choices

Retiree Annual Benefits Enrollment Workbook

2012 - 2013

Montana University System

Scratch Paper

UM Helena COT

UM Missoula

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MSU Billings

Dawson CC

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Director's Note: Important Changes for 2012-2013

We are pleased to present the CHOICES Retiree Workbook for the 2012-2013 Plan Year. The booklet contains information about Retiree options for continuing with the Montana University System (MUS) Group Benefits Plan upon retirement, or if already retired, the available options for Retirees for the next fiscal year. Plan descriptions and related explanations are provided in detail in this booklet, on our web site www.mus.edu/choices/, and on the Retiree enrollment form.

All Retirees should review this booklet carefully, even if enrollment updates are not needed for the next plan year. There are some changes in this year's offerings, which may influence the medical plan you choose for the 2012-2013 plan year. The MUS MAP program will be continued as an option for Medicare-eligible Retirees. If you do not submit a new enrollment form by **May 23, 2012**, your current enrollment will continue as is until June 30, 2013, with appropriate premium changes unless your current plan is no longer available. **If you are currently on New West Managed Care and you do not complete an enrollment form, you will switch to PacificSource effective July 1, 2012. If you are currently on Peak Managed Care and you do not complete an enrollment form, you will switch to Blue Cross Managed Care effective July 1, 2012.**

Closed Enrollment:
As of July 1, 2011, the MUS has had closed enrollment. This means that you may not add dependents to your plan unless you have a qualifying event. You may drop dependents from your plan effective July 1, 2012, but once dropped, they would not be eligible to be added back to the plan without a qualifying event.

Premium Payments:
An eligible Retiree may be able to apply payout of final pay toward Retiree premiums through the end of the calendar year or the benefit year, whichever comes first, on a pretax basis. Discuss this option with your campus HR office. **Note: There is NO employer contribution toward Retiree benefits.**
Other payment options are:

1. Automatic Deductions – when possible, the Retiree should arrange for automatic deductions from his/her monthly retirement benefit received from TRS, MPERA, ORP, or any other retirement benefit, or directly from a checking or savings account if permitted by his/her campus.
2. When automatic deductions are not possible, Retirees must arrange a schedule of timely premium payments with their former campus HR office.

Medicare Enrollment Status:
Retirees and/or spouses who are or become Medicare-eligible are required to be enrolled in both MEDICARE PART A AND MEDICARE PART B as of the first of the month that they become eligible. All Medicare status changes must be reported to the campus HR office to facilitate premium and enrollment adjustments. Any person not correctly enrolled in Medicare will be given 63 days to obtain the missing coverage. After 63 days, the non-enrolled person's status will be changed to non-Medicare-enrolled and premiums will revert to non-Medicare premiums until Medicare enrollment is properly completed and the MUS Benefits Office is notified. **Enrollment in Medicare Part D (drug plan) is NOT permitted.** Responsibility for proper Medicare enrollment belongs to the Retiree or spouse; proof of Medicare enrollment may be required by MUS and/or the Retiree's former campus at any time.

Prescription Drug Coverage:
All medical plans include the MUS prescription drug plan called URx, except the MUS MAP plan which has its own, traditional-style pharmacy plan. Medicare-eligible Retirees may NOT enroll in a Medicare Part D plan. More information about URx is provided later in this workbook. URx is a significant change when compared to MUS's previous pharmacy plan.

Dental Coverage:
CHOICES offers new Retirees a one-time opportunity to enroll in Delta Premium Dental Plan coverage. If you are currently enrolled for dental coverage and wish to keep that coverage, you do not have to complete an enrollment form unless you are changing other portions of your enrollment. If you are enrolled for dental coverage and wish to drop that coverage, you must complete the entire enrollment form and **submit it to your HR office by May 23, 2012**. You will not be allowed to reenroll in the Retiree dental insurance program if you cancel your enrollment! If you did not enroll previously in the Retiree dental insurance program, you may not enroll now, unless a qualifying event occurs or you are a new Retiree.

New Retirees may sign up for Premium Dental coverage during their initial Retiree enrollment or if experiencing a qualifying event. Information and rates for the Delta Premium Dental Plan can be seen within this workbook and on the Retiree enrollment form. Remember: if you do not enroll in Retiree Dental Coverage when it's first offered or you drop your dental coverage, you are not allowed to reenroll unless a qualifying event occurs.

Vision Care Coverage:
MUS has contracted with EyeMed, a national vision care coordinator, to facilitate its vision care plan. If you are not currently enrolled for vision care coverage and want to add that coverage, you must complete the entire enrollment form and **submit it to your HR office by May 23, 2012**. You may add or drop vision coverage with each annual enrollment.

Long Term Care Insurance: If a retiring Employee has UNUM Long Term Care Insurance, she/he should contact his/her HR office for personal payment conversion within 30 days of retirement. Current Retirees can add Long Term Care insurance with medical underwriting at any time. Medical underwriting means that UNUM can reject an application or increase rates due to existing medical conditions.

Long Term Disability Coverage: This MUS coverage ceases as of the date of retirement.

Life Insurance Coverage: Employees may be able to convert their active status policy(s) within 30 days of retirement. MUS does not offer any other life insurance coverage to Retirees.

Dependent Coverage Options:
Continuing existing Medical and Dental coverage for dependents is optional, but a Retiree must elect to continue coverage(s) with the 63-day enrollment period following his/her retirement. New dependents can be added to Medical and/or Dental coverage if the request is made with 63 days of the qualifying event (marriage, birth, adoption/ guardianship, new qualifying dependent, etc.). Existing dependents can only be added to medical or dental coverage if they are losing eligibility for other group coverage or if there is a substantial decrease in the level of existing coverage, as determined on an individual basis by the campus HR office and if the request is made within 63 days of the termination of the other coverage.

Notices for Choices Coverage

Pre-existing Condition Exclusion

Your University System Choices Group Benefit Plan (Plan) may exclude certain medical conditions from coverage if you or an eligible dependent received medical advice, diagnosis, treatment or care for that condition, including prescription medication, within a six (6) month period immediately preceding your enrollment. The enrollment date means the date you or your dependent becomes eligible for University System Group Benefits coverage.

Such pre-existing conditions may be excluded from coverage or be subject to a pre-existing condition limitation for a period of twelve (12) consecutive months beginning on your enrollment date.

Special Enrollment Periods

If you decline retiree medical or dental coverage, you and your dependents will NOT be allowed to enroll in the future. If you are waiving coverage for your eligible dependents (including your spouse) as defined by your Choices Group Plan and this Enrollment Booklet because they are currently covered by other health insurance or another health care plan, you may be able to enroll your dependents for coverage under the Plan in the future, provided that you request such coverage within sixty-three (63) days after such other coverage ends. If you acquire an eligible dependent, as defined by the MUS Plan, as a result of marriage, birth, adoption or placement for adoption of a child under the age of 18, you may enroll your newly acquired dependent child(ren) or spouse for coverage under the Plan, provided that such enrollment occurs within sixty-three (63) days after the marriage, birth, adoption or placement for adoption.

Creditable Coverage

You or your eligible dependent, as defined by the Plan, may submit to the Plan Administrator certification of Creditable Coverage from any prior health insurance or health care plan under which you or your eligible dependent had coverage, for the purpose of reducing, on a day-for-day basis, the pre-existing condition exclusion or limitation imposed by the Plan for any pre-existing condition for which you or your eligible dependent had applicable Creditable Coverage.

You or your eligible dependent have a right to request and receive a Certificate of Creditable Coverage from any insurance carrier or health care plan under which you or your eligible dependent had coverage.

A **"Certificate of Creditable Coverage"** must include the following information in order for us to determine the exact number of days to be reduced from the **pre-existing condition exclusionary or limitation period**.

1. The name or names of the individuals who were previously covered.
2. The date the previous health coverage began.
3. The date the previous health coverage ended.

Insurance ID cards and other similar documents cannot be accepted in lieu of Certificates of Creditable Coverage but may be used as evidence of prior coverage.

All questions about the Pre-existing Condition Exclusion or Limitation and Creditable Coverage should be directed to your campus Human Resources Office.

Important Note:

Enrollment for plan year 2012/13 is Closed Enrollment. No dependents can be added to your plan unless there is a qualifying event (see SPD for qualifying events.)

Choices Enrolling as a Retiree

To select ***Choices*** options as a Retiree you must complete and return an enrollment form:

a. within 63 days of first becoming eligible for Retiree benefits. ***If you do not enroll with the 63-day period, you will permanently forfeit your eligibility for all Retiree insurance coverage.***
b. during annual benefit enrollment by the stated deadline. ***If you do not enroll, you will default to prior coverage or to the stated default coverage if your existing plan(s) is/are changing.***
c. when you have a mid-year qualifying event and want to make an allowed mid-year change in elections. ***This change must be made within 63 days of the event***.

Step-by-Step Process for Completing Your Retiree Choices Annual Benefit Enrollment.

Step 1:
Review this workbook carefully and read the back of the form.

- Discuss this information with your spouse and/or other family members.
- Determine your benefit needs for the coming benefit year if you are enrolling during annual enrollment or for the remainder of the current benefit year if a new Retiree.
- You may want to review the Director's Note section for helpful information about your enrollment options.

Step 2:
Complete the Front Side of Your Enrollment Form.
Your Retiree enrollment form should be included with this workbook. In the event your form is missing or you need another, please contact your campus HR/Benefits Office. If your campus provides on-line annual benefit enrollment, you may enroll on-line at the campus' discretion.

Demographic and Dependent Coverage Sections:
Please fill in these sections completely **every** time you fill out this form.

Medical:
Medical coverage is mandatory for all MUS retirees. For Medical Coverage, you must make two elections: a plan and a coverage category. If you fail to correctly enroll, you will default as described above.

- Review the medical schedule pages to compare benefits between plans.
- Review the service area lists of managed care plans before choosing a managed care plan. You may want to check with your doctor's office as well.
- Check the boxes corresponding to the selected plan and the coverage category you want.
- When you have selected a plan and coverage category, fill in the corresponding monthly cost in the space provided on the right-hand side of the form, by Medical Premium. Premium amounts are listed in the Workbook. If you choose to enroll in MUS MAP (Medicare Advantage Plan), you will have an additional form to complete, found in a New West envelope in your Retiree packet or supplied by your campus HR office. Be sure that you follow all directions and forward all materials to your campus.

Optional Dental:
For Dental coverage, you must be qualified to enroll (see back of form). Choose a coverage category. Retirees are offered enrollment in the Premium Dental Plan only. If you do not make an election when you first retire, you will permanently forfeit your dental coverage eligibility unless a qualifying event occurs.

- Check the box corresponding to the coverage category you want.
- When you have selected a coverage category, fill in the corresponding monthly cost in the space provided on the right-hand side of the form, by Dental Premium.
- OR check the box that "opts out" of Dental coverage entirely.

Enrolling as a Retiree Cont.....

Optional Vision:
Check the correct box if you want optional Vision coverage for the person(s) you want covered and enter the dollar amount in the space provided next to Vision Premium. At this time, you may add or delete vision coverage each year. OR choose the "opt out" box.

Total Your Costs:
Add up the premium amounts and enter the total on the Total Monthly Premium line. If you have not arranged with your campus HR/Benefits Office for automatic payment of your premiums through your pension or bank account, we strongly recommend you consider doing so.

Read the Authorizing Paragraph, then Sign and Date the Form. Sign on the line that corresponds to your family situation.

Return the form by the stated deadline to your campus HR/Benefits Office. For Spring 2012, the deadline is May 23, 2012.

CAMPUS BENEFIT CONTACT
(numbers below) or call MSU Benefits at 877-501-1722 if you have any questions.

MSU-Bozeman	PO Box 172520, Bozeman, MT 59717-2520	406-994-3652
MSU-Billings	1500 University Dr., Billings, MT 59101	406-657-2118
MSU-Northern	PO Box 7751, Havre, MT 59501-7751	406-265-3710
MSU-Great Falls	2100 16th Ave. S., Great Falls, MT 59405	406-268-3701
UM-Missoula	EL 252, 32 Campus Dr., Missoula, MT 59812	406-243-4238
UM-Helena	1115 N. Roberts, Helena MT 59601	406-444-0634
UM-Western	710 S. Atlantic St., Dillon, MT 59725	406-638-7010
MT Tech (UM)	1300 W. Park St., Butte, MT 59701	406-496-4380
OCHE/GSL, MUS Benefits Office	PO Box 203203, Helena, MT 59620-3203	406-444-2574
Dawson Comm. College	300 College Dr., Glendive, MT 59330	406-377-9403
Flathead Valley Comm. College	777 Grandview Dr., Kalispell, MT 59901	406-756-3804
Miles Comm. College	2715 Dickinson St., Miles City, MT 59301	406-874-6292
State Bar of MT, attn: Mary Ann Murray	PO Box 577, Helena, MT 59624-0577	406-442-7660

Medical Rates for 2012-2013

Retiree

Non-Medicare Retirees (generally under age 65)

	Traditional Plan	PacificSource Managed Care	Blue Cross Managed Care	Allegiance Managed Care
Retiree Only	$648	$569	$554	$589
Retiree + One	$979	$860	$837	$890
Retiree + Two or more	$1,145	$1,005	$979	$1,041
Retiree + Spouse ***(mp)**	$658	$578	$562	$598
Retiree + Spouse ***(mp)** + Child(ren)	$820	$720	$701	$746
Survivor	$648	$569	$554	$589
Survivor + Child(ren)	$764	$671	$653	$694

Medicare enrolled *Retirees (generally 65 and older)

	Traditional Plan	PacificSource Managed Care	Blue Cross Managed Care	Allegiance Managed Care	MAP
Retiree* Only	$308	$271	$263	$280	$140
Retiree* + One	$658	$578	$562	$598	na
Retiree* + Two or more	$820	$720	$701	$746	na
Retiree* + Spouse ***(mp)**	$450	$395	$385	$409	$280
Retiree* + Spouse ***(mp)** + Child(ren)	$591	$519	$506	$538	na
Survivor*	$308	$271	$263	$280	$140
Survivor* + Child(ren)	$407	$358	$348	$370	na

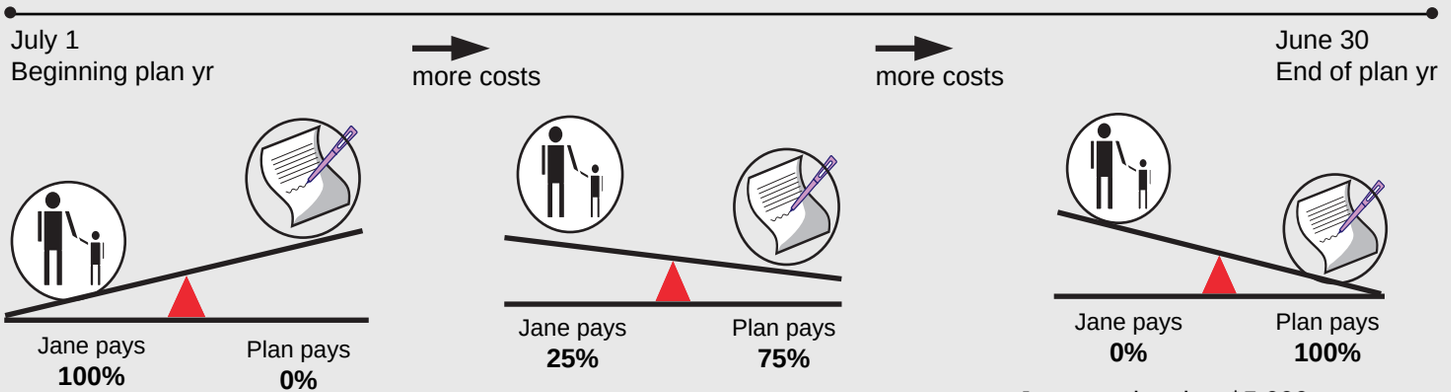
Schedule of Medical Benefits ..... 2012 - 2013

Medical Plan Costs	Traditional Plan In-Network	Traditional Plan Out-of-Network*	Managed Care In-Network	Managed Care Out-of-Network *
Annual Deductible Applies to all services, unless otherwise noted or copayment is indicated	$1,000/Person $2,250/Family	$1,000/Person $2,250/Family Combined with In-network	$500/Person $1,000/Family	Separate $750/Person Separate $1,750/Family
Coinsurance Percentages (% of allowed charges member pays)	25%	35%	25%	35%
Annual Coinsurance Maximums (Maximum coinsurance paid in a benefit year; excludes deductibles and copayments)	$5,000/Person $11,250/Family	$5,000/Person $11,250/Family Combined with In-network	$2,500/Person $5,000/Family	Separate $4,250/Person Separate $9,500/Family
Managed Care ONLY - Copayment (on outpatient visits)	N/A	N/A	$15 copay	N/A

Services from an out-of-network provider have a 35% coinsurance on any plan. In addition, there is a separate deductible and an annual coinsurance maximum on Managed Care Plans. An out-of-network provider can balance bill the difference between the allowance and the charge.

Example *Medical Plan Costs:*

How you and the plan share costs - Traditional Plan Example (in-network). Jane's Plan Deductible is $1,000, her coinsurance is 25%, and her coinsurance max is $5,000.



Jane hasn't reached her deductible yet and she visits the doctor. She pays 100% of the allowable for covered charges.

Jane has seen the doctor several times and reaches her $1,000 deductible. Her plan pays some of the costs of her next visit. She pays 25% of the allowable cost and the plan pays 75% of the allowable cost.

Jane reaches her $5,000 coinsurance maximum. Jane has seen her doctor often and paid $6,000 total (deductible + coinsurance max). The plan pays 100% of the allowable for covered charges for the remainder of the benefit year. *Note: Some services do not apply to the co-insurance maximum and therefore would not be reimbursed at 100% (example DME).

Medical Plan Services	Traditional Plan In-Network Coinsurance	Traditional Plan Out-of-Network Coinsurance	Managed Care In-Network Coinsurance	Managed Care Out-of-Network Coinsurance
Hospital Inpatient Services *Pre-certification of non-emergency inpatient hospitalization is strongly recommended				
Room Charges	25%	35%	25%	35%
Ancillary Services	25%	35%	25%	35%
Surgical Services (see Summary Plan Description for surgeries requiring prior authorization)	25%	35%	25%	35%
Hospital Services (Outpatient facility charges)				
Outpatient Services	25%	35%	25%	35%
Outpatient Surgi-Center	25%	35%	25%	35%
Physician/Professional Provider Services (not listed elsewhere)				
Office visit	25%	35%	$15 copay/visit	35%
Inpatient Physician Services	25%	35%	25%	35%
Lab/Ancillary/Miscellaneous Charges	25%	35%	25%	35%
Second Surgical Opinion	0% (no deductible)	0% (no deductible)	$15 copay/visit for room charges only - lab, x-ray & other procedures apply deductible/coinsurance	35%
Emergency Services				
Ambulance Services for Medical Emergency	25%	25%	$200 copay	$200 copay
Emergency Room Facility Charges	25%	25%	$125 copay/visit for room charges only lab, x-ray & other procedures apply deductible/coinsurance (waived if immediately admitted to hospital)	$125 copay/visit for room charges only lab, x-ray & other procedures apply deductible/coinsurance (waived if immediately admitted to hospital)
Professional Charges	25%	25%	25%	25%
Urgent Care Services				
Facility/professional Charges	25%	25%	$50 copay/visit for room charges only lab, x-ray & other procedures apply deductible/coinsurance	$50 copay/visit for room charges only lab, x-ray & other procedures apply deductible/coinsurance
Lab & Diagnostic Charges	25%	25%	25%	25%
Maternity Services				
Hospital Charges	25%	35%	25%	35%
Physician Charges (delivery & inpatient)	25%	35%	25% (waived if enrolled in WellBaby Program within first trimester)	35%
Prenatal Offices Visits	25%	35%	$15 copay/visit (waived if enrolled in WellBaby Program within first trimester)	35%

Schedule of Medical Benefits ..... 2012 - 2013

Medical Plan Services	Traditional Plan In-Network Coinsurance	Traditional Plan Out-of-Network Coinsurance	Managed Care In-Network Coinsurance	Managed Care Out-of-Network Coinsurance
Preventive Services				
Preventive exams, screenings/ immunizations/flu shots (adult & child Wellcare) Refer to pages 10 & 11 for listing of Preventive Services covered at 100% allowable and for age recommendations	0% (no deductible) for services listed on pg 10 & 11	35%	$0 copay (no deductible) limited to services listed on pg 10 & 11. Other preventive services subject to deductible and co-insurance	35%
Mental Illness Services				
Inpatient Services (Pre-certification is strongly recommended) **Note:** One inpatient day may be exchanged for two partial hospitalization days. No maximum for Severe Mental Illness diagnosis (SMI)	25% Max: 30 days/yr	35% Max: 30 days/yr	25% Max: 30 days/yr	35% Max: 30 days/yr
Outpatient Services No maximum for Severe Mental Illness diagnosis (SMI)	First 4 visits 0% coinsurance then 25% Max: 40 visits/yr	35%	First 4 visits $0 copay then $15 copay/visit Max: 40 visits/yr	35% Max: 40 visits/yr
Chemical Dependency				
Inpatient Services (pre-certification is strongly recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr	25% Max: 30 days/yr	35% Max: 30 days/yr
Outpatient Services	25% First 4 visits 0% coinsurance Max: 40 visits/yr	35% Max: 40 visits/yr	First 4 visits $0 copay then $15 copay/visit Max: 40 visits/yr	35% Max: 40 visits/yr
Rehabilitative Services Physical, Occupational, Cardiac, Respiratory, Pulmonary & Speech Therapy				
Inpatient Services (Pre-certification is strongly recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr	25% Max: 30 days/yr	35% Max: 30 days/yr
Outpatient Services	25% Max: 30 days/yr	35% Max: 30 days/yr	$15 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr

Deductible applies to all services unless otherwise indicated or a copayment applies. Out-of-Network providers can balance bill the difference between their charge and the allowed amount.

Schedule of Medical Benefits 2012 - 2013

Medical Plan Services	Traditional Plan In-Network Coinsurance	Traditional Plan Out-of-Network Coinsurance	Managed Care In-Network Coinsurance	Managed Care Out-of-Network Coinsurance
Complementary Health Care Services				
Acupuncture	Members pay charges over $25/ visit Max: 15 visits/yr in any combination for complementary health care	Members pay charges over $25/ visit Max: 15 visits/yr in any combination for complementary health care	Members pay charges over $25/ visit Max: 15 visits/yr in combination with Naturopathic	Members pay charges over $25/ visit Max: 15 visits/yr in combination with Naturopathic
Naturopathic	Members pay charges over $25/ visit Max: 15 visits/yr in any combination for complementary health care	Members pay charges over $25/ visit Max: 15 visits/yr in any combination for complementary health care	Members pay charges over $25/ visit Max: 15 visits/yr in combination with Acupuncture	Members pay charges over $25/ visit Max: 15 visits/yr in combination with Acupuncture
Chiropractic	Members pay charges over $25/ visit Max: 15 visits/ yr in combination for complementary health care	Members pay charges over $25/ visit Max: 15 visits/ yr in combination for complementary health care	$15/visit Max: 20 visits/yr	35% Max: 20 visits/yr
Extended Care Services				
Home Health Care (Physician ordered prior authorization is strongly recommended (or required) by most plans. See Plan Descriptions)	25% Max: 90 days/yr	35% Max: 90 days/yr	$15 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr
Hospice	25% Max: 6 months	25% Max: 6 months	25% Max: 6 months	35% Max: 6 months
Skilled Nursing (Prior authorization is strongly recommended (or required) by most plans. See Plan Descriptions)	25% Max: 30 days/yr	35% Max: 30 days/yr	25% Max: 30 days/yr	35% Max: 30 days/yr
Miscellaneous Services				
Allergy Shots	25% No deductible	35% No deductible	$15 copay/visit	35%
Durable Medical Equipment, Prosthetic Appliances & Orthotics (Prior authorization is required for amounts greater than $2,500)	25% (Not applied to coinsurance max) Max: $100 for foot orthotics (per ft)/yr	25% (Not applied to coinsurance max) Max: $100 for foot orthotics (per ft)/yr	25% (Not applied to coinsurance max) Max: $100 for foot orthotics (per ft)/yr	35% (Not applied to coinsurance max) Max: $100 for foot orthotics (per ft)/yr

Schedule of Medical Benefits ..... 2012 - 2013

Medical Plan Service	Traditional Plan In-Network Coinsurance	Traditional Plan Out-of-Network Coinsurance	Managed Care In-Network Coinsurance	Managed Care Out-of-Network Coinsurance
Miscellaneous Services cont.				
PKU Supplies (Includes treatment & medical foods)	25%	25%	0% (no deductible)	35%
Education Programs on Disease Processes (when ordered by a physician) and Dietary/Nutritional Counseling (When medically necessary & physician ordered. Prior authorization required for managed care plans and strongly recommended for traditional plans.)	0% (no deductible) Max: 8 visits/yr	0% (no deductible) Max: 8 visits/yr	0% (no deductible) Max: 8 visits/yr	Not covered
Obesity Management (Prior authorization required by all plans)	25% OON not covered. Must be enrolled in WellWeight for non-surgical treatment	Not covered	25% OON not covered. Must be enrolled in WellWeight for non-surgical treatment	Not covered
TMJ (Prior authorization required by managed care plans & strongly recommended for traditional plans)	25% Surgical treatment only	35% Surgical treatment only	25% Surgical treatment only	35% Surgical treatment only
Infertility Treatment (biological infertility only) (prior authorization required for all plans providing coverage)	Not covered	Not covered	25% Max: 3 artificial inseminations/ lifetime	Not covered
Organ Transplants				
Transplant Services (Prior authorization required for managed care plans & strongly recommended for traditional plans)	25%	35%	25%	Not covered
Travel				
Travel for patient only (if services are not available in local community)	25% up to $1,500/yr. with Prior authorization	25% up to $1,500/yr. with Prior authorization	25% up to $1,500/yr. with Prior authorization -up to $5,000/yr. in conjunction with transplants only with Prior authorization	Not covered
Get Healthy Stay Healthy				
Preventive Health Screenings/ Healthy Lifestyle Ed. & Support	see pg 14			
WellBaby	see pg 28			
Infusion Therapy				
Take Control (Diabetes Support Prg.)				
Tobacco Cessation				
WellHeart				
WellWeight				

MAP - Medicare Advantage Program

* All enrolled members under the Retiree's name must be enrolled in both Medicare Part A & Part B.
* In order to enroll, additional forms must be completed and Medicare qualifying time is needed (about 10 days).
* **This is a fully insured product. You must contact New West Health Services for information and assistance.**

Call 1-888-873-8049, TTY 1-888-290-3658.

* MUS Wellness programs are **NOT** available to MAP enrollees. See $0 preventive benefits below.
* Member's permanent address must be in Montana. You may not live elsewhere for more than 6 months per year.

Medical Plan Costs You Pay	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Coinsurance/Copayment Maximums *(Maximum per person out-of-pocket coinsurance/co-payments paid in a benefit year)*	$3,400	
Co-Payments/Coinsurance for:	**In-network**	**Out-of-Network**
Hospital Services – Inpatient facility charges per admission *Prior authorization required, unless an emergency. Includes room charges, ancillary & surgical services*	$400	$600
Hospital Services – Outpatient facility charges Outpatient Services	$10*	$30**
Outpatient Surgery	$10*	$30**
Outpatient Surgery – Ambulatory Surgery Center	$50	$150
Physician/Professional Provider Services *(not listed elsewhere)* Office Visit	$10*	$30**
Lab/X-ray/Ancillary/Miscellaneous Charges	$10*	$30**
Inpatient Physician Services	Included in Facility copayment	
Second Surgical Opinion	$10*	$30**
Emergency Services Ambulance Services for Medical Emergency *(per segment)*	$100	$100
Emergency Room - Facility Charges	$50	$50
Professional Charges	Included in Facility copayment	
Urgent Care Services Facility/Professional Charges	$30	$30
Lab & Diagnostic Charges	Included in Facility copayment	
Preventative Services - each exam Abdominal Aortic Aneurysm Screening, Bone Mass Measurement, Colorectal Screening, Mammogram, Prostate Cancer Screening, Cardiovascular Disease Testing	$0	$30**
Routine Physical Exam (one per year), PAP Test/Pelvic Exam	$0	$30**
Immunizations - Flu and Pneumonia (each)	$0	$30**
Part B Immunizations - other (each)	$0	$30**
Mental Illness Services Inpatient Services - per admission; 190 day lifetime limit *(Prior authorization required, unless in an emergency).*	$400	$600
Outpatient Services	$10	$30**
Outpatient Substance Abuse Care Visit	$10	$30**
Rehabilitative Services *(per visit)* Physical, Occupational, Cardiac, Speech, and certain other Medicare-allowed therapies	$10	$30**
Chiropractic Services - Medicare covered services	$10	$30**

* One in-network copayment per day applies to these services. ** One out-of-network copayment per day applies to these services.

Co-Payments/Coinsurance for:	In-Network	Out-of-Network
Extended Care Services Home Health Care *(Prior authorization required)*	$0	$30**
Hospice	covered by Original Medicare	
Skilled Nursing Facility Care *(Prior authorization required)* No prior hospital stay required. Covered for 100 days each benefit period.	$0/day-days 1-20; $75/day-days 21-100	$100/day-days 1-100
Miscellaneous Services		
Diabetes Supply Item	20%	50%
Radiology Services - CT, MRI or PET Scan *(Prior authorization required for PET Scans)*	$50	$150
Dialysis (Kidney)	20%	20%
Durable Medical Equipment and Prosthetic Devices *(Prior authorization required for items over $500)*	20%	50%
Health and Wellness Education Programs Smoking Cessation Programs - Eight (8) counseling sessions covered per year	$0	$30**
Medicare Part B Prescription Drugs Includes prescription drugs such as those you get in a hospital outpatient department under certain circumstances, injected drugs you get in a doctor's office, certain oral cancer drugs, and drugs used with some types of durable medical equipment. (Prior authorization required for certain drugs)	10%	20%
Vision Services - Vision Exam	$10	$30**
Eyewear	$100 Allowance per year	
Eyewear after cataract surgery One pair of conventional eyeglasses with standard frames or contact lenses after each Medicare-covered cataract surgery that includes insertion of an intraocular lens.	You pay $0	
Hearing Services Hearing Exam	$10	$30**
Hearing Aid	Not Covered	
Dental Services- Preventative care (oral exam, cleaning, periodontal exam, fluoride treatment and dental x-rays)	$200 Allowance per year	
Other Dental Treatment	Not Covered	

* One in-network copayment per day applies to these services. ** One out-of-network copayment per day applies to these services.

SCHEDULE OF PRESCRIPTION DRUG PLAN BENEFITS

Medicare Part D (Prior authorization required for certain Part D Drugs)	**Retail** (30-day Supply)	**Mail Order** (ESI or Ridgeway)
Annual Deductible - per person	$100	$0
Co-Payments/Coinsurance	The greater of:	(30-day/90-day)
Formulary Generic	$10 or 20%	$10/$20
Formulary Preferred Brand	$20 or 30%	$20/$40
Formulary Non-Preferred Brand	$30 or 40%	$30/$60
	Retail	**Specialty Pharmacy**
Specialty Drugs *(co-payments/co-insurance do not apply to out-of-pocket maximum or the $100 deductible)*	$40 or 50%	$0
Annual Coinsurance/Copayment Maximums - per person, in addition to the annual deductible (Maximum out-of-pocket coinsurance/co-payments paid in a benefit year)	$1200 includes retail & mail order	
Formulary *(includes all Medicare Part D covered drugs)*	4 Tier Open	

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Preventive Services

1. What services are Preventive

All MUS health options provide preventive care coverage that complies with the Patient Protection and Affordable Care Act (PPACA). Services designated as preventive care include:

- periodic wellness visits
- certain designated screenings for symptom free or disease free individuals, and
- designated routine immunizations.

When this preventive care is provided by in-network providers it is reimbursed at 100% of the allowed amount, without application of deductible, coinsurance, or co-pay.

The PPACA has used specific resources to identify the preventive services that require coverage: U.S. Preventive Services Task Force (USPSTF) A and B recommendations; and the Advisory Committee on Immunization Practices (ACIP) recommendations adopted by the Center for Disease Control (CDC). Guidelines for preventive care for infants, children, and adolescents, supported by the Health Resources and Services Administration (HRSA), come from two sources: Bright Futures Recommendations for Pediatric health Care and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

U.S. Preventive Services Task Force: www.uspreventiveservicestaskforce.org/
Advisory Committee on Immunization Practices (ACIP): www.cdc.gov/vaccines/recs/ACIP/
CDC: www.cdc.gov/
Bright Future: www.brightfutures.org/
Secretary Advisory Committee: www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/

2. Important Tips

1. Accurate coding for preventive services by your health care provider is the key to accurate reimbursement by your health care plan. All standard correct coding practices should be observed.

2. Also of importance is the difference between a "screening" test and a diagnostic, monitoring, or surveillance test. A "screening" test done on an asymptomatic person is a preventive service, and is considered preventive even if the test results are positive for disease, but future tests would be diagnostic, for monitoring the disease or the risk factors for the disease. A test done because symptoms of disease are present is not a preventive screening.

3. Ancillary services directly associated with a "screening" colonoscopy are also considered preventive services. Therefore, the procedure evaluation office visit with the doctor performing the colonoscopy, the ambulatory facility fee, anesthesiology (if necessary), and pathology will be reimbursed as preventive provided they are submitted with accurate preventive coding.

See next page for listing of covered Preventive Services.

Covered Preventive Services

Periodic Exams Appropriate screening tests per Bright Futures and other sources (previous page)	
WellChild Care Infant through age 17	• Age 0 months through 4 yrs - up to 14 visits • Age 5 yrs through 17 yrs - 1 visit per benefit plan year
Adult Routine Exam Exams may include screening/counseling and/or risk factor reduction interventions for depression, obesity, tobacco use/abuse, drug and/or alcohol use/abuse.	• Age 18 yrs through 65+ - 1 visit per benefit plan year
Preventive Screenings	
Anemia Screening (CBC)	• Pregnant Women
Bacteriuria Screening (UA)	• Pregnant Women
Breast Cancer Screening (mammography)	• Women 40+ - 1 per benefit plan year
Cervical Cancer Screening (PAP)	• Women age 21 - 65 - 1 per benefit plan year
Cholesterol Screening (lipid profile)	• Men age 35+ (age 20 - 35 if risk factors for coronary heart disease are present) • Women age 45+ (age 20 - 45 if risk factors for coronary heart disease are present)
Colorectal Cancer Screening age 50+	• Fecal occult blood testing; 1 per benefit plan year OR • Sigmoidoscopy; every 5 yrs OR • Colonoscopy; every 10 yrs
Prostate Cancer Screening (PSA) age 50+	• 1 per benefit plan year (age 40+ with risk factors)
Osteoporosis Screening	• Post menopausal women - 65+, or 60+ with risk factors - 1 bone density x-ray (DXA)
Abdominal Aneurysm Screening	• Men age 65 - 75 who have ever smoked - 1 screening by ultrasound per plan year
Diabetes Screening (fasting A1C)	• Adults with high blood pressure
HIV Screening **STD screening**	• Pregnant women and others at risk • **Persons at risk**
RH Incompatibility Screening	• Pregnant women
Routine Immunizations	
Diptheria, tetanus, pertussis (DTaP) (Tdap)(TD), Haemophilus influenza (HIB), Hepatitis A & B, Human Papillomavirus (HPV), Influenza, Measles, Mumps, Rubella (MMR), Meningococcal, Pneumococcal (pneumonia), Poliovirus, Rotavirus, Varicella (smallpox), Zoster (shingles) **If needed, see immunization schedules on CDC website (previous page)**	


Bone Density Scans


Height/Weight

Drug Choices

$$
Out-of pocket max:
Individual: $1,650/yr
Family: $3,300/yr

URx Your Pharmacy Plan™

- Any member enrolled in a medical insurance plan will automatically receive URx. There is no separate premium.
- No deductible for prescription drugs.

What is URx?
URx is a prescription drug management program developed by the Montana University System. URx used the prescription process as a mechanism to manage overall care of a member by focusing on producing better clinical outcomes by making sure members get the best drug to treat their condition.

How does URx work?
One component of the URx program is the Pharmacy & Therapeutics Committee (PTAC). Under the Montana University System's oversight, this committee is responsible for evaluating drugs based on their proven clinical results. The PTAC committee is charged with developing the formulary (the list of preferred drugs covered by the plan) that will make the most effective drugs the least expensive to the member, regardless of the drug's actual cost.

With URx there is no deductible and tier A, B, and C and S $150 prescriptions will accumulate toward an out-of-pocket maximum of: Individual - $1,650/yr; Family - $3,300/yr.

Who is eligible?
The Prescription Drug Plan is a benefit for all benefits eligible Montana University System employees, Retirees, and COBRA members and their eligible dependents. Any member enrolled in a medical insurance plan will automatically receive URx. There is no separate premium.

Prescription Options
Prescription drugs may be obtained through the plan at either a local pharmacy (30 day supply) or a mail-order pharmacy (90 day supply). Members who use maintenance medications can experience significant savings by utilizing a mail order pharmacy.

Administrators:

Under URx, the plan's administrative responsibilities are divided among four vendors:

MedImpact is the pharmacy benefit administrator. MedImpact serves as the claims processor. They have a dedicated customer service telephone line for the Montana University System to answer any questions that you may have regarding your benefits or claims processing.

Specialty Pharmacy
Diplomat Specialty Pharmacy, 1-877-319-6337, is the administrator of the specialty pharmacy program. Diplomat will provide assistance and resources to members who are prescribed high dollar oral, intravenous, or injectable medications.

MedVantx and **Ridgeway** will administer the mail-order drug program. MedVantx and Ridgeway will provide mail-order pharmacy services to plan members, based on URx pricing and plan design.

Questions:

About the pharmacy benefit.
call MedImpact at 1-888-648-6764,
or visit: www.urx.mus.edu

About prescriptions or alternatives call 1-888-5-Ask-Urx (527-5879) to speak with pharmacy experts from the University of Montana Pharmacy School.

Generic oral contraceptives are available at a tier A with $0 copay. Effective July 1, 2012

URx Specialty Drug Program

Administered by Diplomat: 1-877-319-6337

Your Pharmacy Plan ™

Specialty Drugs

Specialty drugs are defined as high cost prescription drugs that may require special handling and/or administration to treat chronic, complex conditions. These drugs may be taken orally but often are injectables with complex manufacturing process or may be limited distribution status.

The **URx** Specialty Drug program offers a variety of medications at $0 copay. Other Specialty Drugs are available through the **URx** specialty program with a $150 copay.

If members prefer to receive specialty drugs at retail pharmacies (if available), then the copay is 50% of the total cost of the drug.

Some drugs are limited distribution drugs and may not be available at Diplomat. For these prescriptions, Diplomat will transfer them to specialty pharmacies that are able to dispense these drugs.

Because of the complexity of the medical condition, many of these drugs will require Prior Authorization to ensure appropriate use and to maximize the effectiveness of the drug by encouraging careful adherence to treatment protocols.

Diplomat Specialty Pharmacy is the chosen provider for specialty drug services. To enroll or for any questions regarding the specialty drug program, please contact Diplomat at 1-877-319-6337.

Agents to Treat Multiple Sclerosis	
S-$0	Copaxone, Rebif
S-$150	Avonex, Betaseron, Extavia, Ampyra
Anti-Hemophilic Factors	
S-$0	All Factors including: Alphanate, Alphanine SD, Bebulin VH, Feiba/-VH, Helixate FS, Hemofil-M, Humate-P, Hyate:C, Kogenate FS, Monarc-M, Monoclate P, Mononine, Novoseven, Proplex T, Recombinate, Refacto
Anti-Inflammatory (Rheumatoid Arthritis/Psoriasis)	
S-$0	Humira (PA), Simponi (PA)
S-$150	Amevive, Cimzia (PA), Enbrel (PA), gold sodium thiomalate, Myochrysine, Orencia, Raptiva, Remicade, Stelara
Anti-Inflammatory (Anti-Arthritics)	
S-$0	Hyalgan, Supartz
S-$150	Euflexxa, Orthovisc, Synvisc
Antineoplastics	
S-$0	Arimidex, Revlimid, Nexavar, Tarceva
S-$150	All antineoplastics including: Afinitor, Alkeran, Aromasin, Avastin, Bicnu, Busulfex, carboplatin, Ceenu, cisplatin, Campath, cyclophosphamide, Depocyt, Eligard, Erbitux, etoposide, Gemar, Gleevac, Herceptin, Iressa, Lupron/- Depot, mercaptopurine, Sprycel, Sutent, Trelstar Depot/-LA, Tykerb, Vectibix, Vumon, Xeloda, Zolinza
Growth Hormones/Insulin-Like Growth Factor Hormones	
S-$0	Increlex, Norditropin (PA), Tev-Tropin (PA)
S-$150 (PA)	Genotropin, Humatrope, Nutropin/-AQ, Omnitrope, Saizen, Serostim, Zorbtive
Hepatitis Agents	
S-$0	Epivir HBV, Copegus (PA), Infergen (PA), Peg-Intron, Pegasys (PA), Rebetol (PA), Rebetron, Roferon-A
S-$150	Intron-A
Immunosuppressive Agents	
S-$0	Cellcept, cyclosporine (oral and inj), Gengraf, Myfortic, Prograf (oral and inj), Rapamune, Sandimmune
S-$150	Simulect, Zenapax
Osteoporosis	
S-$0	Reclast
S-$150 (inj)	Aredia, Boniva, Forteo (PA), Miacalcin, pamidronate, Zometa
Pulmonary Arterial Hypertension	
S-$0	Tracleer, Revatio
S-$150	Flolan, Letairis, Remodulin, Tyvaso, Ventavis

URx Drug Classification

Call 1-888-5-Ask-URx (527-5879) and discuss question(s) with pharmacy experts from the University of Montana Pharmacy School. Ask questions about your prescriptions or alternative drugs that may be available.

URx Drug Classification **(Based on medical evidence of impact to health and overall net cost)**	**Drug Class**	**Deductible**	**Retail Rx (30-day supply)**	**Mail Rx (90-day supply)**
Excellent level of value based on best medical evidence, best opportunity for improved health outcomes via disease management, and best overall net cost.	**Tier A**	**$0**	$0 Copayment †	$0 Copayment †
High level of value based on medical evidence of outcomes and lower overall net cost savings. Includes generic and brand drugs compared to higher cost brand name counterparts.	**Tier B**	**$0**	$15 Copayment †	$30 Copayment †
Good level of value based on fair medical evidence grading, but displaying higher overall net cost relative to generic counterparts and less expensive brand name drug or clinical alternatives.	**Tier C**	**$0**	$40 Copayment †	$80 Copayment †
Lower level of value based on evidence of outcomes relative to other clinical alternatives. Generally have much higher overall net costs. *[Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most drugs purchased through URx.]*	**Tier D**	**$0**	50% Coinsurance †* (You will pay half of the discounted price)	50% Coinsurance †* (You will pay half of the discounted price)
These drugs have the lowest level of value (based on clinical evidence) or the highest overall net cost in relation to generic or other brand alternatives. Tier F drugs may also include drugs that were not previously covered, allowing members to purchase them at a substantial discount. *[Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most drugs*	**Tier F**	**$0**	100% Coinsurance †* (You will pay 100% of the discounted price)	100% Coinsurance †* (You will pay 100% of the discounted price)
If you take a specialty drug, you are encouraged to use the URx Specialty Pharmacy program to qualify for a $150 copayment. If you fill your prescription at a retail pharmacy, you will have to pay 50% coinsurance. Specialty drugs are not covered through the mail-order program. Certain preferred specialty drugs will be available at no cost to the member through the URx Specialty Pharmacy program.	**Tier S**	**$0**	50% Coinsurance †* if purchased through standard retail pharmacy	Not Covered

The amounts you pay in these categories do not count toward your annual out-of-pocket prescription maximum.

† ***A copayment is a flat dollar amount you pay for Rx services. Coinsurance is a percentage of the total discounted cost you pay for Rx services. Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most drugs purchased through URx.***

What Class are you in?

What grade would you get when it comes to ordering your prescription drugs? Would you get an A, B, or F? Most people don't realize that just because a drug costs more...doesn't mean it's better. Drug manufacturers spend billions of dollars each year on advertising - so if you see six commercials for a particular drug, that drug may cost you a lot! Currently the Montana University System plan spends more on prescription drugs than on doctor visits!

How do I determine what class my drug is in?

You can look up which class your drug is at www.urx.mus.edu or by calling Montana University System Benefits. If you are unsatisfied with the class or the 'grade' your drug(s) makes, other therapeutically equivalent drugs that are more cost effective will be displayed that you can discuss with your physician. We encourage you to take this information to your physician to determine if you are able to use the therapeutically equivalent drug.

What does it mean that most drugs are covered?

The Montana University System's Pharmacy Benefit Administrator negotiates discounts with pharmaceutical companies. These discounts will be passed on to you regardless of the class of your drug. All drugs, including those that were formerly not covered, will have a discount. This savings will be passed on to you as a member of the Montana University System benefit plan.

Vision (*voluntary*)

Choices

Administered by Eye Med Vision Care:

1-866-723-0596 (prior to enrolling), 1-866-723-0513 (after enrolling)
www.enrollwitheyemed.com/access (prior to enrolling)
www.eyemedvisioncare.com (after enrolling)

Who is Eligible?
Employees, spouses, adult dependents, retirees, and children are eligible if you elect to have this coverage.

Instructions:
Review the premiums on the next page and complete the appropriate sections of the Enrollment Form.

Using Your EyeMed Benefit:
Quality vision care is important to your eye wellness and overall health care. Accessing your EyeMed Vision Care benefit is easy. Simply locate a participating provider, schedule an appointment, present your ID card at the time of service, and the provider will take care of the rest.

Locating Your Doctor
Check the online provider locator at www.eyemedvisioncare.com, choose the ACCESS network for a provider near your zip code.

Once enrolled, visit: www.eyemedvisioncare.com, register by entering your email address and choosing a password to view coverage and eligibility status.

Value Added Discounts
Members will receive a 20% discount on items not covered by the plan at Network Providers. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network. Members receive a 40% discount off complete pair of eyeglasses purchased and an additional 15% discount off conventional contact lenses once the funded benefit has been used.

Out-of-Network Providers
Once enrolled, registered members can access their
out-of-network benefit by:

1. Downloading an Out-of-Network Claim Form from the EyeMed Vision Care website, www.eyemedvisioncare.com, or by calling the Customer Care Center.

2. Make an appointment with an out-of-network provider you trust as your choice for vision care provider.

3. Pay for all services at the point of care and receive an itemized receipt from the provider office.

4. Complete the out-of-network claim form and submit along with receipts to EyeMed Vision Care's claims department for direct

Vision (*voluntary*) cont.

Monthly Vision Rates	
• Employee Only	$6.76
• Employee & Spouse/Adult Dep.	$12.76
• Employee & Child(ren)	$13.43
• Employee & Family	$19.70

Service/Material	Coverage from an EyeMed Doctor	Out-of-Network Reimbursement	Rural OON Reimbursement**
Exam with dilation as necessary: Once every benefit year	$10 copay	Up to $45	Up to $85
Frames: Once every two years	$125 allowance, 20% off balance over $125	Up to $52	Up to $100
Single Vision Bifocal Trifocal Standard Progressives Once every benefit year in lieu of contacts	$20 copay $20 copay $20 copay $85 copay	Up to $45 Up to $55 Up to $65 Up to $55	Up to $45 Up to $55 Up to $65 Up to $55
Contact Lens Materials: Conventional Disposable *Medically Necessary Once every benefit year in lieu of eyeglass lenses	$125 allowance, 15% off balance over $125 $125 allowance paid in full	Up to $80 Up to $80 Up to $200	Up to $100 Up to $100 Up to $200
Contact Lens Exam Fees: Standard Contact Lens Fit & Follow-up Premium Contact Lens Fit & Follow-up Once every benefit year	$20 copay, paid in full fit and two follow up visits $20 copay, 10% off retail price, then apply $35 allowance	Up to $40 Up to $40	Up to $40 Up to $40
Lens Options: UV Coating Tin (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard A/R	$15 copay $15 copay $15 copay $40 copay $45 copay	NA	NA

* Contact lenses that are required to treat medical or abnormal visual conditions, including but not limited to eye surgery (i.e. cataract removal), visual perception in the better eye that cannot be corrected to 20/70 through the use of eyeglasses, and certain corneal or other eye diseases.

**To qualify for the enhanced rural out-of-network benefit, employees must meet the definition of rural employee, meaning any MUS employee and dependents enrolled on the vision plan who reside more than 50 miles from the nearest network provider.

Dental Choice

Choices offers one Dental plan option for Retirees: **Premium Plan**

Retiree enrollment in the dental plan is a one-time opportunity. See the back of the enrollment form for details. If you do not enroll in a timely manner, you will lose your right for coverage unless a qualifying event occurs.

	Premium Plan	Basic Plan - Preventive Coverage
Who May be Enrolled & Monthly Premium	• Retiree Only $59 • Retiree & Spouse/Adult Dep. $106 • Retiree & Child(ren) $106 • Retiree & Family $177	• Not Available to Retirees
Maximum Annual Benefit	**$1,500 per covered individual**	**$750 per covered individual**
Preventive and Diagnostic Services	• Twice Per Benefit Year • Initial and Periodic oral exam • Cleaning • Complete series of intraoral X-rays • Topical application of fluoride • The Diagnostice & Preventive Services listed above do not apply to the $1,500 annual maximum.	• Not Available to Retirees
Basic Restorative Services	• Amalgam filling • Endodontic treatment • Periodontic treatment • Oral surgery	• Not Available to Retirees
Major Dental Services	• Crown • Root canal • Complete lower and upper denture • Dental implant • Occlusal guards	• Not Available to Retirees
Removal of impacted teeth	• Covered benefit	• Not Available to Retirees
Orthodontia	• Available to covered children and adults • $1,500 lifetime benefit	• Not Available to Retirees
Implants	• Included in annual benefit	• Not Available to Retirees

Your Orthodontic Benefits:

The Choices Premium Plan provides a $1,500 lifetime orthodontic benefit per covered individual. Benefits are paid at 50% of the allowable charge for authorized services. Treatment plans usually include an initial down payment and ongoing monthly fees. If an initial down payment is required, Choices will pay up to 50% of the initial payment, up to 1/3 of the total treatment charge. In addition, Delta Dental (our dental plan administrator) will establish a monthly reimbursement based on your provider's monthly fee and your prescribed treatment plan.

Delta Dental: **1-866-579-5717** **www.deltadentalins.com/mus**

MUS DentalSchedule of Benefits

Dental claims are reimbursed based on a Schedule of Benefits. The following subsets of the **Premium** and **Basic Plan** Schedules include the most commonly used procedure codes. Please note, the Basic Plan provides coverage for a limited range of services including diagnostic, preventive, and extractions of impacted teeth. The Schedule dollar amount is the maximum reimbursement for the specified procedure code. Covered individuals are responsible for the difference (if any) between the provider's charge and the Schedule reimbursement amount.

Blue shaded codes are for the **Basic Plan** ONLY. All Codes (shaded and non-shaded) are for the **Premium Plan**. See Summary Plan Description for complete listing.

Procedure Code	Description	Maximum Benefits
D0120	Periodic oral evaluation - established patient	$40
D0140	Limited oral evaluation - problem focused	$58
D0150	Comprehensive oral evaluation -new or established patient	$65
D0180	Comprehensive periodontal evaluation –new or established patient	$72
D0210	Intraoral - complete series (including bitewings)	$110
D0220	Intraoral - periapical first film	$26
D0230	Intraoral - periapical each additional film	$20
D0240	Intraoral - occlusal film	$25
D0250	Extraoral - first film	$58
D0270	Bitewings - one film	$22
D0272	Bitewings - two films	$37
D0273	Bitewings - three films	$45
D0274	Bitewings – four films	$53
D0320	TMJ arthogram including injection	$622
D0330	Panoramic film	$91
D1110	Prophylaxis - Adult	$83
D1120	Prophylaxis - Child	$58
D1203	Topical application of fluoride (prophylaxis not included) child (through age 13)	$27
D1204	Topical application of fluoride (prophylaxis not included) adult (ages 14 through 18)	$28
D1351	Sealant – per tooth (through age 15)	$45
D1510	Space maintainer - fixed - unilateral	$239
D1515	Space maintainer - fixed - bilateral	$388
D1520	Space maintainer -removable -unilateral	$393
D1525	Space maintainer -removable -bilateral	$538
D2140	Amalgam - one surface, primary or permanent	$93
D2150	Amalgam - two surfaces, primary or permanent	$118
D2160	Amalgam - three surfaces, primary or permanent	$147
D2161	Amalgam - four or more surfaces, primary or permanent	$176
D2330	Resin-based composite - one surface, anterior	$98
D2331	Resin-based composite - two surfaces, anterior	$125
D2332	Resin-based composite - three surfaces, anterior	$156
D2335	Resin- based composite - four or more surfaces involving incisal angle (anterior)	$190
D2391	Resin- based composite -one surface, posterior	$116

MUS Dental Schedule of Benefits

Procedure Code	Description	Maximum Benefits
D2392	Resin- based composite -two surfaces, posterior	$148
D2393	Resin- based composite -three surfaces, posterior	$184
D2394	Resin- based composite - four or more surfaces, posterior	$220
D2543	Onlay - metallic - three surfaces	$375
D2544	Onlay - metallic - four or more surfaces	$440
D2643	Onlay - porcelain/ceramic - three surfaces	$375
D2644	Onlay - porcelain/ceramic - four or more surfaces	$440
D2740	Crown - porcelain/ceramic substrate	$453
D2750	Crown - porcelain fused to high noble metal	$423
D2751	Crown - porcelain fused to predominately base metal	$410
D2752	Crown - porcelain fused to noble metal	$414
D2780	Crown - 3/4 cast high noble metal	$406
D2783	Crown - 3/4 porcelain/ceramic	$410
D2790	Crown - full cast high noble metal	$410
D2930	Prefabricatated stainless steel crown - primary tooth	$148
D2931	Prefabricatated stainless steel crown - permanent tooth	$222
D2932	Prefabricated resin crown	$221
D2933	Prefabricated stainless steel crown with resin window	$222
D2940	Sedative filling	$70
D2950	Core buildup, including any pins	$95
D2951	Pin retention - per tooth, in addition to restoration	$38
D2954	Prefabricated post and core in addition to crown	$127
D3110	Pulp cap - direct (excluding final restoration)	$43
D3310	Root canal - Anterior (excluding final restoration)	$489
D3320	Root canal - Bicuspid (excluding final restoration)	$566
D3330	Root canal - Molar (excluding final restoration)	$695
D3346	Retreatment of previous root canal therapy - anterior	$592
D3347	Retreatment of previous root canal therapy - bicuspid	$674
D3348	Retreatment of previous root canal therapy - molar	$814
D3410	Apicoectomy/periradicular surgery - anterior	$435
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$480
D3425	Apicoectomy/periradicular surgery - molar(first root)	$520
D3430	Retrograde filling - per root	$116
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$358
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$113
D4249	Clinical crown lengthening - hard tissue	$455
D4260	Osseous surgery (including flap entry and closure) four or more contigous teeth or bounded teeth spaces per quadrant	$672
D4261	Osseous surgery (including flap entry and closure) one to three contigous teeth or bounded teeth spaces per quadrant	$511
D4271	Free soft tissue graft procedure (including donor site surgery)	$632

MUS Dental Schedule of Benefits

Procedure Code	Description	Maximum Benefits
D4273	Subepithelial connective tissue graft procedure per tooth	$632
D4341	Peridontal scaling and root planing - four or more teeth per quadrant	$154
D4342	Peridontal scaling and root planing - one to three teeth per quadrant	$97
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$59
D4910	Peridontal maintenance	$84
D5110	Complete denture - maxillary	$608
D5120	Complete denture - mandibular	$608
D5130	Immediate denture - maxillary	$666
D5140	Immediate denture - mandibular	$666
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$436
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$436
D5213	Axillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$650
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$650
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$488
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$488
D5510	Repair broken complete denture base	$86
D5520	Replace missing or broken teeth - complete denture (each tooth)	$76
D5610	Repair resin denture base	$89
D5640	Replace broken teeth - per tooth	$76
D5650	Add tooth to existing partial denture	$114
D5660	Add clasp to existing partial denture	$160
D5750	Reline complete maxillary denture (laboratory)	$274
D5751	Reline complete mandibular denture (laboratory)	$274
D5761	Reline mandibular partial denture (laboratory)	$263
D5820	Interim partial denture (maxillary)	$216
D5821	Interim partial denture (mandibular)	$216
D5850	Tissue conditioning, maxillary	$51
D6210	Pontic - cast high noble metal	$399
D6212	Pontic - cast noble metal	$365
D6240	Pontic - porcelain fused to high noble metal	$424

MUS Dental Schedule of Benefits

Procedure Code	Description	Maximum Benefits
D6241	Pontic - porcelain fused predominantly base metal	$391
D6242	Pontic - porcelain fused to noble metal	$408
D6245	Pontic - porcelain/ceramic	$429
D6750	Crown - porcelain fused to high noble metal	$423
D6751	Crown - porcelain fused to predominately base metal	$410
D6752	Crown - porcelain fused to noble metal	$414
D6790	Crown - full cast high noble metal	$410
D6791	Crown - full cast predominately base metal	$402
D6792	Crown - full cast noble metal	$406
D6794	Crown - titanium	$410
D6973	Core build up for retainer, including any pins	$92
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$94
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$160
D7220	Removal of impacted tooth - soft tissue	$176
D7230	Removal of impacted tooth - partially bony	$215
D7240	Removal of impacted tooth - completely bony	$255
D7241	Removal of impacted tooth - completely bony , with unusual surgical complications	$305
D7850	Surgical discectomy, with/without implant	$1,500
D7860	Arthrotomy	$1,500
D7880	Occlusal orthotic device, by report	$469
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$210
D7971	Excision of pericoronal gingiva	$120
D9110	Pallative (emergency) treatment of dental pain - minor procedure	$69
D9220	Deep sedation/general anesthesia - first 30 minutes	$219
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$105
D9241	Intravenous conscious sedation/analgesic - first 30 minutes	$199
D9242	Intravenous conscious sedation/analgesic - each additional 15 minutes	$81
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$67
D9940	Occlusal guards, by report	$245

Long Term Care Insurance (*voluntary*)

Choices

Provided by UNUM Life Insurance Co.

1-800-227-4165 www.unum.com

Options	Choices
Care Type	
Plan 1	Facility (nursing home or assisted living)
Plan 2	Facility + Professional Home Care (Provided by a licensed home health organization)
Plan 3	Facility + Professional Home Care + Total Home Care (Care provided by anyone, including family members)
Monthly Benefit	
Nursing Home	$1,000-$6,000
Assisted Living	60% of the selected nursing home amount
Home Care	50% of the selected nursing home amount
Duration	
3 years	3 years Nursing Home
6 years	6 years Nursing Home
Unlimited	Unlimited Nursing Home
Inflation Protection	
Yes	5% compounded annually
No	No protections will be provided

Unexpected events, such as accidents or illness, can catch us off guard at any age, any time. This can often lead to financial and emotional hardship. Many believe that our health insurance covers long term care situations when, in most cases, it does not. We may be left thinking we should have planned better. Long Term Care Insurance is designed to pick up where our health insurance leaves off. You may never need long term care. However, this year about nine million men and women will need long term care. By 2020, 12 million Americans will need long term care. Most will be cared for at home. A study by the US Department of Health and Human Services indicates that people who reach age 65 have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home stay there five years or longer. The Montana University System offers the opportunity to purchase Long Term Care Insurance from Unum Life Insurance Company of America a subsidiary of Unum Provident.

New employees can enroll in LTC within 30 days of employment without demonstrating evidence of insurability. Continuing employees, spouses, retirees, and grandparents can enroll in our group LTC insurance with medical underwriting at any time.

Who is Eligible

Employees, retirees, spouses, parents, and parents-in-law are eligible for the Long-Term Care Insurance Plan. This plan may be elected, changed, or dropped at anytime.

Enrollment

If you would like to sign up for the Long Term Care Plan, contact your campus Human Resource Department for an enrollment kit.

Get Healthy, Stay Healthy

Overview
The Montana University System (MUS) Benefits Plan offers Wellness services to covered adult plan members (faculty, staff, retirees, and spouses) regardless of which medical plan you choose (Allegiance, BCBSMT, or PacificSource).

Preventive Health Screenings

WellCheck
Every campus conducts heath fairs, called WellChecks. Several lab tests are available at WellCheck, as well as a variety of additional free or discounted health screenings. See the website below for more information on WellCheck dates and times.

Online Registration
Online registration is required on all campuses for WellCheck appointments. To register go to: www.itstartswithme.com.

Lab Tests
Log on to your It Starts With Me Account for a complete listing of tests available at WellCheck: www.itstartswithme.com

Flu Shots
Are offered FREE in the fall, subject to national vaccine availability. See website below for more information.

Wise Consumer Tip:

Getting preventive screenings by attending a campus WellCheck is both cost-effective and smart! You save yourself and our self-funded insurance plan money by taking advantage of the discounts . You can also optimize your own personal health care by taking or sending your results to your primary care provider.

Healthy Lifestyle Education & Support

The Life Connection (TLC) Program
View services at the website below. Select “TLC button” (company code: MUS), or call 1-866-248-4532.

Ask an Expert
This program provides FREE telephone consultation with a registered dietitian and/or exercise specialist. Call toll free 1-866-644-2025 or for an online application see website below.

Classes
Classes are taught live, over the phone and/ or via the internet. See newsletter and website below for current and future listings.

Newsletter
Mailed to home addresses up to three times each plan year. Archived editions can be accessed via the website below.

Online DesktopSpa
A database of unique, brief and highly effective audio and video wellness exercises led by respected health practitioners using yoga, relaxation, acupressure, tai chi, guided imagery and ergonomics. It integrates “mini-treatments” to reduce stress and illness, and increase effectiveness, energy and performance. Go to the website below. Select: DesktopSpa, Enter DesktopSpa, Register as New User, follow all prompts, Corporate Code: MUS (disregard User ID).

Website: www.montana.edu/wellness
See the website for more detailed information.

WELLNESS
MONTANA UNIVERSITY SYSTEM

MUS MAP PLAN MEMBERS ARE NOT INCLUDED IN THE MUS WELLNESS PROGRAM

Get Healthy, Stay Healthy

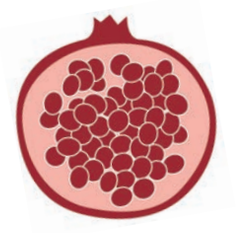
Disease Management Programs

Infusion Therapy Program
The Infusion Therapy Program is offered in partnership with the Walgreens-OptionCare stores in Helena, Billings, Bozeman, and Butte. This program was designed for patients who need medication administered through a needle or catheter, to treat such diseases as congestive heart failure, immune deficiencies, multiple sclerosis, and rheumatoid arthritis. The participating Walgreens stores operate infusion suites, where patients can have their IV drugs administered under the care of medical professionals. (Note: Medicare-primary retirees and disabled retirees should continue to obtain infusion therapy from Medicare-approved facilities, usually at a hospital.)

Plan members who participate receive their treatment at no cost - no deductibles, no copayments, and no coinsurance. The plan reimburses 100% of the allowable charges for those enrolled in this program. The program is easy to use as well, with no prior authorization requirements; and works seamlessly with the MUS medical plans.

To learn more about the Infusion Program call 1-800-287-8266, or you may contact MUS Benefits at 1-877-501-1722. For additional information go to: www.mus.edu/choices.

Take Control "Diabetes Support Program"
Available to plan members with diabetes. For details call 1-800-746-2970 or visit the website below.



Tobacco Cessation
The Tobacco Cessation Program is a once-in-a-lifetime, 12-month benefit, in partnership with the Montana Tobacco Quit Line (QL).
How: For more information and details Call 1-877-501-1722 or visit the website below.

WellBaby
WellBaby is a pregnancy benefit designed to help you achieve a healthier pregnancy. Members must enroll during first trimester to take advantage of Program benefits. For more information call 406-660-0082 or visit www.montana.edu/wellness.

WellHeart
WellHeart is a 18-month, once in a lifetime benefit, available to members with 2 out of 6 specific risk factors associated with heart disease. For more information and details, visit the website below or call 1-866-644-2025.

WellWeight
WellWeight is an 18 month, once in a lifetime benefit, available to members with a body mass index (BMI) of 30 or greater. If a member of WellHeart (above) has both the BMI and waist circumference as criteria, they may also consider the WellWeight benefit. For more information and details, visit the website below.

Website: www.mus.edu/Choices/DiseaseMgmt.asp
See the website for more detailed information.

MUS MAP PLAN MEMBERS ARE NOT INCLUDED IN THE MUS WELLNESS PROGRAM

Additional Benefits

KnovaSolutions

The Montana University System is offering a health information service, known as KnovaSolutions. This service is available to help you better understand and manage your medical care, treatment and medications. This confidential and individualized service is easily accessed by telephone and provides a complete approach to support you with health-related decisions.

KnovaSolutions' nurses and pharmacists will interact with you to provide access to health information and to support you in making the best health decisions possible. Individuals and families facing many healthcare decisions benefit from talking with the nurses and pharmacists at KnovaSolutions. The staff will talk with you about healthcare providers, medications and quality of life issues to assist you in improving your decision making. A relationship built over time provides the opportunity for open discussion about the best way to use the medical care system.

The staff at KnovaSolutions will provide education about the risks and benefits associated with multiple providers, tests, procedures and medications in order to help you better communicate with your providers. These services are intended to enhance, not replace the patient-doctor relationship. The staff at KnovaSolutions are masters-educated, highly experienced nurses and doctorate prepared clinical pharmacists.

Participation in KnovaSolutions is voluntary. For more information you may contact MUS Employee Benefits at 406-444-2574, or toll free at 877-501-1722.

Flathead Valley CC

Dawson CC

Ways to save Money

THE WISE CONSUMER

We don't usually think of ourselves as "shoppers" when it comes to healthcare. Most of us make our health care purchasing decisions by comparing premiums and deductibles and then we stop. The good news is there are more things you can do to keep money in your pocket. Here are some suggestions on how to use *Choices* to be a **WISE** consumer!

Let's start with **Wellness**. Avoiding sickness and disability not only makes economic sense, but also enhances quality of life. The MUS Wellness programs are designed to support this goal. In order to save money, here are some specific services that you may wish to check out in the coming year.

- WellCheck (**Free** to each adult once per year!) – A WellCheck health screening provides you and your physician with important information about your health. It consists of services such as a blood pressure check, oxygen saturation test, bioimpedance (body composition measurement), and labs including a complete blood count (CBC), comprehensive metabolic panel (CMP), and a lipid (cholesterol) panel as well as a number of other tests. The laboratory tests are standard for many office visits and are usually charged in addition to the physician office visit. The cost for the labs is generally $75-125 and the office visit is $95-$130.

⇨ ***Total Cost Savings $170-$255***.

The next step is gathering **Information**. One of the biggest hurdles for health care consumers is gathering information to make informed decisions about the quality and cost of services. The *Choices* plan is designed to help you navigate toward services that focus both on good quality care and keeping costs low. Look for programs where the co-pay, coinsurance, or deductible is waived for the service or part of the program. Some of these include:

- *Infusion Therapy* through Walgreens-OptionCare - $0 for co-pay/coinsurance/deductible
- Disease management programs like the *Take Control* program (free lancets and test strips to members who qualify), *WellBaby* ($0 for certain qualifying services), or *WellWeight* (free or enhanced services for qualifying participants) services are aimed at helping people who have some risk factors, to have a better health outcome
- *URx*$_{TM}$ pharmacy program (Tier A and certain specialty drugs)

⇨ ***Total Cost Savings $500-$2,250.***

Select the medical plan option that works best for your family. At the risk of repeating information listed elsewhere, choosing the medical plan option that best fits your family's needs can save you substantial amounts of money.

- When considering a medical plan, look at your family composition. If you are single and healthy, you may want to select a medical plan that permits you to have employer contribution left over that you can 'flex'. If you have children, you may wish to choose a plan that has co-pay features which reduce the out-of-pocket costs for more frequent doctor's office visits. Determine what fits you 'best'.
- Make sure your providers and preferred hospital are in-network for your plan. (*IMPORTANT – IF YOU GO OUT OF NETWORK, YOU MAY BE RESPONSIBLE FOR CHARGES THAT ARE ABOVE THE AMOUNT THE PLAN PAYS ON YOUR BEHALF*!)
- What types of services do you typically need? Review the schedule of medical benefits beginning on p. 6 to determine which meets your needs most efficiently.

⇨ ***Total Cost Savings $200 – Balance billing amount charged by out-of-network provider.***

Take advantage of the **Education** opportunities offered by the *Choices* Plan to help you improve and maintain your health.

- In addition to WellChecks, the MUS Wellness Program is offering new opportunities to participate in fitness programs, to participate in nutrition and health education programs, and to track your health status from year-to-year.
- Become familiar with the tax advantages of a Medical Flexible Spending Account, a Dependent Care Flexible Spending Account, or an Adoption Assistance Account. These permit employees to save excess employer contribution funds or pre-tax salary to pay for certain expenditures. However, set aside only what you plan to spend. If you do not use those dollars, at the end of the year you forfeit the money remaining in the account.

⇨ ***Total Cost Savings $900 +***

With a bit of work and planning, you can be a **WISE** consumer. You and your family will enjoy the benefits of improved health and quality of life while saving money!

Availability of the MUS Summary Plan Description

All Montana University Sysem (MUS) plan participants have the right to obtain a current copy of the Summary Plan Description (SPD). Despite the use of "summary" in the title, this document is the full legal description of our medical, dental, and pharmacy plans and should always be consulted when a specific question arises about the plan.

Participants may request a hardcopy of the SPD and amendments describing the MUS managed care plans by visiting, writing, or calling their campus benefits office, or by writing to MUS Benefits, P.O. Box 203203, Helena, MT 59620-3203, or by calling the MUS Benefits Office at 406-444-2574, toll free 877-501-1722. Participants should know which medical plan they are enrolled in when calling or writing so that the correct amendment, if any, can be sent. An easier way to access this information for many participants is to visit the MUS website at www.mus.edu/choices. Using the FIND function on your computer will help you to locate the section you need quickly.

All participants are given or mailed a copy of the CHOICES Enrollment Workbook or Retiree Workbook each spring during the annual enrollment period. These workbooks list the various required and optional programs available, and their premiums. We encourage participants to retain this book until it is replaced the following year, as it provides most of the information needed by participants and their families to properly utilize their benefit plans. If additional information is needed after referring to CHOICES enrollment book or the SPD, either the campus benefit office or the MUS Benefits Office should be able to help. Also, many problems can be resolved by contacting the customer service department of the appropriate program administrator.

This notice describes how medical information about you may be used.

The Montana University System self-insured employee health benefit plan has a duty to safeguard and protect the privacy of all plan members' personally identifiable health information that is created, maintained, sent or received by plan employees or persons under our control.

The Montana University System self-insured health plan has contracts with multiple business associates. Business associates do claims processing and perform other health-related services associated with the plan such as counseling, psychological services and pharmaceutical services, etc. The MUS self-insured plans business associates and health care provider(s) must also protect a plan member's personally identifiable health information from inadvertent, improper or illegal disclosure.

The Montana University System self-insured health plan, in administering plan benefits, shares and receives personally identifiable medical information concerning plan members as required by law and for routine transactions concerning eligibility, treatment, payment(s), wellness program (including WellChecks), disease management programs (i.e. Take Control, etc.) healthcare operations, claims processing, including review of payments or claims denied and appeals of payments or claims denied, premiums paid, liens and other reimbursements, health care fraud and abuse detection and compliance. Information concerning those areas may be shared between MUS authorized benefit employees, their supervisors and our business associates(s), members' providers(s) or legally authorized governmental entities without a member's written consent.

Full HIPAA policy available on Website or by contacting Campus HR

Miscellaneous Legal Information and References

Eligibility and Enrollment for coverage by the Montana University System Insurance Plan for persons (and their dependents) who are NOT active employees within MUS:
Detailed rules are published in the MUS Summary Plan Document in these sections:

- Eligibility
- Enrollment, Changes in Enrollment, Effective Dates of Coverage
- Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Spouse, and Retirement Options
- Continuation of Coverage—COBRA and Conversion Rights

It is the responsibility of each employee and former employee to know his (and his dependents') rights and responsibilities for maintaining enrollment in the MUS Plan. You can obtain a copy of the Summary Plan Document from your campus benefits office, by calling the MUS Benefits office at 877-501-1722, or by logging onto www.montana.edu/choices/groupplans.htm.

Coordination of Benefits: Persons covered by any health care plan through the Montana University
System AND also by any other health care coverage, whether private, employer-based, governmental
(including Medicare and Medicaid), or through any other type of insurance (including automobile,
homeowners, third party liability) are subject to coordination of benefits rules as generally accepted by the insurance industry and as specified in the MUS Summary Plan Document, Coordination of Benefits section (see access information above). Rules vary from case to case by the circumstances surrounding the claim and by the active or retiree status of the participant. In no case will more than 100% of a claim's allowed amount be paid by the sum of all payments from all applicable insurances.

Note to Retirees eligible for Medicare coverage: All claims are subject to coordination of benefits with Medicare whether or not the covered person is actually receiving Medicare benefits. Retirees eligible for Medicare and paying Medicare Retiree premium rates as published in the CHOICES Retiree Workbook are expected to be continuously enrolled in BOTH Medicare Part A and Medicare Part B. Due to MUS participation in the Medicare Retiree Drug Subsidy Program, enrollment in Medicare Part D is not permitted.

★ Self Audit Award Program

Be sure to check all bills from your medical providers to ensure charges have not been duplicated or billed for services you did not receive. When you detect billing errors that result in a claims adjustment, the plan will share the savings with you! You may receive an award of 50 percent of the savings, up to a maximum of $1,000.00.

The Self Audit Award Program is available to all plan members who identify medical billing errors which:

- Have not already been detected by the Plan's claims administrator or reported by the provider;
- Involve charges which are allowable and covered by the MUS Group Health Plan; and
- Total $50 or more in errant charges.

To receive the self-audit award, the member must:

- Notify the claims administrator of the error before it is detected by the administrator or the health care provider;
- Contact the provider to verify the error and work out the correct billing;
- Have copies of the correct billing sent to the claims administrator for verification, claims adjustment and calculation of the self-audit award.

In-Network Hospitals Managed Care Plan

This is subject to change. See plan websites for updates

Allegiance Network Hospitals

Anaconda	Community Hospital of Anaconda
Big Sandy	Big Sandy Medical Center
Big Timber	Pioneer Medical Center
Billings	St. Vincent Healthcare
Billings	Billings Clinic
Bozeman	Bozeman Deaconess Hospital
Butte	St. James Healthcare
Chester	Liberty County Hospital
Chinook	Sweet Medical Center
Choteau	Teton Medical Center
Columbus	Stillwater Community Hospital
Conrad	Pondera Medical Center
Cut Bank	Nothern Rockies Medical Center
Deer Lodge	Powell County Medical Center
Dillon	Barrett Hospital and Healthcare
Forsyth	Rosebud Health Care Center
Fort Benton	Missouri River Medical Center
Glasgow	Francis Mahon Deaconess Hospital
Glendive	Glendive Medical Center
Great Falls	Benefis Health Care
Great Falls	Central Montana Surgery Center
Hamilton	Marcus Daly Memorial Hospital
Hardin	Big Horn County Memorial Hospital
Harlowton	Wheatland Memorial Hospital
Havre	Northern Montana Hospital
Helena	St. Peter's Hospital
Kalispell	Kalispell Regional Medical Center
Lewistown	Central Montana Medical Center
Libby	St. John's Lutheran Hospital
Malta	Phillips County Hospital
Miles City	Holy Rosary Health Care
Missoula	Missoula Community Medical Center
Missoula	St. Patrick Hospital
Phillipsburg	Granite CountyMedical Center
Plains	Clark Fork Valley Hospital
Plentywood	Sheridan Memorial Hospital
Polson	St. Joseph Hospital
Red Lodge	Beartooth Hospital & Health Center
Ronan	St. Luke Community Hospital
Roundup	Roundup Memorial Hospital
Scobey	Daniels Memorial Hospital
Shelby	Marias Medical Center
Sheridan	Ruby Valley Hospital
Sidney	Sidney Health Center
Superior	Mineral Community Hospital
Terry	Prairie Community Health Care
Townsend	Broadwater Health Center
Whitefish	North Valley Hospital
White Sulphur Springs	Mountain View Medical Center

BCBSMT (Blue Cross)

Anaconda	Community Hospital of Anaconda
Big Timber	Pioneer Medical Center
Billings	Advanced Care Hospital
Billings	Billings Clinic Hospital
Billings	Morledge Family Surgery Center
Billings	St. Vincent Healthcare
Bozeman	Bozeman Deaconess Hospital
Butte	St. James Healthcare
Chester	Liberty County Hospital
Choteau	Teton Medical Center
Conrad	Pondera Medical Center
Dillon	Barrett Hospital & Healthcare
Ennis	Madison Valley Hospital
Fort Benton	Missouri River Medical Center
Great Falls	Benefis Healthcare
Great Falls	Orth Center of MT Ambulatory Surg Ctr
Great Falls	Central Montana Surgical Center
Hamilton	Marcus Daly Memorial Hospital
Hardin	Big Horn County Memorial Hospital
Harlowton	Wheatland Memorial Hospital
Havre	Northern Montana Hospital
Helena	Shodair Children's Hospital
Helena	St. Peter's Hospital
Kalispell	Kalispell Regional Medical Center
Kalispell	HealthCenter Northwest
Livingston	Livingston Memorial hospital
Miles City	Holy Rosary Healthcare
Missoula	St. Patrick Hospital
Missoula	Community Medical Center
Plains	Clark Fork Valley Hospital
Polson	St. Joseph Hospital
Red Lodge	Beartooth Hospital & Health Center
Ronan	St. Luke Community Hospital
Roundup	Roundup Memorial Hospital
Shelby	Marias Medical Center
Sheridan	Ruby Valley Hospital
Superior	Mineral Community Hospital
White Sulphur Sp	Mountain View Medical Center
Whitefish	North Valley Hospital

PacificSource Network Hospitals

Anaconda	Community Hospital of Anaconda
Big Sandy	Big Sandy Medical Center
Big Timber	Pioneer Medical Center
Billings	Billings Clinic Hospital
Bozeman	Bozeman Deaconess Hospital
Butte	St. James Healthcare
Chester	Liberty County Memorial
Chinook	Sweet Medical Center
Choteau	Teton Medical Center
Columbus	Stillwater Community Hospital
Conrad	Pondera Medical Center
Deer Lodge	Powell County Memorial Hospital
Dillon	Barrett Hospital & Healthcare
Forsyth	Rosebud Health Care Center
Fort Benton	Missouri River Medical Center
Hamilton	Marcus Daly Memorial Hospital
Hardin	Big Horn County Memorial Hospital
Harlowton	Wheatland Memorial Hospital
Havre	Northern Montana Hospital
Helena	St. Peter's Hospital
Helena	Shodair Hospital
Jordan	Garfield County Health Center
Kalispell	Kalispell Regional Medical Center
Lewistown	Central Montana Medical Center
Libby	St. John's Lutheran Hospital
Livingston	Livingston Memorial Hospital
Malta	Phillips County Hospital
Miles City	Holy Rosary Healthcare
Missoula	Community Medical Center
Missoula	Cosmetic Surgical AAS
Phillipsburg	Granite Co. Medical Center Hospital
Plains	Clark Fork Valley Hospital

Note: It is a good idea to contact the claims administrator for the plan you've chosen to make sure your provider is in-network prior to receiving services. This will help you avoid unanticipated out of pocket expenses.

Hospitals/Facilities

This is subject to change. See plan websites for updates

In-Network Hospitals Managed Care Plan

Plentywood	Sheridan Memorial Hospital
Polson	St. Joseph Hospital
Red Lodge	Beartooth Hospital Health
Ronan	St. Luke Community Hospital
Roundup	Roundup Memorial Healthcare
Scobey	Daniels Memorial Hospital
Shelby	Marias Medical Center
Sidney	Sidney Health Center
Superior	Mineral Community Hospital
Terry	Prairie Community Health Center
Townsend	Broadwater Health Center
Whitefish	North Valley Hospital
White Sulphur Spr	Mountain View Medical Center

Traditional Plan

Anaconda	Community Hospital of Anaconda
Big Sandy	Big Sandy Medical Center
Big Timber	Pioneer Medical Center
Billings	St. Vincent Healthcare
Bozeman	Bozeman Deaconess
Butte	St. James Healthcare
Chester	Liberty County Hospital & Nursing Home
Choteau	Teton Medical Center
Columbus	Stillwater Community Hospital
Conrad	Pondera Medical Center
Cutbank	Northern Rockies Medical Center
Deer Lodge	Powell County Memorial Hospital
Dillon	Barrett Hospital & Health Care
Forsyth	Rosebud Health Care Center
Fort Benton	Missouri River Medical Center
Glasgow	Frances Mahon Deaconess Hospital
Glendive	Glendive Medical Center
Great Falls	Benefis Healthcare
	Central Montana Surgery Center
Hamilton	Marcus Daly Memorial Hospital
Hardin	Big Horn County Memorial Hospital
Harlowton	Wheatland Memorial Hospital
Havre	Northern Montana Hospital
Helena	St. Peter's Hospital
Kalispell	Kalispell Regional Medical Center
Libby	St. John's Lutheran Hospital
Livingston	Livingston Healthcare
Malta	Phillips County Hospital
Miles City	Holy Rosary Healthcare
Missoula	St. Patrick Hospital
Philipsburg	Granite County Medical Center
Plains	Clark Fork Valley Hospital
Plentywood	Sheridan Memorial Hospital
Polson	St. Joseph Hospital
Red Lodge	Beartooth Hospital and Health Center
Ronan	St. Luke Community Hospital
Roundup	Roundup Memorial Health Care
Scobey	Daniels Memorial Hospital
Shelby	Marias Medical Center
Sheridan	Ruby Valley Hospital
Sidney	Sidney Health Center
Superior	Mineral Community Hospital
Terry	Prairie Community Health Center
Townsend	Broadwater Health Center
Whitefish	North Valley Hospital
White Sulphur Springs	Mountainview Medical Center

Glossary

Allowable Charges

A set dollar allowance for procedures/services that are covered by the plan.

Benefit Year/Plan Year

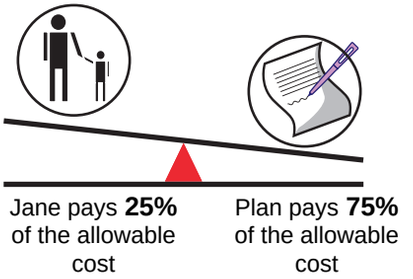
The period starting July 1 and ending June 30.

Certification/Pre-certification

A determination by the appropriate medical plan administrator that a specific service - such as an inpatient hospital stay - is medically necessary. Pre-certification is done in advance of a non-emergency admission by contacting the plan administrator.

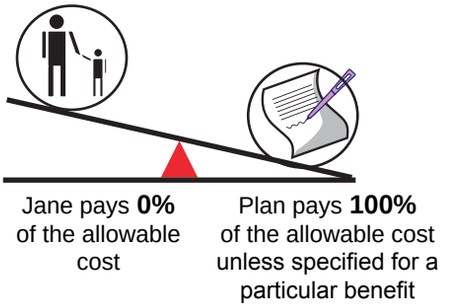
Coinsurance

A percentage of allowable and covered charges that a member is responsible for paying, after paying any applicable deductible. The medical plan pays the remaining allowable charges.
For example, if Jane has met her deductible for the Traditional Plan In-Network medical costs ($1,000), she pays 25% of additional costs and the plan pays 75% of allowable charges.



Coinsurance Maximum

The maximum dollar amount of any coinsurance that a member or family must pay in a plan year. Once the coinsurance maximum has been paid, the member or family is not responsible for paying any further allowable charges for the remainder of the benefit year unless specified for a particular benefit such as Durable Medical Equipment (DME). The coinsurance maximum applies to the plan year July 1 through June 30, regardless of hire date.
For example, Jane has met her coinsurance maximum of $5,000 in the Traditional Plan so the plan pays 100% of allowable charges for an additional expenses.



Copayment

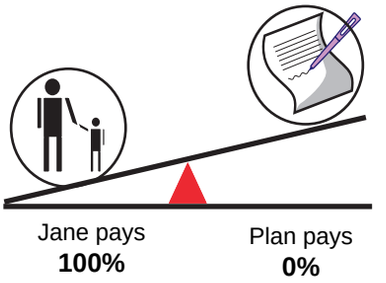
A fixed dollar amount for allowable and covered charges that a member is responsible for paying. The medical plan pays the remaining allowable charges. This type of cost-sharing method is typically used by managed care medical plans.

Covered Charges

Charges for medical services that are determined to be medically necessary and are eligible for payment under a medical insurance plan.

Deductible

A set dollar amount that a member and family must pay before the medical plan begins to share the costs. The deductible applies to the plan July 1 through June 30. For example, Jane's deductible under the Traditional plan is $1,000. Her plan won't pay anything until she has met her deductible.



In-network Providers

Providers who contract with a plan to manage the delivery of care for plan members.

Managed Care Medical Plan

Plans that offer first dollar coverage for services such as office visits that are exempt from deductible. These plans also provide differing levels of benefits for in-network and out-of-network providers.

Out-of-network Provider

Any provider who renders services to a member but is not a participant in the plan's network.

Participating Provider

A provider who has a contract with the plan administrator to accept allowable charges as payment in full.

Prior Authorization

A process that determines whether a proposed service, medication, supply, or ongoing treatment is covered.

URx

A prescription drug management program developed by the Montana University System.

RESOURCES

Montana University System Benefits
Office of the Commissioner of Higher Education
(406) 444-2574 * Fax (406) 444-0222 * Toll Free (877) 501-1722
www.mus.edu/choices

HEALTH PLANS

ALLEGIANCE - Traditional Plan & Allegiance Managed Care Plan
Customer Service 1-877-778-8600
Precertification 1-800-342-6510
www.abpmtpa.com/mus

BLUE CROSS BLUE SHIELD OF MONTANA - Managed Care Plan
Customer Service 1-800-820-1674 or 447-8747
www.bcbsmt.com

PACIFICSOURCE HEALTH PLAN - Managed Care Plan
Customer Service 406-442-6589 or 1- 877-590-1596
Pre-Authorization: 406-442-6595 or 877-570-1563
www.PacificSource.com/MUS

DELTA DENTAL INSURANCE COMPANY
Customer Service 1-866-579-5717
www.deltadentalins.com/MUS

EYEMED VISION CARE
Customer Service 1-866-723-0513
www.eyemedvisioncare.com/access (prior to enrollment)
www.eyemedvisioncare.com (after enrollment)

URx – PRESCRIPTION DRUG PROGRAM

www.URx.mus.edu
ASK-A-Pharmacist 1888-527-5879
Plan Exception Processing Dept. 1-888-527-5879
Plan Exception Fax:406-513-1928

MEDIMPACT
Customer Service 1-888-648-6764

MAILORDER PRESCRIPTION DRUG PROGRAM
RIDGEWAY MAIL ORDER PHARMACY – www.ridgewayrx.com
Customer Service 1-800-630-3214
Fax: 406-642-6050

MEDVANTX MAIL ORDER PHARMACY
Customer Service 1-877-870-6668

DIPLOMAT SPECIALTY PHARMACY
Customer Service 1-877-319-6337

STANDARD LIFE INSURANCE – Life and Disability
Customer Service1-800-759-8702
www.standard.com

UNUM LIFE INSURANCE – Long Term Care
Customer Service 1-800-822-9103
www.unum.com