CONSUMER DIRECT CARE NETWORK

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2021 Benefits Guide

Montana Caregivers

WELCOME TO YOUR BENEFITS

The Consumer Direct Care Network is proud to offer a comprehensive benefits package to our valued employees and their families. This package is designed to provide choice, flexibility, and value.

This summary ("Summary") was prepared for the Consumer Direct Management Solutions Health and Welfare Plan (the "Plan") as it exists on January 1, 2021. Consumer Direct Holdings, Inc. (the "Employer") reserves the right to amend the Plan, and any benefit under the Plan.

Each benefit plan is summarized in a certificate of insurance booklet issued by an insurance company, a summary prepared specifically for that benefit plan or another written governing document (collectively, these documents are referred to as the "governing documents"). Please refer to the governing documents for complete details on specific benefit plans such as benefit coverage, definitions, coordination of benefits, waiting periods, exclusions and limitations. If there is any inconsistency between this Summary and the Plan document or the governing documents, the official Plan document and governing documents will always be followed in the actual determination of your benefits or rights.

This Benefit Guide will help you learn more about your benefits and review highlights of the available plans. This information, along with other decision-making tools, is also available at: **cdmtcaregivers.benefithub.com**. In addition, you can contact the Human Resources Department (HR) or your Benefit Advocate team at Gallagher Benefit Services for help understanding your benefits and completing your paperwork. You can find the relevant phone numbers on page 3 of the guide under "Your Benefit Contacts".

To assist in making decisions regarding your healthcare coverage your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, as required by Healthcare Reform regulations. The SBC is available on the web at **cdmtcaregivers.benefithub.com**. Please contact HR for a paper copy free of charge.

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IMPORTANT:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 23 for more details.

YOUR BENEFITS CONTACTS

CONSUMER DIRECT HUMAN RESOURCES DEPARTMENT

Phone: 844.360.4747

infobenefits@consumerdirectcare.com

Confidential fax: 866.837.1983

GALLAGHER BENEFIT ADVOCATES

If you do not receive satisfactory service from your insurance carriers, a Benefit Advocate (a service provided by Gallagher), is available to help with issues pertaining to your health, life and disability benefits.

Please do not include any confidential or sensitive information, such as social security numbers or health information, via email. Once you are connected to a Benefit Advocate, more sensitive information can be shared.

You can reach a Benefit Advocate at:

bac.consumerdirect@ajg.com

Toll free: 833.678.7790

6:00 a.m. – 6:00 p.m.

Pacific Time

24/7 Benefits Information:

Direct Benefit Contacts

Benefit	Administrator	Contact Information		Website
Medical	BCBS MT	Customer Service	800.447.7828	www.bcbsmt.com
		24-hour Nurse Line	877.213.2565	www.bcbsmt.com/member
Dental	BCBS MT	Customer Service	866.739.4090	www.bcbsmt.com
Telemedicine	98point6	98point6 app is available through Google Play or Apple's App Store		
Voluntary Vision	Vision Service Plan	Customer Service	800.877.7195	www.vsp.com
Life/AD&D, and Voluntary Life/AD&D	Unum	Customer Service	800.421.0344	www.unum.com
Flexible Spending Accounts	Navia Benefit Solutions	Customer Service	800.669.3539	www.naviabenefits.com
Employee Assistance Program	Unum	24/7	800.854.1446	www.unum.com/lifebalance
Concierge Customer Service	Health Advocate		866.695.8622	www.healthadvocate.com/members

ENROLLMENT CHECKLIST

At Consumer Direct, we value our people. Our goal is to offer a benefits package that enhances your and your family's health and lifestyle. We also recognize our employees and their families have unique needs, so we offer benefit options that fit your needs.

BENEFIT PLANS:

- PPO Medical Plan which includes telemedicine
- Dental Insurance (which is included with the medical plan, as well as offered individually as a voluntary option)
- Flexible Spending Accounts for tax savings on health and dependent care expenses
- Voluntary Vision
- Basic Life and Accidental Death & Dismemberment Insurance
- Voluntary Life Insurance
- Voluntary Benefits – Critical Illness, Accident, and Hospital Insurance
- Employee Assistance Program (EAP)

PREPARE EVERYTHING YOU WILL NEED

- Social security numbers for you and any family members whom you want to cover and/or identify as your life insurance beneficiaries
- Dates of birth for your family members
- ID cards for any other medical plans under which you or your family members are covered

CHOOSE YOUR MEDICAL & VOLUNTARY BENEFITS

- Take the time to review the benefit outlines provided in this guide.
- To make sure your family doctor is covered by the plans you have chosen, check the Provider Directory online or call customer service (see "Your Benefits Contacts" on page 3 of this guide).

IDENTIFY YOUR LIFE INSURANCE BENEFICIARY

DECIDE HOW MUCH TO CONTRIBUTE TO FLEXIBLE SPENDING ACCOUNTS

- Determine how much money you should put into your Flexible Spending Account (FSA) for medical and dependent care expenses.
- If you enroll, the company will divide your annual FSA contributions by the number of pay periods remaining in the calendar year, to arrive at your pay period pre-tax FSA contribution.

ENROLL ONLINE

YOU ARE DONE!

ELIGIBILITY

WHO IS ELIGIBLE?

Employees are eligible for benefits based on the number of hours worked per week. Workers who are classified as independent contractors, leased employees or temporary employees are not eligible for coverage under the plan. New employees are eligible for benefits on the first of the month following/coinciding with a 30-day waiting period.

	EAP	Vision Basic Life/AD&D Supplemental Life Dependent Care FSA	Medical Dental Virtual Care Healthcare FSA
All Employees	X		
Employees working 10 hours or more per week	X	X	
Employees working 30 hours or more per week	X	X	X

Please inquire with HR about your benefit eligibility date. You may enroll your eligible dependents in medical, dental, vision and/or life insurance. Dependents are also eligible to receive Employee Assistance Program (EAP) services. Eligible dependents include:

- Your legal spouse
- Your domestic partner (please contact HR to discuss tax implications of domestic partner benefits)
- Your children up to age 26, regardless of student or marital status
- Any dependent child who is incapable of self-support because of a physical or mental disability

MAKING CHANGES TO YOUR BENEFITS

You may make changes to your benefit elections once a year during the annual Open Enrollment period. Selected benefits are effective for a full calendar year, unless you have a "qualifying event", a lapse in benefit premium payment, or leave employment.

If you experience a qualifying event, you can make changes to your benefits by contacting HR within 30 days of the qualifying change event. The change to your benefits must be consistent with the event. For example, if you have a new baby, you can enroll the child as a dependent under your current health plan, but you may not remove another dependent who is already covered.

QUALIFYING EVENT CHANGE GUIDE				
Event	**Sample Documents**	**Medical & Vision**	**Flexible Spending Accounts (FSA)**	**Voluntary Life**
Marriage	Marriage certificate	May enroll newly eligible spouse or you may drop coverage if enrolling in spouse's plan *(Additional documentation required if dropping plans)*	Healthcare FSA or Limited Purpose FSA: Same as Medical Dependent Care FSA: May enroll, increase, decrease or cease election	May enroll, increase, decrease or cease coverage
Gain dependent Birth/adoption Foster child	Birth certificate	May enroll or increase coverage for newly-eligible dependent	May enroll or increase election	No change
Spouse gains employment	Notification from new employer *(Additional documentation required if dropping plans)*	May drop or decrease coverage for self and dependents who become eligible for, and elect coverage under, spouse's plan	May enroll, increase or decrease election	May increase or decrease coverage
Spouse loses employment	Notification from prior employer	May enroll self, spouse or dependents who lose eligibility under spouse's prior plan	May enroll or increase election	May increase or decrease coverage
Loss of spouse	Divorce settlement, death certificate, etc.	May drop election only for spouse. May elect for self or dependents who lose eligibility under spouse's plan.	May decrease election	May enroll, increase, decrease or cease coverage

BENEFIT COSTS

PREMIUM COST – MEDICAL PLAN

	Monthly Cost	Medical & Dental through BCBS MT
Employee only	Total Monthly Cost	$821.83
	Your Monthly Cost	$40.00
	Your Per Pay Period Cost	**$20.00**
Employee + Spouse	Total Monthly Cost	$1,643.66
	Your Monthly Cost	$892.07
	Your Per Pay Period Cost	**$446.03**
Employee + Child(ren)	Total Monthly Cost	$1,397.10
	Your Monthly Cost	$632.56
	Your Per Pay Period Cost	**$316.28**
Employee + Family	Total Monthly Cost	$2,298.13
	Your Monthly Cost	$1,589.49
	Your Per Pay Period Cost	**$794.74**

PREMIUM COST – VOLUNTARY DENTAL

If waiving medical coverage, employees have the option to enroll in the dental plan, unbundled from medical. If enrolling in Medical, your election includes the dental plan.

	Voluntary Dental provided by BCBS MT	
Employee only	Total Monthly Cost	$35.36
	Your Monthly Cost	$35.36
	Your Per Pay Period Cost	**$17.68**
Employee + Spouse	Total Monthly Cost	$70.75
	Your Monthly Cost	$70.75
	Your Per Pay Period Cost	**$35.38**
Employee + Child (ren)	Total Monthly Cost	$60.13
	Your Monthly Cost	$60.13
	Your Per Pay Period Cost	**$30.07**
Employee + Family	Total Monthly Cost	$95.52
	Your Monthly Cost	$95.52
	Your Per Pay Period Cost	**$47.76**

PREMIUM COST – VOLUNTARY VISION

	Voluntary Vision provided by VSP	
Employee only	Total Monthly Cost	$13.70
	Your Monthly Cost	$13.70
	Your Per Pay Period Cost	**$6.85**
Employee + Spouse	Total Monthly Cost	$21.93
	Your Monthly Cost	$21.93
	Your Per Pay Period Cost	**$10.97**
Employee + Child (ren)	Total Monthly Cost	$22.38
	Your Monthly Cost	$22.38
	Your Per Pay Period Cost	**$11.19**
Employee + Family	Total Monthly Cost	$36.09
	Your Monthly Cost	$36.09
	Your Per Pay Period Cost	**$18.05**

The "per pay period" costs are collected from the first two pay periods of the month. During months with 3 paychecks, your premiums will be deducted from the first 2 paychecks.

MEDICAL BENEFITS OVERVIEW

Administered by BlueCross BlueShield of Montana

BLUECROSS BLUESHIELD OF MONTANA

Consumer Direct offers a PPO Medical plan through BlueCross BlueShield of Montana that is supported by a large network of medical care providers. You can elect to use an in-network Comprehensive Major Medical, or "CMM", provider or out-of-network provider for your health care services. If you choose an in-network provider, your cost will be less. Please see the plan highlights on the next page for the difference in coverage between in-network and out-of-network. You do not need a referral for specialist care. You can find providers online or by phone – please see the information in "Your Benefits Contacts" for additional information.

CALENDAR YEAR DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses. The family deductible applies if you have family members enrolled in your plan along with you.

THE BLUECARD® PROGRAM - WORLDWIDE COVERAGE

The BlueCard® Program offers you access to a network of contracted Blue Cross Blue Shield providers across the world if you're traveling or living outside of Montana. Just like at home, these networks can save you time and money. For covered benefits that are available to you outside of Montana, please refer to your Benefit Booklet or call BCBSMT.

Note: For emergency care outside of Montana, go to the nearest hospital and contact BlueCard® if admitted. For assistance finding a PPO provider or questions, contact BlueCard®:

Inside the U.S. call 800.810.BLUE (2583)

Outside the U.S. (call collect): 804.673.1177

NO COST EXTRAS

Through Blue, you have access to many resources through your member portal. Log in to access the Well on Target Member Portal which includes access to Tobacco Cessation, Fitness Programs, Blue Points (where members can earn points and receive rewards), and more. The Blue member access also allows members to connect in programs where applicable—for example the Special Beginnings Maternity Program.

BLUE365® MEMBER DISCOUNT PROGRAM https://www.blue365deals.com/BCBSMT/

Full range of savings from top national and local retailers. Some discounts include:

- Dental, vision and hearing products and services- Dental Solutions, Philips Sonicare, Beltone, HearUSA, EyeMed, Davis Vision, LasikPlus, Contacts Direct. ***Many more..***
- Fitness gear and apparel – Garmin, Fitbit, Livekick, Gym Network 360, Echelon Fitness, Rebok, Sketchers, ***Many more..***
- Gym memberships- Gym Network 360
- Family activities- Petplan, Medline, Petmate, ***Many more..***
- Healthy eating options- InsideTracker, Seattle Sutton, Jenny Craig, Kind, Nutrisystems, ***Many More…***

MEDICAL BENEFITS—PLAN HIGHLIGHTS

	Blue Cross Blue Shield of MT	
PCY = Per Calendar Year	**In-Network**	**Out-of-Network***
Medical Plan Deductible Per Person/Per Family	$1,500/$3,000	$3,000/$6,000
Your cost share will be as follows:		
Preventive Care Routine physical exams, well child care, immunizations, preventive screening tests	Covered in Full	50% after deductible
Routine Mammograms	Covered in Full	Covered in Full
Physicians Services Office visits, outpatient mental health and outpatient chemical dependency	$25 copay	50% after deductible
Urgent Care Services	$25 copay	50% after deductible
Chiropractic Care – Up to 15 visits PCY	$25 copay	50% after deductible
Prescription Drugs – Up to 30-day supply	At Value Pharmacy	At Participating Pharmacy
Generic	$0 copay	$5 copay
Preferred Brand	$35 copay	$45 copay
Non-Preferred Brand	$60 copay	$70 copay
Specialty Prescriptions	Lesser of $200 or 20%	Lesser of $200 or 20%
Mail Order Prescription - Up to 90-day supply	3 x retail copays	
Outpatient Surgery	20% after deductible	50% after deductible
Outpatient Diagnostic Lab & X-Ray	20% after deductible	50% after deductible
Lab, X-Ray and Major Diagnostics (CT, PET, MRI, MRA and Nuclear Medicine)	20% after deductible	50% after deductible
Hospital/ Facility Services	20% after deductible	50% after deductible
Emergency Room Services (in Emergencies)	20% after deductible	
Rehabilitation Services	20% after deductible	50% after deductible
Out-of-Pocket Maximum	$3,000/$6,000	$6,000/$12,000

***OUT-OF-NETWORK ALLOWABLE**

When you use out-of-network services, your plan will pay a percentage of the allowable amount. This amount is usually the same as what the plan would pay for similar in-network services, and it is also known as Usual, Customary & Reasonable (UCR). If your medical provider charges more than the allowable amount, you will responsible for the difference.

PRESCRIPTION DRUG PROGRAM

The medical plan includes a comprehensive prescription drug program. Your out-of-pocket cost is lowest when you buy generic drugs, and highest when you buy brand drugs that are not on the drug formulary or preferred drug list.

Your plan covers a broad list of drugs. To determine whether your drug is on the list, please visit www.bcbsmt.com and view the Performance Drug List to view the plan formulary. There, you can also find a list of in-network pharmacies via the Value Network. The drug list is updated periodically to ensure that newer, more effective drugs are listed. Drugs are automatically removed from the list when generic alternatives become available.

When filling a prescription, present your member ID card to any participating pharmacy. If using an out-of-network pharmacy, you will need to pay the drug cost out-of-pocket and then submit a claim form to be reimbursed for the amount of coverage. If your doctor approves, you can get a 90-day fill of your non-specialty medication at a retail pharmacy.

MAIL ORDER PRESCRIPTION DRUGS

If you take prescription drugs on an ongoing, maintenance basis, you can save a trip to the pharmacy by using the mail order program and ordering a 90-day supply at a time.

To take advantage of this program, download all required Mail order forms online from AllianceRx.

Send your prescription(s), Mail order Form, Health, Allergy and Medication Questionnaire (if you are taking more than one medication), and payment for each prescription to the address on the order form. You will receive your prescriptions by mail in about two weeks, delivered in sealed, insulated (when necessary) and tamper-evident packaging.

We highly recommend comparing prescription drug prices in your local area and with the mail order pharmacy to ensure you receive the best price.

IMPORTANT

When a generic equivalent is available, you will be charged the difference in Brand vs. Generic cost unless your physician indicates on the prescription that generic substitution is not allowed.

Specialty drugs are dispensed solely through a Specialty Pharmacy. You will be notified of the refill procedure if you are taking one of these drugs.

NURSE LINE

Because we understand that your healthcare needs don't have a schedule, the medical plan offers you peace of mind with round-the-clock access to the BCBSMT 24-hour Nurse Line. The Nurse Line is staffed by registered nurses who are trained to offer advice, guidance and support to you and your family.

TREATMENT RECOMMENDATIONS

Nurse Line nurses are trained to ask the right questions to make a recommendation about when and where you should seek treatment for an injury or illness. Nurses base their recommendation on your symptoms and other relevant health conditions or history. If you need immediate care, nurses can direct you to the closest urgent care center in your area.

FREE AND CONFIDENTIAL

All calls to our Nurse Line nurses are free and always remain confidential so you can talk as much and as openly as needed about the health conditions that concern you.

HONEST INFORMATION AND OPEN CONVERSATION

Our Nurse Line nurses have access to high-quality health resources and will listen to your concerns, answer questions and offer advice about many health-related topics. Healthcare advice from the knowledgeable Nurse Line nurses can help you understand and better manage your health conditions, as well as provide peace of mind about what to expect from a health condition. Nurses are accessible by phone 24-hours a day, seven days a week at 877.213.2565.

TELEMEDICINE

Administered by 98point6

98point6 is a new kind of on-demand primary care that connects you with a physician via your smartphone - meaning you can get diagnosis and treatment from anywhere. So whether you're on the go, home sick in bed or multi-tasking throughout your day, immediate care is available on your schedule.

Benefit-enrolled employees and their enrolled dependents ages 1 and older will have unlimited access to 98point6 at **no cost**. Benefits include:

- Expert care from board-certified physicians
- No appointments, no time limits
- Get primary care anywhere on your schedule

ELIGIBILITY

Access to 98point6 is available to all medical benefit enrolled employees and their enrolled dependents ages 1 and older

98POINT6 PHYSICIANS CAN:

- Answer any medical questions you have (no question is too small)
- Diagnose and treat acute and chronic illnesses
- Help you better understand any primary care conditions, including, but not limited to diabetes, asthma, back problems and high blood pressure
- Outline care options
- Order any necessary prescriptions or lab tests

GETTING SET UP WITH 98POINT6 IS EASY:

All you need to create an account and sign in to 98point6 is a mobile phone number. Your mobile number serves as your account number and best of all, there's no password to remember. After entering your mobile number, 98point6 will send you a text to confirm it's you (message and data rates apply). After entering your unique pin, you'll be able to choose between a personal subscription plan or an employer-sponsored plan. Please select employer-sponsored plan. For the best 98point6 experience, it is recommended to download the 98point6 app from the Apple App store or Google Play.

1. Download the free 98point6 app from the App Store or Google Play
2. Create your profile
3. Accept your employer benefit through Consumer Direct

IMPORTANT

Prescriptions or labs ordered will be processed and billed in accordance with your medical plan benefits.

DENTAL

Administered by BlueCross BlueShield of Montana

Oral healthcare is very important to your health and general well-being. Consumer Direct Management Solutions provides comprehensive dental coverage through BCBS of MT. Under this plan, you may seek care from a participating dentist or any licensed dentist; however, if you use a BCBS MT participating dentist, there are no claim forms necessary and dentists cannot charge you for any charges above usual, customary and reasonable (UCR) charges.

	BCBS of MT
Calendar Year Deductible Per Person Per Family	 $50 $150
Calendar Year Maximum Benefit Per Person	$1,000
After the deductible is satisfied, your cost shares will be as follows:	
Diagnostic and Preventive Exams, x-rays, cleanings, topical fluoride application, space maintainers, sealants	Covered in Full (deductible waived)
Basic Services Fillings, extractions, oral surgery, periodontics, endodontics	20% (deductible applies)
Major Services Crowns, bridges, dentures, implants	50% (deductible applies)

Late Enrollment Penalty: If an employee or dependent does not enroll on the dental plan within 30 days of initially becoming eligible for coverage, they will not be able to enroll on the plan until the next open enrollment period.

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

IMPORTANT

Benefits are paid at the negotiated fee level for all providers. Benefits for services will be paid at the 90th percentile of the amount charged by the majority of dentists in the area.

BEFORE TREATMENT BEGINS

You should have your dentist's office contact BCBS of MT if you expect the charges to be more than $300.

Your dentist's office will coordinate with BCBS of MT to determine how much of the cost will be covered under the plan, and how much will be your responsibility.

CONCIERGE CUSTOMER SERVICE

Administered by HealthAdvocate

Health Advocate is a service provided at no cost to you from your employer. The service can help you and your eligible family members resolve healthcare and insurance-related issues.

During your first call, you will be assigned a Personal Health Advocate who will begin helping you right away. The Personal Health Advocates are typically registered nurses, supported by medical directors and benefits and claims specialists.

- Assist with complex conditions
- Find specialists
- Address eldercare issues
- Clarify insurance coverage
- Work on claim denials
- Help negotiate fees for non-covered services

HOW WE CAN HELP

- Point you in the right direction
  - Find the right doctors, dentists, specialist, and other providers
  - Schedule appointments, arrange for treatments and tests
  - Answer questions about test results, treatments and medications
- Confused by health insurance?
  - Clarify benefits; uncover billing errors
  - Get appropriate approvals for covered services
- Want to save on healthcare costs?
  - Find options for non-covered services
  - Negotiate payment arrangements with providers
  - Provide information about generic drug options
- Help with eldercare services
  - Find in-home care, adult day care, assisted living and long-term care
  - Clarify Medicare, Medicare Supplement plans and Medicaid
  - Research transportation to appointments

WHO IS COVERED?

Available to eligible employees who enrolled on a Consumer Direct medical plan, their spouses or domestic partners, dependent children, parents and parents-in-law.

Help Is Only a Phone Call Away!

24/7 Support at:

866.695.8622

Visit online at: **healthadvocate.com/members**

FLEXIBLE SPENDING ACCOUNT (FSA)

Administered by Navia Benefit Solutions

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars to spend on certain health and daycare expenses. You elect how much you want to contribute into your Flex account for the year. Your annual contribution will be taken out semi-monthly from paychecks through the end of the calendar year.

HEALTHCARE SPENDING ACCOUNT

Your Healthcare FSA election will reimburse you for eligible expenses that you, or your IRS qualified dependents incur during the plan year. The entire annual amount you elect can be used at any time during the plan year. When you incur the expense, you can either use your FSA debit card or pay out-of-pocket and send a claim to Navia.

You may contribute up to **$2,750** per calendar year into the Healthcare spending account. Eligible expenses include items like copays, coinsurance, deductibles, orthodontia, glasses/contact lenses, and much more. For a complete list of eligible expenses, refer to IRS Publication 502: at irs.gov/publications.

DEPENDENT CARE SPENDING ACCOUNT

Your Dependent Care (or day care) FSA lets you use "before-tax" dollars to pay day care expenses for children age 12 and under, or elder dependents unable to care for themselves. The care must be necessary for you and your spouse to remain gainfully employed. Care may be provided through live-in care, baby sitters, and licensed day care centers. You can be reimbursed only up to the amount available in your account

You may contribute up to **$5,000** per calendar year (or $2,500 if married and filing separately) into the Dependent Care spending account (only the custodial parent may use the Dependent Care spending account).

IMPORTANT RULES FOR FSAS:

- Plan carefully! You must claim all elected funds by the end of the run-out period. After the run-out period is complete, unused Healthcare and Dependent Care FSA balances will be forfeited. This is sometimes known as the "Use It or Lose It" Rule.
- If you have $550 or less remaining in the Healthcare FSA at the end of the 2021 plan year, that balance will carry over automatically to the 2022 Healthcare FSA year. This carry over feature only applies on the Healthcare FSA.
- Money cannot be transferred between FSA accounts.

NAVIA RESOURCES

To manage your FSA benefits, go to **naviabenefits.com**. When registering for the first time after your effective date, use "CDH" as your employer code. Features of your online account include:

- FSA Debit Card: Use your FSA debit card to pay for eligible FSA expenses at the point of purchase at pharmacies and many other authorized retailers and providers. The debit card lets you pay for eligible expenses directly from your FSA so you do not have to wait for reimbursement. However, in the event Navia requires documentation for a purchase made with the benefits debit card, it is your responsibility to provide the detailed copy of your store receipt (not just a credit slip stating dollar amount).
- Account Access: Order additional debit cards, update bank and address information and see up-to-date details of your benefits.
- Online Claims Submission: Upload your documentation and complete the online wizard.
- Download Mobile App: MyNavia allows you to snap a photo and submit for reimbursement direct from your mobile device.
- FlexConnect. This unique tool assists you in paperless claims filing by linking up to your online BCBSMT accounts to find your reimbursable healthcare claims. Once found, they will appear in your online account and you can select which ones to be reimbursed for.

HOW DO I CONTACT NAVIA?

phone (800)669-FLEX(3539) | fax (866) 535-9227 | claims@naviabenefits.com | P.O Box 53250 Bellevue, WA 98105

VOLUNTARY VISION BENEFITS

Administered by Vision Service Plan

Consumer Direct offers vision coverage through Vision Service Plan (VSP). VSP offers you access to a large network of doctors nationwide. You may choose to obtain your vision services from any provider you wish. However, when you access care from in-network providers, your benefits are greater, and your out-of-pocket costs are less.

Many of the services available through VSP are based on a 365-day benefit cycle. Your eligibility to receive vision benefits is tracked from service date to service date; there is no "grace period". If you use your vision benefits too soon, your claim will be denied. Please refer to the table below to find out how often you are eligible for services. You may also call VSP direct to find out what your service plan year is, or visit their website at **vsp.com**. Click "See your personal benefit information" under "Members" to register and login.

When you see a VSP provider you will receive an additional 20% discount for any charges beyond the plan allowance for services and hardware.

	VSP Provider	Any Licensed Provider
Basic Examination *-once every 12 months-*	Covered in Full	Reimbursed up to $50
Contact Lens Fitting and Evaluation *-once every 12 months in lieu of eyeglasses-*	15% discount off of services, not to exceed $60	Reimbursement included in contact lens allowance
Hardware Co-pay *(does not apply for elective contact lenses)*	$20 co-pay	$20 co-pay
After the copay has been satisfied, your cost shares will be as follows:		
Lens Allowance* *-once every 12 months-* Single Vision Bifocals Trifocals	 Covered in Full Covered in Full Covered in Full	Reimbursed up to: $50 per pair $75 per pair $100 per pair
Contact Lenses (in lieu of eyeglasses) *-once every 12 months-* Medically Necessary Elective	 Covered in Full $130 allowance	Reimbursed up to: $210 $105
Frames *-once every 24 months-*	$130 allowance**	Reimbursed up to $70

*If you purchase oversize lenses or have anything "special" done to your lenses (i.e., tinting, scratch guard, etc.), you will be responsible for this cost.

**Patients choose from a wide selection of fully covered frames. Because of the cosmetic nature of frames and the rapidly changing styles, VSP has a limit on the cost of frames provided under the program. The limit is designed to cover the majority of frames currently in use. More expensive frame styles are also available for an additional charge. Your vision care provider will advise you of which frames are covered at 100%.

HOW DO YOU USE THE PLAN?

When you make an appointment with an in-network provider, identify yourself as a VSP member. The VSP member doctor will contact Vision Service Plan to verify your eligibility and plan coverage. The provider will bill VSP directly for all covered services.

IMPORTANT

Not all lenses are paid in full; some have additional features. Be sure to check with your provider.

BASIC LIFE INSURANCE

Administered by Unum

Life insurance provides financial security for your dependents. When you first enroll in life insurance benefits, you will need to designate a beneficiary who would receive the benefits in the event of your death. You may change or update your beneficiary designation at any time. Consumer Direct provides all eligible employees (employees working 10+ hours per week) with Basic Life and Accidental Death and Dismemberment (AD&D) Insurance benefits as outlined below.

BASIC LIFE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

In the event of your death, this plan pays your beneficiary a benefit equal to $10,000. Your benefit reduces when you reach age 65, and again at age 80.

In the event of your accidental death, this plan pays your beneficiary an additional benefit equal to your basic life amount. If you are seriously injured as the result of an accident (e.g., lose your eyesight, paralysis), this plan will pay a partial benefit to you.

	Life/AD&D
Benefit Amount	$10,000
Guarantee Issue	$10,000
Accelerated Benefit	100% to $10,000
Benefit begins to reduce at age	65

IMPORTANT

When you first enroll in life insurance benefits, you will need to designate a beneficiary who would receive the benefits in the event of your death. You may change or update your beneficiary designation at any time.

SUPPLEMENTAL BENEFITS

Administered by Unum

Since everyone's insurance needs are different, Consumer Direct gives you the option to buy Voluntary Life and Disability insurance for yourself and your family members at discounted group rates.

VOLUNTARY LIFE/AD&D INSURANCE

You are guaranteed up to $250,000 of employee life insurance coverage if you enroll when you are initially eligible. You can elect amounts in $10,000 increments from a minimum of $10,000, up to the lesser of $300,000 or 5 times your salary.

If you choose to enroll in the voluntary life plan, other than when initially eligible, changes to your coverage can only be made during open enrollment, and you will need to complete an Evidence of Insurability form and no dollar amount is guaranteed.

Your spouse or domestic partner may apply for up to $300,000 in coverage, in $5,000 increments. The same evidence of insurability rules apply to a spouse or domestic partner; however, the amount of guarantee issue is $50,000. Your benefit reduces when you reach age 65.

Children up to age 19, or to age 26 if a full-time student, may apply for up to $10,000 in coverage, in $2,000 increments. Maximum benefit of $1,000 up to 6 months of age.

Per $1,000 of Benefit	Employee & Spouse Rates*
24 and under	$0.060
25 - 29	$0.060
30 - 34	$0.080
35 - 39	$0.101
40 - 44	$0.171
45 - 49	$0.280
50 - 54	$0.482
55 - 59	$0.742
60 - 64	$0.987
65 - 69	$1.633
70 - 74	$1.636
75 and over	$1.615
Cost Per Child* – $10,000 Benefit	$0.325 per $1,000 of benefit

* To elect spouse and/or child voluntary life coverage you must elect a level of employee voluntary life coverage. Spouse/domestic partner and child coverage may not exceed 100% of the employee's coverage amount

VOLUNTARY BENEFITS

Administered by Unum

CRITICAL ILLNESS INSURANCE

If you are diagnosed with an illness that is covered by this insurance, you can receive a benefit payment in one lump sum. You can use this money however you want.

Why is this coverage valuable?

- The insurance pays once for each eligible illness. However, the diagnosis must be at least 90 days apart and the conditions can't be related to each other.
- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once

Who is covered?

- You – Choose $5,000, $10,000, $15,000 or $20,000 of coverage. Coverage is guaranteed if you apply during Open Enrollment
- Your spouse – Spouses from ages 17 to 64 can get $5,000 or $10,000 of coverage during Open Enrollment
- Your children – Dependent children up to age 26 are automatically covered at no extra cost. Their coverage is 50% of yours

ACCIDENT INSURANCE

Accident insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. It includes a range of incidents, from common injuries to more serious injuries. It pays benefits for 50+ covered injuries/treatments, including: ER visits, ambulance, emergency dental, broken bones, burns, physical therapy, and more!

Who is covered?

- You – If you're actively at work
- Your spouse – Ages 17 to 64
- Your children – Dependent children until their 26th birthday, regardless of marital or student status

HOSPITAL INSURANCE

Hospital insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. The money is paid directly to you and can help you pay out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.

What is included?

- $1,000 for each covered hospital admission – once per year
- $100 for each day of your covered hospital stay, up to 65 days – once per year
- $200 for each day you spend in intensive care, up to 20 days – once per year

Who is covered?

- You – If you're actively at work
- Your spouse – Ages 17 to 64
- Your children – Dependent children until their 26th birthday, regardless of marital or student status

Wellness Benefit

Every year, each family member who has Critical Illness, Accident, or Hospital Insurance coverage can also receive $50 for getting a health screening test:

- Blood tests
- Chest x-rays
- Stress tests
- Colonoscopies
- And other tests listed in policy

This is included on all three voluntary plans

EMPLOYEE ASSISTANCE PROGRAM

Administered by Unum / Health Advocate

The Consumer Direct Care Network offers an Employee Assistance Program (EAP) through Unum and Health Advocate. The EAP offers free and confidential counseling and assistance in resolving situations that may impact your personal or professional life.

All Consumer Direct employees and their eligible family members (spouses or domestic partners, dependent children, parents and parents-in-laws) are automatically covered by the EAP.

Get through challenges before they become bigger issues – Call for confidential access to a Licensed Professional Counselor who can provide employees support struggling with personal or work-related concerns.

Face-to-Face Visits – Talk to a licensed professional counselor face-to-face. Up to 3 visits per issue per year.

Their trained specialists and professional counselors are available 24 hours a day, seven days a week via this toll-free number (800.854.1446) to confidentially discuss your concerns. Call a Work/Life Specialist to help balance work and life issues as well as help you find resources in your community.

Confidentiality – All calls and counseling sessions are confidential, except as required by law (e.g., when a person's emotional condition is a threat to him or herself or others, or there is suspected abuse of a minor child, and in some states, spousal or elder abuse).

The EAP is a prepaid benefit offered to you, your household members and dependents by the Consumer Direct Care Network. If you are referred to additional resources for help and you elect to use those resources, the resulting co-payments and fees, if any, would be your responsibility. You will want to check your company benefits plan for coverage of those services.

HOW CAN AN EAP HELP ME?

Life is full of changes, both large and small. Some issues are easy to handle...others may require more from you than you can balance on any given day.

A licensed professional can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Job stress, work conflicts
- Family and parenting problems
- Anger, grief, and loss
- And more

Fortunately, for you and your family members, there's a place to turn for help through our EAP program at 800.854.1446

A Work/Life Specialist:

- Child care
- Elder care
- Legal questions
- Identity theft
- Financial services, debt management, credit report issues
- Even reducing your medical/dental bills
- And more

Easy Access to Services

Getting help is easy, convenient and confidential.

Just call Unum's toll-free number **800.854.1446**
or log on to the website at **www.unum.com/lifebalance**

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies in a manner determined in consultation with the attending physician and the patient.

Coverage must include:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or copays and co-insurance amounts.

Organ Transplant

Preauthorization of benefits is required for any and all services, treatments, and supplies related to a transplantation procedure.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose eligibility for Medicaid or CHIP or become eligible for a premium subsidy under Medicaid/CHIP, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after you lose eligibility or become eligible.

To request special enrollment or obtain more information, contact your Human Resources Department. Refer to your benefit booklet for details.

HIPAA Privacy and Security

The Plan maintains policies and procedures to protect the privacy and security of your health information as required under the Health Insurance Privacy and Accountability Act of 1996 ("*HIPAA*"). The Plan also distributes its Notice of Privacy Practices as required by law, which you can find on our web site or request free of charge from Human Resources. Please see the access information in the "Your Benefits Contacts" section of this guide.

IMPORTANT INFORMATION (CONTINUED)

Newborns' and Mothers' Health Protection Act

Federal law requires that group health plans not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

The mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order ("QMCSO") is a state court or administrative agency order that requires an employer's medical, dental, or vision plan to provide benefits to the child of an employee who is covered, or eligible for coverage under the employer's plan. If the Company determines that an order is qualified, the Plan must provide coverage for the employee's child pursuant to the QMSCO, regardless of if the child is in your custody or not. You or your beneficiary may receive, upon request and free of charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

Genetic Information Nondiscrimination Act

In accordance with the Genetic Information Nondiscrimination Act, the Plan will not use, disclose, request, require or purchase genetic medical information for purposes of establishing underwriting. Underwriting includes rules for, or determination of, eligibility, computation of premium or contribution amounts, application of any pre-existing condition exclusion, or other activities related to the creation, renewal, or replacement of a contract for health benefits or insurance. However, genetic information may be used to determine whether a particular benefit is medically appropriate.

Family and Medical Leave Act

If you take a leave of absence for your own serious health condition or to care for a family member with a serious health condition or to care for newborn or adopted child, you may be able to continue your health coverage under the Plan or you may choose to drop coverage for the period of your leave. If you drop your health coverage during the leave, you can have your health coverage reinstated on the date you return to work, assuming you pay any contributions required for the coverage.

Uniformed Services Employment and Reemployment Rights Act of 1995

If you go on leave for military or other uniformed services covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you have certain rights under the law. Please contact the Plan Administrator for more information.

Termination of Coverage

Participation in the Plan will terminate on the date in which occurs the earliest of (1) the end of the month following your termination of employment/service if COBRA Coverage (where applicable) is not elected, (2) the date you are no longer eligible for coverage for any reason or eligible for coverage under benefit plan (then only that benefit plan's coverage will terminate), (3) the date coverage ceases as a result of your failure to remit the required premiums for coverage or COBRA Coverage or your election to terminate coverage (under applicable benefit plan), (4) the date your COBRA Coverage ceases, or (5) the date the Plan is terminated.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1.855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1.866.251.4861
Email: CustomerService@MyAKHIPP.com Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1.855.MyARHIPP (855.692.7447)

California – Medicaid
Website:
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co nt.aspx
Phone: 1-800-541-5555

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://
www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1.800.221.3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1.800.359.1991/State Relay 711
Health Insurance Buy-up Program: https://www.colorado.gov/
pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1.855.692.6442

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1.877.357.3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1.877.438.4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1.800.257.8563

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/
Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618.5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: http://www.maine.gov/dhhs/ofi/application-forms
Phone: 1.800.442.6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: http://www.maine.gov/dhhs/ofi/application-forms
Phone: 1.800.977.6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/medical-assistance.jsp
Phone: 1.800.657.3739

MISSOURI – Medicaid
Website: https://www.mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1.800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1.800.992.0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603.271.5218
Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1.800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1.800.541.2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1.844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1.888.365.3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1.800.699.9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical /HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347 , or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1.888.549.0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1.888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1.800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1.877.543.7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1.800.250.8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/hipp/
Medicaid Phone: 1.800.432.5924
CHIP Phone: 1.855.242.8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1.800.562.3022

WEST VIRGINIA – Medicaid
Website: https://mywvhipp.com
Phone: 1-855-MyWVHIPP (1.855.699.8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1.800.362.3002

WYOMING – Medicaid
Website: https://healthy.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1.800.251.1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323
(Menu Option 4, Ext. 61565)

CERTIFICATE OF NON-CREDITABLE PRESCRIPTION DRUG COVERAGE

IMPORTANT NOTICE FROM CONSUMER DIRECT ABOUT YOUR PRESCRIPTION COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Consumer Direct and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Keep this notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Consumer Direct has determined that the prescription drug coverage offered by the Consumer Direct Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with Consumer Direct, since it is Consumer Direct sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Consumer Direct and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Consumer Direct coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Consumer Direct coverage, be aware that you and your dependents may not be able to get this coverage back by enrolling back into the Consumer Direct benefit plan during the open enrollment period under the Consumer Direct benefit plan.

CERTIFICATE OF NON-CREDITABLE PRESCRIPTION DRUG COVERAGE (CONTINUED)

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Consumer Direct changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Date:	January 1, 2021
Name of Entity/Sender:	Consumer Direct Management Solutions
Contact--Position/Office:	Human Resources
Address:	100 Consumer Direct Way Ste 120 Missoula, MT 59808-5037
Phone Number:	844.360.4747

PLEASE NOTE:
THIS OVERVIEW HAS BEEN PREPARED TO BRIEFLY HIGHLIGHT KEY FEATURES OF YOUR PLAN AND IS NOT TO REPLACE YOUR INSURANCE CONTRACT OR BOOKLET. WE HAVE COMPILED INFORMATION INTO SUMMARY FORM TO ANSWER QUESTIONS WE MOST COMMONLY RECEIVE. PLEASE REFER TO THE INSURANCE CARRIERS' CONTRACTS AND BOOKLETS FOR MORE DETAILED INFORMATION AND PLAN LIMITATIONS. ACTUAL CLAIMS PAID ARE SUBJECT TO THE TERMS AND CONDITIONS OF THE INDIVIDUAL CARRIERS' CONTRACTS.