



Medical Plan

Eligibility

All regular full-time, regular part-time and seasonal employees who are scheduled to work at least 20 hours per week, or for a minimum of 1,000 hours per year, are eligible to participate in the company's medical plan. An employee is eligible to be covered under the plan as either a Participant or a Dependent.

Your family members (Dependents) are also eligible for coverage under the company's medical plan.

Eligible Dependents include your:

- Legal spouse (unless you are legally divorced); and
- Children who are:
 - Less than age 26, regardless of marital status; and
 - Your natural child; step-child; legally adopted child; a child placed with you for adoption and for whom, as part of such placement, you have a legal obligation for the partial or full support of the child, including providing coverage under the company's plan pursuant to a written agreement; or a child for whom you have been appointed the legal guardian by a court of competent jurisdiction prior to the child reaching age 19.

Coverage by More than One Plan

When coverage is provided by more than one medical plan, the company's plan will coordinate payment of an incurred expense with the other plan using a method called Maintenance of Benefits (MOB). MOB limits the total payment provided to no more than what the company's plan would have paid had it been the only plan that provides coverage.

Example: Both the employee and his/her spouse are enrolled for coverage under the company's plan (80/20 coinsurance plan) and the spouse also has coverage under his/her employer's plan (70/30 coinsurance plan). The spouse incurs a medical expense of \$100. Under both plans, the individual deductible amount has been met. Here is how the claim will be processed using MOB:

	Spouse's Plan	Company's Plan
Claim	\$100	
Coinsurance	70/30	80/20
Payment	\$70	\$10

In this example, if both plans had been 80/20 coinsurance plans, the company's plan would not have made a payment on this claim.

Notes:

1. Your Dependent Child's spouse or children are not eligible for coverage under the company's medical plan.
2. The age requirement is waived if your unmarried Dependent Child is mentally handicapped/challenged or physically handicapped/challenged, provided that the Child is incapable of self-supporting employment and is chiefly dependent upon you for support and maintenance. Proof of incapacity must be furnished upon request and additional proof may be required from time to time.
3. Your Dependent Spouse or Child on active military duty for more than thirty-one (31) consecutive days is not eligible for coverage under the company's medical plan.
4. A leased employee, independent contractor, or nonresident alien (as defined in the company's flexible compensation plan) is not eligible for coverage under the plan.



Medical Plan (continued)

Plan

Blue Cross and Blue Shield of Montana (BCBSMT) is the administrator for the company's medical plans. Express Scripts, Inc. (ESI) is the administrator for the pharmacy benefits. Information for BCBSMT and ESI can be found in the resource section of this guide.

Plan Options

Participants can elect coverage under the Premier \$500 Plan, Premier Plan or the HSA-Qualified Plan. All plans have deductibles, coinsurance and out-of-pocket maximums.

Participant Tiers

Under each plan option, participants can elect coverage under any of the following tiers:

- Single (employee only)
- Two Party (employee plus spouse or child)
- Family (employee plus spouse and/or children)

Allowable Fee

The company's medical plan makes claims based on an allowable fee for a given procedure or service. Member providers are bound contractually to accept the plan's allowable fee as the appropriate amount to charge for a product or service. The deductible and coinsurance expenses are the participant's responsibility. Participants using a nonmember provider who bills more than the allowable fee may be responsible to pay the provider any amount that exceeds the plan's allowable fee.

Medical Plan (continued)

MEDICAL PLAN OPTION COMPARISON CHART

	Premier \$500 Plan	Premier Plan	HSA-Qualified Plan
General Provisions			
Deductible ¹	\$500/individual \$1,000/family	\$750/individual \$1,500/family	\$1,750/single \$3,500/family
Coinsurance ²	80%/20%	80%/20%	80%/20%
Out-of-Pocket Maximum ³ (Includes deductible)	\$2,000/individual \$4,000/family	\$3,000/individual \$6,000/family	\$3,500/single \$7,000/family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
At the Doctor's Office			
Office Visit	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
At the Hospital			
Inpatient/Outpatient	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Surgical Center	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Urgent Care	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Emergency Room	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Ambulance	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Other Medical Care			
Chiropractic	Subject to deductible & coinsurance; plan pays max benefit of \$30/visit up to 35 visits/year; max X-ray benefit of \$100/year	Subject to deductible & coinsurance; plan pays max benefit of \$30/visit up to 35 visits/year; max X-ray benefit of \$100/year	Subject to deductible & coinsurance; plan pays max benefit of \$30/visit up to 35 visits/year; max X-ray benefit of \$100/year
Diabetes Education	1st visit – deductible and coinsurance is waived All other visits – subject to deductible and coinsurance	1st visit – deductible and coinsurance is waived All other visits – subject to deductible and coinsurance	1st visit – deductible and coinsurance is waived All other visits – subject to deductible and coinsurance
Routine Hearing Exams	Not covered	Not covered	Not covered
Medical Hearing Exams (If ordered by a Physician)	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Hearing Aids (Employee only coverage)	Deductible waived; plan pays 50% up to \$500 per 5 year period for each ear	Deductible waived; plan pays 50% up to \$500 per 5 year period for each ear	Deductible applies; plan pays 50% up to \$500 per 5 year period for each ear
Home Health Care	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Pregnancy			
Prenatal Office Visit	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Prenatal Lab	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Screening Ultrasound	Deductible waived, plan pays 100% for 1 ultrasound per pregnancy; all other charges, including additional ultrasounds, subject to deductible & coinsurance	Deductible waived, plan pays 100% for 1 ultrasound per pregnancy; all other charges, including additional ultrasounds, subject to deductible & coinsurance	Deductible waived, plan pays 100% for 1 ultrasound per pregnancy; all other charges, including additional ultrasounds, subject to deductible & coinsurance
Routine Newborn Exam	Subject to deductible & coinsurance	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Preventive Care - Children ⁴ (Birth through 18 years)	Deductible waived; plan pays 100%		
Routine Physical Exam	Routine physical exam and associated routine testing provided or ordered at the time of the exam		
Routine Immunization	Recommended immunizations adopted by the Centers for Disease Control and Prevention (CDC) • Hepatitis A • Hepatitis B • Tetanus, Diphtheria, Pertussis • Influenza – Type B • Influenza – Seasonal • Measles, Mumps and Rubella • Pneumococcal • Rotavirus • Inactivated Poliovirus • Varicella • Meningococcal • Human Papillomavirus Frequency established under CDC Recommended Immunization Schedule “For Persons Aged 0 Through 6 Years”, “For Persons Aged 7 Through 18 Years” or “Catch-up Schedule For Persons Aged 4 Months Through 18 Years.” See Resource section of this guide for website address to access these schedules		



Medical Plan (continued)

MEDICAL PLAN OPTION COMPARISON CHART (continued)

	Premier \$500 Plan	Premier Plan	HSA-Qualified Plan
Assessment & Screening	As recommended by the American Academy of Pediatrics and Bright Futures. Assessment Screening • Health History • Height, Weight and Body Mass • Blood Pressure • Developmental Surveillance • Alcohol and Drug Use • Psychosocial/Behavioral • Oral Health Risk • Anticipatory Guidance • Sensory - Vision and Hearing • Developmental • Autism • Metabolic • Hematocrit or Hemoglobin • Lead Exposure • Dyslipidemia • Tuberculin Test • Sexually Transmitted Infection • Cervical Dysplasia Age and frequency established under "Periodicity Schedule - Recommendations for Preventive Pediatric Health Care" as adopted by the American Academy of Pediatrics and Bright Futures; see Resource section of this guide for website address to access the schedule		
Other Preventive Care	Services with a rating of A or B in the recommendations of the U.S. Preventive Services Task Force Screening • Visual acuity – children less than 5 years old • Obesity – children age 6 and older • Depression – children age 12-18 • Hearing loss - newborns • Hemoglobinopathies (sickle cell) - newborns • Phenylketonuria (PKU) – newborns • HIV – adolescent children at increased risk Counseling • Obesity – children age 6 and older • Sexually transmitted infections – adolescent children at increased risk Other • Iron supplements – As prescribed, for children age 6-12 months at increased risk for anemia • Oral Fluoride - As prescribed, for children age 6 months or older if water source is deficient in fluoride • Prophylactic medication for gonorrhea – newborns		
Preventive Care - Adults⁴ (Age 19 and older)	Deductible waived; plan pays 100%	Deductible waived; plan pays 100%	Deductible waived; plan pays 100%
Routine Physical Exam	Routine physical exam and associated routine testing provided or ordered at the time of the exam		
Routine Immunization	Recommended immunizations adopted by the Centers for Disease Control and Prevention (CDC). • Hepatitis A • Hepatitis B • Tetanus, Diphtheria, Pertussis • Influenza • Measles, Mumps and Rubella • Pneumococcal • Varicella • Meningococcal • Human Papillomavirus • Shingles Frequency established under CDC Recommended Adult Immunization Schedule; see Resource section of this guide for website address to access the schedule		
Mammogram	Routine exam and associated lab charges		
Pap Test	Routine exam and associated lab charges		
PSA Test	Routine exam and associated lab charges		
Colorectal Cancer Screening	Tests and procedures within the age and frequency guidelines established by the American Cancer Society (ACS); see Resource section of this guide for website address to access the ACS guidelines (Note: Pursuant to the Affordable Care Act, tests/procedures at any age if at high risk.		
Other Preventive Care (cont.)	Services with a rating of A or B in the recommendations of the U.S. Preventive Services Task Force Screening • Interventions to support breast feeding – pregnant women • High blood pressure • Cholesterol abnormalities - men age 35+ or age 20+, if at increased risk; women age 45+ or age 20+, if at increased risk • Diabetes - adults with sustained blood pressure (either treated or untreated) greater than 135/80 • Abdominal aortic aneurysm - men age 65-75 who have smoked • Depression • Obesity • Bacteriuria - pregnant women at 12 to 16 weeks gestation or at first prenatal visit, if later • Iron deficiency anemia - asymptomatic pregnant women • Hepatitis B - pregnant women • Rh incompatibility- pregnant women • Osteoporosis - women age 65+ or age 60+ if increased risk of osteoporotic fractures • Chlamydial infection - women age <24 or age 19+, if at increased risk • Gonorrhea – women at increased risk • Syphilis – adults at increased risk • HIV - adults at increased risk		



Medical Plan (continued)

MEDICAL PLAN OPTION COMPARISON CHART (continued)

	Premier \$500 Plan			Premier Plan			HSA-Qualified Plan
Other Preventive Care (cont.)	Services with a rating of A or B in the recommendations of the U.S. Preventive Services Task Force (continued). Counseling - BRCA screening – women with family history of BRCA 1 or BRCA 2 risk factors - Chemoprevention of breast cancer – women at high risk - Nutrition/Dietary – adults at increased risk for cardiovascular and diet-related chronic disease - Obesity - Tobacco use - Alcohol misuse pregnant and those at high risk - Human papillomavirus testing - age 30+, every 3 years Other - Aspirin to prevent cardiovascular disease – men age 45-79; women age 55-79, when prescribed by a physician - Folic acid supplements - women capable of pregnancy Women’s Preventive Services - Well-woman visits - annually - Screening for gestational diabetes - women 24 to 28 weeks - Sexually transmitted infections – adults at increased risk - Counseling for sexually transmitted infections - Counseling and screening for human immune-deficiency virus. - Contraceptives methods and counseling - Breastfeeding support, supplies, and counseling - Screening and counseling for interpersonal and domestic violence						
Prescription Drugs	Employee Co-Pay			Employee Co-Pay			Employee Coinsurance Drugs on HSA-Qualified Plan Preventive List - coinsurance amount indicated below All Other Covered Drugs - 100% until medical deductible is met, then coinsurance amount indicated below
Retail - 30 day supply	%	Min	Max	%	Min	Max	
Generic ⁵	10%	\$20	\$200	10%	\$20	\$200	0%
Preferred Brand ⁶	20%	\$30	\$200	20%	\$30	\$200	10%
Non-Preferred Brand ⁷	30%	\$45	\$200	30%	\$45	\$200	20%
Retail - 31-60 day supply	%	Min	Max	%	Min	Max	
Generic ⁵	10%	\$40	\$400	10%	\$40	\$400	0%
Preferred Brand ⁶	20%	\$60	\$400	20%	\$60	\$400	10%
Non-Preferred Brand ⁷	30%	\$90	\$400	30%	\$90	\$400	20%
Retail - >60 day supply	%	Min	Max	%	Min	Max	
Generic ⁵	10%	\$60	\$600	10%	\$60	\$600	0%
Preferred Brand ⁶	20%	\$90	\$600	20%	\$90	\$600	10%
Non-Preferred Brand ⁷	30%	\$135	\$600	30%	\$135	\$600	20%
Specialty - 30 day supply	%	Min	Max	%	Min	Max	
Generic ⁵	10%	\$20	\$200	10%	\$20	\$200	0%
Preferred Brand ⁶	20%	\$30	\$200	20%	\$30	\$200	10%
Non-Preferred Brand ⁷	30%	\$45	\$200	30%	\$45	\$200	20%
Specialty - >30 day supply	%	Min	Max	%	Min	Max	
Generic ⁵	10%	\$60	\$600	10%	\$60	\$600	0%
Preferred Brand ⁶	20%	\$90	\$600	20%	\$90	\$600	10%
Non-Preferred Brand ⁷	30%	\$135	\$600	30%	\$135	\$600	20%
Mail Order - 90 day supply							
Generic	\$30			\$30			0%
Preferred Brand	\$50			\$50			10%
Non-Preferred Brand	\$80			\$80			20%
Rx Out-of-Pocket Max ⁸	\$750 per person			\$750 per person			Medical Out-of-Pocket Maximum



Medical Plan (continued)

Notes and definitions:

Deductible: The amount of eligible expenses that an employee must pay before the plan pays benefits.

- a. Under the Premier \$500 and Premier Plans, the plan will pay benefits under a Single coverage tier once the person has met the individual deductible amount and under a Two Party or Family coverage tier once two or more persons have met the individual deductible amount. **A covered person cannot receive credit toward the family deductible for more than the individual deductible amount.**
- b. Under the HSA-Qualified Plan, the plan will pay benefits under a Single coverage tier once the person has met the individual deductible amount and under a Two Party or Family coverage tier once one or more persons have met the family deductible amount. **A covered person can receive credit toward the family deductible for more than the individual deductible amount.**
2. **Coinsurance:** The participant's share of the cost of eligible expenses after the deductible is met.
3. **Out-of-Pocket Maximum:** The maximum amount of eligible expenses that an employee pays per year through the deductible and coinsurance before the plan pays 100 percent. Note: Under the HSA-Qualified Plan for Two Party or Family coverage, the family out-of-pocket maximum must be met before the plan will pay 100% of the expenses for any family member. A covered person can receive credit toward the family out-of-pocket for more than the individual out-of-pocket.
4. **Preventive Care Benefits** - The preventive care benefits are based on services that have a rating of A or B as set forth in the recommendations of the United States Preventive Services Task Force, immunizations for routine use as set forth in the recommendations of 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 benefits are subject to change.** To view a current list of recommendations and guidelines, access the websites for the above agencies at the addresses listed in the resource section of this guide. (Note: The American Cancer Society recommends that men make an informed decision with their doctor about the PSA test.)
5. **Generic:** A generic drug is a Food and Drug Administration (FDA) approved copy of a brand name drug. Generic drugs (a) contain the same active ingredients as a brand name drug; (b) are identical in dose, form and administrative method; and (c) have the same indications, cautions and instructions. When a brand name drug has a patent that expires, drug companies can introduce, at a lower cost, competitive generic versions after the drug has been thoroughly tested and approved by the FDA.
6. **Preferred Brand:** A Preferred Brand drug is a brand name drug that has been placed on a preferred medication list as determined by the company's pharmacy benefit plan manager based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class.
7. **Non-Preferred Brand:** A Non-Preferred Brand drug is a brand name drug that has not been placed on a preferred medication list as determined by the company's pharmacy benefit plan manager.
8. **Rx Out-of-Pocket Max:** The maximum annual out-of-pocket cost for prescription drugs under the Premier \$500 and Premier Plans is \$750 per family member. The maximum annual out-of-pocket cost for prescription drugs under the HSA-Qualified Plan is the medical plan out-of-pocket maximum.