical and anesthetic supplies;
 - 3) splints, casts, and dressings;
 - 4) drugs and medicines that:
 - i. are approved for use in humans by the U.S. Food and Drug Administration (approved label indications only);
 - ii. are listed in the American Medical Association Drug Evaluation, Physician's Desk Reference, or Drug Facts and Comparisons; and
 - iii. require a physician's written prescription.
 - 5) oxygen and use of equipment for its administration;
 - 6) intravenous injections, and setups for intravenous solutions including the solution, if included in III.4.c, above;
 - 7) physical therapy; occupational therapy; speech therapy, if administered by or under the supervision of a registered therapist employed by the hospital (provision III.C.30);
 - 8) chemotherapy, radiation therapy, and dialysis therapy;
 - 9) respiratory therapy if administered by or under the supervision of a registered respiratory therapist employed by the hospital;
 - 10) administration of blood and blood products (blood donor's fee is excluded);
 - 11) laboratory services;
 - 12) x-rays and other medically necessary diagnostic services; and
 - 13) other medically necessary inpatient hospital services.

5. OUTPATIENT HOSPITAL SERVICES (CLASSIC)

Hospital services and supplies described above in provision III.C.4 are covered if a member is treated at a licensed hospital, but not admitted for bed patient care, with the exception of physical, occupational, and speech therapy (covered under III.C.30).

Charges for observation beds/rooms are covered when medically necessary and in accordance with medical policy for services of less than 24 hours and for charges not exceeding the room rate that would be charged for an inpatient stay of one day.

6. EMERGENCY ROOM SERVICES (CLASSIC)

(Certification requirement applies if admitted for inpatient care.)

Benefits for services and supplies rendered in the emergency room of a hospital are covered for emergency medical conditions defined in Chapter IX.

7. LICENSED AMBULANCE SERVICE (CLASSIC)

Coverage only includes emergency ground or air transportation to the nearest hospital or medical facility that is equipped to furnish the services, unless otherwise approved by the State Plan. The emergency transportation must be medically necessary. Medical necessity is established when the patient's condition is such that other means of transportation would endanger the member's health. Transportation is not covered if not medically necessary or if transport is to a lateral or lower level of care. See the current Schedule of Benefits for the ambulance transportation benefits.

The in-network level of benefits is provided for out-of-network emergency services immediately required to diagnose and treat an emergency medical condition at the nearest appropriate medical facility.

8. SURGICAL SERVICES (CLASSIC)

(Certification requirement applies if performed inpatient. See III.C.3 for coverage of non-certified hospital days.)

Medically necessary (See Chapter IX for definition of medically necessary) surgical services are covered, including normal pre- and post-operative care, for the surgical treatment of injuries and illnesses rendered by a licensed surgeon/physician. Payment for these services is subject to the following conditions:

- a. When two or more surgical procedures are performed, payment will be made for the allowable charge of the procedure with the highest allowance, plus one half of the allowable charge for the procedure with the lowest allowance. No additional payment will be made for incidental surgery. Incidental surgery is a procedure that is an integral part of, or incidental to, the primary surgical service and performed at the same operative session. Surgery is not incidental if:
 - 1) it involves a major body system different from the primary surgical services; or
 - 2) it adds significant time or complexity to the operating session and patient care.
- b. If an operation or procedure is performed in two or more steps, total payment will be limited to the allowable charge for the initial procedure.
- c. If two or more surgeons perform operations or procedures together, other than as an assistant at surgery or anesthesiologist, the allowable charge will be divided among them. (This condition is subject to the conditions in III.C.8, provisions a. and b.)
- d. Assistant-at-surgery charges for actively assisting the operating physician in the performance of covered surgery will be paid as follows depending on whether the assistant-at-surgery is a physician or non-physician assistant:
 - 1) Assistant-at-surgery performed by a physician will be paid at 20 % of the allowable charge for the surgical procedure, or the assistant's charge, whichever is less.
 - 2) Assistant-at-surgery performed by a non-physician assistant or surgical technician will be paid at 10 % of the allowable charge for the surgical procedure, or the assistant's charge, whichever is less.
 - 3) Benefits are not available when an assistant-at-surgery is present only because the facility provider requires such services — for teaching purposes, for example.
 - 4) Benefits for an assistant-at-surgery will be paid only if the State Plan determines that such services were necessary.
 - 5) If two physicians are paid as primary surgeons or co-surgeons for their multiple surgeries, no allowance as an assistant-at-surgery will be made to either of the surgeons. Any charges for an additional assistant-at-surgery will be subject to review.
- e. The charge for a surgical suite outside a hospital is included in the allowable fee for the surgery.

9. SURGICAL FACILITIES / SURGICENTERS (CLASSIC)

Prior authorization of *all* non-emergency surgery is strongly recommended.

Medically necessary services of a surgicenter are covered, including recovery care beds, defined in Chapter IX, if the following criteria are met:

- a. The center is licensed or certified by Medicare by the state in which it is located, and
- b. The surgical procedure performed is recognized as a procedure that can be safely and effectively performed in an outpatient setting.

10. INPATIENT PROVIDER SERVICES – EXCLUDING SURGICAL SERVICES COVERED UNDER III.C.8 (CLASSIC)

Certification requirement applies. See III.C.3 for coverage of non-certified days. Pre-certification of all non-emergency hospital admissions is strongly recommended. See III.C.6 for emergency admissions.

In-hospital services by a covered provider are covered for days that a member is confined to a licensed hospital as a registered bed patient under the care of a licensed physician or surgeon, provided the inpatient days are certified as medically necessary according to II.A.4. Coverage includes health care services performed, prescribed, or supervised by a professional provider, including diagnostic, therapeutic, medical, surgical preventive, referral, and consultative health care services. See III.C.3 for coverage of charges for non-certified hospital days.

Benefits for medical care visits are limited to one visit a day per covered provider, unless the member's condition requires intensive medical care (a physician's constant attendance and treatment for a prolonged period of time).

11. ANESTHESIA SERVICES (CLASSIC)

(Certification requirement applies to inpatient services. See III.C.3 for coverage of services for non-certified hospital days.)

Coverage includes anesthesia services rendered and billed by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist for medically necessary care (see Chapter IX for definition of Medical necessity) of a condition covered under this document.

Benefits will **not** be provided for the following:

- a. Hypnosis;
- b. Local anesthesia (paid as part of a global procedure charge);
- c. Anesthesia consultations before surgery (paid as part of the anesthesia charge); or
- d. Anesthesia for dental services or extraction of teeth (except those covered by III.C.14).

12. OFFICE VISIT SERVICES (CLASSIC)

Covered office visit services are health care services provided by a physician, mid-level practitioner in a physician's office or clinic, or other covered providers in the office/clinic staff under physician direction. This includes but is not limited to diagnostic services, treatment services, allergy shots, laboratory services, x-ray and radiation services, and referral services.

Benefits will not be provided for the following:

- a. Routine physical examinations (including those required for school, athletics or employment, except those listed in III.C.34);
- b. Screening examinations, except those listed in III.C.34;
- c. Pre- or post-surgical visits considered to be inclusive services; or
- d. Conditions for which maternity benefits are payable (covered under provision III.C.15).

Outpatient office visit benefits are limited to payment for one visit per day per provider specialty.

13. URGENT CARE SERVICES (CLASSIC)

Coverage includes care for an acute illness or injury that requires immediate treatment (such as high fever; ear, nose, and throat infections; and minor sprains and lacerations).

14. MEDICAL/DENTAL SERVICES FOR ACCIDENTAL INJURY TO TEETH (CLASSIC)

(Certification requirement applies to inpatient services. See III.C.3 for coverage of non-certified hospital days.)

a. PROFESSIONAL SERVICES

Coverage includes professional services rendered by a physician, surgeon, or doctor of dental surgery for the treatment of a fractured jaw or other accidental injury to sound natural teeth, provided that:

- 1) the injury occurs while the patient is covered under the State Plan; or

2) the injury occurs while the patient is covered under creditable coverage as defined in Chapter IX. Such services are covered only during the 12-month period immediately following the date of injury.

Services for the treatment of accidental injury to teeth caused by biting or chewing are exclusions of this provision (they are covered under the Dental Plan, if enrolled).

Services and supplies provided by a hospital in conjunction with dental treatment will be covered only when a non-dental physical illness or injury exists, which makes hospital care necessary to safeguard the member's health.

Dental factors, such as complexity of dental treatment and length of anesthesia, do not make a dental treatment eligible for hospital benefits.

15. MATERNITY AND NEWBORN SERVICES (CLASSIC)

(Certification requirement applies to inpatient hospital stays. See III.C.3 for coverage of non-certified hospital days.)

Refer to the current Schedule of Benefits in the annual change book for more information.

a. MATERNITY CARE

Coverage includes hospital, physician, and certified licensed RN nurse midwife services for the delivery or attempted delivery of one or more newborns, including prenatal and postpartum outpatient care and hospital services for conditions directly related to the pregnancy including ultrasounds. Inpatient hospital care following delivery will be covered for the length of time medically necessary and will be at least 48 hours following a vaginal delivery and at least 96 hours following a cesarean section. The decision to shorten the length of inpatient stay to less than the above must be made by the attending provider and the mother.

Payment for any maternity services provided by a physician or licensed registered nurse midwife is limited to the allowable fee for total maternity care, which includes delivery, prenatal, and postpartum care.

Coverage includes medically necessary obstetrical and gynecological services.

b. ROUTINE NEWBORN CARE

Coverage includes routine physician and laboratory care of a newborn at birth, standby care provided by a pediatrician at a cesarean section, and hospital nursery care of a newborn infant born in the hospital. The routine newborn care benefit is limited to three days of inpatient care. Additional hospital care required by a medical condition is covered under provision III.C.4.

16. DIAGNOSTIC / LABORATORY SERVICES (CLASSIC)

Prior authorization is strongly recommended for MRIs, CT/CAT Scans, and PET Scans.

Coverage includes x-ray, laboratory and tissue diagnostic examinations, and diagnostic machine tests (such as EKGs) made for the purpose of diagnosing accident or illness when hospital confinement is not required and benefits are not provided elsewhere in this Summary Plan Description.

X-ray and laboratory benefits shall not be provided for the following:

- a. Dental examinations or treatments, except for dental x-rays resulting from injuries sustained in an accident covered under III.C.14;
- b. Visual examinations (covered under II.C.1); or
- c. Premarital examinations and routine physical checkups, including examinations made as a requirement of employment or governmental authority, except as provided in III.C.34.

17. RADIATION THERAPY (CLASSIC)

Coverage includes x-ray, radium, or radioactive isotope therapy ordered by the attending physician and performed by a covered provider for the treatment of disease.

18. CHEMOTHERAPY (CLASSIC)

Coverage includes the use of chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration (FDA), ordered by the attending physician and administered by a covered provider for the treatment of the FDA approved diagnosis.

19. BLOOD TRANSFUSIONS (CLASSIC)

Coverage includes blood transfusions, including the cost of blood and blood products. Storage charges for blood are covered when you have blood drawn and stored for your own use for a planned surgery.

20. MEDICAL SUPPLIES (CLASSIC)

Coverage includes but is not limited to the following medically necessary supplies for which benefits are payable prescribed by a covered provider, all for use outside a hospital:

- a. Sterile dressings for conditions such as cancer or burns;
- b. Catheters;
- c. Splints and casts;
- d. Colostomy bags and related supplies;
- e. Supplies for renal dialysis equipment or machines;
- f. Orthopedic braces, corsets, and trusses;
- g. Syringes and diabetic supplies (may also be covered under prescription drug plan);
- h. Oxygen supplies; and
- i. Syringes and diabetic supplies are also covered under the Prescription Drug Plan described in III.A.

21. DURABLE MEDICAL EQUIPMENT (DME), IMPLANTS, AND PROSTHESES (CLASSIC)

Prior authorization is required for the initial purchase, repair, or replacement of DME or prostheses over \$1,000. No benefit is available for expenses over \$1,000 unless prior-authorized.

Prior authorization is recommended for the initial purchase, repair, or replacement of DME or prosthetics under \$1,000 to assure coverage. See Chapter IX for a definition of durable medical equipment and examples of equipment that are not covered. Coinsurance for DME does not count toward the individual or family annual out of pocket maximum (coinsurance maximum).

Coverage applies to the least expensive appropriate prosthetic device used to replace a body part missing due to accident, injury, or illness (such as artificial limbs or eyes), and the least expensive appropriate type of durable medical equipment necessary for therapeutic purposes in your home (such as oxygen equipment, CPAP machines, crutches, a wheelchair, or a hospital-type bed). Rental (up to the purchase price) of a hospital-type bed, oxygen equipment, CPAP machine, wheelchair, or other durable therapeutic equipment (provided the equipment is designed for prolonged use over a period of years, serves a specific therapeutic purpose in the treatment of an injury or illness, is primarily and customarily used for a medical purpose, is appropriate for use in the home, and is not generally useful to a person in the absence or illness or injury) or the purchase of this equipment if economically justified, whichever is less. For DME for which purchase is not feasible, reasonable rental charges will be paid. The Case Manager shall determine the reasonable rate.

The State Plan will be responsible for determining rental versus purchase agreements. Requests for computerized and "deluxe" equipment, like motor-driven wheelchairs, are reviewed on an individual basis. The State Plan will have the right to decide when standard equipment is adequate. Coverage does not include maintenance, replacement due to loss, or duplication. Replacement can occur when equipment or prosthetics are no longer repairable or when DME has been out-grown, but no sooner than 5 years from the original received dated.

a. DURABLE MEDICAL EQUIPMENT REQUIREMENTS

Durable medical equipment must meet the following criteria:

- 1) able to withstand repeated use (consumables are not covered);
- 2) primarily used to serve a medical purpose rather than comfort or convenience;
- 3) generally not useful to a person who is not ill or injured; and
- 4) prescribed by a professional covered provider.

These devices and equipment are limited to those reasonably required by standard treatment practices as a result of injury or illness. Replacement of such devices and equipment shall be made only if the existing appliance cannot be made satisfactory by standard repair practices. To ensure coverage, contact the State's Plan Administrator regarding buying or rental agreements.

b. PRIOR AUTHORIZATION

You must obtain prior authorization from the indemnity medical plan's Plan Administrator for repair or replacement of durable medical equipment or a prosthesis that is over \$1000 (as well as initial purchase). Prior authorization may be obtained by submitting to the claims administration company the following:

- 1) a professional covered provider's prescription;
- 2) a written explanation by the professional covered provider as to why replacement is necessary or

- 3) an itemized repair and replacement cost statement from the covered provider.
- c. Coverage is provided for the following services and supplies for medical purposes *only in a hospital or for therapeutic use in a member's home*:
 - 1) oxygen services and supplies; and
 - 2) prosthetic appliances including the purchase and fitting of breast prostheses and the purchase and fitting of artificial limbs, larynx, eyes, other prosthetic appliances or permanent internally implanted devices that are not experimental. Repair, maintenance, replacement due to loss, and duplication are not covered. Replacement can occur when the item is no longer repairable; and
 - 3) cochlear implants are covered if the Plan Administrator medical policy criteria are met and prior authorization is approved. Replacement batteries and any equipment upgrades are not covered. Prior authorization is required.
- d. THE FOLLOWING ARE NOT COVERED:
 - 1) durable medical equipment, orthopedic devices, or prosthetics required primarily for use in athletic activities;
 - 2) replacement of lost or stolen durable medical equipment, orthopedic devices, or prosthetics;
 - 3) repair to rental equipment;
 - 4) continuous passive motion devices, except in the case of surgery involving the knee joint, which begins within two days following surgery and is limited to:
 - i. total knee replacement;
 - ii. repair of plateau fractures; and
 - iii. anterior cruciate ligament (ACL) repairs.
 - 5) duplicate equipment purchased primarily for patient convenience when the need for duplicate equipment is not medical in nature; or
 - 6) expenses over \$1,000 that are not prior authorized.

22. CHEMICAL DEPENDENCY TREATMENT (CLASSIC)

(Certification requirement applies to inpatient services. See III.C.3 for coverage of services for non-certified hospital days. Pre-certification of non-emergency hospital admissions is strongly recommended. See III.C.6 for emergency admissions.)

Coverage includes outpatient visits and inpatient treatment. Residential care is not covered. Coverage is provided for inpatient and outpatient treatment for alcoholism and drug addiction (excluding costs for medical detoxification, which is covered under III.C.4).

The State Plan offers a limited number of confidential counseling sessions at no cost to the State Plan member, as described in the current annual change booklet.

a. MEDICAL DETOXIFICATION

Treatment is covered the same as any other illness under the terms of this Summary Plan Description.

b. COVERED PROVIDERS

Covered providers for the treatment of chemical dependency are state-licensed facilities in which services are provided, such as a hospital or as a freestanding inpatient facility specializing in the treatment of chemical dependency; physicians; licensed social workers; and licensed addiction counselors. Residential treatment is not covered. However, services provided by a covered licensed health care provider during residential admission may be covered if billed under the health care provider's license (not billed as part of residential treatment).

c. PARTIAL HOSPITALIZATION BENEFITS

Prior authorization (prior to treatment) is strongly recommended.

Partial hospitalization (intensive outpatient services defined in Chapter IX) for the treatment of chemical dependency is covered when medically necessary. A partial hospitalization program offers four to eight hours of therapy, five days a week. The hours of therapy per day and the frequency of visits per week will vary with each individual, depending on the clinical symptoms and progress being made.

23. MENTAL ILLNESS TREATMENT (CLASSIC)

(Certification requirement applies to inpatient services. See III.C.3 for coverage of services for non-certified hospital days. Pre-certification of non-emergency hospital admissions is strongly recommended. See III.C.6 for emergency admissions.)

a. INPATIENT BENEFITS

Pre-certification (prior to admission) is strongly recommended. Costs for inpatient services can be expensive. Calling the Plan Administrator (at the number on your medical identification card) in advance of admission lets you know whether you meet plan criteria for inpatient coverage, and whether the intended mental health care facility's charges are within plan allowances. If you do not meet inpatient criteria, the Plan Administrator can assist you with finding suitable alternatives such as partial hospitalization described below. If you do meet criteria, they can assist you in finding a mental health facility whose charges are covered by the State Plan.

Coverage includes medically necessary inpatient treatment of mental illness (as defined in Chapter IX).

Coverage is provided for medically necessary inpatient and outpatient treatment of mental illness. Residential treatment is not covered. However, services provided by a covered licensed professional health care provider during residential admission may be covered if billed under the individual professional health care provider's licensure (not billed as part of residential treatment). All residential facilities services are not covered regardless of their licensing.

1) Covered medical services do not include treatment of the following conditions:

- i. developmental and learning disorders;
- ii. speech disorders;
- iii. eating disorders (except bulimia and anorexia nervosa);
- iv. impulse control conduct disorders (except intermittent explosive disorder and trichotillomania);
- v. mental retardation;
- vi. inpatient confinement for environmental change.
- vii. gambling addiction; or
- viii. tobacco addiction

b. SEVERE MENTAL ILLNESS CARE

Pre-certification of all non-emergency hospital admissions is strongly recommended. See III.C.6 for emergency admissions.

1) Coverage includes medically necessary care and treatment of severe mental illness as defined in 33-22-706

MCA. Severe mental illness is:

- i. schizophrenia;
- ii. schizo-affective disorder;
- iii. bipolar disorder;
- iv. major depression;
- v. panic disorder;
- vi. obsessive-compulsive disorder; or
- vii. autism.

c. PARTIAL HOSPITALIZATION BENEFITS

Prior authorization (prior to treatment) is strongly recommended.

Partial hospitalization (intensive outpatient services defined in Chapter IX) for the treatment of mental illness is covered when medically necessary. A partial hospitalization program offers four to eight hours of therapy, five days a week. The hours of therapy per day and the frequency of visits per week will vary with each individual, depending on the clinical symptoms and progress being made.

d. OUTPATIENT BENEFITS

Coverage includes outpatient treatment of mental illness, reimbursed (after deductible) at the percentages specified in the current annual change booklet.

The State Plan offers a limited number of confidential counseling sessions at no cost to the State Plan member, as described in the current annual change booklet.

e. COVERED PROVIDERS AND BENEFIT LIMITATIONS

Covered providers for the treatment of mental illness are state-licensed facilities in which services are provided, such as a hospital specializing in the treatment of mental illness; licensed mental health treatment facilities; physicians/psychiatrists; licensed psychologists; licensed professional counselors; and licensed psychiatric social workers.

Benefits do not include services rendered for learning disabilities; marital, family, or sexual problems; or for services excluded under the definition of mental illness in Chapter IX (except for limited EAP benefits). Benefits also do not include custodial care, residential care, or training.

24. INFUSION THERAPY SERVICES (CLASSIC)

Coverage includes but is not limited to: antibiotic therapy, enteral nutrition, total parenteral nutrition, pain management, and specialized disease state therapy.

- a. Coverage includes medically necessary infusion therapy services provided they are both:
 - 1) ordered by a professional provider, and
 - 2) provided by a licensed infusion therapy agency.
 - b. Home infusion therapy services include:
 - 1) pharmaceuticals and supplies;
 - 2) equipment; and
 - 3) skilled nursing services when billed by an infusion agency. Services billed by a home health agency will be covered under your home health benefit in III.C.29.
- See the current annual change booklet or the HCBP website for information about the Infusion Program.

25. TRANSPLANTS (CLASSIC)

(Certification requirement applies to inpatient services. See III.C.3 for coverage of services for non-certified hospital days.)

Prior authorization (prior to admission) and care management are required. Transplants are one of the most costly medical procedures, and State Plan members need to make sure they are covered. Also, the Plan Administrator will assist you in maximizing your benefits through the use of a hospital in the designated transplant network (as defined in Chapter IX).

a. CORNEA AND KIDNEY TRANSPLANTS

Coverage includes cornea and kidney transplants, including eye bank charges and initial allowable expenses associated with removing the organ from the donor, which are chargeable to the recipient State Plan member and are not covered by the donor's health plan.

Expenses for a State Plan member to donate a kidney or cornea to an individual who is not a State Plan member are not covered.

b. BONE MARROW, HEART, LIVER, LUNG, AND PANCREAS

Organ or tissue transplant services for a member who receives human-to-human organ transplants of bone marrow, heart, heart/lung, liver, lung, and pancreas are covered as specified in the current annual change booklet. These allowances apply to charges related to the transplant for a period of 30 days before the transplant and extending for 18 months.

- 1) Bone marrow transplants are covered, when medically necessary, under the following circumstances:
 - i. Allogenic and Syngeneic Bone Marrow Transplants (Requires HLA Typing Match on at Least Five Out of Six Loci);
 - (a) acute lymphocytic leukemia and non-acute lymphocytic leukemia;
 - (b) chronic myelogenous leukemia;
 - (c) aplastic anemia;
 - (d) Fanconi's Anemia;
 - (e) infantile malignant osteopetrosis;
 - (f) large-cell lymphoma;
 - (g) lymphoma;
 - (h) Severe Combined Immunodeficiency Disease (SCIDS); and
 - (i) Wiscott Aldrich Syndrome
- c. Autologous Bone Marrow Transplants
 - 1) acute lymphocytic leukemia and non-acute lymphocytic;
 - 2) leukemia;
 - 3) Burkitts Lymphoma;
 - 4) large-cell lymphoma;

- 5) non-Hodgkin's lymphoma;
 - 6) Hodgkin's Disease; and
 - 7) neuroblastoma
- d. Stem cell transplants in conjunction with high-dose chemotherapy are covered, when medically necessary. Prior authorization is recommended (a retrospective review will be done if services are not prior authorized). High-dose chemotherapy with either allogenic or autologous stem-cell transplant will be considered on an individual case basis.
- e. INCLUDED SERVICES
The following transplant-related services are covered under this provision (not under other provisions of this Summary Plan Description):
- 1) organ procurement, including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ, and transportation of the donor or donor organ to the location of the transplant operation;
 - 2) inpatient hospital services including room, board, and ancillaries;
 - 3) surgical services including a surgical assistant;
 - 4) anesthesia;
 - 5) outpatient services, including professional and diagnostic services; and
 - 6) medically necessary licensed ambulance travel or commercial air travel for the recipient to the location of the transplant, or in the case of a medical emergency to the nearest hospital with appropriate facilities.
- f. BENEFITS ARE NOT PROVIDED FOR THE FOLLOWING:
- 1) services ordered by a single board certified specialist;
 - 2) transplants of a non-human organ or artificial organ implant;
 - 3) charges for lodging and meals (see III.C.26);
 - 4) Experimental procedures or Services (as defined in Chapter IX);
 - 5) transplants that are not currently approved under Medicare transplant guidelines
 - 6) expenses for a State Plan member to donate an organ or portion of an organ to an individual who is not a State Plan member eligible for a transplant;
 - 7) charges that are not routinely made to all patients receiving similar human organ or tissue transplants; or
 - 8) benefits for a human organ or tissue transplant donor who has coverage for services related to the organ/tissue donation elsewhere. If the donor does not have coverage elsewhere, and the recipient is a member, then the donor will be covered under this plan, but only for health services related to the organ/tissue donation.

26. NON-EMERGENCY TRAVEL BENEFIT (CLASSIC)

Prior authorization by Health Care and Benefits Division (HCBD) is required prior to travel.

The non-emergency travel benefit is only available to members in conjunction with case management. Coverage includes one-way out-of-state transportation by regularly scheduled passenger aircraft, railroad, bus, or round-trip mileage at the current lowest state reimbursement rate for travel by personal automobile inside the United States and Canada to (or from) the nearest medical facility (or facility approved by HCBD) equipped to provide the necessary treatment not available in a Montana facility. Transportation benefits may only be used for services with an in-network provider.

- a. Transportation benefits are limited to medically necessary treatment that cannot be performed in-state as determined by the State's Plan Administrator. If services can be performed in state and the health care provider or patient prefers an out of state provider, travel benefits are not available.
- b. Transportation benefits in any one benefit year shall be limited to one-way transportation (except round-trip mileage at the current lowest state reimbursement rate for travel by personal automobile), or half of a round trip air fare ticket price for:
 - 1) Non-transplant related services – One visit for treatment or surgery and one preparatory or follow-up visit for a condition which cannot be treated in state;

- c. Travel reimbursement is only covered for the patient, family members are not covered unless the patient is a child under 18 years of age. Then the transportation charges of a parent or legal guardian may be allowed if the attending physician certifies the need for such attendance.

TRAVEL PRIOR AUTHORIZATION

Travel will only be authorized if the above criteria, including active case management, are met. Prior authorization is required prior to travel, and retro-active authorization requests will be denied.

Plan members must submit a Travel Prior Authorization form available at:

http://benefits.mt.gov/content/docs/forms/Travel_Prior_Auth.pdf and return it to HCBD for a determination.

27. HOME HEALTH SERVICES (CLASSIC)

Prior authorization (prior to services) through the Plan Administrator is *strongly* recommended to assure coverage.

- a. Coverage includes the following services and supplies furnished by a licensed home health agency in a member's home in accordance with a professional provider's written home health care treatment plan for the treatment of a medically necessary injury or illness:
- 1) part-time or intermittent nursing care by an RN or LPN;
 - 2) part-time or intermittent home health aide services;
 - 3) physical, occupational, speech, respiratory, and home infusion therapy (up to the home health visit maximum described in the current Schedule of Benefits); and
 - 4) medical supplies suitable for use in the home, prescribed medications, and lab services provided at home.
- Home health services are limited to the number of days specified in the current annual change booklet. Home health aide services in excess of four hours in any one day shall be considered an additional day. A day with any home health service is counted toward the maximum home health services
- b. Home health expenses are not payable for:
- 1) services or supplies not included in the home health care plan of treatment;
 - 2) domestic or housekeeping services, including such programs as Meals-on-Wheels;
 - 3) services received in a nursing home or skilled nursing facility (covered under III.C.29);
 - 4) services for mental or nervous conditions;
 - 5) services of a social worker;
 - 6) transportation services; or
 - 7) durable medical equipment and prostheses (covered under III.C.21).

28. HOSPICE SERVICES (CLASSIC)

Prior authorization is recommended.

Coverage includes services of a hospice facility, agency, or service.

- a. Services are subject to the following conditions:
- 1) The services are medically necessary;
 - 2) They are ordered by a physician; and
 - 3) The member is terminally ill and the physician has certified that the patient is not expected to live more than six months.
- b. Covered hospice services are as follows:
- 1) home health care services listed above billed by hospice agency;
 - 2) facility expenses of a hospice facility, hospital, or skilled nursing facility for board, room, and other services and supplies furnished to a person while inpatient for pain control and other acute and chronic symptom management. Expenses for a private room are covered only up to the regular daily expense for a semi-private room unless a private room is medically necessary or a semi-private room is unavailable.
 - 3) Hospice expenses for:
 - i. nursing care provided by a registered nurse or licensed practical nurse, and services of a home health aide;
 - ii. medical social services provided under the direction of a physician;
 - iii. psychological and dietary counseling;
 - iv. medically necessary physical and occupational therapy;
 - v. medical supplies, drugs, and medicines prescribed by a physician; and

- vi. expenses for consultant or case and disease management services, or physical or occupational therapy by health care providers who are not employees of the hospice - but only when the hospice retains responsibility for the care.
 - 4) services of a social worker (M.S.W.); and
 - 5) bereavement follow-up care provided by a licensed social worker employed by the home health agency, limited to two visits per family following the member's death.
- c. Hospice benefits are not provided for the following:
- 1) care for which no charge would customarily be made if insurance coverage did not exist;
 - 2) patient expenses incurred more than six months after the first charge for hospice care is incurred;
 - 3) transportation services; or
 - 4) durable medical equipment and prostheses (covered under III.C.21).

29. SKILLED NURSING FACILITY CARE (CLASSIC)

Certification requirement applies. See III.C.3 for coverage of non-certified days.

Prior authorization (prior to services) is required. Refer to the current annual change booklet for the maximum days covered. Coverage includes medically necessary skilled nursing facility care, as defined in Chapter IX, for up to the maximum days (stated in the current Schedule of Benefits in the annual change book) during convalescence or recovery from an acute illness or injury. Confinements must be ordered by the attending physician. Benefits will no longer be provided when confinement ceases to be rehabilitative and becomes custodial in nature.

30. REHABILITATION THERAPY (CLASSIC)

Certification requirement applies. See III.C.3 for coverage of non-certified days. Prior authorization is strongly recommended. Refer to your current Schedule of Benefits for inpatient and outpatient maximums.

a. INPATIENT REHABILITATION THERAPY

Coverage includes inpatient rehabilitation therapy (physical, occupational, cardiac, pulmonary, and speech therapy as defined in Chapter IX) for up to the number of days specified in the current annual change booklet, which meets the appropriate level of care determined by the Plan Administrator and meets the following criteria:

- 1) provided by a multi-disciplinarian team under the direction of a physician;
- 2) medically necessary to improve or restore bodily function;
- 3) producing measurable progress;
- 4) required because the nature of the treatment (frequency, duration and/or variety) or the physical condition of the patient makes outpatient treatment or skilled nursing facility care an unrealistic alternative; and
- 5) rendered in a licensed rehabilitation care facility.

b. OUTPATIENT REHABILITATION THERAPY

- 1) Coverage includes outpatient physical, occupational, cardiac, pulmonary, and speech rehabilitation therapy services that meet the following criteria:
 - i. prescribed by a licensed physician or mid-level practitioner within the last six months (after six months a new order or referral is required).
 - ii. provided by a licensed physical, occupational, cardiac, pulmonary, or speech therapist.

Benefits for all rehabilitation therapy are limited to the combined visit limit shown in the current annual change booklet — unless the therapy qualifies as Intensive Outpatient Rehabilitation, described below:
- 2) To be eligible for speech therapy coverage, the member must meet one or more of the following criteria:
 - i. has suffered an acute injury or serious illness which debilitates muscles or speech, or hinders the activities of daily living; or
 - ii. is receiving treatment for medically diagnosed congenital defects or birth abnormalities; or
 - iii. is suffering exacerbation of an illness/injury, causing further debilitation.

c. INTENSIVE OUTPATIENT REHABILITATION THERAPY

Prior authorization (prior to services) is required for intensive outpatient rehabilitation therapy benefits exceeding the visit limit on standard outpatient rehabilitation benefits (specified in the current annual change booklet). Coverage includes intense treatment involving at least two modalities, two or three hours a day, three to five times a week for an extended duration of three to six months for a severe injury or medical condition (such as brain injury) requiring extended rehabilitation following hospitalization or meeting criteria for inpatient rehabilitation therapy.

Benefits for intensive outpatient therapy are limited to the number of visits pre-authorized through the State Plan's claims administration company. Services not prior authorized may be denied.

- d. No rehabilitative therapy benefits are provided for the following:
 - 1) custodial care;
 - 2) diagnostic admissions;
 - 3) maintenance, non-medical self-help, or vocational education therapy;
 - 4) learning or developmental disabilities;
 - 5) social or cultural rehabilitation;
 - 6) visual, speech, or auditory disorders;
 - 7) treatment for chemical dependency or mental illness (covered under III.C.22 and III.C.23); or
 - 8) sports conditioning.

31. ALTERNATIVE HEALTH CARE (CLASSIC)

Covered services include acupuncture, naturopath and chiropractic treatments when performed by a licensed chiropractor, licensed naturopath, or licensed acupuncturist practicing within the scope of their license. Alternative health care services are limited to the maximum number of visits per benefit year specified in the current annual change booklet.

- a. The services defined above must meet the following definitions:
 - 1) Therapeutic care — treatment considered necessary to return the member to a pre-clinical status or establish a stationary status; or
 - 2) Palliative care — treatment affording relief, but no cure.
- b. Benefits are not provided for the following:
 - 1) maintenance — a regime designed to provide an optimum state of health while minimizing recurrence or complications of clinical status;
 - 2) preventive treatment — procedures necessary to prevent the development of clinical status;
 - 3) self-help programs;
 - 3) holistic medicine;
 - 4) rolfing or massage therapy;
 - 5) stress management;
 - 6) hypnotherapy;
 - 7) homeopathy; or
 - 8) naturopathic services not specifically covered in this Summary Plan Description.

32. INBORN ERRORS OF METABOLISM (INCLUDING PKU) (CLASSIC)

Coverage includes treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist. Treatment includes diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment including, but not limited to: clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

In-network supplies, including medical foods, are exempt from deductible.

33. MEDICAL EYE CARE (CLASSIC)

(Certification requirement applies. See III.C.3 for coverage of non-certified days.) Coverage includes services of a licensed physician and those services of an optometrist that are within the scope of their licensure, for the medical treatment of disease or injury to the eye.

Routine vision exams, glasses, and laser surgery to correct vision are not benefits of this medical plan (see II.D.1).

34. PREVENTIVE SERVICES (CLASSIC)

Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of

recommendations and guidelines can be viewed at www.HealthCare.gov/center/regulations/prevention.html. Some of the most common periodic exams are listed in the table below:

Periodic exams —Appropriate screening tests	Applicable for members:
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
Prostate cancer screening (PSA) age 50+	1 per plan year (age 40+ with risk factors)
Osteoporosis screening	Post-menopausal women—65+ (60+ with risk factors)—one bone density x-ray (DXA)
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), zoster (shingles)	

35. DISEASE EDUCATION & DIETARY/NUTRITIONAL COUNSELING (CLASSIC)

See the current annual change book for the annual benefit maximum booklet.

Coverage includes limited services of a registered dietician or other covered provider licensed to provide disease education and/or dietary/nutritional counseling services, when ordered by a physician. The services must be needed for reasons other than obesity (unless part of the treatment plan described below for morbid obesity) or routine vitamin supplementation. See the current annual change booklet for the dollar limit on this benefit.

36. BIRTH CONTROL (CLASSIC)

The guidelines for benefits coverage published by the U.S. Department of Public Health and Human Services regarding what contraceptives a benefits plan must provide state:

All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

Coverage on the Classic plan includes birth control medications and supplies, other than oral contraceptives (covered under III.A), when a prescription is required including: Norplant, Depoprovera, diaphragms, IUDs and the fitting or administration of such.

37. AUTISM (CLASSIC)

Prior authorization is required for autism services.

Coverage includes diagnosis and treatment of autism spectrum disorders for a covered child 18 years of age or younger.

- a. Coverage under this section must be provided to a child who is diagnosed with one of the following disorders:
 - 1) autistic disorder;
 - 2) Asperger's disorder; or
 - 3) pervasive developmental disorder not otherwise specified.
- b. Coverage may include:
 - 1) habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
 - 2) medications prescribed by a licensed physician;
 - 3) psychiatric or psychological care; and
 - 4) therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

38. MEDICAL CARE MANAGEMENT SERVICES (CLASSIC)

Case management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility.

Should the need for case management arise, a case management professional will work closely with the patient, his or her family, and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation, or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager may recommend alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

- a. You, your dependent, or an attending physician can request case management services by calling the phone number shown on your ID card during normal business hours Monday through Friday. In addition, your employer or a claim office may refer an individual for case management.
- b. A case management professional or team of professionals assesses each case to determine whether case management is appropriate.

- c. You or your dependent is contacted by an assigned case manager who explains in detail how the program works. Participation in the program is voluntary – no penalty or benefit reduction is imposed if you do not wish to participate in case management.
- d. Following an initial assessment, the case manager works with you, your family, and the attending physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- e. The case manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a hospital bed and other durable medical equipment for the home).
- f. The case manager also acts as a liaison among the insurer, the patient, his or her family, and the attending physician as needed (for example, by helping you understand a complex medical diagnosis or treatment plan).
- g. Once the alternate treatment program is in place, the case manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs. While participation in case management is strictly voluntary, case management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources.

39. EXCLUSIONS AND LIMITATIONS (CLASSIC)

- a. The following services and expenses are not covered:
 - 1) hospitalization for days that are not certified as medically necessary for the therapeutic treatment of an injury or illness, except as specified in III.C.3. This includes the following:
 - i. hospitalization for diagnostic tests, observation, or examinations when treatment does not require bed patient care;
 - ii. hospitalization for physical therapy or inhalation therapy when treatment does not require bed patient care;
 - iii. hospitalization including any services furnished by an institution which is primarily a place for rest, a place for the aged, a nursing home, or any similar institution; or
 - iv. any other hospitalization that is not medically necessary as described in Chapter IX.
 - 2) services for which the member is not legally required to make payment or for which charges are made only because the member has benefits under the State Plan. Benefits are not provided for expenses dismissed by professional or courtesy discounts.
 - 3) services and supplies that you or a dependent member are entitled to receive or do receive from the United States or any city, county, state, or country. This exclusion applies to any programs of any agency or department of any government.
 - 4) Under certain circumstances, the law allows certain governmental agencies to recover expenses for services rendered to you from your State Plan. When such a circumstance occurs, you will receive an Explanation of Benefits.
 - 5) All services and supplies that are provided to treat any illness or injury arising out of employment when your employer has elected or is required by law to obtain coverage for such under state or federal workers' compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This exclusion applies to all services and supplies provided to treat such illness or injury even though the following apply:
 - i. Coverage under the government legislation provides benefits for only a portion of the services incurred;
 - ii. Your employer has failed to obtain such coverage as required by law. This exclusion does not apply if your employer was not required and did not elect to be covered under any workers' compensation, occupational disease laws, or employer's liability acts of any state, country, or the United States;
 - iii. The member waives their rights to such coverage or benefits;
 - iv. The member fails to file a claim within the filing period allowed by law for such benefits;
 - v. The member fails to comply with any other provision of the law to obtain such coverage or benefits; or
 - vi. The member was permitted to elect not to be covered by the workers' compensation laws, but failed to properly make such election effective. This exclusion will not apply if you are permitted by statute not to be covered and you elect not to be covered by the workers' compensation laws, occupational disease laws, or liability laws.

- 6) expenses that are or will be paid by another responsible party as described in Chapter VII;
- 7) services or procedures that are:
 - i. not medically necessary to treat active illness or injury, or specifically listed as a benefit;
 - ii. not generally accepted by the medical profession; or
 - iii. Experimental Procedures or Services, as defined in Chapter IX. The State Plan may consult with physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice.
- 8) treatment of mental, psychoneurotic and personality disorders, chemical dependency disorders, adolescent behavior problems, learning disabilities, and family, marital or sexual problems — except as provided in III.C.22 and III.C.23;
- 9) routine physical examinations and immunizations including premarital, insurance, athletic, school entrance and employment physicals or immunizations, except services specifically covered under III.C.34;
- 10) treatment of a condition caused by or arising out of an act of war (declared or undeclared), insurrection, rebellion, or armed invasion;
- 11) any expense for which a contributing cause was commission by the member of a criminal act, attempt to commit a criminal act, or to which the contributing cause was the member's being engaged in an illegal occupation;
- 12) vision examinations (may be covered under a separate vision exam plan described in II.D.1), orthoptics, vision training, hearing examinations, corrective appliances, and laser eye surgery. Corrective appliances include glasses, contact lenses, and hearing aids.
- 13) infertility treatment.
- 14) dental care, including dental services listed as exclusions of the Dental Plan, with the following exceptions:
 - i. treatment required due to injury to sound natural teeth described in III.C.14, and
 - ii. treatment required due to a dependent child's congenital abnormality, provided the child was born and enrolled while the employee was a member of the State Plan or covered under creditable coverage as defined in Chapter IX.
- 15) speech therapy, except as provided in III.C.30;
- 16) elective or therapeutic abortion as defined in Chapter IX;
- 17) cosmetic surgery, services, or supplies except treatment or surgery due to a dependent child's congenital abnormality, provided the child was born and enrolled while the employee was a member of the State Plan. Cosmetic surgery is surgery that improves appearance or corrects a deformity without restoring a physical function of the body. Some procedures are usually cosmetic but may not always be. In these cases, prior authorization described in III.A.6 is strongly recommended to assure coverage.
- 18) any foot orthotic and foot care, including the following:
 - i. removal or treatment of corns or callosities;
 - ii. hypertrophy, hyperplasia of the skin, or subcutaneous tissues;
 - iii. cutting or trimming of nails;
 - iv. treatment of flat feet, fallen arches, or chronic foot strain;
 - v. orthotic appliances and casting for orthotic appliances, except as provided in III.C.21;
 - vi. padding and strapping; or
 - vii. fabrication.
- 19) medical or surgical reversal of elective sterilization and experimental fertility procedures;
- 20) treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction (TMJ), anterior or internal dislocations, derangements and myofascial pain syndrome, or orthodontics (dentofacial orthopedics) or related appliances. Surgical treatment for these conditions will be allowed only if prior authorized by the Plan Administrator.
- 21) organ or tissue transplants, except as provided in III.C.25;
- 22) humidifiers, air conditioners, exercise equipment, home traction units, whirlpools, health spas or swimming pools, whether or not prescribed by a licensed provider;
- 23) implantable and/or inflatable prosthesis;
- 24) services and supplies related to sexual inadequacy or dysfunction, or sexual transformations and reversals of such procedures;

- 25) personal services such as radio, television, and phone service;
- 26) sanitarium care, custodial care, rest cures, or convalescent care to help you with daily living tasks such as: walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparing special diets, and supervising medications which are usually self-administered;
- 27) health clubs, health spas, and exercise programs, whether or not approved or prescribed by a licensed provider;
- 28) any expense incurred after group coverage terminates;
- 29) education or tutoring services, except as specifically included as a benefit of state indemnity medical plans in this Summary Plan Description;
- 30) any facility charges for chronic pain management services provided by an inpatient pain center;
- 31) services and supplies related to any of the following treatments or related procedures:
 - i. self-help programs;
 - ii. religious counseling;
 - iii. marriage counseling;
 - iv. holistic medicine;
 - v. rolfing;
 - vi. stress management;
 - vii. hypnotherapy;
 - viii. homeopathy;
 - ix. massage or massage therapy; and
 - x. naturopathic services not otherwise covered in this Summary Plan Description.
- 33) services and supplies primarily for personal comfort, hygiene, or convenience, which are not primarily medical in nature;
- 34) travel for a member or provider, unless specifically covered as a benefit of this Summary Plan Description;
- 35) private duty nursing, except as specifically included as a benefit of this Summary Plan Description;
- 36) any additional charge for inclusive procedures or services as defined in Chapter IX and as determined by the Plan Administrator;
- 37) services or supplies for complications resulting from services that are not covered;
- 38) any service provided in conjunction with a non-covered service.
- 39) services and supplies not provided by a licensed provider or which are not listed as a benefit of state medical plans in this Summary Plan Description;
- 40) residential care services, boot camps, or rehabilitative schools;
- 41) autism- related services provided in a public school setting;
- 42) No payment will be made for duplicate services with respect to any scheduled visit;
- 43) food or nutritional supplements;
- 44) Treatment for obesity (surgical or non-surgical).
- 45) **NON-AUTHORIZED SERVICES**
Exclusions include services not performed, arranged, authorized, or approved as specified in this document.
- 46) **PRESCRIPTION DRUGS**
Exclusions include outpatient prescription drugs, which are covered by a separate prescription drug plan.
- 47) **PRE-EXISTING CONDITIONS**
Pre-existing conditions are excluded for up to one year from a member's coverage effective date. However, the period of exclusion may be reduced by creditable coverage as described in I.C.4.
- 48) **NON-STANDARD OR SELF-PRESCRIBED SERVICES AND SUPPLIES**
Except as specifically provided in this Supplement, plan exclusions include all services for non-standard or self-prescribed therapies. Exclusions include, but are not limited to:
 - i. orthomolecular therapy, including nutrients, vitamins, and food supplements;
 - ii. acupuncture or acupressure;
 - iii. biofeedback; and
 - iv. chelating therapy (except for mineral or metal poisoning)
- 49) **INJURY OR SICKNESS RELATED TO A RIOT**
Exclusions include the care and treatment of injuries or sickness due to voluntary participation in a riot.

50) LEGALLY-ORDERED SERVICES

Exclusions include services which are required by a court order, or as a condition of parole or probation.

51) ADMINISTRATIVE CHARGES

Exclusions include charges for missed appointments or other administrative sanctions.

52) INJURY OR SICKNESS RELATED TO MILITARY SERVICE

Exclusions include services for (or related to) any sickness or injury suffered as a result of (or while in) military service.

53) CERTAIN PRIVATE ROOM CHARGES

Exclusions include private room accommodations that are in excess of the State Plan's allowable for the most common semi-private room charge, unless a private room is deemed medically necessary by the State Plan.

54) UNUSUAL CIRCUMSTANCES

Neither the State Plan nor any network or in-network providers shall have any liability or obligation because of a delay or failure to provide covered medical services or benefits under the following circumstances:

- i. complete or partial destruction of facilities;
- ii. war;
- iii. riot;
- iv. civil insurrection;
- v. major disaster;
- vi. disability of a significant part of the in-network hospital and/or provider network;
- vii. epidemic; or

viii. labor dispute not involving the State Plan, in-network hospitals, and/or other in-network providers.

In-network providers will make their best efforts to provide services and benefits within the limitations of available facilities and personnel. If the rendering of covered medical services or benefits is delayed due to a labor dispute involving the State Plan or in-network providers, non-emergency care may be deferred until after the resolution of the labor dispute.

55) VOCATIONAL REHABILITATION

56) CHARGES RESULTING FROM LEAVING A HOSPITAL OR FACILITY CONTRARY TO MEDICAL ADVICE

C. MISCELLANEOUS BENEFITS – IDENTICAL FOR THE CLASSIC AND CHOICE PLANS

1. OPTIONAL VISION BENEFITS

Members who are enrolled in the optional Vision Insurance Plan are entitled to the following:

- a. Periodic eye examinations from an in-network provider, or a periodic allowance toward an exam from an out-of-network provider, as defined in the current annual change book.
- b. A periodic set of lenses, including single vision, lined bifocal, and lined trifocal lenses from an in-network provider, or a periodic allowance toward a set of these lenses from an out-of-network provider, as defined in the current annual change book.
- c. A periodic dollar allowance toward frames, as defined in the current annual change booklet.
- d. As an alternative to lenses and frames, a periodic allowance toward a contact lens exam and contact lenses, as defined in the current annual change booklet.
- e. Preferred pricing (discounts) for covered services from in-network providers including:
 - 1) a contact lens exam for assessment of suitability for, and fitting of, contacts;
 - 2) a year's supply of contacts from the vision insurance company;
 - 3) costs of additional lens options in excess of allowances for lenses listed above (such as progressive lenses); and
 - 4) frame costs in excess of allowance, all as defined in the current annual change booklet.
- f. Preferred pricing (discounts) for additional non-covered vision services from in-network providers, including:
 - 1) a contact lens exam, even though the vision coverage was used for glasses;
 - 2) a year's supply of contacts from the vision insurance company, even if the vision coverage was used for glasses;
 - 3) extra pairs of prescription glasses, including prescription sun glasses; and
 - 4) laser surgery at in-network centers, all as defined in the current annual change book.

See the current annual change booklet for updates on covered services, frequency of coverage, dollar allowances, and copayment amounts. Also, see the current annual change book for the current vision insurance company and

the web site where you can find in-network providers in your area. See Chapter I for information on obtaining benefits and enrollment.

CHAPTER IV: DENTAL BENEFITS

A. DENTAL BENEFITS AND EXCLUSIONS

1. COVERED DENTAL EXPENSES

Expenses covered by the Dental Plan are:

- a. Expenses within allowable charges. (You are responsible for expenses over allowable charges unless you use an in-network provider);
- b. Expenses within specified benefit limitations contained in this chapter and the current annual change book which meet other requirements of this Summary Plan Description; and
- c. Expenses for covered dental services, defined below.

2. COVERED DENTAL SERVICES

Covered dental services are services, procedures, or supplies that are:

- a. Listed in sections IV.A.4 –IV.A.6 of this Summary Plan Description and not excluded in IV.A.7;
- b. Provided to a member by a covered provider; and
- c. Provided and coded in accordance with applicable dental policy.

3. COVERED DENTAL EXPENSES YOU PAY

The plan will reimburse according to the percentage listed in the current annual change book for each of three types of covered services. Each member is responsible for the coinsurance amount remaining.

Type A - Preventive Services

Type B - Basic Services

Type C - Extensive Services

Types B and C also have a deductible listed in the current annual change book that must be met before the plan reimburses.

Type A services are subject to an annual benefits maximum listed in the current annual change book.

Types B and C services are subject to an annual benefit maximum listed in the current annual change book.

4. TYPE A – COVERED BASIC AND PREVENTIVE SERVICES

- a. Diagnostic – Dental x-rays are limited to one full-mouth x-ray or series in any period of five years, and not more than two sets of supplementary bitewing x-rays in any benefit year.
- b. Preventive – Oral examination, including prophylaxis (cleaning), limited to two examinations and/or applications in any benefit year, and for enrolled children through age 19, topical application of fluoride. Dental sealants are limited to enrolled children through age 15.
- c. Amalgam fillings - Two or more fillings on the same surface are considered as one procedure even though the fillings are not in contact with each other.
- d. Emergency Pain Relief – Unscheduled minor emergency treatment to relieve pain. Type B and C services are not minor treatment procedures for purposes of this provision, except palliative treatment and an emergency examination.

5. TYPE B – COVERED DENTAL SERVICES

Covered type B services include:

- a. Passive space maintainers.
- b. Extractions.
- c. Fillings consisting of resin-based composite. Two or more fillings on the same surface are considered as one procedure even though the fillings are not in contact with each other.
- d. Mucogingivoplastic surgery (plastic surgical procedures for correction of gingiva, mucous membrane relationships that complicate periodontal disease), management of an acute infection, and oral lesions.
- e. Endodontics – The diagnosis and treatment of disease of the dental pulp. This includes:
 - 1) removal of tooth pulp;
 - 2) pulp capping;

- 3) root canal treatment; and
- 4) retrograde procedures.
- f. Periodontics – The diagnosis and treatment of diseases of tissues around the teeth. This includes:
 - 1) gingival and osseous surgery;
 - 2) periomaintenance;
 - 3) periodontal scaling up to four times per benefit year; and
 - 4) root planing.
- g. Oral surgeries that are not covered under Chapter III – Medical Benefits.
The types of surgeries that are excluded from dental benefits because they are considered medical procedures are listed in IV.A.7, provision a.
- h. General anesthesia (prior authorization recommended to assure coverage) performed by a physician/anesthesiologist, dentist (other than the attending dentist), or by a nurse anesthetist for oral surgery, teeth extraction, or when certified as medically necessary by the attending dentist.

6. TYPE C – COVERED EXTENSIVE SERVICES

Coverage includes:

- a. Single restoration (temporary and permanent) crowns, bridge abutments (bridge retainers - crowns), inlays, onlays, pontics (wire attachment to sound teeth for a bridge) and porcelain fillings. Replacement of crowns is limited to once every five years.
- b. Bridges, limited to no more than one replacement every five years.
- c. Repair, relining, and rebasing of existing dentures that have not been replaced by a new denture.
- d. Initial dentures and replacement dentures, limited to no more than one set of replacement dentures every five years. (This limitation is waived in the case of damage through accidental injury to the mouth described below.) Adjustment of bridges or dentures is covered only after six months of use of the appliance.
- e. Dental implants (devices surgically inserted into the jawbone) for an edentulous mouth (no teeth in an arch or the entire mouth) are limited to a maximum benefit as indicated in the current annual change booklet per lifetime when:
 - 1) the member has an edentulous mouth; and
 - 2) the member has no ability to use customary prosthodontic appliances or devices, such as dentures. (Prior authorization is required as specified below.)

Implant Benefits include:

- i. any necessary buildup of the dental ridge by bone interface material such as, but not limited to, hydroxyapatite (bone supplement material). The necessity for the bridge augmentation must be documented;
- ii. implant procedure; and
- iii. removable prosthesis that sets over the implants.

Bone grafts, anesthesia, and hospitalization related to edentulous implants will be subject to and paid according to medical benefit provisions (see Section L). Absent medical health care coverage, these services will be covered under the Dental Plan as Type C services, subject to the applicable lifetime maximum.

Maintenance and care of the implant(s), such as cleaning or periodontal services, are covered under prosthodontic, endodontic, and periodontic service provisions.

Prior authorization must include:

- 6) a written narrative showing the proposed treatment is necessary;
- 7) an estimated cost of the proposed treatment; and
- 8) panoramic x-ray and study models demonstrating the status of the member's edentulous mouth.
- f. Limited dental implants benefits in lieu of, and up to, the amount allowed (allowable fee) for a bridge or partial denture, to replace single or multiple missing teeth. The allowance may be applied to crowns, a partial denture, or a fixed bridge denture that fits over the implant. Prior authorization is required.

7. EXCLUSIONS AND LIMITATIONS

Dental benefits are not provided for the following services and expenses:

- a. Expenses covered under Chapter III – Medical Benefits, whether or not they are paid in whole or in part. This includes:
 - 1) dental care required because of accidental injury to sound natural teeth (see III.B.14 for the Classic plan and III.C.14 for the Choice plan);
 - 2) removal of cysts, tumors, neoplasms, inflammatory lesions, and scar tissue from the mouth;
 - 3) surgery to drain abscesses;
 - 4) treatment of bone fractures; and
 - 5) the repair of traumatic wounds to the mouth.

If you have questions about whether a particular surgical procedure is a medical procedure (payable only if you are enrolled for medical benefits) or a dental procedure (payable only if you are enrolled for dental benefits), please call the Plan Administrator at the number on your identification card.
- b. All services and supplies that are provided to treat any illness or injury arising out of employment when your employer has elected or is required by law to obtain coverage for such under state or federal workers' compensation laws, occupational disease laws, or similar laws, including labor or liability laws of the United States. This exclusion applies to all services and supplies provided to treat such illness or injury even though the following apply:
 - 1) Coverage under the law provides benefits for only a portion of the services incurred;
 - 2) Your employer has failed to obtain such coverage as required by law. This exclusion does not apply if your employer was not required and did not elect to be covered under any workers' compensation, occupational disease laws, or employer's liability laws of any state, country, or the United States;
 - 3) The member waives their rights to such coverage or benefits;
 - 4) The member fails to file a claim within the filing period allowed by law for such benefits;
 - 5) The member fails to comply with any other provision of the law to obtain such coverage or benefits; or
 - 6) The member was permitted to elect not to be covered by the workers' compensation laws, occupational disease laws, or liability laws but failed to properly make such election effective. This exclusion will not apply if you are permitted by statute not to be covered and you elect not to be covered by the workers' compensation laws, occupational disease laws, or liability laws;
- c. Services for which the member is not legally required to make payment or for which charges are made only because the member has benefits under the State Plan. Benefits are not provided for expenses dismissed by professional or courtesy discounts.
- d. Dental services that do not have uniform professional endorsement, are an Experimental Procedure or Service, as defined in Chapter IX or are for research.
- e. Any expense for which a contributing cause was commission by the member of a criminal act, attempt to commit a criminal act, or the member's engagement in an illegal occupation.
- f. Treatment of a condition caused by or arising out of an act of war (declared or undeclared), insurrection, rebellion, or armed invasion.
- g. Dental treatment while in active military service.
- h. Charges for services normally included in the basic charge, such as local anesthesia.
- i. Treatment by someone other than a dentist, oral surgeon, or licensed denturist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist.
- j. Services beyond the scope of a covered provider's license.
- k. Any service or supplies for congenital malformation, whether or not they are covered benefits under Chapter III (see III.B.42.a.14 for the Classic plan and III.C.43.a.14 for the Choice plan).
- l. Services or supplies for orthodontic treatment, except for extractions incidental thereto.
- m. Precision or other elaborate attachments for any appliance.
- n. Habit appliances and patient education, including instructions for plaque control or oral hygiene.
- o. Surgical implants and precision or semi-precision attachments of any type, except services described in IV.A.6, provisions e and f.
- p. Bite registrations and splinting.

- q. Sealants to prevent decay, including fissure sealants, unless for an enrolled dependent under age 16 (see IV.A.6, provision g).
- r. Non-surgical treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction (TMJ), anterior or internal dislocations, derangements and myofascial pain syndrome, or orthodontics (dentofacial orthopedics) or related appliances (see III.B.42.a.20 for the Classic plan and III.C.43.a.20 for the Choice plan).
- s. Ridge augmentation, except as noted under IV.A.6, provision e.
- t. Hospitalization for dental services. If hospitalization is medically necessary, it is covered under the medical plan.
- u. Services or supplies cosmetic in nature.
- v. Services, appliances, or restorations used primarily to increase vertical dimensions or to restore occlusion.
- w. Services or supplies for complications resulting from services that are not covered — including the removal of dental implants and the treatment of complications of the implant procedure — unless the implant met the requirements of IV.A.6, provision e. This includes the requirement that the edentulous status of the mouth and inability to support dentures without implants be established during a prior authorization process.
- x. Services and supplies you or a dependent member are entitled to receive or do receive from the United States or any city, county, state, or country. This exclusion applies to any programs of any agency or department of any government.

Related Information

Under certain circumstances, the law allows certain governmental agencies to recover expenses for services rendered to you from your State Plan. When such a circumstance occurs, you will receive an Explanation of Benefits.

- y. Any expense incurred after group coverage terminates.
- z. Any additional charge for inclusive procedures or services as defined in Chapter IX and as determined by the Plan Administrator.

CHAPTER V: LONG-TERM CARE INSURANCE, LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D), & LONG-TERM DISABILITY INSURANCE BENEFITS

A. LONG-TERM CARE INSURANCE

1. LONG-TERM CARE BENEFIT OPTIONS

Eligible employees and their spouses, parents, parents-in-law, grandparents, or grandparents-in-law, and retirees and their spouses (all through the age of 84), may apply for long-term care insurance coverage from the State Plan's long-term care insurance company as described in Chapter I. Benefit options include:

a. CARE OPTIONS PLAN

The enrollee or applicant may choose the plan (or package) of care options that will be eligible for benefits if they are disabled and eligible for long-term care insurance benefits. Available care options plans are:

- 1) Facility Plan – Care by a facility only (nursing home or assisted living facility);
- 2) Facility + Professional Home Care Plan – Care by a facility or professional home care (provided by a licensed home health organization); or
- 3) Facility + Professional Home Care Plan + Total Home Care Plan – Care by a facility, professional home care, or total home care (provided by anyone including family members).

b. MONTHLY BENEFIT AMOUNT

The enrollee or applicant may choose a monthly benefit amount to be paid to them if they are disabled and qualify for long-term care insurance benefits. A monthly benefit amount between \$1,000 and \$6,000 in \$1,000 increments may be elected (elections of \$5,000 or \$6,000 always require evidence of insurability, as described in V.A.2). The elected amount is the monthly benefit for nursing home care, which is the highest cost care. If your care is from an assisted living facility, you will receive 60 % of the monthly benefit amount. If your care is professional home care or total home care, you will receive 50 % of the monthly benefit amount.

c. DURATION OF COVERAGE

The enrollee or applicant may choose the period of time for which they will receive a long-term care insurance benefit if they are disabled and eligible for long-term care insurance benefits. Three periods of time or durations of coverage are available:

1) Three Years

This provides three years of benefits if paid out at 100 percent for nursing-home care; five years if paid out at 60 percent for assisted-living-facility care; and six years if paid out at 50 percent for professional home care or total home care.

2) Six Years

This provides six years of benefits if paid out at 100 percent for nursing home care; 10 years if paid at 60 percent for assisted-living-facility care; and 12 years if paid out at 50 percent for professional home care or total home care.

3) Unlimited

This provides unlimited benefits regardless of the type of provider (within your elected care option plan) who provides your care and whether the elected monthly benefit amount is paid out at 100 percent, 60 percent, or 50 percent.

d. INFLATION PROTECTION

The enrollee or applicant may choose to purchase inflation protection. This option is designed to inflate your long-term care insurance benefit over time based on the assumption that the cost of long-term care will inflate over time. Inflation protection increases your elected monthly benefit amount by 5 percent each year on a compounded basis up to 200 percent of your original monthly benefit amount.

OTHER PLAN PROVISIONS AND PREMIUM RATES

Carefully read the outline of coverage, rate sheet, and other materials in the long-term care insurance enrollment package before applying for long-term care insurance. The monthly premium is based on the age of the applicant at the time of application and is impacted by each of the above choices. Once enrolled, your monthly premium for the enrolled coverage does not increase with your age (but may be increased by the insurance company).

2. EVIDENCE OF INSURABILITY

All eligible employees who apply during their 31-day initial enrollment period are guaranteed coverage for up to \$3,000 in a monthly benefit amount and up to a six-year duration of coverage. Employees who apply for more coverage, apply at a later date, and all other eligible applicants must submit evidence of insurability (provide information on their medical status) and may be denied coverage.

3. BENEFIT PAYMENT PROVISIONS

You (or a family member enrolled in long-term care insurance) are eligible for a monthly benefit if you meet all of the following conditions:

a. You become disabled.

You are disabled for purposes of long-term care insurance if you meet criterion 1) or 2) below:

- 1) You are unable to perform, without substantial assistance from another individual, at least two of the following activities of daily living:
 - i. bathing;
 - ii. dressing;
 - iii. toileting;
 - iv. transferring (moving in and out of a bed, chair, or wheelchair);
 - v. continence (the ability to maintain control of bowel or bladder function); or
 - vi. eating.
- 2) You require substantial supervision by another individual to protect you from threats of health and safety due to severe cognitive impairment.

b. A physician has certified that you are unable to perform, without substantial assistance from another individual, two or more of the above activities of daily living for a period of at least 90 days, or that you require substantial supervision by another individual to protect you or others from threats to health or safety due to severe cognitive impairment. (A physician's certification is required every 12 months.)

c. You are receiving services in a nursing home or assisted living facility, or you are receiving professional home care (if the care options plan you elected includes a professional home care benefit) or total home care (if the care options plan you elected includes a total home care benefit).

d. You have satisfied the 90-day elimination period specified in your plan. (The elimination period is the number of consecutive days, beginning when you meet the above criteria, that you must wait before receiving benefits.) Once the above requirements are met, the monthly benefit amount, or the percentages of the monthly benefit amount (specified in V.A.1 for assisted living facility care, professional home care, and total home care) will be paid to you or your designated guardian regardless of the actual cost of the care.

4. COVERAGE CONTINUATION

- a. When you stop working for the State of Montana, group long-term care insurance coverage ends, but may be converted to individual coverage at the same premium, as described in I.E.11. Conversion requests must be submitted to the long-term care insurance company within 31 days of termination of State Plan coverage and premiums must be paid directly to the long-term disability (LTD) company.
- b. When you are disabled and begin drawing benefits, your coverage will continue at no more cost to you for as long as you continue to be eligible for a monthly benefit. Premiums are not waived while receiving payment for respite care as described in I.E.4.

B. TERM LIFE INSURANCE

1. CORE BENEFITS

The State Plan provides each enrolled employee with some basic term life insurance (Plan A), as part of the core benefits package. This coverage is automatic provided you are eligible and enrolled in the State Plan. See I.B on how to enroll and the current annual change booklet for the amount of core life insurance.

2. LIFE INSURANCE OPTIONS – EMPLOYEE PLANS

Employees may increase their coverage at the favorable rates the State Plan has negotiated with its selected life insurance company as follows:

PLAN C

You may elect optional Plan C coverage of:

- a. One times your annual salary rounded to the next highest multiple of \$5,000; or
- b. Additional coverage in \$5,000 increments, up to a maximum of \$500,000.

Newly eligible employees may receive coverage of one times their annual salary described above without evidence of insurability and approval of the State Plan's life insurance company if they enroll within the 31-day initial enrollment period. Additional coverage and late enrollment requires evidence of insurability and life insurance company approval (see I.B).

If your annual salary increases and exceeds the Plan C coverage based on your earlier annual salary, your Plan C coverage will automatically increase to reflect your new salary. Your premium costs (and payroll deduction) will automatically increase to match the increased coverage. Your premium costs (and payroll deduction) will also automatically increase when your age changes to the next five-year age bracket. See a current annual change booklet for premium costs.

COVERAGE CONTINUATION

Coverage will be continued without payment of premium if you qualify for a disability waiver described in I.E.4 of this document. See I.E for information on conversion to an individual policy when you cease active employment.

3. LIFE INSURANCE OPTIONS – DEPENDENT PLANS

Eligible employees may obtain term life insurance coverage on dependents who are eligible for benefits (as defined in I.A.2) and not specifically excluded below, by electing one or both of the following optional dependent plans (see I.B).

a. PLAN B – BASIC DEPENDENT LIFE

Plan B provides \$2,000 of coverage on your spouse/domestic partner and \$1,000 on each child. This coverage is only available during the 31-day initial enrollment period and within 31 days of acquiring a spouse/domestic partner or first child. No evidence of insurability and life insurance company approval are required.

b. PLAN D – SUPPLEMENTAL SPOUSE/DOMESTIC PARTNER LIFE

Plan D provides coverage on your spouse/domestic partner in \$5,000 increments up to 100 percent of your total coverage under Plan C.

Newly eligible employees may receive supplemental spouse/domestic partner coverage up to \$10,000 without evidence of insurability and approval of the State Plan's life insurance company if they enroll within the 31-day initial enrollment period. Additional coverage requires evidence of insurability and life insurance company approval (see I.B).

The premium for Plan D is based on the employee's age, and the premium (and payroll deduction) automatically increases when the employee's age changes to the next five-year age bracket. To receive this coverage you must:

- 1) be enrolled in Plan C; and
- 2) submit evidence of insurability for your dependent spouse/domestic partner (above \$10,000 issued to newly eligible employees) and be approved by the State Plan's life insurance company.

c. EXCLUDED DEPENDENTS

The following dependents and former dependents are not eligible for either basic dependent life – Plan B or supplemental spouse/domestic partner life – Plan D:

- 1) children or a spouse in full-time active military service;
- 2) children age 26 and over, unless the dependent child is disabled under I.A.3;
- 3) married children; or

4) an ex-spouse.

d. **COVERAGE CONTINUATION**

Dependent coverage will be continued without payment of premiums as follows:

- 1) for five months after your death;
- 2) during any period when you become totally and permanently disabled and qualify for continued life insurance and premium waiver as described in I.E.4; or
- 3) during any period when your only insured dependent is a disabled child as defined in I.A.3.

See I.E of this document for information on conversion to an individual policy when you cease active employment.

4. BENEFICIARY DESIGNATION

When you enroll in core life insurance or optional life insurance benefits, you will be asked to designate one or more beneficiaries. You may designate one or more primary beneficiaries, plus one or more first contingent and second contingent beneficiaries.

At death, benefits will be distributed to a living primary beneficiary or split evenly among multiple living primary beneficiaries, unless you specify their respective shares. In the absence of any living primary beneficiary, benefits will be evenly split among any first contingent beneficiaries, and, in their absence, among any living second contingent beneficiaries.

If there are no living designated beneficiaries, benefits will be distributed to the following living relatives in order of distribution: first to the spouse; if the spouse is not living, evenly split among living children; or if the children are not living, to surviving parents. If none of these survivors exists, the benefits will be paid to your estate.

When beneficiaries are minor children, benefits are paid to their legal guardian. Trust fund arrangements are available through the life insurance company.

Benefits will not be paid to a beneficiary who intentionally and wrongfully causes an insured's death.

Beneficiary designations may be changed at any time and should be kept current.

5. BENEFIT PAYMENT PROVISIONS

a. **DEATH BENEFIT PAYOUT OPTIONS**

Death benefits in excess of a threshold amount specified by the life insurance company are paid to beneficiaries through the default mechanism of an interest bearing checkbook — unless the beneficiary requests another payout option. A checkbook gives the beneficiary the flexibility of immediately writing a check on (and withdrawing) the entire balance or withdrawing funds at the beneficiary's convenience. Other payout options, which may be requested when a claim is filed, include receiving death benefits in a lump sum or in installments over several years upon mutual agreement between the beneficiary and the State Plan's life insurance company.

b. **ACCELERATED BENEFIT OPTION**

Employees with life insurance coverage described in this section may receive during their lifetime a portion of their elected life insurance amount as an accelerated benefit if they meet the following eligibility requirements. To apply for this benefit call the State Plan's life insurance company.

1) **Eligibility**

i. To qualify, the covered employee must:

- a) qualify for waiver of premium (see I.E.4, provision a), and
- b) give satisfactory proof of having a qualifying medical condition.

A qualifying medical condition means:

1. you are terminally ill, with a life expectancy of less than 12 months, or
2. you are permanently confined to a nursing home and have been in residence there for at least 60 days.

The life insurance company may require a medical exam to verify eligibility.

2) **Benefit**

A qualified individual may receive an accelerated benefit of up to 75 percent of their insurance coverage (not including accidental death and dismemberment), not to exceed \$500,000. The minimum accelerated benefit is the greater of \$5,000 or 10 % of insurance coverage. If the amount of coverage is scheduled to go down within 24 months of the date you apply for an accelerated benefit, the benefit will be based on the lesser amount.

Benefits are limited to once per lifetime and paid in a lump sum. If you should recover from the qualifying medical condition, you will not be required to repay the benefit.

3) Exclusions

No accelerated benefit will be paid if:

- i. all or part of your insurance must be paid to your child(ren), spouse, or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement;
- ii. you are married and live in a community property state, unless you obtain signed written consent from your spouse;
- iii. you have filed for bankruptcy, unless you obtain written approval from the bankruptcy court for payment of the accelerated benefit;
- iv. you are required by a government agency to use the accelerated benefit to apply for, receive, or continue a government benefit or entitlement; or
- v. you have previously received an accelerated benefit under the group policy.

C. Accidental Death and Dismemberment (AD&D) Insurance – Plan E

1. AD&D OPTIONS

Eligible employees may elect accidental death and dismemberment coverage under Plan E on themselves and dependents who are eligible for benefits as follows:

a. ELECTIVE EMPLOYEE AD&D

Up to \$500,000 in \$25,000 increments, not to exceed 10 times your annualized salary.

b. ELECTIVE DEPENDENT AD&D

If you are enrolled for AD&D on yourself, you may elect the following AD&D coverage on your eligible dependents:

- 1) On your spouse/domestic partner:
 - i. 50 % of your own coverage, if no children are covered; or
 - ii. 40% of your own coverage, if children are covered.
- 2) On your child(ren): 10 % of your own coverage.

Enrollment of eligible employees and dependents does not require evidence of insurability or approval by the State Plan's life insurance company and may be made at any time consistent with mid-year premium change restrictions for individuals under the Pre-tax Plan (see I.B.5).

2. BENEFIT PAYMENT PROVISIONS

Benefits are payable for accidental deaths or dismemberments not exempted in V.C.3 that:

- a. Are caused solely and directly by accidental bodily injuries and are independent of all other causes;
- b. Occur while you are insured under Plan E; and
- c. Occur within 365 days after the date of the accident.

The scheduled benefits will be paid to your designated beneficiary in the event of your accidental death and will be paid to you in the event of your bodily loss or in the event of your dependent's accidental death or bodily loss. For a list of specific scheduled benefit amounts payable, contact the State Plan's AD&D insurance company.

3. EXEMPTIONS

Even though a loss results from accidental bodily injuries, no payment will be made if either the accidental bodily injuries or the loss is caused by or contributed to by any of the following:

- a. Insurrection, war, or act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict with organized forces of a military nature;
- b. Suicide or any other intentionally self-inflicted injury, while sane or insane.
- c. Committing or attempting to commit an assault or a felony or your active participation in a violent disorder or riot. Active participation does not include being at the scene of a violent disorder or riot in the performance of your official duties;
- d. The voluntary use or consumption of any poison, chemical compound, or drug (including but not limited to prescribed medications), unless used or consumed in accordance with the directions of a physician;
- e. Any sickness or pregnancy existing at the time of the accident;

- f. Heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebral infarction);
- g. Medical or surgical treatment for any of 1 – 6 above; or
- h. Travel, flight, or descent from any kind of aircraft as a pilot or crew member, except in state-owned, leased, or operated aircraft while on state business.

D. LONG-TERM DISABILITY (LTD) INSURANCE

See Chapter I for information on enrolling in long-term disability (LTD), continuing long-term disability when you are taking a leave of absence and reinstatement options following a leave or termination.

1. LONG-TERM DISABILITY BENEFIT

Eligible employees (excluding member of the legislature) who are enrolled in a medical plan (subject to eligibility requirements in Chapter I) may apply for LTD insurance from the State Plan's long-term disability insurance company as described in Chapter I.

LTD insurance pays a monthly benefit to enrolled members who cannot work because of a covered illness or injury. Upon enrollment, a certificate of group LTD insurance will be issued by the State Plan's LTD insurance company.

a. MONTHLY BENEFIT AMOUNT

The monthly benefit amount is 60% of the first \$15,333 pre-disability earnings reduced by deductible income.

The minimum benefit is \$100 or 10% of the LTD benefit before reduction by deductible income, whichever is greater. The maximum benefit is \$9,200 before reduction by deductible income.

Pre-disability earnings are your monthly rate of earnings and typically include:

- 1) salary;
- 2) contributions you make to your deferred compensation plan with the State of Montana; and
- 3) amounts contributed to your medical and/or dependent care flexible spending account(s).

Pre-disability earnings generally exclude commissions, bonuses, shift differential pay, overtime pay, your employer's contribution to a pension plan or any other extra compensation. They are based on your earnings in effect on the last full day of active work.

b. MAXIMUM BENEFIT PERIOD

The maximum benefit period is determined by member's age when the disability begins as follows:

- 1) age 59 or younger - maximum benefit period to age 65;
- 2) age 60 through 64 - maximum benefit period of five years;
- 3) age 65 through 68 - maximum benefit period to age 70; and
- 4) age 69 or older - maximum benefit period of one year.

c. WAITING PERIOD

The waiting period before benefits are paid is 180 days.

d. PAYABLE BENEFITS

If you become disabled and your claim for LTD benefits is approved by the State Plan's LTD company, LTD benefits become payable after you have been continuously disabled for 180 days and remain continuously disabled. LTD benefits are not payable during the benefit waiting period.

2. DEDUCTIBLE INCOME

Deductible income is income you receive or are eligible to receive while LTD benefits are payable. It is used to reduce the amount of your LTD benefit and includes, but is not limited to, the following:

- a. Sick pay, annual or personal leave pay, severance pay or other forms of salary continuation (including donated amounts) paid by your employer;
- b. Benefits under any workers' compensation law, state disability income benefit law or similar law;
- c. Amounts under unemployment compensation law or similar law;
- d. Social Security disability or retirement benefits, including benefits for your spouse/domestic partner and children;
- e. Disability benefits from any other insurance, including individual insurance for professionals;
- f. Disability or retirement benefits under your retirement plan;
- g. Earnings from work activity while you are disabled, plus the earnings you could receive if you worked as much as you are able to considering your disability;

- h. Earnings or compensation included in your pre-disability earnings and which you receive or are eligible to receive while LTD benefits are payable;
- i. Amounts due from or on behalf of a third party because of your disability; and
- j. Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above.

3. EVIDENCE OF INSURABILITY

All eligible employees who apply during their 31-day initial enrollment period are guaranteed coverage. Employees who apply at a later date, and all other eligible applicants must submit evidence of insurability (provide information on their medical status) and may be denied coverage unless the State Plan's long-term disability insurance company permits guaranteed enrollment during a specific annual change period.

4. DISABILITY

You are disabled if you meet one of the following definitions during the periods they apply:

a. OWN OCCUPATION DEFINITION OF DISABILITY

During the benefit waiting period and the own occupation period, you are required to be disabled only from your own occupation.

You are disabled from your own occupation if, as a result of the physical disease, injury, pregnancy, or mental disorder:

- 1) you are unable to perform with reasonable continuity the material duties of your own occupation; and
- 2) you suffer a loss of at least 20% in your indexed pre-disability earnings when working in your own occupation.

You are not disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. During the own occupation period, you may work in another occupation while you meet the own occupation definition of disability. However, you will no longer be disabled when your work earnings from another occupation meet or exceed 80% of your indexed pre-disability earnings. Your work earnings may be deductible income.

b. ANY OCCUPATION DEFINITION OF DISABILITY

During any occupation period, you are required to be disabled from all occupations. You are disabled from all occupations if, as a result of physical disease, injury, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation. Material duties mean the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience generally required by employers by those engaged in a particular occupation that cannot be reasonably modified or omitted.

c. DEFINITION OF INDEXED

Indexed means adjusted by the rate of increase in the Consumer Price Index for Urban Workers (CPI-W).

5. FILING A CLAIM

Employees enrolled in the long-term disability benefit who become disabled may file a claim by calling the current LTD insurance company or the Health Care and Benefits Division.

6. WAIVER OF PREMIUM

Payment of long-term disability premiums are waived while long-term disability benefits are payable.

7. RETURN TO WORK PROVISIONS

During the own occupation period, no LTD benefits will be paid for any period when you are able to work in your own occupation and able to earn at least 20 % of your indexed pre-disability earnings, but you elect not to work.

During the any occupation period, no LTD benefits will be paid for any period when you are able to work in any occupation and able to earn at least 20% of your indexed pre-disability earnings, but you elect not to work.

8. EXCLUSIONS TO LONG-TERM DISABILITY COVERAGE

You are not covered for a disability caused or contributed to by any of the following:

- a. You are committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot;
- b. An intentionally self-inflicted injury, while sane or insane;
- c. War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature);

- d. The loss of your professional or occupational license or certification; or
- e. A preexisting condition or the medical or surgical treatment of a preexisting condition unless on the date you become disabled, you have been continuously insured under the group policy for the 12-month exclusion period and actively at work for at least one full day after the end of the exclusion period.

CHAPTER VI: FLEXIBLE SPENDING ACCOUNT BENEFITS

A. FLEXIBLE SPENDING ACCOUNT (FSA) BENEFITS

SEE CHAPTER I FOR INFORMATION ON ENROLLING IN FSAs (I.B.6), CONTINUING AN FSA WHEN YOU TERMINATE EMPLOYMENT, TAKING A LEAVE OF ABSENCE, AND REINSTATEMENT OPTIONS FOLLOWING A LEAVE OR TERMINATION. SEE II.D.4 FOR INFORMATION ON SUBMITTING CLAIMS.

1. MEDICAL FSA

a. ELIGIBLE EXPENSES

Out-of-pocket medical expenses eligible for reimbursement from a Medical FSA include most health care expenses not covered by health insurance or not paid by insurance because of exclusions, limitations, deductibles, and coinsurance requirements. Eligible expenses include out-of-pocket expenses for the following:

- Acupuncture
- Alcoholism treatment
- Ambulance service
- Artificial limbs
- Birth control pills
- Braille books and magazines
- Car controls for individuals with mobility disabilities
- Chiropractic care
- Crutches
- Dental fees
- Dental implants
- Diagnostic tests
- Doctors' fees
- Duplicate prosthetic devices
- Chemical dependency disorders
- Drugs requiring a prescription
- Experimental medical treatment
- Guide dogs
- Hearing treatment
- Hospital services
- Inpatient therapy for mental or nervous disorders
- Injections
- In-vitro fertilization
- Lab fees
- Laser eye surgery
- Learning disability tuition
- Nursing services
- Optometrist fees care
- Orthodontic treatment that is not primarily cosmetic in nature
- Orthopedic shoes
- Oxygen
- Periodontal services
- Psychoanalysis
- Qualifying over-the-counter medicines & drugs that are purchased pursuant to a prescription
- Special schools for people with disabilities
- Surgery
- Telephone for the deaf
- Transplants of organs

Transportation for medical

Vaccinations

Vision exams, including eye glasses and contact lens fees

The list is not complete. More details are available from your current FSA program administrator's web site (see the current annual change booklet) or IRS Publication 502. However, expenses qualify for the medical FSA based on when the expense was incurred, not when paid.

b. Ineligible Expenses

Expenses not payable by a Medical Flexible Spending Account include:

- 1) any expenses not incurred during the eligible timeframe of your FSA. For claims submission information, go to the Plan Administrator's website or your current annual change booklet;
- 2) expenses reimbursed by any other source, such as your or your spouse's medical or dental plan or another Flexible Spending Account. (If you receive a duplicate payment, you must declare the second reimbursement as taxable income on your tax return.); and
- 3) expenses for services or supplies that are cosmetic or not typically medical in nature.

Examples of Ineligible Medical Expenses

Insurance premiums, long term care expenses, warranties, service agreements, cosmetic procedures or products, health club dues, non-qualifying drugs, vitamins, herbs, and nutritional supplements.

c. IRS Rules for Eligible Expenses

The IRS has four basic rules for reimbursement of eligible expenses through a Flexible Spending Account:

- 1) an individual may only be reimbursed for expenses incurred while a member in the plan;
- 2) an expense is incurred when the service is performed, not when it is billed or paid. (If you plan to pay for a service that spans two benefit years through an FSA — such as orthodontia — contact your FSA program administrator in advance of setting up your FSA for best results.);
- 3) the member must submit documentation showing when the expense or service was provided. It is very important that the doctor's statement has the type of service provided and the actual dates the service occurred. Payment receipts or bills with "balance forward" amounts will not work; and
- 4) the expense must be reimbursed from FSA funds for the timeframe as defined in the current annual change booklet in which the expense was incurred. Expenses or unused funds cannot be carried over to a different benefit year.

IRS regulations require Medical FSAs to reimburse a claim up to the elected annual amount minus any reimbursements already received, regardless of the account balance at the time the claim is submitted.

2. DEPENDENT CARE FSA

Most expenses for the custodial care of your children or other eligible dependents while you and your spouse work, look for work, or go to school full time are eligible for reimbursement from a Dependent Care FSA.

For Flexible Spending Account purposes the IRS defines eligible dependents as either:

- a. Children under age 13 who are claimed by you as dependents on your tax returns, or
- b. Dependents (like an elderly parent) who are physically or mentally incapable of caring for themselves, live with you, and are being claimed by you as dependents on your tax return.

Services of licensed day care centers, preschools, caretakers inside your home, and day camps are eligible for Dependent Care FSA reimbursement, provided the expenses are incurred during the benefit year of your Dependent Care FSA.

In order for day care expenses to be eligible, you must report the name, address, and taxpayer identification number of your day care provider on your federal income tax return.

Please note that care provided by an individual you claim as a dependent on your tax return (an older brother or sister), child support payments, and overnight camps are not eligible for reimbursement from a Dependent Care FSA. For more information on reimbursable expenses visit your FSA program administrator's web site (listed in the current annual change booklet), or see IRS Publication 503.

Dependent Care FSAs can only reimburse up to the current account balance at the time a reimbursement claim is submitted. Services must be rendered before reimbursement can be paid.

CHAPTER VII: REIMBURSEMENT, COORDINATION OF MEDICAL/DENTAL BENEFITS WITH OTHER PARTIES RESPONSIBLE FOR PAYMENT AND SUBROGATION

A. COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a program adopted by most group benefits plans in the United States to eliminate problems that result from duplicate group health care coverage and other party liability. COB limits the benefits that may be received by a plan member covered by more than one health plan to no more than the total health care expenses allowed and divides responsibility for those expenses between the plans. The State Plan's right to reimbursement, through COB or any other means, is separate from and in addition to its right of Subrogation (See VII.B). If the State Plan pays benefits for medical expenses on a member's behalf, and another party was responsible or liable for payment of those medical expenses and pays those medical expenses, the State Plan has a right to be reimbursed by the member for the amounts the State Employee Benefit Plan paid.

The member shall cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any benefits paid by the State Plan from any liable third party. This cooperation includes but is not limited to, making full and complete disclosure in a timely manner of all material facts regarding the accident, injury, condition, or illness to the Plan Administrator; reporting all efforts by any person to recover any such monies; providing the Plan Administrator with any and all requested documents, reports and other information in a timely manner regarding any demand, litigation or settlement involving the recovery of benefits paid by the State Plan; and notifying the Plan Administrator of the amount and source of funds received from third parties as compensation or damages for any event from which the State Plan may have a reimbursement claim.

Coverage under the State Plan plus another plan will not guarantee 100% total reimbursement.

1. COORDINATION OF BENEFITS (COB) RULES

- a. If a member is covered by another group plan(s), the benefits will be coordinated. One plan will be determined as the primary plan and will pay benefits first. The other plan(s) will be secondary.
- b. The secondary plan(s) will limit benefits so that the sum of all benefits paid by the primary plan and by the secondary plan(s) does not exceed 100 % of the total allowed amount.
- c. The plan that pays benefits first (primary plan) is determined by using uniform order-of-benefit determination rules, as follows:
 - 1) When another group plan does not have a COB provision, that plan will be the primary plan.
 - 2) When another group plan has a COB provision, the following will determine the primary plan:
 - i. **Employee/Dependent** – The plan covering the claimant as an employee pays benefits first. The plan covering the Claimant as a Dependent pays benefits second.
 - ii. **Dependent Children of Parents Not Separated or Divorced/Dual Coverage of Dependent Children** – The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered the parent longer pays first. The plan that covered the other parent for the shorter time pays second.
 - iii. **Dependent Children of Separated or Divorced Parents/Dual Coverage of Dependent Children** – When parents are separated or divorced, the birthday rules do not apply. Instead:
 - a) The plan of the parent with custody pays first;
 - b) The plan of the spouse of the parent (step-parent) pays next; and
 - c) The plan of the parent without custody pays last.
 - iv. However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the plan obligated to pay by the divorce decree has actual knowledge of the court decree, the plan covering the parent with such financial responsibility will pay first. Any other plan covering the Dependent Child shall pay second. Parents with a court decree making them

financially responsible for the health care expenses of a child should notify the Plan Administrator of this fact so coordination of benefits can be administered properly.

- 3) If none of the above rules applies, the plan which has covered the claimant for a longer period of time will pay benefits first, except when:
 - i. one plan covers the claimant as a laid-off or retired employee (or dependent of such an employee), and
 - ii. the other plan has a COB rule for laid-off or retired employees, then the plan that covers the claimant as other than a laid-off or retired employee (or dependent of such employee) will pay first.
- d. The primary plan then pays benefits as it would in the absence of duplicate coverage.
- e. The secondary plan(s) will limit benefits so that the sum of all benefits paid by the primary plan and by the secondary plan(s) does not exceed 100% of the total allowed amount.
- f. The other parties who may be responsible for payment under COB include, but are not limited to
 - 1) group insurance or any other arrangement for coverage for covered persons in a group whether on an insured or uninsured basis, including but not limited to:
 - i. hospital indemnity benefits, and
 - ii. hospital reimbursement-type plans that permit the plan member to elect indemnity at the time of claims;
 - 2) hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
 - 3) hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
 - 4) a licensed Health Maintenance Organization (HMO);
 - 5) any coverage for students sponsored by, or provided through a school or other educational institution;
 - 6) any coverage under a governmental program, and any coverage required or provided by any statute;
 - 7) individual automobile insurance coverage on an automobile leased or owned by the State;
 - 8) individual automobile insurance coverage based upon the principles of "No-Fault" coverage; or
 - 9) an individual tortfeasor or entity responsible for injury to a member.
- g. The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement that reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.
- h. When one part of a plan coordinates benefits and another part does not, each part will be treated as a separate plan.
- i. If COB reduces benefits under more than one provision of the State Plan, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefits limit in plan provisions.
- j. A member must provide the Plan Administrator with any information that is needed to coordinate benefits as a condition to receiving benefits from the State Plan.
- k. The Plan Administrator may release or receive any information about a member that is necessary to administer and operate COB.
- l. If benefits are paid by another plan and such benefits were the liability of the State Plan, the State Plan may reimburse the other plan. Amounts reimbursed are State Plan benefits and may be used to satisfy State Plan liability. However, when more than one plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.
- m. If the State Plan is the secondary plan, the benefits that would be payable under the State Plan in the absence of coordination will be reduced by the benefits payable under all other plans for the expense covered under the State Plan.
- n. If the State Plan pays charges for services and supplies that should have been paid by the primary plan, the State Plan will have the right to recover such payments. The State Plan will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, healthcare plan, or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

- o. The State Plan, without consent or notice to you, may obtain information from and release information to any other plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information (including an Explanation of Benefits paid under the primary plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

2. COORDINATION WITH MEDICARE

Medicare will be considered a plan for the purposes of COB. This State Plan will coordinate benefits with Medicare whether or not the member is actually receiving Medicare benefits. Typically, members may not have Medicare Part D unless they are receiving Medicare Part D through Medicaid.

For all purposes, this State Plan will be primary to Medicare Part D.

- a. **WORKING AGED:** An employee covered on the State Plan who is eligible for or enrolled in Medicare Part A or Part B as a result of age may be covered under this State Plan and be covered under Medicare. In this case, the State Plan will pay primary. An employee covered on the State Plan who is eligible for or enrolled in Medicare Part A or Part B as a result of age may elect to discontinue coverage and not to be covered under this State Plan. If such an election is made, coverage under this State Plan will terminate and *cannot* be reinstated.
A covered dependent spouse (of an employee covered on the State Plan) eligible for or enrolled in Medicare Part A or Part B as a result of age, may also be covered under the State Plan and be covered under Medicare. In this case, the State Plan again will pay primary. A covered dependent spouse, eligible for Medicare Part A or Part B as a result of age, may elect to discontinue coverage and no longer be covered under this State Plan. If such election is made, coverage under this State Plan will terminate and *cannot* be reinstated.
- b. **FOR RETIRED PERSONS:** Medicare is primary and the State Plan will be secondary for the covered Retiree if he/she is an individual who is eligible for Medicare Part A or Part B as a result of age and retired.
Medicare is primary and the State Plan will be secondary for the covered Retiree's Dependent spouse who is eligible for Medicare Part A or B if both the covered Retiree and his/her covered Dependent spouse are enrolled in Medicare Part A or Part B as a result of age and retired.
Medicare is primary for the Retiree's Dependent spouse when the Retiree is not eligible and/or enrolled for Medicare Part A or Part B as a result of age and the Retiree's Dependent spouse is eligible for Medicare Part A or Part B as a result of age.
- c. **FOR COVERED PERSONS WHO ARE DISABLED:** The State Plan is primary and Medicare will be secondary for a covered active employee or any covered dependent who is eligible for Medicare by reason of disability and for whom Medicare requires the employer plan to pay primary.
The State Plan is secondary and Medicare will be primary for the covered employee or any covered dependent who is eligible for Medicare by reason of disability if the employee is retired or otherwise not actively working for the employer.
- d. **END-STAGE RENAL DISEASE:** The State Plan will be primary only during the first 30 months of Medicare coverage for Employees, Retirees, and their Dependents, for whom Medicare requires the employer plan to pay primary, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD). Thereafter, the State Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above:
 - 1) The member has no dialysis for a period of twelve (12) consecutive months and then resumes dialysis, at which time the State Plan will again become primary for a period of thirty (30) months; or
 - 2) The member undergoes a kidney transplant, at which time the State Plan will again become primary for a period of thirty (30) months.If a member is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the member becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary and the State Plan will be secondary.

3. COORDINATION WITH MEDICAID

If a member is entitled to and covered by Medicaid, the State Plan will always be primary and Medicaid will always be secondary coverage.

4. COORDINATION WITH TRICARE/CHAMPVA

If a member is entitled to and covered under TRICARE/CHAMPVA, the State Plan will always be primary and TRICARE/CHAMPVA will always be secondary coverage. TRICARE coverage will include programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

5. COORDINATION WITH VA

If the member is eligible for Medicare and entitled to veterans' benefits through the Department of Veterans Affairs (VA), the State Plan will always be primary and the VA will always be secondary for non-service connected medical claims. For these claims, the State Plan will make payment to the VA as though the State Plan was making payment secondary.

6. COORDINATION WITH MEDI-GAP POLICIES

If the member is eligible for Medicare Parts A and B and also has a Medi-gap Supplemental policy, this State Plan will always be secondary coverage to that policy.

B. SUBROGATION

1. SUBROGATION/RIGHT OF REIMBURSEMENT

If a member incurs a covered expense for which, in the opinion of the State Plan or its Plan Administrator, another party may be responsible or for which the member may receive payment as described above:

a. SUBROGATION

The State Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a member may have against such party and shall automatically have a lien upon the proceeds of any recovery by a member from such party to the extent of any benefits paid under the State Plan. A member or his/her representative shall execute such documents as may be required to secure the State Plan's subrogation rights.

b. RIGHT OF REIMBURSEMENT

The State Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted herein, but only to the extent of the benefits provided by the State Plan.

c. LIEN OF THE STATE PLAN

By accepting benefits under the State Plan, a member:

- 1) grants a lien and assigns to the State Plan an amount equal to the benefits paid under the State Plan against any recovery made by or on behalf of the member which is binding on any attorney or other party who represents the member whether or not an agent of the member or of any benefits company or other financially responsible party against whom a member may have a claim provided the attorney, benefits carrier, or other party has been notified by the State Plan or its agents;
- 2) agrees that this lien shall constitute a charge against the proceeds of any recovery and the State Plan shall be entitled to assert a security interest thereon;
- 3) agrees to hold the proceeds of any recovery in trust for the benefit of the State Plan to the extent of any payment made by the State Plan.

d. ADDITIONAL TERMS

- 1) No adult member hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor dependent of the adult member without the prior express written consent of the State Plan. The State Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- 2) No member shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the State Plan.
- 3) The State Plan's right of recovery shall be a prior lien against any proceeds recovered by the member.

- 4) The State Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any member, whether under comparative negligence or otherwise.
- 5) If a member shall fail or refuse to honor its obligations hereunder, then the State Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The State Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the member has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- 6) By acceptance of benefits under the State Plan, the member agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the State Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the State Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

CHAPTER VIII: GENERAL PROVISIONS

A. RIGHTS & OBLIGATIONS OF THE STATE PLAN, CONTRACTORS, & MEMBERS

1. PLAN AMENDMENTS

In order to provide the maximum possible benefits within the limits of designated resources and maintain a fiscally sound State Plan as required by Montana law, Health Care and Benefits Division (HCBD), in consultation with the State Employee Group Benefits Advisory Council, expressly reserves the right, at any time, and in its sole discretion to:

- a. Terminate any medical or dental benefit or amend either the amount or conditions of any medical or dental benefit;
- b. Alter the method of payment of any medical or dental benefit;
- c. Amend or rescind any other provisions of this Summary Plan Description within limits of any applicable statutes or contractual provisions in effect; and
- d. Change the required benefits contribution.

2. COMPLIANCE WITH LAW AND REGULATIONS

Any provision of this Summary Plan Description, or amendment thereto, that conflicts with applicable Montana or United States laws is hereby amended to conform with the minimum requirements of those laws.

3. ACCESS TO INFORMATION BY COMPANIES AND STATE ADMINISTRATIVE STAFF WHO

ADMINISTER OR PROVIDE STATE HEALTH BENEFITS OR SERVICES DESCRIBED IN THIS DOCUMENT

Plan Administrators and other contractors involved in providing or administering health benefits for the State Plan shall have access to medical, hospital, and dental records relating to the diagnosis, treatment, or services provided to the member or to other information needed to administer provisions of this Summary Plan Description. Providing such access is a condition of receipt of medical and dental benefits under the State Plan and benefits may be denied if access to required information is denied. Such information will be protected as specified in Chapter IX.

Insurance companies who provide State-sponsored insurance benefits (such as vision, long term care, life, long term disability and accidental death and dismemberment insurance, etc.) shall have access to information required to verify a loss or administer provisions of the insurance policy. Providing such access is a condition of receipt of benefits.

State administrative staff members directly involved in:

- a. Conducting claim reviews requested by State Plan members;
- b. Reviewing requests by members, or the Plan Administrator, for extended care management services;
- c. Reviewing requests for alternate benefits; and
- d. Reviewing eligibility for State Plan membership

shall have access to the information needed to conduct these activities and shall keep it strictly confidential as specified in Chapter IX.

4. RIGHT TO CONDUCT A MEDICAL EXAMINATION OR AUTOPSY

The State Plan, at its expense, shall have the right and opportunity to require an examination by an independent medical professional of any member. The plan also has the right to order an autopsy, where it is not forbidden by law.

5. RIGHT TO MAKE PAYMENTS

The Plan Administrator that administers the State Plan may, at the State's discretion, make payment to the member, the provider, the member and the provider jointly, or any individual or entity who paid for the services on the member's behalf.

Whenever payments that should have been made under a State-sponsored medical or dental plan have been made by any other plan or governmental program, the Plan Administrator may, exercisable alone and in its sole discretion, reimburse the organization making such other payments in any amounts that are determined to be warranted in order to satisfy the provisions of this Summary Plan Description. These amounts are benefits paid under the State Plan, and, to the extent of such payments, the Plan Administrator and State of Montana are fully discharged from liability under this State Plan.

6. RIGHT TO RECOVER PAYMENTS

Whenever payments have been made in excess of the amount of payment necessary to satisfy the provisions of this Summary Plan Description, the Plan Administrator that administer the dental and medical plan may recover the excess payment from any one or more of the following:

- a. Any person such payments were made to, for, or on behalf of;
- b. Any insurance company; and
- c. Any other individuals or entities.

7. NO OBLIGATION TO PROVIDE BENEFITS IF MEDICAL AND DENTAL CARE NOT AVAILABLE

Neither the State, the State Plan, nor any insurance plan contracting with the State Plan is obligated to provide benefits if hospital facilities are not available, or if care is not available because of epidemic, public disaster, or other causes beyond its control.

8. STATE NOT LIABLE FOR ACTS OF MEDICAL/DENTAL CARE PROVIDERS

The State is not liable for any act of commission or omission by any hospital, medical, or dental care provider.

9. COVERAGE EXTENDS TO SERVICES OUTSIDE THE UNITED STATES

Expenses for services provided outside the United States are covered in the same manner as expenses for services provided within the United States.

10. CLERICAL AND PLAN REPRESENTATION ERRORS

Clerical errors or misrepresentations shall not prevent administration of the State Plan in strict accordance with its terms. Authority to interpret the provisions of this plan is vested solely in the Department of Administration, HCBD, acting through its duly authorized employees, except as specifically delegated to companies providing contractual services, acting through their respective staff members dedicated to service of the State Plan.

11. ALTERNATE BENEFIT

The State Plan may, at its sole discretion, make payment for medical or dental services that are not listed as covered services or benefits of this Summary Plan Description in order to provide quality care at a lesser cost. Such payments shall be made only upon mutual agreement by the member and the State Plan.

12. MEMBERS MAY BE REMOVED FROM STATE EMPLOYEE PLANS FOR FALSE CLAIMS

Any State Plan member or provider who submits bad faith or false claims, misrepresents facts, or attempts to perpetuate a fraud upon the State Plan may be subject to criminal charges or a civil action brought by the Plan Administrator or HCBD as permitted under state and federal laws. Additionally, if a member has been found to have committed such acts after an informal, non-MAPA hearing with the Plan Administrator or HCBD, the member shall immediately become ineligible to remain on the plan.

13. MEMBERS MAY BE REMOVED FROM STATE PLAN FOR A PATTERN OF FRIVOLOUS CLAIM APPEALS

A State Plan member who evidences a pattern of appealing baseless, frivolous claims that were initially denied may be dropped from the plan. The Plan Administrator or HCBD shall issue a 15-day notice to the plan member to cease and desist and abide by the plan terms or be dropped. If the member continues to insist on appealing matters that are deemed frivolous, the Plan Administrator or HCBD may issue a 30-day notice dropping the member from the plan.

CHAPTER IX: DEFINITIONS & NOTICES

ABORTION

Elective – The interruption of a pregnancy before the 20th week of gestation at the woman’s request for other than maternal health or fetal disease.

Therapeutic – The interruption of a pregnancy before the 20th week of gestation because the pregnancy endangers the mother’s life or health or because the baby presumably has health defects.

ACCELERATED BENEFIT (APPLIES TO LIFE INSURANCE ONLY)

A partial life insurance benefit that a member may receive during the member’s lifetime if the member qualifies for a waiver of life insurance premium (described in I.E.4 of this document) and meets the eligibility requirements of terminal illness or confinement to a nursing home (described in V.B.5).

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D) AND AD&D INSURANCE COMPANY

Insurance that pays a specified percentage of the amount of AD&D coverage for which you enrolled, in the event of accidental loss of your (or a covered dependent’s) life, one or more specified body parts, or eye sight. Accidental death and dismemberment insurance company refers to the company on contract with the Health Care and Benefits Division (HCBD) to offer AD&D insurance plan options to State Plan members. See V.C and the current annual change booklet for information on the program and the current AD&D insurance company.

ALLOWABLE CHARGE(S)

Charges that are both:

- a. For services covered by the State Plan, in which you are enrolled, and
- b. Within an applicable negotiated fee contained in a State Plan contract with the provider, or in the absence of such a contract, within the allowable fee established by the Plan Administrator.

ALLOWABLE FEE

- a. For the Classic plan

The dollar allowance for each procedure set by the Plan Administrator based on the following:

- 1) Any applicable contractual fee agreement between the Plan Administrator and provider.
- 2) The Resource Based Relative Value System (RBRVS) developed by the Harvard School of Public Health Study for the Centers for Medicare and Medicaid Services used to assign values to procedure codes based on resources related to the procedure (such as the time required by the provider, intensity of work effort, practice costs, and malpractice insurance costs). This value is multiplied by a conversion factor to arrive at a dollar allowance. The conversion factor is based on the level of practice (physician, mid-level nurse practitioner, etc.), current charges by Montana providers, Medicare’s conversion factor, the consumer price index, and the cost impact.
- 3) In the absence of the above, a percentile of actual charges by like providers in the geographical area.

The allowance for out-of-network covered providers in Montana is set 10% below the allowance for in-network covered providers defined in this chapter.

- b. For the Choice plan

The allowance for each procedure set by the Plan Administrator based on:

- 1) any applicable contractual fee agreement between the Plan Administrator and the provider, and
- 2) the Plan Administrator’s selected methodology for assigning allowances to procedure codes.

- c. For the State Plan’s prescription drug and vision exam insurance plans

The fee allowance for each prescription drug (set by the prescription drug benefits administration company) and vision exam service (set by the vision insurance company) based on:

- 1) contractual agreement with HCBD, and
- 2) any applicable fee agreements with manufacturers and retailers.

- d. For the dental plan

The allowance for each procedure set by the dental Plan Administrator

ANNUAL CHANGE BOOKLET

A benefit period description of deductibles, coinsurance, copayments, maximum out-of-pockets, maximum lifetime benefits and other benefit specific limitations and conditions that apply to benefits received under the various plans

during the benefit year. The current annual change booklet must be read in conjunction with the Summary Plan Description for a complete description of current benefits. A current annual change booklet is distributed each annual change period for the coming benefit year and may be obtained from the HCBD.

ANNUAL CHANGE PERIOD

A period of time designated by the HCBD (usually in the Fall), in which State Plan members may change their medical plan and make allowed changes in optional benefits (flexible spending, vision, life insurance) for the coming benefit year.

ASSISTED LIVING FACILITY (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

A 24-hour residential facility that provides assistance to the elderly and/or people with disabilities. An assisted living facility may also be referred to as a residential care facility or as an adult foster care facility.

BENEFIT PLAN

Employer-sponsored health care coverage.

BENEFIT YEAR/PLAN YEAR

The period commencing January 1 and ending December 31 of each year.

BIOLOGICAL INFERTILITY

The biological inability of a person to contribute to conception after attempting for 12 months

CARE MANAGEMENT

There are two components to Care Management. Case Management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet the member's health needs through communication and available resources to promote high quality, cost effective outcomes. Disease Management is a system of coordinated health care interventions and communications for members with conditions in which self-care efforts are significant in decreasing complications from chronic illnesses and promoting overall health improvement for the member.

CARE OPTIONS PLAN (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

Any one of three care option packages that you (or a family member) must elect when enrolling in long-term care insurance, described in chapter V. The care option plan determines the type of long-term care (nursing home care, assisted living facility care, professional home care, or total home care) that is eligible for benefits if you (or a family member) are disabled and qualify for benefits.

CERTIFICATION (OF MEDICAL NECESSITY) AND 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.

CHEMICAL DEPENDENCY

Substance abuse and addiction, including alcoholism and drug addiction, involving such substances as ethyl alcohol, tranquilizers, narcotics, narcotic synthetics, sedatives/hypnotics, amphetamines, cocaine, hallucinogens, products containing tetra-hydro-cannabinol, and volatile inhalants.

CHEMICAL DEPENDENCY TREATMENT FACILITY

A facility that provides a program for the treatment of chemical dependency consistent with a written treatment plan approved and monitored by a physician or addiction counselor certified by the state. The facility must also be approved as a chemical dependency treatment facility by the Montana Department of Public Health and Human Services.

CLAIMS ADMINISTRATION AND CLAIMS ADMINISTRATION COMPANY

The function and management of determining and making appropriate payment of claims under the terms of an insurance benefit plan. Claims administration company refers to the company under contract with the HCBD to provide claims administration services for its medical plans, dental, and prescription drug plans. See the current annual change booklet for information on the current claims administration companies.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 and subsequent amendments (Public Law 99-272, Title X), which entitles a member of a group medical plan who loses eligibility for group benefits to extend coverage for a specified period of time by self-paying premiums. The term COBRA is used to refer both to the law and to the coverage extension program required by the law (see I.E.1).

COINSURANCE

Coinsurance is a means of cost sharing. The State Plan pays a percentage of allowed charges (after any applicable deductible has been met) and the member pays a percentage - the coinsurance. See the current annual change booklet for your current coinsurance for various services.

CONTINGENT STEP THERAPY

Trial of a lower-cost prescription drug option for treatment of an illness or injury before moving to a high-cost designer drug.

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

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 State Plan pays remaining allowable charges. See the current annual change booklet for any current copayment obligations.

CORE BENEFITS

The minimum benefits package an active employee or non-Medicare retiree enrolled in the State Plan may carry. Core benefits are:

- a. Medical insurance (you choose one of the available medical plans) including prescription drug coverage;
- b. Dental insurance; and
- c. Basic (Plan A) life insurance.

COVERED DENTAL SERVICE

A service, procedure, or supply that is:

- a. Listed in Chapter IV of this Summary Plan Document and not excluded in IV.A.7;
- b. Provided to a member by a covered provider; and
- c. Provided and coded in accordance with applicable dental policy.

COVERED MEDICAL & DENTAL EXPENSE

An expense within allowable charges and any specified benefit limitations for a covered medical service (or a covered dental service) defined above.

COVERED MEDICAL SERVICE

A service, procedure, or supply that meets the following criteria:

- a. Listed as a benefit in Section L and not excluded in Section L of this document; b. Determined to be medically necessary for the diagnosis or treatment of injury, illness, or maternity care (unless a preventive benefit clearly listed in this document; expenses associated with inpatient hospital days only meet medical necessity criteria for an indemnity medical plan if they are certified as described in III.B.2);
- c. Provided to a member by a covered provider; and
- d. Provided and coded in accordance with applicable medical policy, as defined in Chapter III.

COVERED PROVIDER

A provider of medical and/or dental services, who has both:

- a. Satisfied the necessary requirements to practice within the State of Montana or in another state or country where services are received, and
- b. Been recognized by the company which administers claims as a provider of the kind of services received, based on the nature of the services and extent of the providers licensure.

A provider may, because of the limited scope of practice, be a covered provider only for certain services.

CREDITABLE COVERAGE

Previous comprehensive medical coverage of a new State Plan enrollee under any of the following plans and programs, provided there is no 60-day or greater lapse in coverage:

- a. Group health plan;
- b. Individual health plan;
- c. Medicare;
- d. Medicaid;
- e. Indian Health Services coverage;

- f. State health risk pool;
- g. Public health plan; or
- h. Other coverage as specified by the Health Reform Act of 1996.

There must not be a lapse of 60 days or more between the previous coverage and enrollment in the State Plan. If there was an earlier 60-day or greater lapse in the prior coverage, only prior coverage since the lapse is creditable coverage.

CUSTODIAL CARE

The provision of room and board, with or without routine nursing care, training, personal hygiene, and other forms of self-care or supervisory care for a person who is mentally or physically disabled as a result of retarded development or body infirmity, and who is not under special medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable such person to live outside an institution. Custodial care includes services or treatment that could be rendered safely by a person without medical skills and is mainly to help the patient with daily living activities.

DEDUCTIBLE

Allowed charges a member and family must pay before a medical plan makes payment.

DENTAL PLAN

A plan of dental benefits offered by the State Plan to its members that primarily pays an allowed fee (less any member deductible and coinsurance obligation) for covered dental services defined in Chapter IV.

DEPENDENT (OR ELIGIBLE DEPENDENT)

An individual who has a relationship to a State Plan member, as described in I.A.2 of this document, which makes the individual eligible to be enrolled in the State Plan when the individual meets other enrollment requirements described in Chapter I.

DURABLE MEDICAL EQUIPMENT

The most cost effective appropriate equipment for medically necessary therapy of a medical condition in your home.

- a. Covered durable medical equipment must meet the following criteria:
 - 1) able to withstand repeated use – consumable goods are not covered;
 - 2) generally not useful to a person who is not ill or injured;
 - 3) primarily used to serve a medical purpose rather than comfort and convenience; and
 - 4) prescribed by a physician.
- b. The following are examples of items that are not covered as durable medical equipment:
 - 1) exercise equipment;
 - 2) car lifts or stair lifts;
 - 3) biofeedback equipment;
 - 4) self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition;
 - 5) air conditioners and purifiers;
 - 6) whirlpool baths, hot tubs, or saunas;
 - 7) water beds;
 - 8) computerized and deluxe equipment like motor-driven wheelchairs or beds when standard equipment is adequate; and
 - 9) other equipment not always used for healing or curing.

DURATION OF CARE (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

Any one of three periods of time you (a family member) must elect when enrolling in long-term care insurance, described in V.A.1. The duration of care determines the maximum duration of benefits if you (or a family member) become disabled, qualify for benefits, and receive care by a nursing home. The duration is extended if care is provided by a covered provider other than a nursing home, as described in V.A.1, provision c.

EFFECTIVE DATE

The date on which a new enrollee's coverage begins.

EMERGENCY MEDICAL CONDITION

A condition manifesting itself with symptoms of sufficient severity, including severe pain, and which the absence of immediate medical attention could reasonably be expected to result in any of the following:

- a. The member's health would be in serious jeopardy;
- b. The member's bodily functions would be seriously impaired; or

c. A bodily organ or part would be seriously damaged.

EMPLOYEE OR ELIGIBLE EMPLOYEE

An individual who is employed by the State of Montana and who is eligible to be enrolled in the State Employee Benefit Plan as defined in Chapter I of this document.

ENROLL/ENROLLED

An eligible individual's act of completing necessary requirements and procedures to obtain coverage or membership under a plan or program; a plan's or program's act of extending coverage or membership; and the past extension of coverage or membership which is still in effect in any plan or program to which the term is applied.

EVIDENCE OF INSURABILITY

An application to an insurance plan for coverage involving submission of medical information and documentation required by the plan to determine if the applicant meets plan requirements for enrollment.

EXPERIMENTAL PROCEDURES OR SERVICES

Experimental, investigational, and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse, or other health care technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by the Plan Administrator's utilization review physician to be one or more of the following:

- a. Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- b. Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- c. The subject of review or approval by an Institutional Review Board for the proposed use; or
- d. The subject of an ongoing phase I, II or III clinical trial.

FIRST-DOLLAR COVERAGE

If coverage does not require a deductible, it is said to offer first-dollar coverage; that is, it pays benefits beginning at the first dollar of expense.

FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM

A program under which enrolled employees pay for eligible expenses on a pre-tax basis and save tax dollars. It is offered in accordance with U.S. Internal Revenue Code (IRC) Section 125 and applicable regulations. A Medical FSA allows you to pay for your own or a family member's eligible medical expenses that are not covered by insurance (including expenses that you must pay to meet deductible, coinsurance, or copayment requirements), on a pre-tax basis. A Dependent Care FSA allows you to pay for eligible day care expenses for dependents on a pre-tax basis. See I.B.6 and Chapter VI for details of this program.

FLEXIBLE SPENDING ACCOUNT PROGRAM ADMINISTRATOR

The company under contract with HCBd to administer the Flexible Spending Account Program. See the current annual change booklet for information on the current Flexible Spending Account program administrator.

FOCUSED CASE AND DISEASE MANAGEMENT

Care management services to members identified as having significant medical risks, chronic health care needs, or a catastrophic accident or illness which can benefit from focused services of a care management nurse. This nurse works with the member, attending physician, and family to identify and arrange the most appropriate, effective, and cost-efficient treatment or disease management program possible and make the best use of available insurance benefits.

FORMULARY

A listing of brand name prescriptions that are preferred prescriptions in their therapeutic Tier because of their effectiveness and favorable cost. Copayments and/or coinsurance amounts members pay for formulary prescriptions are lower than for non-formulary brand name prescriptions.

HEALTH CARE & BENEFITS DIVISION (HCBd)

The division within the Department of Administration that administers the State Employee Benefit Plan. The HCBd can be reached at (406) 444-7462; (800) 287-8266; TTY (406) 444-1421; or you may find information you need at its website benefits.mt.gov.

HEALTH MAINTENANCE ORGANIZATION (HMO)

Composed of professional medical providers that agree to a set payment amount from a health plan while directing care for patients in a set geographical area. The HMO provider agrees to a reduced payment amount in order to participate in the health plan and in addition receives a set compensation payment per patient.

HOME HEALTH AGENCY

An agency licensed by the state which provides part-time skilled nursing services and other covered therapeutic services including physical, speech, and occupational therapy, medical social services, and home health aide services.

HOME INFUSION THERAPY

The preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a member by a home infusion therapy agency. Services include education for the member, the member's care giver, or a family member.

HOME INFUSION THERAPY AGENCY

A health care facility that provides home infusion therapy services. A licensed hospital that provides home infusion therapy services must have a home infusion therapy agency license or endorsement.

HOME HEALTH CARE PLAN

A written treatment plan established by a physician who certifies that the home health care plan is medically necessary.

HOSPICE

A facility, agency, or service that meets the following criteria:

- a. Arranges, coordinates, and/or provides care for the terminally ill patient;
- b. Is licensed, accredited, or approved by the state to establish and manage hospice care programs;
- c. Maintains records of hospice care services provided and bills for such services; and
- d. Is a home health agency, which provides hospice care.

HOSPITAL

- a. An acute-care facility licensed by the state where it is located and which meets the following criteria:
 - 1) primarily provides facilities for diagnosis and therapy for medical/surgical treatment under the supervision of a staff of physicians, and
 - 2) provides 24-hour daily nursing services under the supervision of registered graduate nurses.
- b. The term does not include the following, even if such facilities are associated with a hospital:
 - 1) a nursing or convalescent home;
 - 2) a rest home;
 - 3) hospice;
 - 4) a rehabilitation facility;
 - 5) a skilled nursing facility;
 - 6) a place solely for care and treatment of chemical dependency;
 - 7) a place solely for the treatment of mental illness; or
 - 8) a long-term chronic-care institution or facility providing the type of care listed above.
- c. The term hospital for purposes of certification includes any facility that provides inpatient medical, psychiatric, or chemical dependency services, not just facilities that meet the above definition.

IDENTIFICATION CARD (IDENTIFICATION NUMBER)

The card you receive from the company that provides claims administration for your selected state sponsored plans. An identification card provides such information as a unique member identification number, a group identification number, and other information required for claims administration. It may also include information on dependent coverage, plan requirements, and customer service.

ILLNESS

A bodily disorder, disease, physical sickness, mental illness or functional nervous disorder.

INCLUSIVE SERVICES/PROCEDURES

A portion of a service or procedure that is necessary for completion of the service or procedure, or which is considered to be part of another service or procedure.

INDEMNITY MEDICAL PLAN

A plan of medical benefits offered by the State Plan to its members that primarily pays an allowed fee (less any member deductible and coinsurance obligation) for medically necessary covered medical services of any covered provider

(including in- and out-of-network covered providers). The Classic Plan is an indemnity medical plan. In most cases the member has to pay the deductible and coinsurance *before* the indemnity plan begins paying.

INITIAL ENROLLMENT PERIOD

The first 31 days following the date an employee first becomes eligible to enroll in the State Employee Benefit Plan. For new employees, this is the 31 days following the first day of employment.

INJURY

Physical damage to the body not caused by disease or bodily infirmity.

IN-NETWORK LEVEL OF BENEFITS

The highest level of benefits provided by a benefit plan, as defined in the current annual change booklet.

IN-NETWORK (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).

LIFE INSURANCE AND LIFE INSURANCE COMPANY

Term life insurance that pays to designated beneficiaries the amount of insurance you enrolled (or you enrolled a dependent) for under the terms of the insurance policy if you (or your dependent) die and are still covered at the time of death. Life insurance company refers to the company on contract with HCBP to offer life insurance plans to State Plan members. Term life insurance pays only in the event of death, and has no redeemable cash value. See Section P of this document for details. A copy of the controlling policy or certificate of coverage is available upon request.

LONG-TERM CARE (LTC) INSURANCE AND LONG-TERM CARE INSURANCE COMPANY

Insurance that pays your (or an enrolled family member's) elected monthly benefit amount (or a defined portion of that amount for other than nursing home care), if you are (or a covered family member is) disabled under the terms of the policy, enrolled at the time of disability, and receive care from a provider that is covered under the elected plan of care. Long-term care insurance company refers to the company on contract with the HCBP to offer long-term care insurance plans to State Plan members and eligible family members. See Chapter V.A of this document and a long-term care insurance enrollment kit for details. A copy of the controlling policy or certificate of coverage is available upon request.

LONG-TERM DISABILITY (LTD) INSURANCE AND LONG-TERM DISABILITY INSURANCE COMPANY

Insurance that pays a monthly benefit amount to enrolled members who cannot work because of a covered illness or injury. Long-term disability insurance company refers to the company on contract with HCBP to offer a long-term disability plan to State Plan members and eligible family members. A copy of the controlling policy or certificate of coverage is available upon request.

MEDICAL NECESSITY (MEDICALLY NECESSARY)

A service or supply provided by a covered provider of your selected medical plan and determined by the company which provides claims administration services for the plan to meet the following criteria:

- a. Appropriate for the symptoms and diagnosis of the member's condition, illness, or injury.
- b. Provided for the diagnosis, or the direct care and treatment of the member's condition, illness, or injury.
- c. In accordance with standards of accepted medical practice.
- d. Not primarily for the convenience of the member or the provider.
- e. The most appropriate supply or level of service that can safely be provided to the member. When applied to inpatient care, this further means that the member requires acute care as a bed patient due to the nature of the services rendered or the member's condition, and the member cannot receive safe or adequate care on an outpatient basis.

The fact that services were recommended or performed by a covered provider does not automatically make the services medically necessary and a service may meet medical necessity criteria but not be a covered benefit of the plan. To determine if a planned procedure or service meets medical necessity criteria and is a covered benefit of the plan you may obtain a prior authorization described in II.A.5

MEDICAL POLICY (AND DENTAL POLICY)

The policy applied by the company that administers claims for a health plan (or dental plan) to determine if health (or dental) care services, including procedures, medication, equipment, processes, and technology meet nationally accepted criteria such the following:

- a. Final approval from the appropriate governmental regulatory agency or agencies.
- b. Conclusive scientific evidence of improved health outcome.
- c. Compliance with established standards of good medical (and dental) practice and established coding procedures for insurance reimbursement.

MEMBER

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

- a. 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;
- b. Is enrolled in the State Plan and any insurance plan offered by the State Plan to which the term is applied; and
- c. Is named as the member by the HCBD and by the insurance company as shown on its identification card.

MENTAL HEALTH TREATMENT FACILITY

A facility that provides treatment for mental illness through multiple modalities or techniques following a written treatment plan approved and monitored by an interdisciplinary team including a licensed physician, psychiatric social worker, and psychologist. The facility must also be:

- a. Licensed as a mental health treatment facility by the state;
- b. Funded or eligible for funding under federal or state law; and
- c. Affiliated with a hospital with an established system for patient referral.

MENTAL ILLNESS

- a. A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with any of the following:
 - 1) present distress or a painful symptom;
 - 2) a disability or impairment in one or more areas of functioning; or
 - 3) a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.
- b. Mental illness does not include:
 - 1) developmental disorders;
 - 2) speech disorders;
 - 3) psychoactive substance abuse disorders;
 - 4) eating disorders (except bulimia and anorexia nervosa); or
 - 5) impulse control disorders (except for intermittent explosive disorder and trichotillomania).

MID-LEVEL PRACTITIONER

A licensed APRN (Nurse Practitioner), PA (Physician Assistant), or CNMW (Certified Nurse Midwife) who practices in conjunction with a licensed M.D. or O.D. This practice must include 24-hour coverage for emergency admissions and health care.

MONTHLY BENEFIT AMOUNT (APPLIES TO LONG-TERM-CARE INSURANCE ONLY)

Any one of six monthly benefit amounts you (or a family member) must elect (when enrolling in long-term care insurance benefits) to receive if you (or a family member) become disabled, qualify for benefits, and receive care from a nursing home. This amount increases each year if inflation protection described in V.A.1 was elected, and a designated portion of the elected amount (as increased by applicable inflation protection) is the benefit for care from a covered source other than a nursing home.

MORBID OBESITY

A condition of persistent and uncontrollable weight gain that is potentially life-threatening and is defined as a body mass index (BMI) greater than 40. Some non-surgical benefits related to morbid obesity may be available to those with a BMI over 35. BMI is calculated as weight (kilograms)/height (meters) squared.

OBSERVATION BEDS/ROOMS

Outpatient beds that are used to either:

- a. Provide active short-term medical/surgical nursing services or
- b. Monitor the stabilization of the patient’s condition.

OCCUPATIONAL THERAPY

Treatment of the physically disabled due to disease, injury, or loss of bodily part by means of constructive activities designed and adapted to promote the restoration of an individual’s ability to perform required daily living tasks.

OPTIONAL BENEFITS

Benefits sponsored by the State Plan in which State Plan members may choose to enroll, or if required apply for coverage on themselves and eligible dependents. Optional benefits include dependent medical and dental insurance benefits, vision, life insurance plans B, C, and D, accidental death and dismemberment Plan E, long-term care insurance, long-term disability and Flexible Spending Accounts. For information on optional benefits, see this Summary Plan Description. A copy of the controlling policies or certificates of coverage are available upon request.

OUT-OF-NETWORK LEVEL OF BENEFITS

The lower level of benefits provided by a benefit plan (as defined in the current annual change booklet), when the member uses a provider outside the provider network.

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 an insurance plan's out-of-pocket maximum that you must pay in a benefit year for:

- a. An individual member (the individual out-of-pocket maximum); or
- b. 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. See the current annual change booklet for information on the individual and family out-of-pocket maximums and the coinsurance that are credited to the out-of-pocket maximum.

Related Information

There are separate out-of-pocket maximums for your medical plan and the Prescription Drug Plan. There is no out-of-pocket maximum for the Vision Insurance Plan.

PARTIAL HOSPITALIZATION (FOR MENTAL ILLNESS ONLY)

A time-limited ambulatory (outpatient) program offering active, therapeutically intensive treatment, which involves structured clinical services within a stable, therapeutic program. The program can involve day, evening, and weekend treatment. The underlying aim of this treatment is clinical stabilization required due to severe impairment and/or dysfunction in major life areas. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PARTICIPATING PHARMACY

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 claims administration company or by calling the customer service number on the identification card for the plan.

PERSONAL CARE PROVIDER (PCP)

A physician or mid-level practitioner who specializes in family practice, internal medicine, general practice, or pediatrics, and who is selected by a member to manage their continuum of care and coordination of covered services.

PHYSICAL THERAPY

Treatment of disease or injury by physical means such as hydrotherapy; heat or similar modalities; physical agents; bio-mechanical and neuro-physiological principles; and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a body part.

PHYSICIAN

An individual who has satisfied the necessary qualifications to practice as an M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy).

PLAN ADMINISTRATOR

A company contracted with the State of Montana to provide services including but not limited to claims processing, maintaining a provider network, coordination and continuation of care, health education, notices, quality assurance, reporting, case management services, and customer service

POINT-OF-SERVICE PLAN

A point-of-service plan is a medical plan in which the level of benefits you receive for a medical service is determined by the health care provider you use for the service. If you use an in-network provider, you receive higher level (in-network) benefits. If you use a provider outside the Plan's network without authorization, you receive lower level (out-of-network) benefits with a separate deductible and out-of-pocket maximum. The State Plans are point-of-service plans for most services.

PREFERRED PROVIDER

A health care provider who has contractually agreed to provide medical services to members of the State Plan's indemnity medical plan according to the fees and other terms of the contract in exchange for a higher percentage of plan payment.

PREFERRED PROVIDER ORGANIZATION (PPO)

A health care system composed of professional medical providers and facilities that agree to provide medical services at a reduced payment amount in order to participate with a health plan

PRESCRIPTION DRUG BENEFITS ADMINISTRATION COMPANY

A company on contract with the HCBP to administer the Prescription Drug Plan for State Plan members.

PRESCRIPTION DRUG PLAN

The plan of prescription drug benefits described in Section K of this Summary Plan Description.

PRE-TAX PLAN

A plan for paying your share of benefits contributions payments with pre-tax dollars rather than with after-tax dollars so you realize tax savings. This plan is offered in accordance with U.S. Internal Revenue Code (IRC) Section 125 and applicable federal regulations. See I.B.5 and Chapter VI for information on this plan.

PREVIOUS COVERAGE CREDIT

Application of creditable medical coverage to the State Plan's one-year waiting period, which applies to members/dependents over the age of 19, for coverage of a pre-existing medical condition. The waiting period is reduced by the amount of creditable coverage applied.

PRE-EXISTING CONDITION

A condition for which medical advice, diagnosis, care, or treatment (including prescription drugs) was recommended or received by a member within the six-month period ending on the member's enrollment date. Pregnancy and any conditions of an eligible dependent newborn or an adopted eligible dependent child are not pre-existing conditions.

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:

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

See II.A.5 of this Summary Plan Description for more information on obtaining a prior authorization for dental plan and indemnity medical plan services. See II.B.1 of this document for information on prior authorization of prescription drugs.

PROFESSIONAL HOME CARE (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

Long-term care by a licensed home health organization or agency that may be eligible for benefits under long-term care insurance sponsored by the State Plan, depending on the care options plan you (or a family member) enrolled in, and other terms of the long-term care insurance policy (see V.A).

PROFESSIONAL PROVIDER

An individual who has satisfied the necessary qualifications to practice medicine within the State of Montana or another state or country. Professional providers may include, but are not limited to, physicians; mid-level practitioners; naturopaths; podiatrists; or physical, occupational, or speech therapists.

PROTECTED HEALTH INFORMATION

Individually identifiable health information transmitted, including electronic transmission, or maintained in any form or medium.

QUALIFYING EVENT

An event that triggers a special enrollment period or allows a member to make a mid-year change in benefits that affects the amount of premium paid pre-tax (see I.B.2, I.B.3, and I.B.5).

RECOVERY CARE BED

A bed occupied in an outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATION THERAPY

Specialized treatment for an injury or physical deficit, which meets the following criteria:

- a. Provided in an inpatient or outpatient setting;
 - b. An intense, comprehensive program of therapies and services provided by a multi-disciplinarian team of health service providers who are licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. This also includes associated general and medical services incidental to rehabilitation care;
 - c. Designed to restore the patient's maximum function and independence; and
 - d. Under the direction of a qualified physician and includes a formal written treatment plan with specific goals.
- Rehabilitation therapy includes respiratory, physical therapy, occupational therapy, and speech therapy.

RESIDENTIAL PSYCHIATRIC CARE

Twenty-four-hour a day, voluntary, short-term, supervised psychiatric care provided by a facility licensed to provide residential psychiatric care.

RETIREE

A former state employee who meets the eligibility requirements of I.E.6.

SKILLED NURSING FACILITY CARE

Medically necessary inpatient skilled nursing services provided by an institution, or distinct part thereof, which is licensed pursuant to state or local law to provide skilled nursing services only. A skilled nursing facility is primarily engaged in providing continuous nursing care by, or under the direction and supervision of, a registered nurse for sick or injured persons during the convalescent stage of their illness or injuries. Skilled nursing facility care is not, other than incidentally, a rest home or home for custodial care or for the aged. In no event does this term include care by an institution or any part of an institution which is primarily engaged in the care and treatment of mental illness or chemical dependency.

SPECIAL ENROLLMENT PERIOD

A 60-day period triggered by a qualifying event in which an eligible dependent can enroll in the State Employee Benefit Plan (see I.B.2).

SPEECH THERAPY

Treatment for the correction of speech impairment resulting from disease or trauma.

STAGE ONE UNCONTROLLED HIGH BLOOD PRESSURE

If your systolic (the first number) blood pressure reading is 140 mmHG or higher OR your diastolic (the second number) pressure is 90 mmHG or higher *and* you are not receiving medical care for your condition

STAGE TWO UNCONTROLLED HIGH BLOOD PRESSURE

If your systolic (the first number) blood pressure reading is 160 mmHg or higher OR your diastolic (second number) is 100 mmHG or higher *and* you are not receiving medical care for your condition

STATE CONTRIBUTION

The monthly amount the State of Montana contributes toward the costs of State Plan insurance benefits for employees.

STATE EMPLOYEE BENEFIT PLAN (OR STATE PLAN)

The benefit plan described in this Summary Plan Description.

SUMMARY PLAN DESCRIPTION

This document and supplements and amendments here to which describe the benefit package.

SURGICAL CENTER

A licensed facility that is equipped and operated solely as a setting for the ambulatory surgery. The facility must have the following:

- a. Staffing that includes:
 - 1) direction by a staff of physicians or surgeons;
 - 2) presence of a physician or surgeon during each surgical procedure and recovery period (and presence of a certified anesthesiologist when general or spinal anesthesia is required);
 - 3) provision of full-time skilled nursing services in the operating and recovery rooms; and
 - 4) Extension of staff privileges to physicians or surgeons who perform surgery in the area hospital.
- b. Facility and equipment which includes:
 - 1) at least two operating rooms and one recovery room;
 - 2) diagnostic x-ray and lab equipment (or a contract to use such equipment at an area medical facility); and
 - 3) emergency equipment.
- c. Policies and procedures by which the facility:
 - 1) regularly charges patients for services and supplies and
 - 2) contracts with an area hospital and displays written procedures for immediate transfer of emergency cases.

TOTAL HOME CARE (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

Long-term care by anyone, including a family member or friend that may be eligible for benefits under the State Plan's Long-Term Care Insurance Plan, depending on the care options plan you (or a family member) enrolled in and other terms of the long-term care insurance policy (see V.A).

TRANSPLANT NETWORK

A network of transplant centers whose services are covered by the State Plan's indemnity medical plan as described in III.B.26. Institutions that participate in a transplant network must meet established criteria for quality and agree to a negotiated, all-inclusive rate for a package of transplant services that includes professional, facility and ancillary services, and/or a predetermined length of time.

URGENT CARE/URGENT MEDICAL CONDITION

Health care for an acute illness or injury that is not life threatening but requires treatment within 24 hours (such as high fever; ear, nose and throat infections; and minor sprains and lacerations).

URGENT CARE FACILITY

A facility distinct from a hospital emergency room or a provider's office/clinic, the purpose of which is to provide urgent care.

URX

A prescription drug management program developed by the State of Montana for all plan members

VISION INSURANCE AND VISION INSURANCE COMPANY

Insurance that provides a vision benefits for adults and children enrolled in the plan. Vision insurance company refers to the company on contract with the HCBP to provide vision benefits to State Plan members who are enrolled in the State Plan's vision insurance benefit plan. A copy of the controlling policy or certificate of coverage is available upon request.

STATE OF MONTANA

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Health Information Privacy

This Notice is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to describe how the State Plan will protect your health information with respect to its self-insured health benefits.

References below to the State Plan means the medical, prescription drug, dental, vision, employee assistance and healthcare flexible spending account benefits provided by the State Plan.

“Health Information” for this purpose means information that identifies you and either relates to your physical or mental health condition, or relates to the payment of your health care expenses. This individually identifiable health information is known as “protected health information” (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal or state health information privacy laws.

State Plan Privacy Obligations

The State Plan is required by law to:

Ensure that health information that identifies you is kept private;

Give you this Notice of its legal duties and privacy practices with respect to health information about you; and

Follow the terms of the Notice that are in effect.

How the State Plan May Use and Disclose Protected Health Information (PHI) About You

The State Plan may use health information or disclose it to others for a number of different reasons. The following are the different ways that the State Plan may use and disclose your PHI without your authorization:

For Treatment. The State Plan may disclose your PHI to a health care provider who provides, coordinates or manages health care treatment on your behalf. For example, if you are unable to provide your medical history as a result of an accident, the State Plan may advise an emergency room physician about the different medications that you may have been prescribed.

For Payment. The State Plan may use and disclose your PHI so claims for health care treatment, services, and supplies that you receive from health care providers may be paid according to the State Plan’s terms. The State Plan may also use your PHI for billing, reviews of health care services received, and subrogation. For example, the State Plan may tell a doctor or hospital whether you are eligible for coverage or what percentage of the bill will be paid by the State Plan.

For Health Care Operations. The State Plan may use and disclose your PHI to enable it to operate more efficiently or to make certain that all of its members receive the appropriate health benefits. For example, the State Plan may use your PHI for care management to refer individuals to disease management programs, for underwriting, premium rating, activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, to arrange for medical reviews, or to perform population-based studies designed to reduce health care costs. In addition, the State Plan may use or disclose your PHI to conduct compliance reviews, audits, legal reviews, actuarial studies, and/or for fraud and abuse detection. The State Plan may also combine health information about members and disclose it to the State of Montana in a non-identifiable, summary fashion so that the State of Montana can decide, for example, what types of coverage the State Plan should provide. The State Plan may also remove information that identifies you from health information that is disclosed to the State of Montana so that the health information that is used by the State of Montana does not identify the specific State Plan members.

To The Plan Sponsor. The State Plan is sponsored by the State of Montana. The State Plan may disclose your PHI to designated personnel at the State of Montana so that they can carry out related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the individuals authorized to receive such information under the State Plan. These individuals will protect the privacy of your health information and ensure that it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the State Plan to any other employee or department of the State of Montana and (2) will not be used by the State of Montana for any employment-related actions or decisions, or in connection with any other employee benefit plans sponsored by the State of Montana.

To a Business Associate. Certain services are provided to the State Plan by third-party administrators known as “business associates.” For example, the State Plan may place information about your health care treatment into an electronic claims processing system maintained by a business associate so that your claim may be paid. In so doing, the State Plan will disclose your PHI to its business associates so that the business associates can perform their claims payment functions. However, the State Plan will require its business associates, through written agreements, to appropriately safeguard your health information.

For Treatment Alternatives. The State Plan may disclose your PHI to tell you about possible treatment options or health care alternatives that may be of interest to you.

For Health-Related Benefits and Services. The State Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

To Individuals Involved in Your Care or Payment of Your Care. The State Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The State Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death, unless other laws would prohibit such disclosures.

As Required by Law. The State Plan will disclose your PHI when required to do so by federal, state, or local law, including those laws that require the reporting of certain types of wounds, illnesses or physical injuries.

Special Use and Disclosure Situations

The State Plan may also use or disclose your PHI without your authorization under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the State Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other forms of lawful due process.

Law Enforcement. The State Plan may release your PHI if asked to do so by law enforcement official, for example, to report child abuse, to identify or locate a suspect, material witness, missing person or to report a crime, the crime’s location or victims, or the identity, description, or location of the person who committed the crime.

Workers’ Compensation. The State Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers’ compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. Armed forces, the State Plan may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The State Plan may use and disclose your PHI when necessary to prevent serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The State Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medications or problems with medical products, or to notify people of recalls of products they have been using.

Health Oversight Activities. The State Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain limited circumstances, the Health Plan may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The State Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law, and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the State Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The State Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The State Plan may also release your PHI to a funeral director, as necessary, to carry out his/her responsibilities.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information that the State Plan maintains about you:

Right to Inspect and Copy Your Personal Health Information. You have the right to inspect and copy your PHI that is maintained in a “designated record set” for so long as the State Plan maintains your PHI. A “designated record set” includes medical information about eligibility, enrollment, claim and appeal records, and medical and billing records maintained by the State Plan, but does not include psychotherapy notes, information intended for use in a civil, criminal or administrative proceeding, or information that is otherwise prohibited by law.

To inspect and copy health information maintained by the State Plan, submit your request in writing to the Privacy Official. The State Plan may charge a fee for the cost of copying and/or mailing your request. The State Plan must act upon your request for access no later than 30 days after receipt (60 days if the information is maintained off-site). A single, 30-day extension is allowed if the State Plan is unable to comply by the initial deadline. In limited circumstances, for example, the State Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to your health information, you will be informed as to the reasons for the denial and of your right to request a review of the denial.

You may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies, if any must be reasonable and based on the State Plan’s cost.

Right to Amend Your Personal Health Information. If you feel that the health information that the State Plan has about you is incorrect or incomplete, you may ask the State Plan to amend it. You have the right to request an amendment for so long as the State Plan maintains your PHI in a designated record set.

To request an amendment, send a detailed request in writing to the Privacy Official. You must provide the reason(s) to support your request. The State Plan may deny your request if you ask the State Plan to amend health information that was: (1) accurate and complete; (2) not created by the State Plan; (3) not part of the health information kept by or for the State Plan; or (4) not information that you would be permitted to inspect and copy. The State Plan has 60 days after the request is received to act on the request. A single, 30-day extension is allowed if the State Plan cannot comply by the initial deadline. If the request is denied, in whole or in part, the State Plan will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and, if permitted under HIPAA, have the statement included with any future disclosures of your PHI.

Right to An Accounting of Disclosures. You have the right to request an “accounting of disclosures” of your PHI. This is a list of disclosures of your PHI that the State Plan has made to others for the 6 year period prior to the request, except for those disclosures necessary to carry out treatment, payment, or health care operations, disclosures previously made to you, disclosures that occurred prior to the date on which the accounting is requested, or in certain other situations described under HIPAA.

To request an accounting of disclosures, submit your request in writing to the Privacy Official. Your request must state a time period, which may not be longer than 6 years prior to the date accounting was requested. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the State Plan provides you with a written statement of the reasons for the delay and that date by when the accounting will be provided. If you request more than one accounting within a 12-month period, the State Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Right to Request Restrictions. You have the right to request a restriction on the health information that the State Plan uses or discloses about you for treatment, payment, or health care operations. You also have the right to request that the State Plan limits the individuals (for example, family members) to whom the State Plan discloses health information about you. For example, you could ask that the State Plan not use or disclose information about a surgical procedure that you had. While the State Plan will consider your request, it is not required to agree to it except in those situations where the requested restriction relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment, and the PHI pertains solely to a health care item or service that was paid for out of pocket in full). If the State Plan agrees to the restriction, it will comply with your request until such time as the State Plan provides written notice to you of its intent to no longer agree to such restriction, or unless such disclosure is required by law.

To request a restriction or limitation, make your request in writing to the Privacy Official. In your request, you must state: (1) what information you want to limit; (2) whether you want to limit the State Plan's use, disclosure, or both; and (3) to whom you want to limit(s) to apply. Note: By law the State Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the State Plan communicates with you about health matters using alternative means or at alternative locations. For example, you may ask that the State Plan send your explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Official. The State Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you want to be contacted.

State Privacy Rights. You may have additional privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. You may write to the Privacy Official to request a written copy of this Notice at any time.

Changes to this Privacy Notice

The State Plan reserves the right to change this notice at any time and from time to time, and to make the revised or changed Notice effective for health information that the State Plan already has about you, as well as any information that the State Plan may receive in the future. The revised Notice will be provided to you in the same manner as this Notice, or electronically if you have consented to receive the Notice electronically.

Complaints

If you believe that health information privacy rights as described under this Notice have been violated, you may file a written complaint with the State Plan by contacting the person listed at the address under "Contact Information." You may also file a written complaint directly with the regional office of the U.S. Department of Health and Human Services, Office for Civil Rights. The complaint should generally be filed within 180 days of when the act or omission complained of occurred. Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this Notice or by the laws that apply to the State Plan will be made only with your written authorization. If you authorize the State Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the State Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the State Plan will not reverse any uses or disclosures already made in reliance on your prior authorization. The Plan will notify you in the event that there is a breach involving unsecured PHI.

Contact Information

To receive more information about the State Plan's privacy practices or your rights, or if you have any questions about this Notice, please contact the State Plan at the following address:

Contact Office or Person: Amber Godbout, Privacy Official

State Plan Name: State of Montana Employee Benefit Plan

Telephone: (406) 444-7462 (in Helena) or

(800) 287-8266

TTY (406) 444-1421

Address: Health Care and Benefits Division

PO Box 200130

Helena, MT 59620-0130

Email: agodbout@mt.gov

Copies of this Notice are also available at 100 North Park Avenue, Suite 320, Helena, MT 59601 and on our website benefits.mt.gov. This Notice is also available by sending an e-mail to the above address.

Effective and Last Updated: February 17, 2010

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 its plan in order to comply with applicable law.