MONTANAVEBA
HEALTH REIMBURSEMENT ACCOUNT

Plan Summary

January 2020

Introduction

Effective January 1, 2020, the Department of Administration restated the Plan Document and this Plan Summary for the Montana VEBA HRA. The Montana VEBA HRA was initially adopted January 1, 2003.

Please carefully review this Plan Summary.

The Plan Sponsor has retained the services of an independent Claim Administrator for plan enrollment and claims administration. If you have questions, you may contact the Claims Administrator at the toll-free number in this Plan Summary. The Claim Administrator maintains plan records and accounts.

If there is a discrepancy between this Plan Summary and the Plan Document and Trust, the Plan Document and Trust control.

Claim Administrator
REHN & ASSOCIATES
P.O. Box 5433
Spokane, WA 99205-0433
1-800-VEBA101 (832-2101)
Fax: (509) 535-7883
montana@rehnonline.com

Plan Sponsor
State of Montana
Department of Administration
Health Care & Benefits Division
100 N Park Ave, Suite 320
(800) 287-8266
TTY (406) 444-1421
Fax: (406)444-0080

Trustee and Investment Advisor
Washington Trust Bank
Spokane, WA

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PART I

Questions & Answers

What is the Montana VEBA Health Reimbursement Account ("Montana VEBA HRA")?
The Montana Voluntary Employees' Beneficiary Association Health Reimbursement Account or the "Montana VEBA HRA" is a retirement and post-separation health reimbursement plan. After retirement, the Claim Administrator can help you set up your participant account and your employer can make a tax-free contribution to the Montana VEBA HRA on your behalf. Funds are held in a tax-exempt voluntary employees' beneficiary association (VEBA) trust established under 26 IRC § 501(c)(9). You can use these tax-free funds to reimburse eligible out-of-pocket healthcare costs and premiums for yourself, your spouse, and your tax-qualified dependents.

What is a VEBA?
A voluntary employees' beneficiary association (VEBA) is a tax-exempt trust established under 26 IRC § 501(c)(9). Objectives of the Montana VEBA HRA are a tax-free way for your:

1. Employer to help you pay for qualified health care expenses for you, your legal spouse and your tax-qualified dependents;
2. Employer to convert your accrued sick and annual leave to a tax-free contribution to your Montana VEBA HRA participant account; and
3. Montana VEBA HRA account to earn additional income to spend on qualified health care expenses.

Montana VEBA HRA contributions will not be reported on your Form W-2. You do not report Montana VEBA HRA contributions, earnings, or benefit payments on your individual 1040 federal income tax form.

Do contributions reduce my State of Montana pension benefits?

PERS members – potentially. If you have accrued sick or annual/vacation leave when you retire or separate from service, MPERA may enhance your monthly retirement benefit by using that accrued leave to increase the calculation of your final average salary (FAS). For State of Montana employees, the PERS calculation of your FAS compensation will NOT include the 25% of your accrued sick leave or the 100% of your accrued annual/vacation leave account if you are a Montana VEBA HRA member at the time of your retirement. Only if your Montana VEBA HRA group did NOT elect accrued annual leave as a contribution source, will your accrued annual leave (100%) be included in your PERS FAS calculation.

TRS members – potentially. TRS members who elect to contribute accrued sick leave at retirement to enhance their TRS benefit will likely see a greater retirement benefit than if that accrued sick leave were contributed to a Montana VEBA HRA account.

You should consult with your financial advisor to determine the impact to your retirement benefits.

How do I file a claim for benefits? If you have paid qualified health care expenses for yourself, your spouse or your tax-qualified dependent, you can complete and submit a Montana VEBA HRA Claim Form. The claim should be submitted to the Claim Administrator at the address on the first page of this Plan Summary.

You should include proper substantiation of your expenses, such as a detailed receipt or an EOB (Explanation of Benefits) from your health insurance provider.

Claims are paid weekly and direct deposit is available. When the balance in your participant account reaches zero, your account will be closed. No more claims may be submitted if your account is closed.

What expenses are eligible for reimbursement?

If you have the full scope plan option,
eligible expenses include any healthcare expense that would qualify under 26 IRC §213(d) as a medical expense. Generally, these expenses include medical, dental, and vision expenses not reimbursed by Medicare or your health insurance, health insurance premiums, Medicare Part B and Part D premiums, Medicare supplement premiums, and tax-qualified long-term care insurance premiums. A list of qualified health care expenses is available at **www.montana.rehnonline.com.**

Premium payments for Exchange coverage are not eligible for reimbursement if you receive a subsidy for that coverage. If Exchange coverage is your best option for health coverage, you must waive Montana VEBA HRA benefits for the year in which you receive subsidized Exchange coverage. You may also enroll in the limited scope plan option for dental and vision expenses only. Health insurance premiums that are or could be deducted pre-tax through a 26 IRC § 125 cafeteria plan are not eligible for reimbursement.

If you have the limited scope plan option,
eligible expenses are limited to dental and vision expenses, including premiums for dental or vision coverage.

Whose expenses are eligible?
Expenses incurred after your retirement or separation date by you, your legal spouse and your tax-qualified dependents. Under 26 IRC §105(b), a tax-qualified dependent includes any child who has not, as of the end of the taxable year, turned 27. See IRS Publication 502, available at www.irs.gov for more information.

Can my Montana VEBA HRA automatically reimburse me for my insurance premiums? Yes. If you have retiree coverage under your employer provided health plan, you can authorize the MPERA to deduct your medical premium from your monthly defined benefit pension check. You can obtain reimbursement from your Montana VEBA HRA account by contacting the Claim Administrator and completing the Systematic Premium Reimbursement Form. Direct deposit is available. The Claim Administrator will mail a check to you or use direct deposit each month to reimburse you for the cost of qualified insurance premiums not deducted from your pension benefits.

What is a health savings account (HSA)? Can I contribute to an HSA if I have a Montana VEBA HRA account?

You can contribute to your HSA up until your retirement. After retirement, you may not contribute to an HSA, but you may use both your HSA and the Montana VEBA HRA for your qualified health care expenses – with certain limitations.

HSAs are a type of tax-favored medical savings account (your Montana VEBA HRA is not an HSA). If you want to make contributions to an HSA, you must have qualifying high deductible health plan coverage and meet the contribution eligibility requirements. For more information, see Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans at www.irs.gov.

If you have an HSA, you must choose the limited scope plan option for your Montana VEBA HRA account for dental and vision expenses only (including premiums for that coverage). You will need to submit a completed and signed Election of Limited Scope Plan Option form. When your HSA account has a zero balance and you are no longer making contributions to that account, you can change to the full scope plan option of the Montana VEBA HRA.

If you are retired and enrolled in Medicare (Parts A, B, or D), you cannot contribute to an HSA.

Can I use my Montana VEBA HRA account if I go back to work for my employer?
Yes, but you must change to the limited scope plan option.

What happens if you (as a participant) die?
If you die with a positive balance in your participant account, your surviving spouse, if any, may file claims for the qualified health care expenses incurred by you before your death, your surviving

spouse, and other tax-qualified dependents. If you die without a surviving spouse, but with a tax-qualified dependent, the guardian of that dependent may file claims for qualified health care expenses of that dependent. After the death of the last person to die of the participant, surviving spouse or qualified tax-dependents, the executor or administrator of the estate may file claims for qualified health care expenses incurred by that person. After reimbursement of any qualified health care expenses for that person, any remaining account balance will be allocated pro rata among all active participant accounts.

Will I receive a statement of my account? Yes. You will receive semi-annual statements (in January and July) detailing all activity in your account. You may also contact the Claim Administrator to request additional statements at any time. Contact the Claim Administrator if you have questions about your account, pending claims, or you need claim forms.

Can I view my account information online? Yes. Login to your account at www.montana.rehnonline.com to view your personal account information including account balance, detailed account activity, investment fund allocation, and to change your fund allocations or your address. Additional account login information and assistance is available from the Claim Administrator.

What expenses does the Montana VEBA HRA have and how are they paid?

Expenses include costs associated with plan administration, including claims processing activities, preparing and issuing statements, legal fees, consulting fees, participant education, trustee fees, printing, postage, investment management, auditing, mail service, custodial and banking services. Plan expenses are paid by plan participants as a monthly asset-based fee. The fee is 1.50% of total plan assets calculated on an annualized basis and assessed monthly to participant accounts. Investment advisor fees vary based upon the fund(s) selected and are listed on the investment Fund Overview. Plan administration and investment advisor fees may change at the discretion of the Department of Administration. The State of Montana does not receive any financial benefit from the Montana VEBA HRA Plan.

Who is responsible for administration of the Montana VEBA HRA?

The Health Care & Benefits Division of the Department of Administration, State of Montana, is responsible for on-going management of the Plan. The Department of Administration contracts with various service providers to assist with plan administration.

Who is the Trustee of the Plan? Washington Trust Bank in Spokane, Washington is the Trustee of the Montana VEBA HRA Plan. The Trustee safeguards the plan assets and advises the Department of Administration on the investment funds available to plan participants.

Where do I get more information?

State of Montana (Plan Sponsor)
Department of Administration
Health Care & Benefits Division
P.O. Box 200130
Helena, MT 59620-0130
(406) 444-3745 (406)
(406) 444-0080 (fax)
benefitsquestions@mt.gov (Subject line – Montana VEBA HRA)

REHN & ASSOCIATES (Claim Administrator)
P.O. Box 5433
Spokane, WA 99205-0433
1-800-VEBA101 (832-2101)
(509) 535-7883 (fax)
montana@rehnonline.com

What if my contact information or health insurance premium changes?

Contact the Claim Administrator immediately to notify of any address, name, or health insurance premium change.

PART II

Plan Information

1. Plan Name

The name of the plan is the State of Montana Voluntary Employees' Beneficiary Association Health Benefit Plan.

The plan may also be referred to as the Montana Voluntary Employees' Beneficiary Association Health Reimbursement Account or the Montana VEBA HRA.

2. Plan Benefits

This Plan Summary, together with the Plan Document and the Trust Entity Agreement form the Plan and describe the benefits available to plan participants.

3. Plan Effective Date

This plan was established January 1, 2003 by the State of Montana. This Plan Summary and the Plan Document were restated, effective January 1, 2020.

4. Plan Year

The plan year begins each January 1st and ends each December 31st.

5. Plan Administrator

The Plan Administrator is the Plan Sponsor, which is the State of Montana, Department of Administration.

6. Named Fiduciary

State of Montana, Department of Administration.
Address: 100 N. Park Ave, Suite 320
PO Box 200130
Helena, MT 59620

7. Named Trustee

Washington Trust Bank
Attn: Wealth Management
and Advisory Services
717 W. Sprague Avenue
P.O. Box 2127
Spokane, WA 99210-2127

8. Claim Administrator

Rehn & Associates
P.O. Box 5433
Spokane, WA 99205-0433

9. Agent for Service of Legal Process

The Plan's agent for service of legal process is the State of Montana, Department of Administration.

10. Plan Funding

This plan is funded entirely by contributions from the participating employers.

11. Plan Termination

The Plan Sponsor reserves the right to terminate, suspend, withdraw, amend, or modify the plan in whole or in part at any time.

12. Participant Accounts

Participant accounts are 100% vested at the time of the contribution by the participating employer. Participant accounts will close when the account balance reaches zero. If after a continuous period of 35 consecutive months, there were no withdrawals, no communications from the respective plan participant, and at least two attempts were made to contact the plan participant (both of which were returned undeliverable), the unclaimed account funds will revert to the plan to distribute pro rata among all active participant accounts.

13. Plan Identification Number

EIN: 71-0900343

PART III

Claims Appeal Procedure

If your claim is denied in whole or in part, you will receive written notice of the denial from the Claim Administrator. An explanation of benefits (EOB) will be provided to show:

- Sufficient information to identify the claim involved (date of service, claim amount);
- The reason the claim was denied;
- Reference to the specific plan provision and/or IRS rule upon which the claim denial was based;
- If additional information is necessary to make a determination on your claim, a description of the additional information needed and reasons why; and
- An explanation of your right to appeal the claim denial for a full and fair review and of your right to bring a civil action following the denial of the appeal.

In most cases, you should receive the EOB within 30 days of the Claim Administrator's receipt of your claim form.

If you do not understand the reason for a claim denial, you should contact the Claim Administrator at the address or telephone number on the cover page of this Plan Summary or the EOB.

You must appeal the claim denial before you may exercise your right to bring a civil action. This plan provides two (2) levels of appeal review and you must exercise both levels of review before bringing a civil action.

First Level of Review

If your claim is denied, you (or your authorized representative) may appeal the denial in writing to the Claim Administrator. You have 180 days from the date you receive written notification of your denial to make your appeal. You will have the right to review your claim file documents. You should in writing, state the reasons you disagree with the denial. You may also include any additional information you believe supports your appeal. Your appeal and the additional documentation, if any, should be submitted to the Claim Administrator at the address on the cover page of this Plan Summary.

The Claim Administrator will review your appeal and additional submitted documentation and provide you with a written response within 30 days of receipt of your appeal.

If, based on the Claim Administrator's review, the denial is upheld, you may initiate the process for a second level of review of your claim denial.

Second Level of Review

If your first level appeal is denied, you (or your authorized representative) may appeal in writing to the Claim Administrator. You have 60 days from the date you receive written notification of your denial to make your appeal. The appeal submission process mirrors the process used for the first level of review: 1) state in writing, the reasons you disagree with the denial, and 2) include any additional information you believe supports your appeal. Your appeal and the additional documentation, if any, should be submitted to the Claim Administrator at the address on the cover page of this Plan Summary.

For the second level of review, the Plan Administrator (Health Care & Benefits Division, Department of Administration) will review your appeal and additional submitted documentation and provide you with a written response within 30 days of receipt of your appeal.

Other

If more time or information is needed to make a determination on an appeal, the Claim Administrator or Plan Administrator, as applicable, will request in writing, an extension of up to 15 days and specify what additional information, if any, is necessary to make a determination.

You may request, free of charge, claim information and copies of any relevant documents used to

make the determination on your claim or appeal, as applicable.

If new information is considered, relied upon or generated in connection with the appeal review, the Claim Administrator or Plan Administrator will provide you with this information, free of charge and sufficiently in advance of the determination on your appeal, so you have an opportunity to respond.

PART IV

Investment Fund Information

You may choose from the investment funds listed on the Enrollment Form. You may have your Montana VEBA HRA funds invested in any combination of the listed investment funds, and you may change your investment allocations as often as monthly. An Investment Fund Overview with investment results history and fund objectives is available for each investment fund option. You may also view up-to-date fund fact sheets and prospectuses on each fund's website. Website addresses are listed on the Investment Fund Overview.

Investment Risk
Stock, bond, and asset allocation funds are not guaranteed and will fluctuate in value on a monthly basis. Benefit withdrawals from these types of funds may be worth more or less than your original deposit.

You should periodically review your selected investment fund choice(s). Should your objectives change, you should reevaluate your fund selection(s) and notify the Claim Administrator of any changes. Remember that investment returns, particularly over shorter time horizons, are highly dependent on trends in various investment markets. Thus, stock, bond, or asset allocation investments are suitable primarily as longer-term investments and not for short-term investing. You may wish to select money market funds if your goal is to preserve capital.

Using Multiple Funds
You may have your Montana VEBA HRA allocated to any combination of the available funds.

Transfers
You may transfer your account funds among funds monthly. Transfers are effective the first business day of each month. The Claim Administrator must receive transfer requests by the 25th of each month in order to be effective on the first business day of the following month.

Withdrawals
If you have multiple funds, benefit withdrawals (claims) made from your account will be prorated based on your fund allocation percentage on file with the Claim Administrator, unless you request otherwise in writing.

Investment Advice
Participants are encouraged to seek advice regarding investing their account funds from their personal financial advisor. The Trustee and Claim Administrator do not give investment advice.

Investment Expenses
Expenses are calculated as a percent of assets on an annualized basis and are deducted monthly from investment earnings, or if there are no earnings, from participant account balances.

PART V

COBRA General Notice

Important information regarding COBRA continuation coverage rights

Introduction
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides participants and those covered by this Plan the right to continue to make contributions and/or file claims for a specified time period if such rights are lost due to certain qualifying events.

This notice is intended to generally explain your COBRA continuation coverage rights and your responsibilities as described by the law. This notice is a summary only. It is not an exhaustive description.

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to the Claim Administrator.

General Information

A "qualifying event" is an event resulting in the loss of coverage to which you would have otherwise been entitled under the Plan.

Individuals losing coverage due to a qualifying event are known as "qualified beneficiaries." Qualified beneficiaries have a right to elect COBRA continuation coverage; however, the participant is required to notify the Claim Administrator within certain time limits for COBRA continuation coverage rights to apply.

COBRA continuation coverage must begin on the day coverage would otherwise end; no lapse in coverage is permitted. Qualified beneficiaries electing COBRA continuation coverage must pay a monthly premium for such coverage. In addition, an administrative fee of 2% is added as permitted by COBRA law.

Qualifying events

Spouse. If you are the legal spouse of a participant, you will become a qualified beneficiary if you lose coverage under the Plan as a result of your divorce or legal separation from the participant. For more information, contact the Claim Administrator.

Tax-qualified Dependents. Children of a participant will become qualified beneficiaries if continued coverage under the Plan is lost due to: (1) divorce or legal separation of participant and spouse; or (4) child no longer meets the definition of a tax qualifying child.

Qualifying event notification

The Claim Administrator will offer COBRA continuation coverage to qualified beneficiaries after being notified of a qualifying event within allowable time limits.

The participant or qualified beneficiary must notify the Claim Administrator within 60 days of the occurrence of the qualifying event, with the Notice of COBRA Qualifying Event form. The participant should mail, or hand deliver a completed form to the Claim Administrator. A copy of the divorce decree or decree of legal separation is required if the qualifying event is divorce or legal separation. If mailed to the Claim Administrator, the completed form must be post-marked on or before the 60th day following the qualifying event for the qualified beneficiary to receive an opportunity to elect COBRA coverage.

COBRA continuation period

The "COBRA continuation period" is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA. COBRA continuation coverage can last for up to 36 months or the date the coverage amount is exhausted (see Qualify events – Spouse for information on the coverage amount) when the qualifying event is legal separation or divorce, and when a child no longer meets the definition of tax-qualified dependent.

Information resources

Questions concerning your COBRA continuation coverage under this Plan (including the cost of such coverage and when payments are due) should be directed to the Claim Administrator. You may visit www.dol.gov/ebsa to view more information or locate a U.S. Department of Labor Employee Benefits Security Administration (EBSA) office near you.

PART VI

Privacy Notice

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Contact the Claim Administrator to find out how to do this.
- We will provide a copy or summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records.

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Contact the Claim Administrator to find out how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or cell phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all disclosures except those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you ask us to make). We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of the privacy notice

- You can ask for a paper copy of the privacy notice at any time, even if you have agreed to receive the notice electronically. Contact the Claim Administrator to request a paper copy.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint by contacting the Claim Administrator at the address on the first page of this Plan Summary.
- You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

Your choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

You have both the right and choice to tell us to Share information with your family, close friends, or others involved in payment for your care.

If you are not able to tell us your preference, for example if you are unconscious, we decide to share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to your health or safety.

We never share your information unless you give us written permission to do so for marketing purposes. We will never sell your personal health information.

For more information, contact the Claim Administrator with the information on the first page of this Plan Summary.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals treating you.
- Example: *A doctor requests information about your coverage from us so he can arrange additional services*.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage or to set the price of that coverage.
- Example: *We use health information about you to develop better services for you*.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- Example: *We share information about you with your health insurer to coordinate reimbursement for your health or dental insurance*.

Administer your plan

- We may disclose your health information for plan administration.
- Example: *The Health Care and Benefits Division exchanges your personal health information with the Claim Administrator to answer your appeal if your claim was denied and you submit an appeal to the Claim Administrator for that denial*.

How else can we use or share your health information? We are permitted or required to share your information in other ways – such as for public health and research. We must meet certain conditions before we can share your information for these purposes. For more information, contact the Claim Administrator with the information on the first page of this Plan Summary.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require that we disclose your personal health information to determine our compliance with state or federal privacy laws.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when a participant dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers compensation claims
- For law enforcement purposes or with a law enforcement official
- With certain health oversight agencies authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you to respond to a court or administrative order, or to a subpoena for information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. You must tell us in writing if you change your mind.

Contract the Claim Administrator with the information on the first page of this Plan Summary if you want more information.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our (Claim Administrator's) website, and we will mail a copy to you.

PART VII

Medicare Part D Notice of Non-creditable Coverage

For participants, spouses, children and dependents eligible or becoming eligible for Medicare.

Important notice regarding your prescription drug coverage under this Plan and Medicare Part D.

Introduction

Please read this notice carefully and keep it where you can find it. This notice contains information about prescription drug coverage provided by this Plan and Medicare Part D prescription drug coverage available for everyone with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Medicare Part D prescription drug coverage became available in 2006.

You may have heard about Medicare's prescription drug coverage and wondered how it will affect you.

Medicare prescription drug coverage became available to everyone with Medicare in 2006. All Medicare Part D prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

You might want to consider enrolling in Medicare prescription drug coverage.
Prescription drug coverage provided by this Plan is limited to your available account balance and is considered "non-creditable." In other words, coverage provided by this Plan is, on average for all Plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. Therefore, you might want to consider enrolling in a Medicare prescription drug plan.

If you don't enroll when first eligible, you may pay more and have to wait to enroll. Generally, individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. If, after becoming eligible for Medicare, you go 63 days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's prescription drug coverage), your premium will go up at least 1% per month for every month that you did not have creditable coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than what many other people pay.

If you or your spouse, children, or dependents are currently Medicare eligible, you need to make a decision.
The terms of this Plan will not change if you choose to enroll in a Medicare prescription drug plan. This Plan will continue to reimburse all qualified premiums and expenses, including prescription drug costs not payable under the Medicare prescription drug plan, subject to the terms of the Plan and limited to your available account balance.

When making your decision whether to enroll, you should compare your current coverage, including which drugs are covered, with the coverage offered by the Medicare prescription drug plans in your area.

Information resources
More detailed information about Medicare plans that offer prescription drug coverage is contained in the Medicare & You handbook from Medicare available online at www.medicare.gov. You may also be contacted directly by Medicare-approved prescription drug plans. Obtain additional information by (1) visiting www.medicare.gov for personalized help; (2) calling your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for telephone numbers); or (3) calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Find out more by visiting the Social Security Administration online at www.socialsecurity.gov, or by calling 1-800-7721213 (TTY 1-800-325-0778).

NOTE: You might receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage and when necessitated by coverage changes. You may also request a copy at any time from the third-party administrator.