Gallatin County
MONTANA

Gallatin County
2024 BENEFITS

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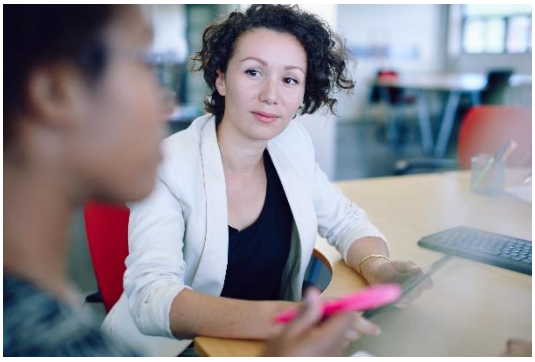


WELCOME TO YOUR BENEFITS GUIDE

Gallatin County MONTANA

BIG NEWS!!!

Effective January 1, 2024 there will be no change to your health plan premiums or benefit offerings!!

Gallatin County will continue with the additional employee benefits that were offered effective January 1, 2023, including a buy-up dental plan that includes implant coverage and child orthodontia benefits. You will find tons of useful information regarding our vendor partners and benefit offerings in this Benefit Guide.

Open Enrollment will be held from November 13th through November 30th.

EMPLOYEES WANTING TO MAKE CHANGES TO THEIR CURRENT ENROLLMENT FOR THEMSELVES OR ANY FAMILY MEMBERS MUST TAKE ACTION. ALL CHANGES MUST BE MADE VIA THE ONESITE ENROLLMENT SYSTEM BETWEEN NOVEMBER 13-30.

This guide is an overview

The benefits in this summary are effective January 1, 2024 through December 31, 2024.

This guide is about your benefits, but it's also about *you* and how to protect your health, your lifestyle, your future, and the people who are important to you.

You'll find details about your benefits and medical plan, as well as tips on how to use them.

You will also discover the programs that Gallatin County provides to help you save time and money, and balance your work and home life.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are regular active employee working 80 hours or more per month.

Eligible dependents

- Legally married spouse
- Natural, adopted or step children up to age 26.
- Children over age 26 who are disabled, incapable of self-supportive employment and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. **Open Enrollment will begin November 13th and end November 30th.** New hire coverage begins on the first of the month following 30 calendar days of employment.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason), unless you have a qualified life event (aka change in status), which is described on the next page.

Enrollment can be completed through the OneSite Benefit Enrollment System at www.mybensite.com/gallatin. Please reach out to Human Resources, 406-582-3045, with questions.

ENROLLING FOR BENEFITS

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

CHANGING YOUR BENEFITS

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a significant change in your life, including the following events. All change requests must be received within 30 days of the event.

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

All change requests must be received within 30 days of the event and completed using our OneSite Enrollment System at www.mybensite.com/gallatin. Please reach out to Human Resources, 406-582-3045,with any questions.

Welcome to Your Employee Benefits Supersite!

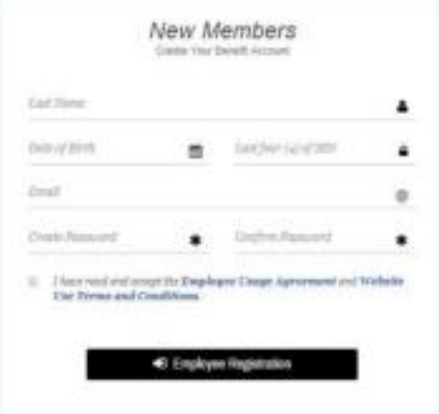
mybensite.com/gallatin

New Member Login

Create Account: Verify employee last name, date of birth and last 4 digits of Social Security Number.

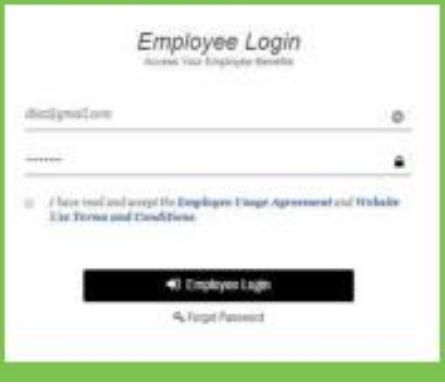
Email: An email address is required. If you don't have one, click on the Gmail or Yahoo links to establish a free email account. Your email becomes your username.

Password: Create and confirm your password to complete registration.



Existing Members

In the Employee Login section, enter your email address and password, then check the box to agree to website terms and conditions.



Gallatin County
MONTANA

Step 1 – Know Your Benefit Options

We believe that employees are our greatest resource. We offer a competitive benefit package for you and your family, and the support system to help you make great decisions.

Review your Benefits Supersite and know your options:

- Benefit summaries
- Side by side comparisons
- Insurance carrier information
- Member service information
- Provider search directories
- Forms and plan documents

Step 2 – Benefit Shopping

Click **Enroll Now** to shop and elect benefits:

- Step by step enrollment guidance
- Price per paycheck is displayed for each benefit elected
- Add and manage covered dependents
- Update beneficiaries
- Review and submit final elections
- Save Benefit Confirmation Statement (BCS) for your records

WHEN CAN I ENROLL?

New Hires

You must enroll during your new hire eligibility window.

- Benefits are effective 1st of the month following 30 days from your date of hire.
- You have **60** days from your date of hire to complete your enrollment.

If you fail to enroll on time, you must have a qualifying event, or wait until open enrollment.

Qualifying Events

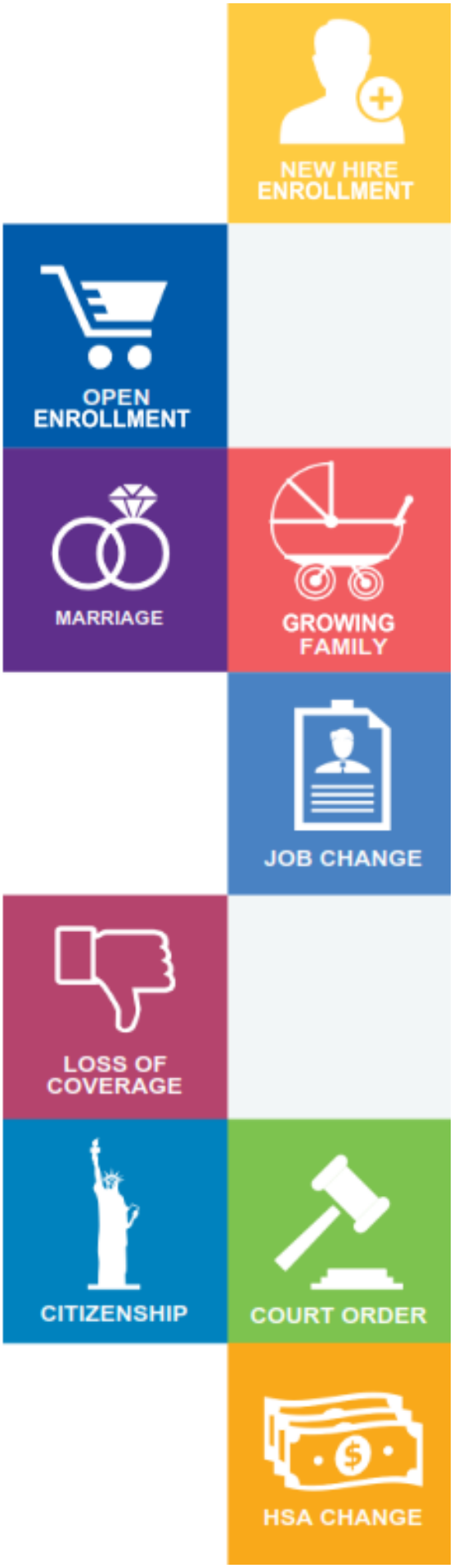
If you experience a "Qualifying Event," such as marriage, birth, adoption, loss of other coverage, etc., you must request the appropriate changes online in the benefits portal and supply the required documentation within **60** days of the event.

If you are unable to meet this requirement, you may need to wait until open enrollment to make changes.

Open Enrollment

You may enroll and make changes online during the annual open enrollment window. Once open enrollment has closed, you may not make any changes to your benefit elections unless you experience a qualifying event.

mybensite.com/gallatin/



HEALTHCARE

MAKE TIME FOR HEALTH

OUR COMMITMENT

We believe that our employees should have access to healthcare coverage that promotes preventive care and helps cover the cost of illness.

Eligible employees and their eligible dependents can enroll in medical, dental, and vision coverage through the Gallatin County benefits program.

Medical

We offer one medical plan (see next page for details). Preventive care is fully covered if obtained in-network. Review the network provider information and benefit guide so you can understand how the plan works.

Dental

Some people don't like going to the dentist, but no one likes big dental bills. Regular checkups and cleanings are covered at 100% and can identify issues before they become serious. If you do need dental services, our dental coverage helps cover the cost (see page 16 for details).

Vision

An eye exam can uncover health conditions you may not know you have, such as glaucoma, or even high blood pressure. Our vision plan helps cover the cost of eye exams, eyeglasses, and contact lenses to ensure you're seeing and feeling your best (see page 16 for details).

Refer to Summary Plan Document for details.

GALLATIN COUNTY HEALTH BENEFIT PLAN

	Full Pharmacy
Calendar Year Benefit	**In-Network**
Annual Medical Deductible	$400 Individual / $1,000 Family
Annual Medical Out-of-Pocket Maximum	$2,400 Individual / $5,500 Family
Office Visit	Deductible applies, then paid at 80%
Accidental Injury	Deductible waived, paid at 100%, $500 Maximum Benefit
Lab and X-ray	100%, Deductible waived up to $250. Charges exceeding the maximum may be eligible under the Medical Benefits, subject to applicable Cost Sharing Provisions.
Urgent Care	Deductible applies, then paid at 80%
Emergency Room	Deductible applies, then paid at 80%
Maternity Services	Deductible applies, then paid at 80%
Newborn Initial Care	Deductible applies, then paid at 80%
Home Health	Deductible applies, then paid at 80%
Hospitalization	Deductible applies, then paid at 80%
Outpatient Professional Services	Deductible applies, then paid at 80%
Outpatient Facility Services	Deductible applies, then paid at 80%
Inpatient Facility Charge/Ambulance	Deductible applies, then paid at 80%
Preventive Care – In Network	**Deductible waived, paid at 100% per ACA regulation**
PRESCRIPTION DRUGS	
Deductible	$50 per Covered Person
Out-of-Pocket Maximum	$3,000 Individual / $7,700 Family
Generic	$10 Copay, after Deductible
Preventive Generic (determined by ProAct)	100%, Deductible Waived
Brand Name Formulary	$30 Copay, after Deductible
Brand Name Non-Formulary	$50 Copay after Deductible
Mail Order	
Generic	$20 Copay after Deductible
Brand Name Formulary	$60 Copay after Deductible
Brand Name Non-Formulary	$100 Copay after Deductible

This is a general description of benefits and not to be interpreted as all inclusive. Balance billing may occur for Non-Participating Providers. Please see Plan Document for Out-of-Network Benefit Schedules.

Find a Doctor: Locate a doctor/hospital/facility in your network

Select a PCP: Choose a Primary Care Physician

Cost & Quality: Compare cost and quality for providers based on procedure

Eligibility & Benefits: View people covered by your plan, benefits and eligibility, demographic information for you and your dependent(s), and benefit plan documents

Claims: View paid claims for yourself and any underage dependents and view/print Explanations of Benefits (EOBs)

Health Resources: Review additional health offerings, access procedure pricing, health tools, physician information, and other health information resources

ID Card: Order an ID card for yourself or your dependent(s)

Forms: Access Medical and Vision Claim forms, Release of Information, Authorized Representative, etc.

Electronic EOBs: Enroll in paperless statements*

News & Updates: Learn what's new

Contact Us: Access contact information

Account Settings: Reset your password, update your email, etc.

**Please Note: Dependents that are 18 and older need to enroll in paperless statements separately*

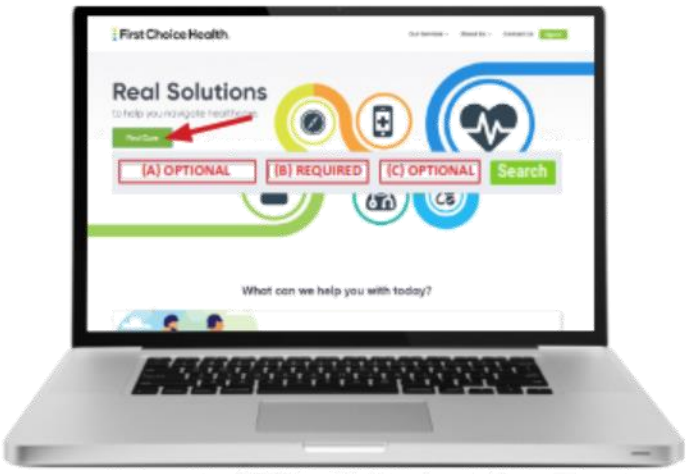
First

Go to www.fchn.com and click the green Sign In button at the top right corner to create an account. (Check your ID card for your member ID number - you'll need it to create an account.)

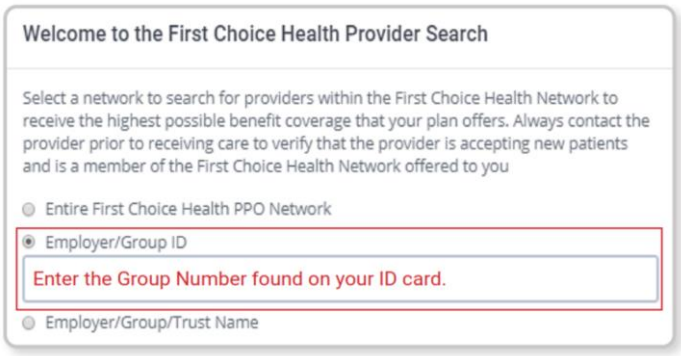
Contact a Customer Care Representative at the **phone number located on your ID Card** Monday through Friday, 8am to 5pm PST.

First Choice Health

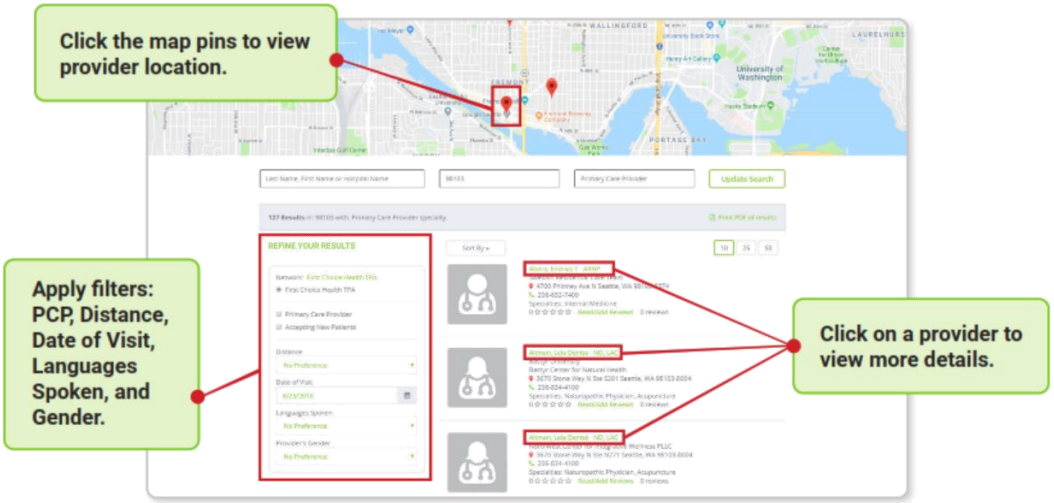
How to Register for myFirstChoice: https://www.youtube.com/watch?v=Wku52V8bLRI



1. Go to www.fchn.com to access the First Choice Health website.
2. Click "**Find Care**" and enter search criteria. City, Zip or Address is required.
3. Select "Search" and when a pop-up window appears enter your Member ID or Group Name.
4. In the drop down, choose the option that pertains to your benefit plan and click "Continue".
5. You will receive a list of search results along with a map with displays the first 10 providers. Use the filters on the left to further refine your search.



Please Note: If you perform a search by a specific clinic, you must select the clinic to view the preferred providers at that clinic.



How to Find a Provider: https://www.youtube.com/watch?v=UaAgpWojNoY

Personal CASE MANAGERS

Your health benefits plan has contracted with First Choice Health to offer you the professional services of a Personal Case Manager.

What is Case Management?

Comprehensive Case Management is a service designed to help you and your family get through the healthcare maze when you have a health condition or injury.

Our nurses and Behavioral Health Counselors at First Choice Health will:

- Provide you with free, voluntary, and confidential assistance
- Work with you over the telephone to identify needs and create a plan
- Coordinate your care with your health benefits plan and physician
- Advocate for you to obtain the most appropriate and cost effective care
- Help you understand your diagnosis and make decisions regarding your healthcare
- Provide support and resources for you and your family
- Provide assistance with basic questions regarding claims

Behavioral Health Case Manager

Behavioral Health Case Managers are licensed counselors who assist with recovery from mental, emotional, and substance abuse problems.

Your Case Manager will help you:

- Find a counselor or program
- Understand mental health therapies and medicines
- Develop a care plan tailored to your needs
- Reach your treatment goals
- Ensure your care team is working together smoothly
- Transition from inpatient to out-patient care

Medical Case Manager

If you have a medical condition or injury, your Registered Nurse Case Manager will:

- Contact you and discuss your current medical condition
- Arrange for home health care or medical equipment needs
- Help you find a healthcare provider in the First Choice Health Network
- Work with you and your provider to address your healthcare needs
- Maintain contact throughout your treatment

READY TO START?
Call (800) 808-0450

Ask for a Case Manager.

How To Access a Case Manager:

1. You, your family member, one of your care providers, or your benefits plan may contact First Choice Health's Case Management department by phone at (800) 808-0450.
2. An Intake Coordinator will forward your request to a Medical or Behavioral Health Case Manager.
3. A Case Manager will contact you to discuss your needs or concerns, and address how Case Management might help you.
4. An Information Packet and Consent Form will be mailed to your home.

First Choice Health

PROACT+PLUS

A new approach to reducing your prescription costs!

ProAct is revolutionizing your prescription drug coverage. Our unique **ProActPLUS** strategy offers a three-tiered suite of services to drive enhanced benefits and savings to you–the member.

HERE'S WHAT YOU NEED TO KNOW:

ProActPLUS is a 100% concierge, member-centric program. As a ProAct member, there is no enrollment required. If your existing or new drug therapy is eligible for **ProActPLUS**, a member of our team will reach out to you.

COST OPTIMIZATION DRUG TARGETS

ProAct begins by reviewing hundreds of medications in a variety of categories to identify opportunities for member cost reduction.

Did you know?

Pharmaceutical manufacturers provide various funding mechanisms intended to reduce or eliminate a member's out-of-pocket costs on select therapies.

SPECIALTY THERAPIES TIER

Significant savings is realized by utilizing manufacturer programs to reduce the cost of specialty drugs by up to 100%.

COPAY OPTIMIZATION TIER

Plan savings are enhanced by our full service copay card optimization program. Providing valuable savings to the plan on not just specialty but high cost brand medications – allowing your employer to keep your pharmacy benefit costs in check.

INTERNATIONAL PHARMACY TIER

Dramatic savings are available on many brand-name drugs through our Canadian retail pharmacy partner. These FDA-equivalent approved medications are provided to members at no cost.

Did you know?

Most of the brand-name drugs consumed in the US are manufactured outside of the US in countries like Canada.

For questions specific to the ProActPLUS program, please reach out to: 888-242-9798
Monday - Friday, 8:00am-6:00pm EST

PROACT PHARMACY BENEFIT MANAGEMENT

CancerCARE
Right Care. Right Place. Right Time.

What is CancerCARE?

The CancerCARE Program is a free, fully integrated cancer solution included in YOUR health plan that supports you from the first day of your diagnosis well into the stages of aftercare. CancerCARE coordinates care and benefits for patients with new or existing cancers. Our expert medical team advocates for the best possible care in your community or at a leading national Centers of Excellence location.

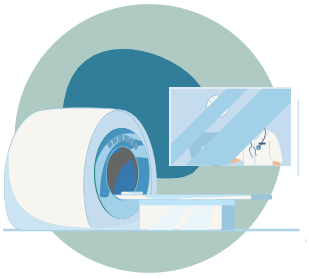
Day One Help

The day you receive a cancer diagnosis is overwhelming. Our CancerCARE professionals will answer questions about your diagnosis and help you evaluate your treatment options. They will also help maximize your health benefits and minimize your out-of-pocket expenses.

Register online or by phone promptly (within 72 hours) of diagnosis for the highest care impact.

Personalized Care

Today's cancer treatments vary by cancer type, stage of spread, and the patient's genetic makeup. The most effective care occurs when it is genetically personalized for you. Genetic testing is often not a covered benefit; however, it is fully covered when used for treatment planning with CancerCARE's recommendation.



National Resources

New treatments are developed and tested at leading cancer centers called Centers of Excellence. Treatment received from your local oncologist is often the best possible, but in some instances, we may suggest new treatments that are only offered at a Center of Excellence when those treatments could be more beneficial to you. Two examples would be Clinical Trials or proven new treatments that have not yet been written and given to community oncologists.

Expert Medical Team

During your Initial registration call, our highly trained Intake Coordinators will quickly gather your medical and health plan information. When a diagnosis permits, you will be assigned your own personal Oncology Nurse Expert who will answer any questions you have regarding your diagnosis as well as your care options. CancerCARE's entire team of Doctors, Nurses, and Medical Experts is dedicated to being with you throughout your treatment journey.

CancerCARE
Right Care. Right Place. Right Time.

Frequently Asked Questions

How do I use the Program?

To gain access to our services, register online at CancerCAREprogram.com, or call us at 1-877-640-9610. **Once you are registered in our system, a nurse will be assigned to your case and they will help you for the rest of your cancer journey.**

Do I have to pay for CancerCARE?

The CancerCARE Program is an additional service included in the health plan offered by your company. **Registration and program features are covered by your health plan. Contact your HR representative for more information.**

What if I am already being treated for cancer?

You can join CancerCARE at any point during your treatment. Once registered, **we are able to collaborate with your local oncologist** and give them access to resources they may not have at their facility. We will also review your treatment plan to ensure everything is evidence-based quality care.

I don't have cancer, do I still need to register?

Registration is only required if you have been diagnosed with cancer. If you had cancer in the past and are now cancer-free, you can still register as a survivor and we will help you deal with any long-term issues and concerns. **Covered dependents can also register for CancerCARE.**

+1 877 640 9610 cancermanagement@cancercareprogram.com cancercareprogram.com

2024 GALLATIN COUNTY DENTAL PLAN

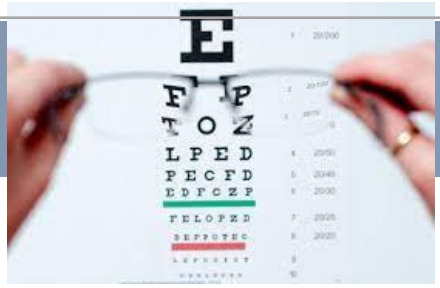
INCLUDED W/Medical	PPO/Premiere/UCR
Annual Deductible	None
Annual Plan Maximum	$1,500 Maximum Benefit per Covered Person
Diagnostic & Preventive (limited to two visits per year)	100%
Basic and Major Services	80%
This benefit is included in your medical coverage.	

BUY-UP OPTION *Must be enrolled in Medical to Purchase*	Employee Monthly Premiums
Employee	$6.97
Employee + Spouse	$16.56
Employee + Child(ren)	$22.54
Family	$35.34

Buy-up Dental premiums are deducted on a pre-tax basis.

Buy-up Dental Plan through Delta Dental

BUY-UP OPTION	PPO/Premiere/UCR
Annual Deductible	None
Annual Plan Maximum	$2,000 Maximum Benefit per Covered Person
Diagnostic & Preventive (limited to two visits per year)	100%
Basic and Major Services (includes Implants	80%
Child Orthodontia	50%, $1,500 Lifetime Maximum
Implant Coverage	80%
Buy-up Option Enhances Basic Option and is not in addition to the Basic Option.	



2024 GALLATIN COUNTY VISION PLAN

Your vision checkup and material are covered in full up to a $200 annual benefit maximum.

	Frequency	Annual Benefit
Exam and Materials	Once per year	100% to a maximum of $200 per Year
This benefit is included in your medical coverage.		

Delta Dental Value-Added Benefits

DELTA DENTAL

Keep Smiling

Delta Dental PPO™

Stay in network to save

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

If you can't find a PPO dentist, consider a Delta Dental Premier® dentist. These dentists have agreed to set fees and offer another opportunity to save.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need to provide your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

COUNTY PROVIDED LIFE AND AD&D INSURANCE

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. **The cost of coverage is paid in full by the County.**

Basic Life and AD&D Coverage Amounts
Regular Active Employees working 80 hours per month or more.
$50,000 – Regular Active Employee $5,000 – Retired Employee AD&D Benefit matches Life Benefit; No AD&D on Retiree Life Age Reduction: Age 70: 65% | Age 75: 50%

What features are included?

Accelerated Benefit – If you become terminally ill and are not expected to live more than 12 months, you may request up to 75% of your life insurance amount not to exceed $37,500. A doctor must certify your condition. Upon your death, any remaining benefit will be paid to your designated beneficiaries.

Portability / Conversion – If you retire, reduce your hours or leave Gallatin County, you can take this coverage with you, unless you have a medical condition which could shorten your life expectancy. In that case, you may be able to convert your term life policy to an individual life insurance policy.

Survivor Financial Counseling – Financial advice and planning support from impartial counselors is available for beneficiaries and for covered employees who are terminally ill.

Included with your AD&D Plan

Education Benefit – This benefit can help defray the cost of tuition for your children if they are in college or other post-secondary school training. Up to $3,000 per year payable to the spouse for education at a trade school, college, university or other institution of higher learning. Child education payable equal to 5% of the principle sum up to $5,000. Both spouse and child education benefit payable to a maximum of four consecutive years. Please see plan certificate for details.

Repatriation Benefit – If you or a covered dependent dies in an accident 100 or more miles form home, this benefit will help defray the costs of preparing and transporting the body to a chosen mortuary.

Seat Belt and Airbag Benefit – Pays an additional benefit if you die in a covered private passenger car accident while wearing a seat belt. An additional benefit can also be paid if the seat is protected by an airbag and seat belt and your seat belt is properly fasted. The total combined maximum seat belt/airbag benefit is 100% of the principal sum up to the plan maximum.

YOUR MONTHLY BENEFIT COSTS

Great news, there will be no increase to premiums for the 2024 plan year!! The total amount that you pay for your benefits depends on how many dependents you cover. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

2024 Full Pharmacy Card PPO, Dental and Vision

Full Time Status (160+ hours/month)	Monthly County Contribution	EE Monthly Premium Rate	EE Monthly Premium Rate W/Health Screening
EMPLOYEE ONLY (EE)	$1,144	$50	$0
EE/ONE CHILD	$1,144	$128	$78
EE/TWO CHILD	$1,144	$149	$99
EE/THREE CHILD	$1,144	$170	$120
EE/FOUR CHILD	$1,144	$191	$141
EE/SPOUSE	$1,144	$393	$293
EE/FAMILY	$1,144	$510	$410

Part Time Status (minimum 80 hours per month)	Monthly County Contribution
76 - 80 Hours/ Pay Period	$1,144
70 - 75 Hours / Pay Period	$1,050
60 - 69 Hours / Pay Period	$955
50 - 59 Hours / Pay Period	$795
40 - 49 Hours / Pay Period	$635

FLEXIBLE SPENDING ACCOUNT (FSA)

ARE YOU ELIGIBLE?

If you are eligible to enroll in the medical plan you may participate in the healthcare FSA.

HealthEquity:

Visit the HealthEquity website to see details on the additional features, www.healthequity.com

- FSA Store
- Mobile App
- Visa Card debit card linked directly to your FSA to pay for out-of-pocket medical expenses
- Comprehensive online portal that provides participants with convenient ways to manage their benefit accounts.

Do you pay for dependent care?

See page 19 for information on tax savings through the Dependent Care FSA.

Employees must opt into this benefit at each Open Enrollment if they choose to participate.

Set aside medical, dental and vision dollars for the coming year

A FSA allows you to set aside tax-free money to pay for medical, prescription, dental and vision expenses you expect to have over the coming year.

How the FSA works

- You estimate what you and your family's medical, prescription, dental and vision out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as medications, glasses, orthodontia, etc.
- **You can contribute up to $3,050**, per the 2024 annual limit set by the IRS. Contributions are deducted from your pay pretax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA to pay for qualified services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- For a small percentage of participants, Social Security retirement benefits may be affected by participating in FSAs. Participation in this plan reduces your W-2 income, on which retirement benefits are based.
- IRS regulations do not allow domestic partner claims to be submitted for reimbursement through the Flex plan unless they qualify as a tax dependent under Code Section 152.

Estimate carefully!

If you don't spend all the money in your account, you have a Grace Period until March 15th in which to use the additional funds. All funds not spent by the end of the Grace Period will be forfeited.

FSA SAVINGS EXAMPLE

	Without FSA	With FSA
Annual Pay	$60,000	$60,000
Pre-Tax FSA Contributions for Healthcare Expenses	$0	($2,000)
Taxable Income	$60,000	$58,000
Federal Taxes	($10,852)	($10,259)
After-Tax Medical, Dental and Vision Expenses	($2,000)	$0
NET INCOME	**$47,148**	**$47,741**

Your savings will depend on your income, tax bracket, and FSA contribution amount.

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by ASI.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

For a small percentage of participants, Social Security retirement benefits may be affected by participating in FSAs. Participation in this plan reduces your W-2 income, on which retirement benefits are based.

Estimate carefully! You CANNOT change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours
Urgent care, Walk-in clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Varies, up to 24/7
Emergency room 	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7

* Average out-of-pocket cost after deductible. Your actual cost may vary depending on your plan and location.

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

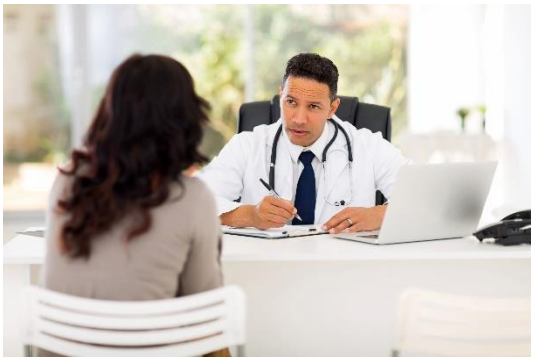
Need	Alternative	Features	Savings
Surgery 	Ambulatory Surgery Center (ASC)	• Specializes in same-day surgeries • Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more • Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy 	Free-standing physical therapy center	• Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study 	Home testing	• Diagnoses sleep apnea and other conditions • Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy 	Home or outpatient infusion therapy	• For drugs that must be delivered by intravenous injections, or epidurals • Delivered by licensed infusion therapy provider • Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay* **in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on the First Choice Health website, www.fchn.com.

Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer
- Depression
- STIs

Preventive care for women should include breast and gynecological exams

For men, preventive care should include prostate cancer screening and a testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, gender and medical history. Visit **cdc.gov/prevention** for recommended guidelines. **Preventive care is covered in full only when obtained from an IN-NETWORK provider.**

Not all exams and tests are considered preventive

Exams performed by specialists are not generally considered preventive and may not be covered at 100 percent. Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services. If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Should I skip my checkup due to COVID-19?

Staying safe from the coronavirus doesn't necessarily mean skipping preventive healthcare. Talk to your doctor about whether you need a checkup right away or can delay until there is a lower risk of being exposed to COVID-19. Depending on your medical needs, you may be treated with a combination of telehealth and in-person care.

Consider scheduling a flu shot when they're available to avoid a potential combined infection of COVID-19 and the flu. And, of course, seek medical care right away if you have symptoms that need immediate attention. Nearly every doctor's office has added new practices to ensure the safety of patients, providers and other employees.

ARE PRESCRIPTION DRUGS BREAKING YOUR BUDGET?

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Preferred Brand Name Drug
$$$	Non-Preferred Brand Name Drug
$$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers". These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug counterparts.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

SAVE NOW, ENJOY LATER

WHAT ARE YOUR PLANS?

Whether your retirement plans include traveling the world, enjoying a hobby, or relaxing with family, you need a plan to get there.

Retirement Savings Plan

Retirement Systems:

- **PERS/SRS:**

Questions about your PERS or SRS retirement or just want to learn more?

Visit the MPERA website for complete and most up to date information: http://mpera.mt.gov/

You will be able to find webinars, videos and handbooks.

Call Center Staff can be reached at: 1-877-275-7372 or Email our Education Specialists below:

Terry Dalton: tdalton@mt.gov

Joel Thompson: jthompson3@mt.gov

Option 457 b Deferred Compensation and ROTH Plans:

- **Offered through Empower and Nationwide**
- **Please see the following two pages to see how you can enroll or make changes to your current plan.**

Meet your Montana team

Julie, Trevor, and Corinne are here to help you prepare for a better retirement!

Julie Lucas
Retirement Plan Counselor
Phone: (406) 417-1690
julie.lucas@empower.com

Trevor Bell
Retirement Plan Counselor
Phone: (406) 880-9144
trevor.bell@empower.com

Corinne Moncada
Retirement Plan Counselor
Phone: (406) 876-2933
corinne.moncada@empower.com

Please scan the QR code to schedule a one-on-one with your local representative.

They are available to provide you one-on-one counseling with personalized account services, such as:

- **Contributions**
- **Enrollment**
- **Individualized account reviews**
- **Investment choices**
- **Presentations**
- **Rollovers** – Consider all your options and their features and fees before moving money between accounts.

The State of Montana 457(b) Deferred Compensation Plan can help you be better prepared for retirement, and managing your account online is easier than ever!

I want to enroll.

How do I get started?

Go to **www.MPERAdcplans.com**.

- Click on the *REGISTER* button.
- Click on *I have a plan enrollment code.*
- Enter Group ID: 98469-01
- Enter Plan Enrollment Code: R6XTrJTc
- Plan Enrollment Code expiration date: Feb. 1, 2024

FOR ILLUSTRATIVE PURPOSES ONLY.

Follow the on-screen instructions to complete the enrollment process. You will only need this code when you are enrolling for the first time. After that, use the unique username and password you will create to log in to your account.

If you have questions or want help going through the process, contact your local Empower Retirement Plan Counselor at **www.MPERAdcplans.com.**

We're available to meet virtually

Education and guidance are needed no matter the circumstance. In fact, a little education can give you more confidence. Take advantage of the insights and educational resources available to you.

Together, we can help you gain the confidence to make the right choices to meet your financial goals.

Have questions? Your Nationwide Retirement Specialist is here to help.

This material is not a recommendation to buy or sell a financial product or to adopt an investment strategy. Investors should discuss their specific situation with their financial professional.

Jared Williams
406-600-6702
j.williams1@nationwide.com

To schedule an individual appointment, scan this code.

NRM-17526AO.2 (11/22)

Nationwide

Information provided by Retirement Specialists is for educational purposes only and not intended as investment advice. Nationwide Retirement Specialists and plan representatives are Registered Representatives of Nationwide Investment Services Corporation, member FINRA, Columbus, Ohio.

WELLNESS PROGRAM

Provided by *It Starts With Me*

Enhance your well-being

Being well involves more than just using your healthcare plans. Wellness is a daily commitment to eating healthy, staying active, managing stress and maintaining balance.

With this in mind, we coordinate biometric screenings through *It Starts With Me* to help you keep tabs on your level of well-being.

Once a year, biometric screenings will be coordinated with our wellness partner, *It Starts With Me*. These screenings are covered by your health plan at 100%, but you will have options to purchase additional tests, such as, Vitamin D level, etc. We recommend you share the report you receive from It Starts With Me with your healthcare provider(s) so they have the information on file to help solidify treatment plans when necessary and to avoid duplicating tests.

Participation in the biometric screenings are voluntary, but you will receive a discount in your medical premium for participating.

ADDITIONAL WELLNESS BENEFITS:

Health Club Memberships: Participating Clubs at discounted rates through payroll deduction, please visit the HR Department for details.

Flu Shots: Our City-County Health Department will be on-site during the health screening with "It Starts With Me" to provide employee/spouse flu vaccines. Gallatin County will pick up the cost for County employees to receive the flu vaccine (no health benefits information is needed). There is a cost for the spouse's flu vaccine (the Health Department will bill First Choice Health or other coverage).

Ski Passes/Tickets: Discounted rates available. Visit the Commissioner's office for more details.

IPHARM: The goal of the IPHARM program is to help individuals manage chronic conditions such as Pre-diabetes, Diabetes, High blood pressure, Heart disease (high cholesterol) and Asthma.

Health care professionals, faculty, and students will work with you to review medications, health, and any recent lab results. You will be counseled on medication issues, disease management, and lifestyle changes that may be appropriate. There is also the opportunity for referrals to local resources via the CONNECT system.

If you are interested in scheduling an appointment with IPHARM, please complete the survey at the link below and they will reach out to you and schedule a time to talk.

IPHARM worksite program

EMPLOYEE ASSISTANCE PROGRAM

Access Counseling & Benefit Information

Call **(800) 395-1616**

Website:
www.uprisehealth.com/members

Click on "**IBH**"

Access Code: Gallatin

Password: Gallatin

EAP Services for Employees and Families

Confidential Counseling:

Up to 6 face-to-face, video or telephonic counseling sessions for relationship and family issues, stress, anxiety, and other common challenges at NO COST to you.

Tess, AI Chat-bot:

24/7 chatbot for emotional support and check-ins to boost wellness.

24-hour Crisis Help:

Toll-free access for you or a family member experiencing a crisis.

Peer Support Groups:

Online support groups for addiction recovery, depression, anxiety, parenting, frontline workers, grief and loss and more.

EAP Phone App

Easy access to information about the EAP, upcoming events and resources. Visit www.uprise.com or download the Uprise Health app.

Lunch + Learn Webinars

Industry experts will present live monthly employee and supervisor webinars on a variety of topics, followed by Q+A.

Online Resources

Access life-balance and wellbeing resources, monthly webinars, newsletters and more.

Work-Life Balance Services Available

Child & Parenting Services
Adult & Eldercare Services
Webinars & Trainings
Financial Help
Online Legal Forms
Legal Services

Support for Supervisors

Organizational Development
Education & Training
Conflicts in the workplace
Critical Incidents
Drug-free workplace
Employee referrals

TIME AWAY FROM WORK

Paid time off policies

There is no perfect, one-size-fits-all balance between work and home. We provide time off so you can take some "me time" to relax, recover from illness, and take care of personal and family business. Our time off benefits include:

- Paid time off for vacation and illness
- Time off for jury duty and voting
- Bereavement (Up to 40 Hours of Sick Leave)
- Paid Parental Leave

Refer to the Gallatin County personnel policy or your Collective Bargaining Agreement for information on eligibility and specific leave policies.

Sick Leave Donation

Eligible employees have an opportunity to donate sick leave hours to the “Sick Leave Fund” and/or make a “Direct Sick Leave Donation”. Please refer to the “317 Sick Leave Donation Policy”.

If you choose to volunteer a donation, the maximum total donation an employee can make in a calendar year to both the “Sick Leave Fund” and/or “Direct Sick Leave Donation” is 50 hours. Remember, the hours you donate are irrevocable.

Donated hours will be deducted in the following payroll period when the donation is made.

Paid holidays

Gallatin County provides the following paid holidays unless otherwise recognized under a collective bargaining agreement

New Year’s Day

MLK Day

Presidents’ Day

Memorial Day

Independence Day

Labor Day

Columbus Day

Election Day*

Veterans’ Day

Thanksgiving Day

Christmas Day

* Election Day is a paid holiday every two years.

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

- Voluntary Life
- Accident
- Critical Illness

* NOTE that any pre-tax plans can only be enrolled for at annual renewal. Termination of pre-tax plans can only be done if you experience a qualifying event, annual renewal or termination of employment.

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

Gallatin County offers plans to help:

- provide income for survivors
- replace income if you're injured or ill

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

These benefits are offered through Mutual of Omaha.

VOLUNTARY LIFE INSURANCE

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

This benefit is a post-tax payroll deduction.

Voluntary Life Coverage Amounts:

Employee	$10,000 up to $500,000 or 5 times annual earnings, whichever is less. Guaranteed issue of $200,000 for all employees (please see Guaranteed Issue Rules Below).
Spouse	Up to 100% of the employee's amount in increments of $5,000 up to $250,000. Guaranteed issue of $25,000.
Child(ren)	$1,000 up to $10,000. Guaranteed issue of $10,000. Unmarried dependent children from 14 days to age 26.

GUARANTEED ISSUE

If you want to purchase life insurance coverage above the "guaranteed issue" amount OR if you did not elect voluntary life during your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

If you purchased voluntary life insurance during Open Enrollment last year or during your initial eligibility period, you can purchase an additional $20,000 during Open Enrollment with no Evidence of Insurability needed.

VOLUNTARY LIFE INSURANCE COSTS

If you elect Voluntary Life Insurance, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck. Your rate is based on your actual age as of the effective date of the group policy or effective date of coverage. Your rate will increase as you age and move to the next age band.

EMPLOYEE AND SPOUSE VOLUNTARY LIFE/AD&D RATES

	Employee and Spouse Rate
AGE	Per $10,000
<20	$1.20
20-24	$1.20
25-29	$1.20
30-34	$1.30
35-39	$1.50
40-44	$2.10
45-49	$3.20
50-54	$4.90
55-59	$7.40
60-64	$11.30
65-69	$19.80
70-74	$35.10
75-79	$57.60
80+	$116.20
AD&D Coverage	Included in above rates per $1,000

Spousal coverage is based on spouse age.

Eligible children include dependent unmarried children under age 26 as long as you apply for and are approved for coverage for yourself. Premium includes all eligible children.

This is a post-tax payroll deduction.

TO CALCULATE YOUR PREMIUM (do this for the life)

1. Desired Coverage ($1,000 increments)

You:	Spouse:	Children:

2. Step 1 Divided by 1,000 =

You:	Spouse:	Children:

3. Step 2 Multiplied by Rate for Age (or child coverage) =

You:	Spouse:	Children:

TOTAL COST PER MONTH:

You + Spouse + Child from Step 3 =

DEPENDENT CHILDREN

COVERAGE AMOUNT	RATE per $2,000 of coverage
Life	$0.34
AD&D Coverage	Included

Accident Insurance

Insured through Mutual of Omaha

Accident Insurance helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

This benefit is a pre-tax payroll deduction.

COVERED INJURIES MAY INCLUDE:

- **BROKEN BONES**
- **BURNS**
- **TORN LIGAMENTS**
- **CONCUSSIONS**
- **EYE INJURIES**
- **RUPTURED DISCS**
- **LACERATIONS**

THINGS TO CONSIDER

- Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

MEET MARGIE!

MARGIE'S SON KYLE SUFFERED AN ACCIDENT WHILE PLAYING IN HIS FIRST VARSITY FOOTBALL GAME

Benefits paid by Accident Example	
Emergency Room Visit	$150
X-ray	$50
Fractured Wrist	$500
Physical Therapy (3)	$105
TOTAL	$805

Critical Illness

Insured through Mutual of Omaha

Critical illness insurance can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, child care, lost income, or any other need following a critical illness. **You choose a benefit amount from $5,000 to $30,000 for yourself, spouse and dependents.**

You, your spouse and covered children may even be eligible for a $50 Wellness benefit each if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

This benefit is a post-tax payroll deduction.

COVERED CONDITIONS INCLUDE, BUT ARE NOT LIMITED TO:

- **INVASIVE CANCER**
- **HEART ATTACK**
- **STROKE**
- **MAJOR ORGAN FAILURE**
- **END STATE RENAL FAILURE**
- **COMA**

MEET George!

45 YEARS OLD

ELECTED $20,000 OF COVERAGE

DIAGNOSIS: HEART ATTACK

DIAGNOSIS: CANCER (12 MONTHS AFTER HEART ATTACK)

Benefits paid by Critical Illness Example	
Heart Attack	$20,000
Invasive Cancer	$20,000
TOTAL	$40,000

Voluntary Accident

Monthly Premium			
Employee	Employee+Spouse	Employee+Child(ren)	Family
$17.11	$24.40	$30.63	$40.31

Voluntary Critical Illness

Rates per $1,000 Monthly

Age	Employee/Spouse
<30	$0.22
30-39	$0.42
40-49	$0.95
50-59	$1.95
60-69	$4.03
70-79	$7.51
80-99	$10.46

Child insurance is automatic, no separate premium is required.
Spouse premium is based on Employee Age. Rates are adjusted each year on the plan anniversary.

PLAN CONTACTS

HELPFUL RESOURCES

MEDICAL / VISION
First Choice Health
www.fchn.com
Customer Service
(833) 375-0128

DENTAL
Delta Dental
www.deltadentalins.com
Customer Service
(800) 521-2651

FLEXIBLE SPENDING ACCOUNTS (FSA) / DEPENDENT CARE
Health Equity
www.healthequity.com
Customer Service
(866) 735-8195

PHARMACY
ProAct Pharmacy Benefit Management
www.proactrx.com
Member Services
(877)-635-9545

CANCER DIAGNOSIS CASE MANAGEMENT
CancerCARE
Member Services
cancermanagement@cancercareprogram.com
www.cancercareprogram.com
(877) 640-9610

LIFE / AD&D / CRITICAL ILLNESS / ACCIDENT VOLUNTARY LIFE
Mutual of Omaha
www.mutualofomaha.com
Customer Service
(800) 775-8805

EAP
Uprise Health
www.uprisehealth.com/members
Select “IBH”
Access Code: Gallatin | Password: Gallatin
(800) 395-1616

ADDITONAL RESOURCES

Gallatin County
Susan Shane
HR Benefits Manager
(406) 582-3045
Susan.shane@gallatin.mt.gov

Alliant Insurance Services
Sarah Harne
Account Executive
(406) 438-3344
sarah.harne@alliant.com

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

GLOSSARY

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

Gallatin County
MONTANA

This is only a summary of benefits. Please review full details within the carrier policies. If there is a discrepancy between the information contained within this summary and the policies, the policy prevails.