choices

Annual Benefits Enrollment Workbook

2012 - 2013

MontanaUniversity System

Choices

Table of Contents

How Choices Works

1.....Who's Eligible

2.....How to Enroll

Mandatory (must choose) Benefits

3.....Medical

3.....Traditional or Managed Care Plans

5.....Schedule of Medical Plan Benefits

10.....Preventive Services

12.....Get Healthy Stay Healthy

14.....Prescription Drug

17.....Dental Plan

22.....Life Insurance, AD&D & Long Term Disability

Optional (voluntary) Benefits

23....Supplemental Life Insurance Employee

23....Supplemental Life Dependent

24....Supplemental Accidental Death & Dismemberment

25....Vision

27....Long Term Care Insurance

28....Flexible Spending Account

Additional Benefits

30 ...KnovaSolutions & Dependent Hardship Waiver

31 ...Ways to Save Money, Wise Consumer

Resources

33....Medical Spending Worksheet

34....Privacy Rights & Plan Documents

35....Glossary

38....Listing of Plan Services Areas

STOP!

Waiver of Health Coverage

You have the option to waive coverage with the Montana University System plan. You must sign the enrollment form stating you are waiving coverage and turn the form into your campus Human Resources Office. If you do not sign or turn in an enrollment form you will default (see default coverage below). However, Optional Reimbursement Accounts do not continue without a new election.

If you waive coverage:

- You forfeit the employer portion of your benefit coverage,
- You waive all Choices options including medical, dental, life/AD & D, and LTD,
- You cannot enroll until you have a qualifying event, and
- A waiting period for coverage of pre-existing conditions will apply if you did not have prior coverage or if there was a break of more than 63 days between the termination of your prior coverage and your effective date on this policy.

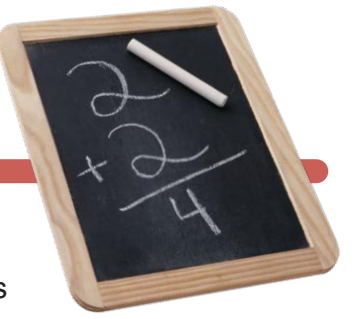
If you do not sign or turn in an enrollment form, your default coverage is:

- Existing employees default to present elections if continuing in FY 2013, or to the Traditional Plan. If your present election is New West Managed Care, you will default to PacificSource Managed Care. If your present election is Peak Managed Care, you will default to Blue Cross Managed Care.
- New employees who do not enroll during the initial 30 day enrollment period default to:
  1) Employee Only Traditional Plan
  2) Employee Only Basic Dental
  3) $10,000 Basic Life Insurance/AD & D and
  4) Long Term Disability Option 1 (60% of pay/180 day waiting period)

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 pg 2 qualifying events).

How Choices Works



This workbook is your guide to Choices – Montana University System's benefits program that lets you match your benefits to your individual and family situation. To get the most out of this opportunity to design your own benefits package, you need to consider your benefits needs, compare them to the options available under Choices and enroll for the benefits you've chosen. Please read the information in this workbook carefully. If you have any questions, please contact your campus Human Resources Department. This enrollment book is not a guarantee of benefits; please consult your group benefit plan booklets (Summary Plan Descriptions - see last page for availability).

1. Who's Eligible

A person employed by a unit of the University System, Office of the Commissioner of Higher Education, or other agency or organization affiliated with the University System or the Board of Regents of Higher Education is eligible to enroll in the Employee Benefits Plan if qualified under one of the following categories:

1. Permanent faculty or professional staff members regularly scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of more than six months in a 12-month period.

2. Temporary faculty or professional staff members scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of six months or more, or who actually do so regardless of schedule.

3. Seasonal faculty or professional staff members regularly scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of six months or more, or who actually do so regardless of schedule.

4. Academic or professional employees with an individual contract under the authority of the Board of Regents which provides for eligibility under one of the above requirements.

Note: Student employees who occupy positions designated as student positions by a campus are not eligible to join the Plan.

Enrolling Family members:

Important Note: Enrollment for plan year 2012/13 is Closed Enrollment for continuing employees. No dependents can be added to your plan unless there is a qualifying event (see pg 2 for qualifying events).

If you're a new employee, you may enroll your family for certain benefits under Choices, including medical, dental, vision, life insurance and AD&D coverage. Eligible family members include your:

- **Legal spouse**, as defined under Montana law, or one other unrelated adult dependent as defined in the Summary Plan Description. To enroll an adult dependent other than a spouse, you will need to obtain criteria from your campus Human Resources Office and complete a Declaration of Adult Dependent form, also available there.

Continued on next page

Eligible family members include your:

- Dependent children under age 26*. Children include your natural children, stepchildren, and children placed in your home for adoption before age 18 or for whom you have court-ordered custody or you are the legal guardian.

  *Coverage may continue past age 26 for an unmarried dependent child who is mentally or physically disabled and incapable of self-support.

2. How to enroll

1. Each eligible faculty and/or staff member receives a monthly employer contribution. This amount is based on the Montana State legislature's allocation toward the cost of benefits for state employees.

2. Within 30 days of first becoming eligible for benefits, or during annual enrollment each year, you select or make changes from among the benefit plan options. Note: Must enroll within 30 days of hire or 63 days of qualifying event (see qualifying events).

3. Each benefit option in Choices has a monthly cost associated with it. These costs are shown on your enrollment form or in this Enrollment Workbook.

   Mandatory (must choose):
   Medical pg 3
   Prescription Drug pg 14
   Dental pg 17
   Basic Life Insurance and AD&D pg 22
   Long Term Disability pg 22

   Optional (voluntary):
   Supplemental Life Insurance pg 23
   Dependent Life Insurance pg 23
   Supplemental AD&D Insurance pg 24
   Vision pg 25
   Long Term Care pg 27
   Flexible Spending Acct. pg 28

4. The enrollment form will walk you through your coverage options and monthly costs. To determine the before-tax cost of your benefits, add up the total cost of the benefits you've selected and compare it to the employer contribution provided to you by the Montana University System. (A worksheet is provided on pg 33 to help you determine costs for the choices you make).

If the benefits you choose cost . . .

- The same as your employer contribution, you won't see any change in your paycheck.
- More than your employer contribution, you'll pay the difference through automatic payroll deductions.
- Less than your employer contribution, you'll either forfeit the remaining employer contribution or you may apply it to a Medical Flexible Spending Account in your name.

Your annual Choices elections remain in effect for the entire plan benefit period following enrollment, unless you have a change in status (qualifying event).

Qualifying Events
- Marriage
- Birth of a child
- Adoption of a child
- Loss of eligibility for other health insurance coverage

All questions about the enrollment process or qualifying events should be directed to your campus Human Resources Office.

Medical (*must choose*) Choices

Choices gives you the opportunity to choose from a traditional plan and up to three managed care plans (depending on availability in your area). The next two pages will help explain the Traditional and Managed Care plans and the corresponding medical rates for each plan.

Traditional Plan

The Traditional plan is administered by Allegiance who contracts with health care providers to offer plan members a provider network (providers who have agreed to accept certain payments for specific services).

How The Plan Works:
Plan members receive medical services from a participating health care provider. If the provider is a preferred provider, the provider submits a claim for the member. The administrator processes the claim and sends an EOB to the member, showing the member's payment responsibilities (deductible and/or coinsurance costs) to the provider. The plan then pays the remaining allowable charges, which the provider accepts as full payment.

If your provider is not an in-network provider you may have to pay the entire fee to the provider and file a claim.

Staying In-network
You can protect yourself from unexpected expenses by making sure a provider is in-network (providers who contract with a plan to manage the delivery of care for plan members). If you see a provider that is out-of-network (a provider not in a plans' network) you are subject to paying a higher coinsurance and can be balanced billed for the difference between their charge and the allowable charge.

Details:

- Traditional Plan – (available everywhere)
- An annual deductible – the amount you pay each benefit year before the plan begins to pay.
- Coinsurance – a percentage of allowable fees you pay until you reach the benefit year's coinsurance maximum.
- In-Network providers – Providers (including facilities) who contract with the plan administrator to deliver care according to agreed upon prices.

- Out of Network providers – You pay 25% coinsurance for services of an in-network provider; and 35% for an out-of-network provider. Out-of-network providers can also balance bill you for any difference between their charge and the allowable charge.

Managed Care

PacificSource, Blue Cross Blue Shield, and Allegiance are the Managed Care choices. The plans provide the same basic benefits but have differences in providers and plan requirements.

How The Plan Works:
The benefits of these plans depend on the health care provider the member uses. When a network provider is used, in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply.

Major Plan Differences
The major differences in the managed care plans are the participating providers. Check which providers participate on the medical plan administrator's website. See back cover for website addresses.

Details:

- PacificSource Managed Care Plan (available in limited towns and zip codes).
- Blue Cross Managed Care Plan (available in limited towns and zip codes).
- Allegiance Managed Care Plan (available in limited towns and zip codes).

- Emergency services are covered everywhere. However, out-of-network providers may balance bill the difference between allowance and charge.
- Note – The Managed Care Plans cover the same services and have:

  Network Providers – Providers who have contracted with the managed care plan to manage and deliver care at agreed upon prices. Members may self-refer to in-network providers and specialists.

  Better benefits for services received **In-Network** than for services **Out-of-Network** – You pay a $15 copayment for most visits to In-Network providers (no deductible) and 25% (after deductible) for most In-Network hospital/ facility services. You pay 35% of allowable fees (after a separate deductible) for most services received Out-of-Network.

  Out-of-network providers may balance bill the difference between their charge and the allowable charge.

Medical Rates for 2012-2013

Monthly Premiums	Traditional Plan	PacificSource Managed Care	Blue Cross Managed Care	Allegiance Managed Care
Employee Only	$673	$591	$575	$612
Employee & Spouse\AD	$905	$795	$774	$823
Employee & Child(ren)	$882	$774	$754	$802
Employee & Family	$1137	$998	$972	$1033

The employer contribution for 2012-2013 is $733 per month for eligible active employees.

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

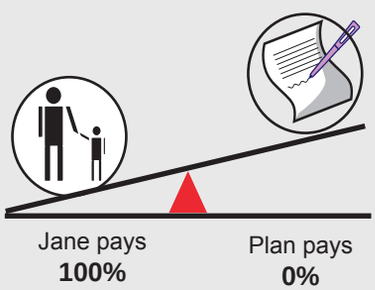
Medical Plan Costs	Traditional Plan In-Network	Traditional Plan Out-of-Network*	Managed Care In-Network	Managed Care Out-of-Network *
Annual Deductible Applies to all services, unless otherwise noted or copayment is indicated	$1,000/Person $2,250/Family	$1,000/Person $2,250/Family Combined with In-network	$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:*

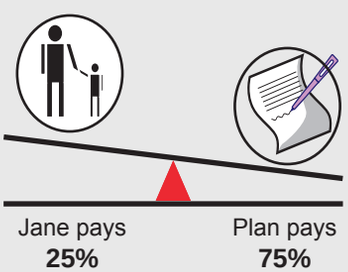
How you and the plan share costs - Traditional Plan Example (in-network). Jane's Plan Deductible is $1,000, her coinsurance is 25%, and her coinsurance max is $5,000.

July 1
Beginning plan yr



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

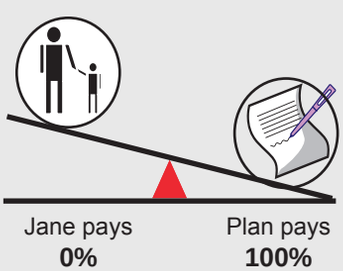
more costs



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.

more costs

June 30
End of plan yr



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

Reminder: 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.

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 coin-surance 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 12			
WellBaby	see pg 13			
Infusion Therapy				
Take Control (Diabetes Support Prg.)				
Tobacco Cessation				
WellHeart				
WellWeight				

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

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

Get Healthy, Stay Healthy

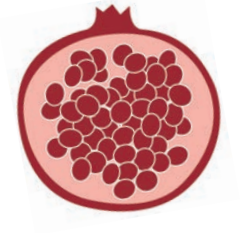
Disease Management Programs

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.

Drug Choices

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

URx Your Pharmacy Plan™

URX is 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 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.

Dental (*must choose*) Choices

Because dental coverage is an annual required benefit choice, you can select from two options: **Basic Plan** and **Premium Plan**.

Review the chart below and pay close attention to the different benefits and the different rates to help you make your selection.

	Basic Plan - Preventive Coverage	Premium Plan
Who May be Enrolled & Monthly Rates	• Employee Only $17 • Employee & Spouse/Adult Dep. $32 • Employee & Child(ren) $32 • Employee & Family $46	• Employee Only $44 • Employee & Spouse/Adult Dep. $84 • Employee & Child(ren) $84 • Employee & Family $119
Maximum Annual Benefit	**$750 per covered individual**	**$1,500 per covered individual**
Preventive and Diagnostic Services	• Twice Per Benefit Year • Initial and Periodic oral exam • Cleaning • Complete series of intraoral X-rays	• Twice Per Benefit Year • Initial and Periodic oral exam • Cleaning • Complete series of intraoral X-rays NEW The Preventive & Diagnostic Services listed above do not apply to the $1,500 annual maximum
Basic Restorative Services	• Not covered	• Amalgam filling • Endodontic treatment • Periodontic treatment • Oral surgery
Major Dental Services	• Not covered	• Crown • Root canal • Complete lower and upper denture • Dental implant • Occlusal guards
Removal of impacted teeth	• Not covered	• Covered benefit

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**

Dental Codes:

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

Dental Codes 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

Dental Codes 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

Dental Codes Schedule of Benefits .....

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
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

 The procedures described and maximum allowances indicated on this table are subject to the terms of the contract and Delta Dental processing policies. These allowances may be further reduced due to maximums, limitations, and exclusions. Please refer to the SPD for complete information.

Life Insurance/AD&D & Long Term Disability

(must choose)

Administered by Standard Insurance Co.
1-800-759-8702, www.standard.com

Basic Life/AD&D Insurance:

Life insurance under Choices pays benefits to your beneficiary or beneficiaries if you die from most causes while coverage is in effect. Accidental Death & Dismemberment (AD&D) coverage adds low-cost accidental death protection by paying benefits in the event your death is due to accidental causes. Full or partial AD&D benefits are also payable to you following certain serious accidental injuries.

Who is Eligible:
Employee Only (May increase one level of coverage during annual benefit enrollment, if you are eligible and in an active work status).

Basic Life/AD &D Monthly Premiums		
Basic Life/AD&D	$10,000	$ 1.55 for both
Basic Life/AD&D	$20,000	$3.10 for both
If you are enrolling in Choices you must select a Basic Life Insurance		

Long Term Disability (LTD):

LTD coverage can help protect your income in the event you become disabled and unable to work. Choices includes three LTD options designed to supplement other sources of disability income that may be available to you:

- 60% of pay, following 180 days of disability
- 66-2/3% of pay, following 180 days of disability
- 66-2/3% of pay, following 120 days of disability

The three LTD options differ in terms of the amount of your pay they replace; when benefits become payable; and premium costs. Employees may increase coverage during annual enrollment. However, the increase in coverage will be subject to a pre-existing condition exclusion for disabilities occurring during the first 12 months that the increase in insurance is effective. Any coverage existing for at least 12 months prior to the increase will not be subject to the pre-existing condition exclusion.

Employees on a leave status may not be eligible for long term disability coverage. Please consult with your Human Resources Department.

Who May Enroll:
Employee Only

Amount of Benefit:
Option 1: 60% of pre-disability earnings, to a maximum benefit of $9,200 per month. The minimum monthly benefit is the greater of $100 or 10% of your LTD benefit before reduction by deductible income.

Option 2: 66-2/3% of pre-disability earnings, to a maximum benefit of $9,200 per month. The minimum monthly benefit is $100 or 10% of your LTD benefit before reduction by deductible income.

Option 3: 66-2/3% of pre-disability earnings, to a maximum benefit of $9,200 per month. The minimum monthly benefit is $100 or 10% of your LTD benefit before reduction by deductible income.

Do you have Other Disability Income
The level of LTD coverage you select ensures that you will continue to receive a percentage of your base pay each month if you become totally disabled.

Some of the money you receive may come from other sources, such as Social Security, Workers' Compensation, or other group disability benefits. Your Choices LTD benefit will be offset by any amounts you receive from these sources. The total combined income will equal the benefit level you selected.

This is a brief summary provided to help you understand your coverage. Please review the group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. This information can be found on the Choices website: www.mus.edu/choices.

Long Term Disability Monthly Premiums		
Option 1	60% of pay/180 days waiting period	$ 5.90
Option 2	66 2/3 of pay/180 days waiting period	$11.75
Option 3	66 2/3 of pay/120 days waiting period	$14.66

Supplemental Life Insurance (*voluntary*)

Choices

Optional Supplemental Life Insurance eligibility:

This is an employee only benefit. If you enroll for Optional Supplemental Life Insurance, your cost depends on your age as of July 1 and the amount of coverage you select, as shown in the following table. Remember, this cost is paid on an after-tax basis.

If you are not enrolling for the first time, other than new employees, you may increase one level of coverage during annual enrollment without having to submit evidence of good health - if you are eligible and are in an active work status. You may also increase coverage more than one level. However, you will need to submit evidence of good health to the insurance company for the increase above more than one level.

Optional Supplemental Life Insurance Costs (after tax): If you enroll for Optional Supplemental Life Insurance, your cost depends on your age as of July 1 and the amount of coverage you select, as shown in the table below. Remember, this cost is paid on after-tax basis. Employees may NOT cover other MUS employed family members.

Optional Supplemental Life Monthly Premium	$25,000-$300,000 (increments of $25,000)

Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000	$225,000	$250,000	$275,000	$300,000
under 30	$1.43	$2.85	$4.28	$5.70	$7.13	$8.55	$9.98	$11.40	$12.83	$14.25	$15.68	$17.10
30-34	$2.00	$4.00	$6.00	$8.00	$10.00	$12.00	$14.00	$16.00	$18.00	$20.00	$22.00	$24.00
35-39	$2.25	$4.50	$6.75	$9.00	$11.25	$13.50	$15.75	$18.00	$20.25	$22.50	$24.75	$27.00
40-44	$3.10	$6.20	$9.30	$12.40	$15.50	$18.60	$21.70	$24.80	$27.90	$31.00	$34.10	$37.20
45-49	$5.30	$10.60	$15.90	$21.20	$26.50	$31.80	$37.10	$42.40	$47.70	$53.00	$58.30	$63.60
50-54	$8.03	$16.05	$24.08	$32.10	$40.13	$48.15	$56.18	$62.20	$70.23	$78.25	$86.28	$94.30
55-59	$13.43	$26.85	$40.28	$53.70	$67.13	$80.55	$93.98	$107.40	$120.83	$134.25	$147.68	$161.10
60-64	$16.50	$33.00	$49.50	$66.00	$82.50	$99.00	$115.50	$132.00	$148.50	$165.00	$181.50	$198.00
65-69	$32.50	$65.00	$97.50	$130.00	$162.50	$195.00	$227.50	$260.00	$292.50	$325.00	$357.50	$390.00
over 70	$75.00	$150.00	$225.00	$300.00	$375.00	$450.00	$525.00	$600.00	$675.00	$750.00	$825.00	$900.00

Optional Dependent Life Insurance eligibility:

Your spouse and unmarried child(ren) from live birth to age 25. Optional Dependent Life Insurance is designed to protect you against certain financial burdens (such as funeral expenses) in the event a covered dependent dies. You are automatically the beneficiary of any benefits that become payable. This benefit is paid with after-tax dollars. Employees may NOT cover other MUS employed family members. In addition, dependent children may not be insured by more than one member.

If you are not enrolling for the first time, other than new employees, you may increase one level of coverage during annual enrollment without having your dependent spouse submit evidence of good health, if you are in an active work status. You may increase coverage more than one level; however, your dependent spouse will need to submit evidence of good health to the insurance company for increases above more than one level.

Optional Dependent Life Monthly Premiums	$2,500 Spouse/$1,250 Child(ren)	**$0.77**
	$5,000 Spouse/$2,500 Child(ren)	**$1.54**
	$10,000 Spouse/$5,000 Child(ren)	**$3.08**
	$25,000 Spouse/$5,000 Child(ren)	**$7.71**

Supplemental AD&D Coverage (*voluntary*)

Choices

Administered by Hartford:
www.thehartford.com

Optional Accidental Death & Dismemberment (AD&D) coverage can be a relatively inexpensive way to provide additional protection in the event of certain serious injuries or death in an accident. Optional AD&D benefits that become payable are in addition to any other life insurance or AD&D benefits which may be paid.

If you decide to enroll in Optional AD&D coverage, you may choose from the following coverage categories:

- Employee Only
- Employee & Family Coverage

Your before-tax cost for Optional AD&D coverage will depend on the coverage category you select and the amount of coverage you choose. Employees may NOT cover other MUS employed family members.

Monthly Premiums	Employee Only	Employee & Family
$25,000	$0.63	$1.18
$50,000	$1.25	$2.35
$75,000	$1.88	$3.53
$100,000	$2.50	$4.70
$150,000	$3.75	$7.05
$200,000	$5.00	$9.40
$250,000	$6.25	$11.75
$300,000	$7.50	$14.10

Who May Be Enrolled
Employee only or Employee and Family (employee, spouse, and child(ren) to age 25)

Family Benefits are paid accordingly:

- Your spouse only: he or she is covered for 60% of the amount you have chosen.
- Child(ren) only: each child is covered for 20% of the amount you have chosen.
- Spouse and children: your spouse is covered for 50% and each child is covered for 15% of the amount you have chosen.
- Cannot exceed 10x annual salary.

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 reimbursement.

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

NEW

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.

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.

Flexible Spending Account (*voluntary*) Choices

Administered by Flex Connect- Insurance Coordinators of Montana:

1-866-640-FLEX (3539) - www.insurancecoordinators.com - flex@icmont.com

Account Types	Annual Amount	Qualifying Expense Examples
Medical NEW	Minimum: $120 Max: $2,500/Employee (The Patient Protection & Affordable Care Act - PPACA required a reduction in the maximum election)	Doctor visits, copays and deductibles, dental exams and services, eye exams, contact lenses and solution, glasses, chiropractic care, prescription drugs and insulin, hearing aids and exams
Dependent Care	Minimum: $120 Max: $5,000/Employee	Day care centers (must comply with state and local law), babysitters, preschools, and general-purpose day camps
Administration Fee	$30.00 ($2.50 per month)	For one or both Medical and Dependent Care FSAs
Adoption Assistance	Minimum: $120 Max: $12,650 (total max-NOT annual max)	Adoption fees, court costs, attorney fees, related travel expenses

Who is Eligible

Active employees eligible for MUS benefits are eligible for the Flexible Spending Account (FSA) Program (Optional Reimbursement Accounts).

After your initial enrollment (within 31 days of hire), there are limited opportunities to change your election during the plan year. Contributions can only be changed if you experience a family status change such as:

- marriage, divorce, birth/adoption of a baby, death of spouse/dependent child, or a change in employment status

The change must be consistent with the change in family status. For example, new dependents warrant increasing a medical FSA, not decreasing it. The change must be made within 63 days of the qualifying event.

How FSAs Work

Flexible Spending Accounts (FSAs) work very much like tax-favored savings accounts. You can enroll in a Medical FSA to pay for family medical expenses not covered by insurance and a Dependent Care FSA to pay for day-care expenses.

Expenses must be incurred during the plan year. This may or may not be the same time that you are billed or pay for the services or products.

You decide how much money you want to deposit in the FSA for the benefit year. That amount is then divided by 12 to determine the monthly election amount.

Your selected amount is deducted from your paychecks in equal installments, first from any unused employer contribution, and then from gross pay (before taxes) and deposited into your FSA. There is a monthly $3.05 administration fee for one or both FSAs.

After you have incurred a qualifying expense, you will file a claim with FlexConnect, who will then reimburse you for the claimed amount. FlexConnect processes claims daily. An expense is considered incurred when the services are provided.

Use It or Lose It!

Any money not used for qualified expenses incurred during the plan year is forfeited. This is known as the "use it or lose it" provision of Section 125 of the IRS code. Therefore, be conservative and accurate when estimating expenses for the plan year.

The Medical and Dependent Care FSAs are separate accounts. If you enroll in both, you may not use funds deposited in the Medical FSA for dependent care expenses, or vice versa.

Getting Reimbursed

To be reimbursed for qualified expenses, submit a claim form and expense receipt(s) (ex: Explanation of Benefits or day care provider receipt) to FlexConnect either by fax, email or mail at the address listed on the claim form. FlexConnect will send reimbursement within 3 days of receiving your expense claim. Forms are available on the FlexConnect website.

Sign up for claims rollover with Delta Dental - any amount remaining after Delta Dental processes your dental claim, can automatically be transferred to ICMI to process through your medical FSA!

Tax Issues

Since you receive pre-tax treatment on the money you place in an FSA, you cannot claim the items reimbursed to you through an FSA on your tax return. On your tax return, non-FSA medical expenses are only deductible if they exceed 10% of your adjusted gross income. For most families, a Medical FSA provides more tax benefit. Please consult your tax advisor for more information.

Because day care expenses are typically much greater than predictable out-of-pocket medical expenses, Dependent Care FSAs typically generate the greatest tax savings.

Important:

- Left over employer contributions can be deposited in a medical flex account
- You must re-enroll each year to participate in a Flexible Spending Account (NOT automatic!)
- All claims must be received by Flex Connect by September 30, 2013 to be eligible for reimbursement
- No exceptions can be made on late enrollment or late submissions

Dependent FSA or Child Care Credit?

Generally, families with an adjusted gross income of $28,000 or more will save more money with the flexible spending plan. However, you should check with your tax advisor concerning your circumstances. Any amounts reimbursed through the plan cannot be claimed through Child Care Credit.

Will a Medical FSA Account Help You?

Medical FSAs may be used to reimburse out-of-pocket medical expenses (expenses not paid by insurance) which are allowed as medical deductions by the IRS on your federal tax return. The full amount you elect for the plan year is available at any time during the plan year, even though the full amount is not yet collected.

If you answer "yes" to any of the following questions, and you pay income taxes, a Medical FSA can save you money.

- Is anyone in your family planning on getting a hearing aid, contact lenses or glasses, or laser eye surgery?
- Do you expect to pay deductible, coinsurance, or copayments under your medical and prescription drug insurance plans?
- Is anyone in your family planning on noncosmetic orthodontia treatment during the next year?

Qualifying Health Care Expenses:

- Eye exams, contact lenses, glasses
- Dental exams, cleanings fillings, crowns, braces
- Chiropractic care
- Prescription drugs
- Over the counter drugs with prescription
- Hearing aids and exams
- Routine doctor visits
- Copays & deductibles

Ineligible Health Care Expenses

- Please see the website below

Benny™ Debit Card

Participants in the Medical FSA may now choose to use a debit card to pay for services at the "point of sale". FlexConnect provides the Benny™ Card to use with the medical flex account. Keep your card!! It is reloaded at the beginning of the year with your new Medical FSA election amount.

When you use the debit card, the funds are automatically deducted from your Medical Optional Reimbursement Account. You are required to keep all itemized bills and/ or receipts. If the item cannot be automatically substantiated, FlexConnect may contact you for a copy of the receipt.

There is a $10 set up fee for the card and NO monthly processing fee. In year one, the charge for use of the card will be $10. Indicate your interest at the time of benefit enrollment or you may elect to get a card at any time during the year. The total annual charge for the card will be deducted from your flex account at the beginning of the plan year or at any other time you choose to get a card.

Do You Qualify for a Dependent Care FSA?

The costs of child care and the care of dependent adults unable to care for themselves are very predictable. That predictability helps you determine how much money to put into a Dependent Care FSA. Under governing IRS statutes, the child care necessary for you and your spouse (if married) to work or attend school full time could be reimbursed from a Dependent Care FSA under the following circumstances:

- The amount to be reimbursed must not be greater than your or your spouse's annual earnings, whichever is lower.
- A dependent child must be younger than 13 and dependent upon you for at least 50 percent of his/her financial support. Care may be provided either inside or outside your home, but may not be provided by anyone considered your dependent for income tax purposes, such as an older child.
- A dependent adult must be physically or mentally incapable of caring for himself or herself and must be dependent upon you for at least 50 percent of his or her financial support. Care may be provided either inside or outside your home. However, expenses outside your home are eligible only if the dependent regularly spends at least eight hours each day in your household.

Unlike the Medical FSA, Dependent FSA claims are reimbursed only after contributions have been deposited in the account.

Qualifying Day Care Expenses

For a complete list of qualifying day care expenses, refer to IRS Publication 503. Some examples include:

- Day care centers (must comply with state and local laws)
- Baby-sitters
- Preschool (before Kindergarten)
- General-purpose day camps

Ineligible Day Care Expenses

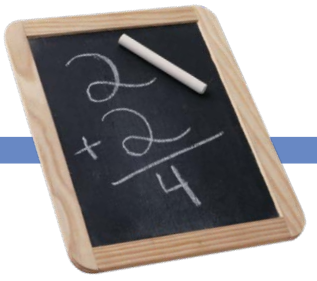
- Please see the website below

Adoption Assistance

- Please see the website below

Log onto and view account balance, claims, and deposit activity 24/7 at: www.insurancecoordinators.com

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.

Your Health Your Decisions

Dependent Hardship Waiver

The MUS Benefit Plan offers a dependent hardship waiver to allow medical coverage for children. The family must first apply for Healthy Montana Kids (HMK) for all children under the age of 19. If HMK denies coverage and the family has a hardship, an application may be submitted to MUS Employee Benefits requesting the Dependent Hardship Waiver. If the total household income is not more than 115% of the HMK guidelines, the dependent children will be eligible for the waiver for the plan year. For more information, please contact your campus Human Resources office or call MUS Benefits at 406-444-2574, or toll free at 877-501-1722.

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.

Resources

33....Medical Spending Worksheet
34....Privacy Rights & Plan Documents
35....Glossary
38....Listing of Plan Services Areas

Miles CC


Flathead Valley CC


MSU Bozeman


MT Tech


MSU Northern

Monthly Out-of-Pocket Benefit Premium Costs

Employer Contribution for July 2012 through June 2013

Active Employees			$ 733	(a)

MANDATORY (must choose) BENEFITS (unless you waive all benefits)

MEDICAL PLAN	(rates on page 4)	Traditional Plan	$_____	(b)
		PacificSource Managed Care	$_____	(b)
		BCBS Managed Care	$_____	(b)
		Allegiance Managed Care	$_____	(b)
DENTAL PLAN	(rates on page 17)	Basic	$_____	(c)
		Premium	$_____	(c)
LIFE INSURANCE	(rates on page 22)	Basic Life/AD&D $10,000	$_____	(d)
		Basic Life/AD&D $20,000	$_____	(d)
LONG TERM DISABILITY	(rates on page 22)	Option 1	$_____	(e)
		Option 2	$_____	(e)
		Option 3	$_____	(e)
TOTAL MANDATORY BENEFITS PREMIUM		Add lines b,c,d, and e	$_____	(f)

OPTIONAL (voluntary) BENEFITS - Pre tax

VISION PLAN	(rates on page 26)			$_____	(g)
SUPPLEMENTAL AD&D	(rates on page 24)			$_____	(h)
FLEXIBLE SPENDING ACCOUNT (FSA)		Medical	**Note:** if you select Medical & Dependent FSAs you are charged one $2.50/month admin fee for both.	$ 2.50 +	(i)
		Dependent		$ 2.50 +	(j)
				_____	
TOTAL OPTIONAL BENEFITS PREMIUM (Pre-Tax)		Add lines g,h,i and j		$_____	(k)

TOTAL MONTHLY OUT-OF-POCKET COSTS FOR BENEFITS JULY 2012 – JUNE 2013

MANDATORY BENEFITS		Enter amount from line (f)	$_____	(l)
OPTIONAL BENEFITS		Enter amount from line (k)	$_____	(m)
TOTAL BENEFITS		Add lines (l) and (m)	$_____	(n)
EMPLOYER CONTRIBUTION		Amount from line (a)	$ 733	(o)
TOTAL MONTHLY OUT-OF-POCKET COST (Pre-Tax)		Subtract lines (o) and (n)	$_____	(p)
SUPPLEMENTAL LIFE	(rates on page 23)		$_____	(q)
DEPENDENT LIFE	(rates on page 23)		$_____	(r)
OPTIONAL BENEFITS	**(Post-Tax)**	Add lines p,q and r	$_____	(s)

Note: If you select the optional Long Term Care benefit, UNUM will provide the rate. This benefit has not been included on this worksheet.
****Your benefit premiums will be applied as pre-tax or post-tax based on amounts eligible for pre-tax vs. post-tax.

Privacy Rights & Plan Documents

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The Montana University System (MUS) Employee Group Benefit Plan, which is a non-federal, self-funded plan, has elected to exempt MUS from #5 and #7 of the following requirements:

1. Limitations on preexisting condition exclusion periods.
2. Special enrollment periods.
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status.
4. Standards relating to benefits for mothers and newborns.
5. Parity in the application of certain limits to mental health benefits.
6. Required coverage for reconstructive surgery following mastectomies.
7. Coverage of dependent students on medically necessary leave of absence.

The exemption from these federal requirements will be in effect for the FY 2013 Plan Year which begins July 1, 2012 and ends June 30, 2013. The election may be renewed for subsequent plan years.

The MUS Plan presently provides dependent coverage independent of student status.

HIPAA also requires the Plan to provide covered employees and dependents with "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion of you joining another employer's health plan, or if you wish to purchase an individual health insurance policy. Please contact your chosen health plan administrator identified on your MUS insurance card for more information regarding a certification of creditable coverage.

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

Glossary

Allowable Charges

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

Benefit Year/Plan Year

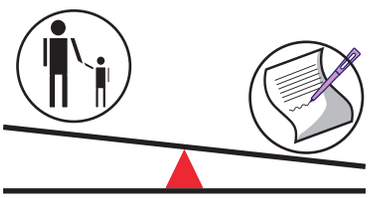
The period starting July 1 and ending June 30.

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.

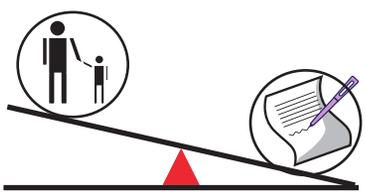


Jane pays **25%** of the allowable cost

Plan pays **75%** of the allowable cost

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.



Jane pays **0%** of the allowable cost

Plan pays **100%** of the allowable cost unless specified for a particular benefit

Copayment

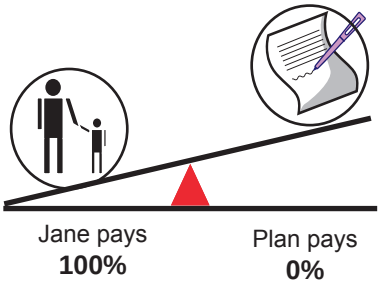
A fixed dollar amount for allowable and covered charges that a member is responsible for paying. The medical plan pays the remaining allowable charges. This type of cost-sharing method is typically used by managed care medical plans.

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.

Availability of the MUS Summary Plan Description

All Montana University System (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 Annual Benefits Enrollment Workbook or Retiree Workbook each spring during the annual benefits 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 Annual Benefits 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.

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

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.

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

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)

FLEXCONNECT - Flex Plan Administrator
Customer Service 1-866-640-3539
www.insurancecoordinators.com

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