BlueCross BlueShield of Montana

ADMINISTRATION MANUAL

Group Term Life and AD&D, Group Critical Illness, Group Accident Insurance, Group Hospital Indemnity, Group Disability and Group Vision

Customer Service: 866-739-4090

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NOTE: This manual contains information regarding Life, Accidental Death & Dismemberment, Critical Illness, Accident, Hospital Indemnity, Short-Term Disability, Long-Term Disability, and Vision. If your company has any of those plans with other carriers, please refer to those carriers for administration information.

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Group Insurance Plan Information

This section includes an overview of the plan information. Please see your insurance policy for full benefit descriptions including eligibility, termination, and limitation provisions. This reference guide is based on our fully insured policies. If you are self-insured, please refer to your Summary Plan Description for complete plan information.

PLEASE NOTE: This guide includes information only on the plans we offer. If you have any of these plans with other insurance carriers, the information contained within this document does not reflect how those benefits should be administered with other carriers.

New Employees

New employees should be automatically enrolled in 100% employer-paid plans. New employees may elect to enroll for employee-paid benefits during their initial eligibility period, within 31 days of the end of their waiting period. Guarantee issue amounts only apply during the initial eligibility period.

Employees who do not enroll during their initial eligibility period, or who waive employer-paid benefits, are considered late entrants. Late entrants may only enroll for benefits as allowed by the policy. Satisfactory Evidence of Insurability (EOI) may be required for late entrants. Please refer to your policy(ies) to determine if EOI is required.

Effective Dates of Coverage

The effective date for 100% employer-paid plans is the first day following completion of the new hire waiting period, if any. The effective date for employee-paid plans varies depending on when the employee enrolls. If the employee enrolls for benefits before the end of the waiting period, coverage will become effective on the first day following the waiting period. If the employee enrolls within 31 days of the end of the waiting period, coverage will become effective on the first of the month following the date the employee enrolls. If the employee does not enroll within 31 days of the end of the waiting period, they will be considered a late entrant and may only enroll when permitted by the policy. Regardless of the above, if EOI is required, coverage will not be effective until we approve coverage, and premium deduction or payment should not begin until we approve coverage and notification is received. Please see the Evidence of Insurability Process below for more information.

Evidence of Insurability (EOI)

Our EOI process enables employees to submit their application through an online portal. This requires us to have the elected coverage information. Therefore, you as a benefits administrator will need to register for Benefits Manager. Once you register, log in and navigate to the EOI page, you will find the instructions to initiate the EOI process for your employees.

Employees who do not have access to submit their applications online can still submit a paper application. Guarantee issue (GI) amounts for Life plans are only available during the initial eligibility period. Any amount in excess of the GI amount requires satisfactory Evidence of Insurability (EOI) before coverage becomes effective. Following initial eligibility, satisfactory EOI is required to enroll for Life coverage. EOI may also be required to enroll for Disability coverage. However, employees may be eligible to enroll for benefits without EOI during a qualified change in status event. Please refer to your policy(ies) to determine if EOI is required.

Evidence of Insurability Process

The completed EOI form is submitted to us. The EOI must be signed and dated by the applicant(s). EOIs should be received by us within 30 days of being signed. We will request any additional and/or missing information needed to make a decision. Once all necessary information has been received, we will make a determination within 15 business days.

For EOI application status:

1. You may call us.
2. You may view status reports on Benefits Manager. Please see the "Benefits Manager" section for information on how to review the status on an EOI.

Payroll deductions should only be made for amounts of coverage that do not require EOI. Once you are notified of EOI approval, you may begin payroll deductions on the approved amount of coverage.

Notification of EOI Decisions

We send notification of approval, denial, and closure to the employee. Decision letters are also sent to your office. Notification letters sent to you contain the effective date for the new or increased coverage but do not contain protected health information.

Previously Eligible Employees (Late Entrants)

Previously eligible employees may enroll for new coverage or change existing coverage when permitted by the policy. EOI may be required to add or change Life and Disability coverage. Please refer to your policy to determine if EOI is necessary. (It is imperative that you ensure that late entrants or increases in coverages that require EOI go through the EOI application process for approval before premium deduction or payment to avoid any misrepresentation.)

Annual Enrollment

If you hold an annual enrollment, all employees may enroll for new coverage or make changes to existing coverage during that time. A late entrant is still required to submit EOI during annual enrollment. If EOI is required, the EOI form should be submitted to us within 30 days of the date the EOI is signed. If you use online enrollment platforms, all changes that require EOI have to be properly programmed to notify employees of the required steps for the EOI application process. You can send them your group EOI link if you have already initiated their EOI application by providing their election information through Benefits Manager. It is important that you ensure that your enrollment vendor sets the eligiblity rules to accurately capture employees requiring EOI in alignment with your group policy(ies).

Change in Family Status

Employees are usually permitted to add or change coverage within 31 days of a qualified change in family status event. EOI may be required. Please see your policy to determine if employees are allowed to enroll during this time and if EOI is necessary.

When Changes Become Effective

Annual Enrollment

New coverage, or changes to existing coverage, elected during annual enrollment will become effective on the later of your policy anniversary date or the date any required EOI is approved.

Change in Family Status

If the employee elects new coverage or a change to existing coverage within 31 days of the change in family status event, coverage will become effective on the later of the first of the month following the change request or the date any required EOI is approved. If the employee does not enroll within 31 days after the event, he or she must wait to enroll until your policy allows a future enrollment.

Non-Active Employees

Any increases in coverage for employees not actively at work are deferred until the employee returns to active work.

Eligibility Management

This section describes the changes to an insured's eligibility that must be managed and reported to us if you are list billed. Examples of eligibility changes that must be managed and reported are:

- Name changes
- Salary changes*
- Changes in family status*
- Changes in an insured's eligibility status, such as transferring from active to retired status*
- Coverage or employment terminations*
- Covered children reaching the limiting age

**These changes may impact the premium and benefit calculations for an employee. To ensure that both are properly recorded, these changes must be made in a timely fashion*.

All changes must comply with the policy provisions, including those impacting active work, eligibility, effective dates, and evidence of insurability. Please refer to your policy for all provisions.

Salary Changes

The benefit plans available to your employees may include salary-based products. As described above, you must record salary changes as of the 1st of the month following the date of the salary change. Please review the definition of earnings contained in your policies to determine what should be reported.

Life insurance plans contain guarantee issue (GI) limits. If the salary change results in an insurance amount in excess of the GI amount, the employee must complete an evidence of insurability form the first time the benefit exceeds the limit. If the salary change results in an insurance increase of $50,000 or more, evidence of insurability is required.

If evidence of insurability is required, the change will become effective on the date we approve the benefit amount in excess of the GI amount.

Beneficiaries

At the time an employee enrolls for Life, Accidental Death & Dismemberment, Critical Illness and Accident insurance, a beneficiary designation form should be completed. The beneficiary can be any individual or legal entity the employee wishes to name to receive benefits in the event of his or her death. However, the beneficiary cannot be the policyholder. For religious, education, and healthcare entities, divisions of the policyholder may be named as beneficiary (i.e., a local parish, an alumni association, or a hospital wing).

If the employee has multiple life coverages, such as Basic and Supplemental or Voluntary Life coverages, a separate beneficiary designation(s) should be completed for each coverage if different beneficiaries are desired by product.

An insured should designate both a primary beneficiary and a contingent beneficiary. A contingent beneficiary will receive the proceeds of an employee's life insurance only if the employee and his or her beneficiary die at the same time or the primary beneficiary precedes the employee in death.

If the employee does not designate a beneficiary, or if the named beneficiary dies before the employee, the death benefits will be paid as defined in the Facility of Payment section of the policy.

If an employee is married and designates someone other than his or her spouse as a primary beneficiary, the spouse should sign the beneficiary designation. The spouse's signature is not required. However, it will help reduce delays in claims payments, especially in community property States.

A beneficiary designation can be changed at any time. The employee can obtain a beneficiary designation form from you or from our website. Questions may be directed to our Customer Service department.

Employees Ceasing Active Work Due to Disability or Leave

This section describes the impact on coverage(s) when an employee:

1. Ceases work due to the leave types described below
2. Resumes work from the same type of leave

Retiree coverage will not be continued as described in this section.

Continuation of coverage is dependent upon premiums being paid when due during the continuation period. In no event will continuation of coverage under these scenarios extend coverage beyond the policy provisions that explain when coverage terminates.

Any increases in benefits while the employee is not actively at work are deferred until he or she returns to active work. When the employee returns to work, you need to review his or her coverages to determine if increases occurred during the leave. Increases become effective on the date the employee returns to active work. Decreases in benefits, such as age reductions, are **not** deferred until the employee returns to active work. Decreases in benefits are administered in the same manner as active employees.

Disability

Life, Accidental Death & Dismemberment, Critical Illness, Accident Insurance, Hospital Indemnity, and Vision Insurance

While disabled, an employee may continue coverage until the end of the twelfth month following the month in which the disability begins. If the employee returns to active work within 12 months and is in a class eligible for coverage, his or her coverage will continue without interruption. If the employee does not return to work within 12 months, coverage will terminate. The employee may be eligible to convert and/or apply for Waiver of Life Premium for Life insurance coverage. Please refer to the Conversion and Waiver of Premium sections for more information.

Short-Term Disability and Long-Term Disability Insurance

Coverage may be continued at the employer's discretion during an approved FMLA leave provided required premiums are paid when due. Premium for Short-Term Disability is automatically waived while the employee is receiving weekly STD benefits. Premium for Long-Term Disability is automatically waived while the employee is receiving monthly LTD benefits. For Uniformed Service Members, coverage will reinstate as of the date the employee returns to work or as required under USERRA laws.

Layoff

Life, Accidental Death & Dismemberment, Critical Illness, Accident Insurance, Hospital Indemnity, and Vision Insurance

An employee may continue coverage to the end of the month following the month in which the layoff begins.

If your policy contains a rehire provision and the employee returns to active work in a class eligible for coverage within the time limit indicated in your Benefit Booklet(s), the following requirements will be waived:

- Eligibility waiting period
- Requirement for evidence of insurability, similar to new hire

If the employee returns to active work after any rehire provision has been exhausted, he or she must meet all the requirements of a new employee.

Short-Term Disability and Long-Term Disability Insurance

Coverage ends on the date the layoff begins.

Leave of Absence (including Sabbatical)

Life, Accidental Death & Dismemberment, Critical Illness, Accident Insurance, Hospital Indemnity, and Vision Insurance

An employee may continue coverage during a leave period agreed to by you and the employee but no longer than the time period specified in the policy. Premium must be paid during this period. The leave of absence must be approved by the employer and in writing, setting forth the leave period. If the employee does not return to work within the agreed upon leave period, his or her coverage will terminate as of the date he or she was to return to active work.

Short-Term Disability and Long-Term Disability Insurance

Coverage ends on the date the leave begins.

Military Leave of Absence

Life, Accidental Death & Dismemberment, Critical Illness, Accident Insurance, Hospital Indemnity, and Vision Insurance

An employee may continue coverage to the end of the twelfth* month following the month in which the military leave begins. If he or she does not return to active work within the agreed upon leave period, his or her coverage will terminate as of the date he was to return to work.

**Please note some policies allow for a longer duration; please refer to your policy to confirm the length of the extension. State law requires coverage for uniformed personnel employed by cities in Texas to be available for the entire length of the military leave.*

Short-Term Disability Insurance

Coverage ends on the date the leave begins.

Long-Term Disability Insurance

As required under USERRA, an employee may continue his or her coverage if called to active military duty for the length of time defined in the insurance policy. Premiums must be paid during this period. If the employee does not elect to continue coverage during a leave, he or she must re-enroll upon returning to active work. For those employees who do not elect to continue coverage during a leave for active military service, coverage will be reinstated in accordance with USERRA once he or she returns to work.

Federal or State Medical Leave

Life, Accidental Death & Dismemberment, Critical Illness, Accident Insurance, Hospital Indemnity, and Vision Insurance

An employee may continue his or her coverage for as long as he or she is on an approved FMLA leave or any other applicable state family medical leave law. If the employee does not return within the agreed upon leave period, his or her coverage will terminate as of the date he or she was to return to active work.

Short-Term Disability Insurance

At the employer's discretion, an employee may continue his or her coverage for as long as he or she is on an approved FMLA leave or any other applicable state family medical leave law. If the employee continues his or her disability coverage and returns to work on the first day following the end of the agreed upon leave, his or her coverage will continue without interruption. If he or she does not return to work on the agreed upon date, his or her coverage will terminate on the date the agreed upon leave ends. If an employee does not elect to continue coverage during a leave, he or she must re-enroll upon returning to active work.

Long-Term Disability Insurance

At the employer's discretion, an employee may continue his or her coverage for as long as he or she is on an approved FMLA leave or any other applicable state family medical leave law. If the employee continues his or her disability coverage and returns to work on the first day following the end of the agreed upon leave, his or her coverage will continue without interruption. If he or she does not return to work on the agreed upon date, his or her coverage will terminate on the date the agreed upon leave ends. If the employee does not elect to continue coverage during a leave, he or she must re-enroll upon returning to active work.

Reserve National Guard

Your policy may include an extension for employees serving in the Reserves of the National Guard. If so, an employee may continue coverage for the amount of time defined in the policy while he or she is absent from active work because of National Guard duty, subject to the rules set forth in the policy. If the employee does not return to work at the conclusion of National Guard service, his or her coverage will terminate as of the date he or she was to return to work. Please see the policy for full details on continuation of coverage during a Reserve National Guard leave.

Labor Dispute

Your policy may include a labor dispute extension. If so, an employee may continue coverage for the amount of time defined in the policy while he or she is absent from active work because of a general work stoppage (including a strike or lockout) resulting from a labor dispute between the policyholder and the employee's collective bargaining unit, subject to the rules set forth in the policy. If the employee does not return to work at the conclusion of the labor dispute, his or her coverage will terminate as of the date he or she was to return to work. Please see the policy for full details on continuation of coverage during a labor dispute.

COBRA

COBRA extensions are allowed for Vision coverage. It is your responsibility to provide the appropriate notices to your employees in order to comply with COBRA laws. Coverage may continue for the amount of time specified in your Vision policy.

COBRA is not available for Life, AD&D, Short-Term Disability, Long-Term Disability, Critical Illness or Accident Insurance.

Termination of Coverage

Coverage ends on the last day an employee is a member of a covered class, stops making any required premium contributions, or ceases active work, except as described in the above sections.

Conversion

Conversion allows insureds to convert some of their life insurance coverage to an individual policy. Insureds who have elected to port coverage are not eligible to convert, except if the group policy terminates. Please see the Portability section below for more information on porting coverage. Please note that conversion is available after portability ends in certain circumstances, and you should consult your policy to advise insureds of those situations.

Life Insurance

Individuals covered under a Life plan may convert their coverage to an individual whole life policy if they lose coverage (or any portion of it) because they are no longer eligible in accordance with the terms of the policy. For example, an insured may lose coverage because:

- The employee is no longer employed with your company
- The insured is no longer eligible for coverage due to age or a change in family status

Please refer to your policy for the conversion provisions that apply to eligibility situations.

Notification

You should notify the insured of his or her right to convert coverage. This can be accomplished by providing the employee with a copy of the Application to Convert Group Life Insurance, which is located on our website.

Time Frames to Apply

To complete the life conversion process, we must receive the completed application and the first premium within 31 days after the insured's life insurance (or the portion of their life insurance) ceases. The application contains the information needed to calculate the premium that must be submitted.

If these terms are met, a policy will be issued regardless of the individual's health at the time of conversion. The policy issued will be an individual whole life insurance policy and will not contain any Accidental Death & Dismemberment benefits, Waiver of Premium benefits, or any additional supplemental benefits.

Accidental Death & Dismemberment Insurance

Conversion is not available for Accidental Death & Dismemberment.

Short-Term Disability Insurance
Conversion is not available for Short-Term Disability.

Long-Term Disability Insurance
Conversion is usually not available for Long-Term Disability. Please refer to your policy to determine if conversion is available.

Critical Illness Insurance
Conversion is not available for Critical Illness Insurance.

Vision Insurance
Conversion is not available for Vision Insurance.

Hospital Indemnity Insurance
Conversion is not available for Hospital Indemnity Insurance.

Accident Insurance
Conversion is not available for Accident Insurance.

Portability
Portability allows insureds to continue some of their Term Life, Accident, Critical Illness or Hospital Indemnity coverage by remitting premium directly to us. Employees who have elected to convert life coverage are not eligible to port that amount of life coverage. Please see the Life Insurance Conversion section above for more information on converting coverage.

Voluntary or Supplemental Life Insurance
Individuals covered under a Voluntary or Supplemental Life, Accident and Critical Illness plan may port their coverage if coverage terminates while the group policy is in effect. For example, coverage may be lost because:

- An employee is no longer employed with your company
- An insured is no longer eligible for coverage due to age or a change in family status

Evidence of insurability is not required to port Voluntary or Supplemental coverage. Please refer to your policy for the provisions that apply to eligibility situations.

Notification
You should notify the insured of his or her right to port coverage. This can be accomplished by providing the employee with a copy of the Portability Application, which is located on our website.

Time Frames to Apply
To complete the portability process, we must receive the completed application and the first premium within 31 days after the employee's life insurance ceases. The application contains the information needed to calculate the premium that must be submitted.

Accidental Death & Dismemberment Insurance
Portability is not available for Accidental Death & Dismemberment.

Short-Term Disability Insurance
Portability is not available for Short-Term Disability.

Long-Term Disability Insurance
Portability is not available for Long-Term Disability.

Critical Illness Insurance
Portability is available for Critical Illness Insurance.

Accident Insurance
Portability is available for Accident Insurance.

Hospital Indemnity Insurance
Portability is available for Hospital Indemnity Insurance.

Vision Insurance
Portability is not available for Vision Insurance.

Accelerated Death Benefit
Employees insured for Life plans are eligible for an accelerated death benefit. If the insured has a terminal condition as defined in the policy, he or she may be eligible to receive an advanced payment of his or her Life insurance benefit. If a claim is approved, payment will be made to the employee. Once the accelerated death benefit has been paid, the amount of insurance remaining in force is reduced by the amount of the accelerated benefit paid. Upon the insured's death, the remaining life insurance benefit is payable to the beneficiary.

This benefit applies to Life insurance only.

How Much Premium to Pay
If the accelerated death benefit is approved, we will mail a notification to you and the employee explaining the amount of benefit paid and the amount of the remaining benefit. After the accelerated death benefit has been paid, premium is due only for the remaining amount of insurance. For example, an employee has a Life benefit of $100,000 and may receive 75% of his or her benefit under this provision. The accelerated death benefit of $75,000 is paid. Future premiums are due only for the remaining $25,000 of coverage.

Waiver of Premium

Life Insurance
Employees are eligible for a waiver of premium benefit on Life insurance. If the employee meets all the eligibility requirements defined in the policy, he or she may file a claim for waiver of Life premium.

If the employee is receiving Long-Term Disability payments from us, we will automatically initiate and process the employee's waiver of Life premium claim. The employee does not need to submit another claim form. If the employee is **not** receiving Disability benefits from us, he or she must file a claim for waiver of Life premium within the time limits specified in the policy. If approved, premium will continue to be waived as defined in the policy.

Important: Premiums must be paid for the entire length of the elimination period for coverage to remain in force and eligibility for Waiver of Premium to continue. You may continue the employee's coverage as defined in the "Employees Ceasing Active Work Due to Disability or Leave" section. Premium payment options are: (1) You collect any required payments from the employee and remit premium to us with your regular monthly premium; OR (2) the employee may file for conversion and pay us directly.

If premiums are not paid during the Waiver of Premium elimination period, the employee will lose his or her eligibility for this provision and hence his or her Life insurance coverage.

Accidental Death & Dismemberment Insurance

There is no Waiver of Premium benefit for this coverage.

Short-Term Disability Insurance

STD premium is automatically waived for employees who are receiving STD benefits from us. There is no need to file a claim for waiver of STD premium. Please note that premiums are due while the employee is satisfying the elimination period.

Long-Term Disability Insurance

LTD premium is automatically waived for employees who are receiving LTD benefits from us. There is no need to file a claim for waiver of LTD premium. Please note that premiums are due while the employee is satisfying the elimination period.

When to Stop Paying Premium

You must continue to remit premium until you are notified by us that the waiver of Life premium has been approved or that STD or LTD benefits have begun. If premium payments cease prior to our approval, the employee's coverage will terminate as of his or her last day worked. If coverage terminates, the employee may be eligible to continue coverage under the conversion privilege. Please see the "Conversion" section for more information.

When to Resume Paying Premium

Premiums will be waived until the earlier of the date:

- You and the employee are notified the employee no longer qualifies for waiver of Life premium
- STD or LTD benefits cease
- The employee returns to active work

If the employee no longer qualifies for waiver of life premium or STD/LTD benefits and does not return to work, you should notify the employee of his conversion or portability rights, whichever is available under the terms of the policy. Refer to the "Conversion" and "Portability" sections for more information.

If the employee returns to work, you should resume premium payments as of the first premium due date following the return to active work. Any increases in benefit, which were deferred while the employee was not actively at work, take effect when the employee returns to work.

Pre-Existing Conditions

The Short-Term Disability, Long-Term Disability, Critical Illness, and Hospital Indemnity plans may contain pre-existing condition provisions. Generally, a pre-existing condition clause contains restrictions on receiving disability, critical illness, or Hospital Indemnity benefits for conditions treated prior to the employee's effective date of coverage. Please refer to your policy for the definition of a pre-existing condition.

Exclusions and Limitations

Our plans contain exclusions. Please refer to your policy(ies) for a complete list of your plan's exclusions and limitations.

Billing and Payroll Deductions

If you are list-billed, we will prepare regular billing statements, which may be viewed on Benefits Manager. You should pay the amount billed each month. Any necessary adjustments for enrollment changes will be reflected on the next bill. It is your responsibility to notify us of any changes to the covered employees, such as any new hires,

terminated employees or change in status or class. This will allow us to adjust your bill appropriately to ensure your employees are properly enrolled.

If you are self-administered, you will not receive a premium billing statement from us. You are responsible for calculating your bill and remitting premium each month. It is your responsibility to ensure that employees are enrolled in accordance with the contract and premiums remitted accordingly. If an employee's coverage requires satisfactory EOI, do not deduct or remit premiums until you receive the approval of coverage notification from us. At that point, you may add the employee coverage to your premium calculation and remittance.

How to Calculate Premium

To calculate premium due, multiply the benefit amount by the premium rate set forth in your policy. Be sure to apply salary definitions, benefit maximums, rounding rules, age reductions, guarantee issue limits, and spouse coverage limitation or restrictions. These are set forth in your policy. Please see the examples below to calculate premium. The volumes and rates are for illustration purposes only.

Life and Accidental Death & Dismemberment Insurance

Premium for Life and AD&D coverage is based on the full benefit amount. The premium rate is expressed per $1,000 of benefit.

Example: Benefit equals $15,000 with a rate of $0.20 per $1,000 of coverage.

15,000 (benefit) ÷ 1,000 (rate units) = 15 (units) x .20 (rate) = $3.00 of monthly premium

Salary Based Life and Accidental Death & Dismemberment Insurance

Example: Life benefit equals 2 times salary to a maximum of $100,000 with a rate of $0.10 per $1,000 of coverage.

If the employee's annual salary is $25,250, premium is calculated as follows:

25,250 (annual salary) x 2 (salary multiplier) = 50,500 (benefit) rounded to the next higher 1,000 = 51,000

51,000 (benefit) ÷ 1,000 (rate units) = 51 (units) x .10 (rate) = $5.10 of monthly premium

Using the previous example, if the annual salary is $65,000, premium is calculated as follows:

65,000 (annual salary) x 2 (salary multiplier) = 130,000. However, the benefit is limited to a maximum of $100,000.

100,000 (benefit) ÷ 1,000 (rate units) = 100 (units) x .10 (rate) = $10.00 of monthly premium

Dependent Life Insurance

Premium for Dependent Life is based on either a rate per $1,000 of benefit or a family unit. If based on a rate per $1,000, you may use the above examples for calculating premium.

NOTE: The dependent rates are regardless of the number of children the employee is covering. If the benefit is $10,000 and the employee has 5 children, you calculate premium based on $10,000 only, not $50,000.

If the rate is based on a family unit, use the example below:

Example: If 50 of your employees elect dependent life coverage and the dependent life rate is $1.25 per family unit, premium is calculated as follows:

50 (employees) x 1.25 (rate per employee) = $62.50 of monthly premium

Short-Term Disability Insurance

Premium for STD is based on the weekly benefit amount. The premium rate is expressed per $10 of benefit.

Example: STD benefit equals 60% of weekly salary to a maximum of $500.

If the employee's weekly salary is $400 and the STD rate is $0.80 per $10, premium is calculated as follows:

400 (weekly salary) x 60% (benefit percentage) = 240 (weekly benefit)

240 (benefit) ÷ by 10 (rate units) = 24 (units) x .80 (rate) = $19.20 of monthly premium.

Using the previous example, if the employee's weekly salary was $1,200, premium is calculated as follows:

1,200 (weekly salary) x 60% (benefit percentage) = 720. However, the benefit is limited to a maximum of $500.

500 (benefit) ÷ 10 (rate units) = 50 (units) x .80 (rate) = $40.00 of monthly premium.

Long-Term Disability Insurance

Premium for LTD is based on the monthly salary (also called covered payroll). Premium is not based on the benefit amount. The premium rate is expressed per $100 of monthly covered payroll.

Example: LTD benefit equals 60% of salary to a maximum monthly benefit of $5,000.

If the employee's monthly salary is $2,538, and your LTD rate is $0.65 per $100, the benefit and premium are calculated as follows:

Benefit: 2,538 (monthly salary) x 60% (benefit percentage) = $1,522.80 of benefit.

Premium: 2,538 (monthly salary) ÷ 100 (rate units) = 25.38 (units) x .65 (rate) = $16.50 of monthly premium

The LTD benefit was calculated to verify the employee had not reached the maximum benefit of $5,000 allowed under the policy. The LTD benefit is not part of the premium calculation.

Using the previous example, if the employee's monthly salary was $9,000, the benefit and premium are calculated as follows:

Benefit: 9,000 (monthly salary) x 60% (benefit percentage) = 5,400 (monthly benefit). However, the benefit is limited to a maximum of $5,000.

Premium: 5,000 (maximum monthly benefit) ÷ .60 (benefit percent) = 8,333 (maximum monthly covered payroll) ÷ 100 (rate units) = 83.33 (units) x .65 (rate) = $54.16 of monthly premium

Prorating Premium

You do not need to prorate premium for employees with new coverage, terminated coverage, benefit increases, or benefit reductions occurring during the month. Premium adjustments are made on the first premium due date following the change.

Example: If you have a new employee effective June 20, and your next premium due date is July 1, you will begin remitting premium for the new employee as of July 1. Even though premium is not paid for the time period between June 20 and July 1, the employee is covered under the policy as of June 20.

Terminations are calculated in the same manner. If an employee's coverage terminates effective April 12, you will remit premium for the entire month of April and discontinue remitting premium as of May 1, the next premium due date. Even though premium is paid for the time period between April 12 and May 1, the employee is not covered under the policy after April 12.

This method of charging premium is for accounting purposes only. It will neither commence any insurance after the date it would otherwise begin nor extend any insurance coverage beyond the date it would otherwise terminate according to the policy.

When to Start Payroll Deductions

Premium is due to us on the first day of the month for which coverage is provided. IMPORTANT: If an employee is required to submit evidence of insurability (EOI) for all or any portion of his or her coverage, the coverage being underwritten is not effective until we determine the evidence is satisfactory. **We provide written notice of approval or declination. Premiums should not be collected or remitted on the amounts that require EOI until you receive an approval from us.**

Claims Submissions and Processing

This section describes how to submit claims, an overview of the claim process, and how we will manage transitions between types of claims. All the claim forms can be found on our website.

Please note proof of payroll deductions are needed for employee-paid coverages at time of claim. We will contact you to obtain any necessary information or if we require clarification. Claims must be filed within a specified time frame from the date of the event; please refer to your policy for this provision. For Waiver of Premium claims where the employee does not have Long-Term Disability coverage with us, it is important the Waiver of Life Premium claim is initiated in a timely fashion, typically 12 months from the disability date. Refer to your policy for the specific time frame for your group.

Claims will typically be processed within 10 calendar days of receipt of all needed documentation to support the claim(s).

Life and Accidental Death & Dismemberment Claims

Claim forms must be submitted to apply for benefits. The claim forms that should be submitted are as follows:

- Basic Life, Supplemental Life, and Accidental Death – submit a Life Claim Form
- Accelerated Death Benefit – submit an Accelerated Death Claim Form
- Waiver of Premium – submit a Group Life Waiver of Premium Claim Form
- Accidental Dismemberment – submit an Accidental Dismemberment Claim Form

Claims may be submitted:

- Online through Benefits Manager with all required documents attached
- Fax as specified in the instructions on the claim forms
- By mail as specified in the instructions on the claim forms

Eligibility records to establish coverage for claims include:

- Original, photocopy or screen print of enrollment form, if applicable
- Payroll records verifying annual salary at the time of claim, if benefit is salary based
- For voluntary benefits, proof of payroll deduction

Please see the “Waiver of Premium” section for information regarding when a claim form is not needed.

The claim forms specify any additional information that must be submitted with the claim. The forms also describe the multiple step process that is involved with the filing of Accelerated Death Benefit, Waiver of Premium, and Accidental Dismemberment claims and the recommended sequence and timing to follow.

Critical Illness, Accident, and Hospital Indemnity Insurance

The claim forms that should be submitted are as follows:

- Critical Illness – submit a Group Critical Illness Claim Form
- Accident Insurance – submit a Group Accident Insurance Claim Form. Please note that this benefit claim form may be mistaken for the Accidental Dismemberment claim form.
- Hospital Indemnity – submit a Group Hospital Indemnity Claim FormCompleted claim forms for these products may be emailed to GroupSupplementalClaimsMT@BCBSMT.com

Vision Insurance

The provider will electronically bill us for any claims. Claim payments will be made directly to the provider. If an employee wishes to pay for the services and get reimbursed, he or she should use the Vision Claim Form.

Short-Term Disability Claims

To make the submission process as convenient as possible, we offer multiple ways to submit a Short-Term Disability claim.

Online

If the employee chooses to file a claim online, they can do so by creating a My Benefits account at ancillary.bcbsmt.com. My Benefits, our online self-service tool, allows members to securely and conveniently submit and manage their disability claims online at any time from anywhere. They can submit online without registering for an account, but this option does not allow them to manage their claim online after they submit it.

Using a desktop or mobile device, they will follow the guided steps to set up their account and submit their claim online. They will need an email address to create their account. When they submit their claim online, they will be provided with additional forms that will need to be completed by their employer and their attending physician.

Email, Fax or Mail

If the employee chooses to file a claim form, they can download the STD claim forms at bcbsmt.com/ancillary/employees/forms. Once the forms are completed, they can email them to us at DisabilityClaimsMT@bcbsmt.com, or they can fax or mail them to the number/address on the claim form.

Forms should be completed by submitting a STD claim after the employee's last day worked. Completed forms should be faxed or mailed to us at the address shown on the claim form.

Please Note: If you have Voluntary STD coverage with us, please submit the most current enrollment form your employee has completed, as well as any recent change forms that have been completed during past annual enrollment periods.

Telephonically

If the employee chooses to file a claim telephonically, the following steps should be taken:

1. The employee contacts us via phone at 866-739-4090.
2. The Claim Intake Specialist captures all information and begins the process to secure the required authorizations needed to obtain medical information.

We will contact you and the claimant's physician, usually telephonically, to obtain any needed information and to advise you that a claim has been filed.

Long-Term Disability Claims

If the employee is receiving Short-Term Disability benefits from us, no claim form is required to file for Long-Term Disability benefits. We will manage any possible transition from Short-Term to Long-Term benefits by automatically beginning to evaluate the employee's claim for Long-Term Disability benefits. We may contact you and/or the claimant if additional information is required to evaluate eligibility for Long-Term Disability benefits.

If the employee is not receiving Short-Term Disability benefits from us, a Long-Term Disability Claim form must be filed. The claim form should be submitted approximately 6-8 weeks before the end of the elimination period. The claim form describes any additional information that must be submitted with the claim. They can submit the claim online by creating a My Benefits account at ancillary.bcbsmt.com. My Benefits, our online self-service tool, allows members to securely and conveniently submit and manage their disability claims online at any time from anywhere.

Transition from FMLA to Short-Term Disability Claims

If you use FMLASource as your FMLA administrator and us as your Short-Term Disability carrier, FMLASource will notify us when an employee opens a FMLA claim due to his or her own medical condition. We will contact the employee and you to obtain the necessary information to process the claim.

Transition from LTD to Life Waiver

If the employee is receiving Long-Term Disability benefits from us, no claim form is required to file for Waiver of Life Premium. We will manage any potential Waiver of Life Premium claim by automatically beginning to evaluate the claim as part of the Long-Term Disability claim process. We may contact you and/or the employee if additional information is required to evaluate the employee's eligibility for Life waiver benefits and confirm premium continuation throughout the elimination period. It is imperative that you make sure the premium payments for your employees are continued during the elimination period for Waiver of Premium.

If an employee is on Disability and his or her Life insurance coverage is terminating before he or she is approved for Life Waiver of Premium, it is imperative that you provide him or her with the right to convert in a timely manner to allow him or her the opportunity to continue his or her coverage and pay premiums.

Transition from Accelerated Death Benefit to Life Waiver

If an employee is filing an Accelerated Death Benefit claim, is under age 60, and is not in active work, no additional claim form is required to file for Waiver of Life Premium benefits. We will manage any potential Waiver of Premium claims by automatically beginning to evaluate the claim as part of the Accelerated Death Benefit claim process. We may contact you and/or the claimant if additional information is required to evaluate eligibility for Waiver of Premium benefits. We will also review any Life Waiver claim to determine if Accelerated Death benefits may be available to the insured.

Appeal Process

If a claim is denied, a letter will be sent to the claimant explaining the reason for denial and his or her right to appeal the decision. Generally, the claimant must:

1. Submit a written request to us along with any additional information in support of the claim
2. Submit the appeal request within the specified time as stated in the policy

The denial letter will inform the employee of the time frame he or she has to appeal the decision. The letter will also inform the employee of the time frame we have to re-evaluate the claim. The time frames follow ERISA requirements. If additional information is required, the appeal process may be extended. The claimant will be notified of the extension via letter. Your office will be provided a copy.

Reference Information

Benefits Manager

Benefits Manager is a password-protected site that allows the group administrator to view payment information; pay your list bill online; view or download your group's plan documents; view or edit your employee membership data; submit claims for Life and Waiver of Premium; view claims status, including payment information; initiate the evidence of insurability applications; and view status of evidence of insurability applications. You also can run reports on open, closed, and pending claims and EOI applications.

Once you have your unique user ID and password, you may begin using Benefits Manager. You will log in from our website by entering your log in information into the Secure Login section.

Billing and Payment Information

You may view premium information and list bills under the Billing & Payments tab. Information available includes current and past list bills, monthly summary of premium and payment history; current paid-to-date; and premium payment information such as check number, check amount, and received date.

Plan Documents

Your group's plan documents are located under the Policies & Documents tab. Plan documents include policies, policy amendments, and employee certificate booklets. You will select the type of document you wish to view from

a drop-down list and click the Show button. A list of documents in that category will display. Simply click on the document name to open a PDF version, which can be saved to your computer.

Evidence of Insurability Applications

Evidence of insurability reports are available under the EOI tab. You may select to view EOI applications based on the following categories: approved, declined, incomplete, pending, withdrawn, or all categories. You may also select the date range for which you want to view the report. This feature does not allow you to view copies of the employees' EOI application forms.

You can initiate the EOI application and provide the link to your employees. Then they can submit their medical evidence of insurability online.

Claims Reports

Under the Claims tab, you may view and run reports on your group's claims, including claims experience reports and disability benefits paid reports. You may select the date range for which you want to view the report, as well as the specific product. For experience reports, you may also choose an individual claimant's name. This feature does not allow you to view copies of the employees' claim forms or supporting medical information. Explanations of each reports' fields may be found in the FAQs and Glossary section within Benefits Manager.

Membership Data

If your plan is list billed, you may view or edit your employees' membership data under the Enrollment Management tab.

If you are sending a regular eligibility file to us, you should not make any membership changes online. Any membership changes will be overwritten by the eligibility file received by us. It is recommended that you make any changes in your eligibility system and include the change in the weekly eligibility file. If you have an emergency update, please contact your Account Executive or Customer Service to have the insured added immediately.

Travel Resource Services™[1]

This program provides a 24-hour emergency service that can help your employees access needed assistance when they are traveling 100 or more miles away from home. Key services include:

- Medical search and referral
- Medical monitoring
- Medical evacuation/return home
- Dependent children assistance

Employees may access the service from our website.

Disability Resource Services™[2]

This program offers employees who are have Long-Term Disability insurance with us, and their immediate family, with an easy and convenient way to find assistance, resources, solutions and support to the issues that arise due to disability. The assistance comes in the form of a secure, interactive, password-protected website as well as three face-to-face working sessions in geographically accessible locations.

Beneficiary Resource Services™[3]

This program provides all beneficiaries with information on the legal issues, funeral planning, emotional needs, and financial concerns they may be facing as a result of losing a loved one. Whether it impacts the employee personally or a member of his or her family, this program is here to help 24 hours a day, 7 days a week. Your employees may also create a Last Will and Testament online at no cost. Employees or his or her spouse will complete a questionnaire

that creates the Will. He or she can then review and print the document along with instructions for finalizing and storing the Will.

Reports

We will provide you with the necessary reports to administer your account. We will provide you with sick pay reports, FICA reports, and annual W2 reports.

[1]Travel Resource Services is administered by Assist America, Inc. Assist America is an independent organization that does not provide Blue Cross and Blue Shield of Montana or Dearborn Life Insurance Company products or services. Assist America is solely responsible for the products and services associated with Travel Resource Services. Usage of the Assist America mobile app may be subject to additional terms and conditions. Available to groups with 51 or more eligible employees.

[2]Disability Resource Services is administered by ComPsych® Corporation. ComPsych® Corporation is an independent organization that does not provide Blue Cross and Blue Shield of Montana or Dearborn Life Insurance Company products or services.

[3]Beneficiary Resource Services is provided by LifeWorks. LifeWorks is an independent organization that does not provide Blue Cross and Blue Shield of Montana or Dearborn Life Insurance Company products or services.

This information is only a product highlight. Benefits are available from the EyeMed Vision Care, LLC provider network and are administered by First American Administrators, Inc., independent companies that offer benefits on behalf of Blue Cross and Blue Shield of Montana. Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Blue Cross and Blue Shield of Montana is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.