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- 877-590-1563
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.eyevedvisioncare.com/access (prior to enrollment)
www.eyevedvisioncare.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 1988-527-5879
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 Service 1-800-759-8702
www.standard.com

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

Annual Benefits Enrollment Workbook
2012 - 2013
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. Lake Community Hospital
Roundup            Roundup Memorial Healthcare
Scooby             Daniels Memorial Hospital
 Shelby            Marias Medical Center
Sidney             Sidney Health Center
Superior           Mineral Community Hospital
Torry              Prairie Community Health Center
Townsend           Broadwater Health Center
Whitefish          North Valley Hospital
White Sulphur Springs Mountain View Medical Center

Traditional Plan
Anaconda          Community Hospital of Anaconda
Big Sandy         Big Sandy Medical Center
Big Timber         Pioneer Medical Center
Billings           St. Vincent Healthcare
Bozeman           Bozeman Deaconess
Butte              St. James Healthcare
Chester            Liberty County Hospital & Nursing Home
Choteau            Teton Medical Center
Columbus           St. Jill Community Hospital
Conrad             Pondera Medical Center
Cutbank            Northern Rockies Medical Center
Dert Lodge         Powell County Memorial Hospital
Dillons            Barrett Hospital & Health Care
Forysth            Rosebud Health Care Center
Fort Benton        Missouri River Medical Center
Glasgow            Frances Mahon Deaconess Hospital
Glendive           Glendive Medical Center
Great Falls         Benefits 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. Lake Community Hospital
Roundup            Roundup Memorial Health Care
Scooby             Daniels Memorial Hospital
Shelby             Marias Medical Center
Sheridan           Ruby Valley Hospital
Sidney             Sidney Health Center
Superior           Mineral Community Hospital
Torry              Prairie Community Health Center
Townsend           Broadwater Health Center
Whitefish          North Valley Hospital
White Sulphur Springs 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.

How Choices Works
1.......Who’s Eligible
2.......How to Enroll

Mandatory (must choose) Benefits
3......Medical
3......Traditional or Managed Care Plans
3......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
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).
This 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 or 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 employees 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
To receive the self-audit award, the member must:

- Identify medical billing errors that result in a claims adjustment. The Self Audit Award Program is available to all plan members who identify medical billing errors billed for services you did not receive.
- Be sure to check all bills from your medical providers to ensure charges have not been duplicated or
- Notify the claims administrator of the error before it is detected by the administrator or the
- Have not already been detected by the Plan’s claims administrator or reported by the provider;
- Involves charges which are allowable and covered by the MUS Group Health Plan; and
- Total $50 or more in errant charges.

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

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).

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;
- Involves 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.

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.
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.**

**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.
Glossary

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

Benefit Year/Plan Year
The period starting July 1 and ending June 30.

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

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

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

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

Managed Care
PacificSource, Blue Cross Blue Shield, and Allegience 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.

Managed Care Plans cover:
• Emergency services are covered everywhere. However, out-of-network providers may balance bill the difference between allowance and charge.
• 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 services Out-of-Network.

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

Managed Care Plans:

Managed Care Plan
Employee Only
Employee & Spouse/AD
Employee & Child(ren)
Employee & Family

PacificSource
$673
$905
$882
$1137

Blue Cross
$591
$795
$774
$998

Allegience
$575
$745
$754
$972

Managed Care
$612
$823
$802
$1033

Medical Rates for 2012-2013

The employer contribution for 2012-2013 is $733 per month for eligible active employees.
## Schedule of Medical Benefits 2012 - 2013

<table>
<thead>
<tr>
<th>Medical Plan Costs</th>
<th>Traditional Plan In-Network</th>
<th>Traditional Plan Out-of-Network*</th>
<th>Managed Care In-Network</th>
<th>Managed Care Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$1,000/Person</td>
<td>$1,000/Person</td>
<td>$500/Person</td>
<td>Separate $750/Person</td>
</tr>
<tr>
<td>Applies to all services, unless otherwise noted or copayment is indicated</td>
<td>$2,250/Family</td>
<td>$2,250/Family</td>
<td>Separate $1,750/Family</td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance Percentages</strong></td>
<td>25%</td>
<td>35%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>(Maximum coinsurance paid in a benefit year; excludes deductibles and copayments)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Coinsurance Maximums</strong></td>
<td>$5,000/Person</td>
<td>$5,000/Person</td>
<td>Separate $4,250/Person</td>
<td>Separate $9,500/Person</td>
</tr>
<tr>
<td>(Example DME).</td>
<td>$11,250/Family</td>
<td>$11,250/Family</td>
<td>Separate $5,000/Person</td>
<td></td>
</tr>
<tr>
<td><strong>Managed Care ONLY - Copayment (on outpatient visits)</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>$15 copay</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*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.

### 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 pays 100%
  - Plan pays 0%

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

**June 30**

- **End of plan yr**
  - Jane pays 0%
  - Plan pays 100%

- Jane reaches her $5,000 coinsurance maximum. She has seen her doctor seven times and reaches her $1,000 deductible. Her plan pays 75% of the allowable cost and the plan pays 75% of the allowable cost.

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

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### Privacy Rights

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 certificate 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) or legally authorized governmental entities without a member’s written consent. The MUS Plan presently provides dependent coverage independent of student status.

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

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**Full HIPAA policy available on Website or by contacting Campus HR**
## Monthly Out-of-Pocket Benefit Premium Costs

### Employer Contribution for July 2012 through June 2013

<table>
<thead>
<tr>
<th>Active Employees</th>
<th>$ 733 (a)</th>
</tr>
</thead>
</table>

### 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)
- Medical $_______ (h)
- Dependent $_______ (h)

#### FLEXIBLE SPENDING ACCOUNT (FSA) (waived if immediately admitted to hospital)
- $2.50/month admin fee for both

### TOTAL OPTIONAL BENEFITS PREMIUM (Pre-Tax)
Add lines g,h,j and k $_______ (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 (r) $_______ (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)

---

### Medical Plan Services

<table>
<thead>
<tr>
<th>Medical Plan Services</th>
<th>Traditional Plan In-Network Coinsurance</th>
<th>Traditional Plan Out-of-Network Coinsurance</th>
<th>Managed Care In-Network Coinsurance</th>
<th>Managed Care Out-of-Network Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient Services</td>
<td><strong>Pre-certification of non-emergency inpatient hospitalization is strongly recommended</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room Charges</td>
<td>25%</td>
<td>35%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>25%</td>
<td>35%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>25%</td>
<td>35%</td>
<td>25%</td>
<td>35%</td>
</tr>
</tbody>
</table>

#### 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

#### 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 & Diagnostic Charges 25% 25% $50 copay/visit for lab, x-ray & other procedures apply deductible/coinsurance
- Facility/professional Charges 25% 25% $50 copay/visit for room charges only

#### Maternity Services
- Hospital Charges 25% 35% 25% 35%
- Physician Charges (delivery & inpatient) 25% 35% 25% (waived if enrolled in WellBaby Program within first trimester)
- Prenatal Offices Visits 25% 35% $15 copay/visit (waived if enrolled in WellBaby Program within first trimester)

---

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.
# Schedule of Medical Benefits 2012 - 2013

## Medical Plan Services

<table>
<thead>
<tr>
<th>Preventive Services</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Coinsurance</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>Preventive exams, screenings/ immunizations/flu shots (adult &amp; child Wellcare)</td>
<td>0% (no deductible) for services listed on pg 10 &amp; 11</td>
<td>$0 copay (no deductible) limited to services listed on pg 10 &amp; 11. Other preventive services subject to deductible and co-insurance</td>
</tr>
<tr>
<td>Refer to pages 10 &amp; 11 for listing of Preventive Services covered at 100% allowable and for age recommendations</td>
<td>35%</td>
<td>35%</td>
</tr>
</tbody>
</table>

## Mental Illness Services

### Inpatient Services

| 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 |
| First 4 visits 0% coinsurance then 25% Max: 40 visits/yr | First 4 visits $0 copay then $15 copay/visit Max: 40 visits/yr | 35% Max: 40 visits/yr |

### Outpatient Services

| No maximum for Severe Mental Illness diagnosis (SMI) | 25% First 4 visits 0% coinsurance then $15 copay/visit Max: 40 visits/yr | First 4 visits 0% coinsurance then $15 copay/visit Max: 40 visits/yr | First 4 visits 0% coinsurance then $15 copay/visit Max: 40 visits/yr | First 4 visits 0% coinsurance then $15 copay/visit Max: 40 visits/yr |

## Chemical Dependency

### Inpatient Services

| 25% Max: 30 days/yr | 35% Max: 30 days/yr | 25% Max: 30 days/yr | 35% Max: 30 days/yr |

### Outpatient Services

| 25% Max: 40 visits/yr | 35% Max: 40 visits/yr | First 4 visits $15 copay/visit Max: 40 visits/yr | First 4 visits $15 copay/visit Max: 40 visits/yr |

## Rehabilitative Services

### Physical, Occupational, Cardiac, Respiratory, Pulmonary & Speech Therapy

### Inpatient Services

| 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.
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, biop寝nance (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 - $0 for co-pay/coinsurance/deductible
- Disease management programs like the Take Control program (free lancets and test strips to members who qualify), WellBaby ($) 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 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 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.

<table>
<thead>
<tr>
<th>Medical Plan Services</th>
<th>Traditional Plan In-Network</th>
<th>Traditional Plan Out-Of-Network</th>
<th>Managed Care In-Network</th>
<th>Managed Care Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Members pay charges over $25/visit</td>
<td>Max: 15 visits/yr in any combination for complementary health care</td>
<td>Members pay charges over $25/visit</td>
<td>Max: 15 visits/yr in combination with Naturopathic</td>
</tr>
<tr>
<td>Naturopathic</td>
<td>Members pay charges over $25/visit</td>
<td>Max: 15 visits/yr in any combination for complementary health care</td>
<td>Members pay charges over $25/visit</td>
<td>Max: 15 visits/yr in combination with Acupuncture</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Members pay charges over $25/visit</td>
<td>Max: 15 visits/yr in any combination for complementary health care</td>
<td>Members pay charges over $25/visit</td>
<td>Max: 15 visits/yr in combination with Acupuncture</td>
</tr>
<tr>
<td>Extended Care Services</td>
<td>Home Health Care</td>
<td>(Physician ordered prior authorization is strongly recommended (or required) by most plans. [See Plan Descriptions])</td>
<td>25% Max: 90 days/yr</td>
<td>35% Max: 90 days/yr</td>
</tr>
<tr>
<td></td>
<td>Hospice</td>
<td>25% Max: 6 months</td>
<td>35% Max: 6 months</td>
<td>25% Max: 6 months</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing</td>
<td>25% Max: 30 days/yr</td>
<td>35% Max: 30 days/yr</td>
<td>35% Max: 30 days/yr</td>
</tr>
<tr>
<td></td>
<td>Miscellaneous Services</td>
<td>25% No deductible</td>
<td>35% No deductible</td>
<td>$15 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Allergy Shots</td>
<td>25% (Not applied to coinsurance max) Max: $100 for foot orthotics (per f)</td>
<td>35% (Not applied to coinsurance max) Max: $100 for foot orthotics (per f)</td>
<td>35% (Not applied to coinsurance max) Max: $100 for foot orthotics (per f)</td>
</tr>
</tbody>
</table>
Schedule of Medical Benefits 2012 - 2013

<table>
<thead>
<tr>
<th>Medical Plan Service</th>
<th>Traditional Plan</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>Coinsurance</td>
<td>Coinsurance</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>PKU Supplies</td>
<td>25%</td>
<td>25%</td>
<td>0% (no deductible)</td>
<td>35%</td>
</tr>
<tr>
<td>Education Programs on Disease</td>
<td>0% (no deductible)</td>
<td>0% (no deductible)</td>
<td>0% (no deductible)</td>
<td>Not covered</td>
</tr>
<tr>
<td>and Dietary/Nutritional</td>
<td>Max: 8 visits/yr</td>
<td>Max: 8 visits/yr</td>
<td>Max: 8 visits/yr</td>
<td>Not covered</td>
</tr>
<tr>
<td>Counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity Management</td>
<td>25%</td>
<td>Not covered</td>
<td>25%</td>
<td>Not covered</td>
</tr>
<tr>
<td>(Prior authorization required)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>by all plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TMJ</td>
<td>25%</td>
<td>35%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>(Prior authorization required)</td>
<td>Surgical treatment only</td>
<td>Surgical treatment only</td>
<td>Surgical treatment only</td>
<td>Surgical treatment only</td>
</tr>
<tr>
<td>by managed care plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and strongly recommended for</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>traditional plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td>Not covered</td>
<td>Not covered</td>
<td>25%</td>
<td>Not covered</td>
</tr>
<tr>
<td>(biological infertility only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(prior authorization required)</td>
<td></td>
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<tr>
<td>for all plans providing</td>
<td></td>
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<tr>
<td>coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>25%</td>
<td>35%</td>
<td>25%</td>
<td>Not covered</td>
</tr>
<tr>
<td>(Prior authorization required)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>for managed care plans</td>
<td></td>
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<tr>
<td>and strongly recommended for</td>
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<tr>
<td>traditional plans</td>
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<td></td>
</tr>
<tr>
<td>Travel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel for patient only</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
<td>Not covered</td>
</tr>
<tr>
<td>(if services are not available</td>
<td>up to $1,500/yr. with Prior authorization</td>
<td>up to $1,500/yr. with Prior authorization</td>
<td>up to $1,500/yr. with Prior authorization</td>
<td>Not covered</td>
</tr>
<tr>
<td>in local community)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Get Healthy Stay Healthy</td>
<td></td>
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</tr>
<tr>
<td>Preventive Health Screenings/</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Lifestyle Ed. &amp; Support</td>
<td>see pg 12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WellBaby</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take Control (Diabetes Support Prg.)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td></td>
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</tr>
<tr>
<td>WellHeart</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>WellWeight</td>
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<td></td>
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</tr>
</tbody>
</table>

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.
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

Medical FSA

A Medical FSA enables employees to set aside pre-tax dollars to pay for eligible medical expenses. 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 choose to use a Benny™ Debit Card to pay for services at the “point of sale.” Participants in the Medical FSA may now choose to use a Benny™ Debit Card. Ineligible Health Care Expenses

- Please see the website below

Ineligible Day Care Expenses

- Please see the website below

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

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 deuctions 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?

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- Copays & deductibles

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- Copays & deductibles

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Ineligible Health Care Expenses

- Please see the website below

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- Dental exams, cleanings
- Fillings, crowns, braces
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- 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

Ineligible Health Care Expenses

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Ineligible Health Care Expenses

- Please see the website below

Qualifying Health Care Expenses:

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- Dental exams, cleanings
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- 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

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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

Ineligible Health Care Expenses

- Please see the website below
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 Screening**
  - 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**  
  - Pregnant women and others at risk

- **STD screening**  
  - Persons at risk

- **RH Incompatibility Screening**  
  - Pregnant women

**Routine Immunizations**

- **Diphtheria, 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)

---

Flexible Spending Account (voluntary)

Administered by Flex Connect - Insurance Coordinators of Montana: 1-866-640-FLEX (3539) - www.insurancecoordinators.com - flex@icmont.com

<table>
<thead>
<tr>
<th>Account Types</th>
<th>Annual Amount</th>
<th>Qualifying Expense Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum: $120 Max: $2,500/Employee</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td><strong>Dependent Care</strong></td>
<td>Minimum: $120 Max: $5,000/Employee</td>
<td>Day care centers (must comply with state and local laws), babysitters, preschools, and general-purpose day camps</td>
</tr>
<tr>
<td><strong>Administration Fee</strong></td>
<td>$30.00 ($2.50 per month)</td>
<td>For one or both Medical and Dependent Care FSAs</td>
</tr>
<tr>
<td><strong>Adoption Assistance</strong></td>
<td>Minimum: $120 Max: $12,650 (total max-Not annual max)</td>
<td>Adoption fees, court costs, attorney fees, related travel expenses</td>
</tr>
</tbody>
</table>

**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, if a dependent removes from school and is no longer a dependent, the FSA contribution must be changed. 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 qualified 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.
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. Inflation Protection

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

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

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

Get Healthy, Stay Healthy

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

Preventive Health Screenings
WellCheck
Every campus conducts health 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.

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, 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.
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 medical plans.

Take Control “Diabetes Support Program”
Available to plan members with diabetes. For details call 1-800-746-2970 or visit the nearest network provider.

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.

Vision (voluntary) cont.

Monthly Vision Rates

<table>
<thead>
<tr>
<th>Service/Material</th>
<th>Coverage from an EyeMed Doctor</th>
<th>Out-of-Network Reimbursement</th>
<th>Rural OON Reimbursement**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam with dilation as necessary:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once every benefit year</td>
<td>$10 copay</td>
<td>Up to $45</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Frames:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once every two years</td>
<td>$125 allowance, 20% off balance over $125</td>
<td>Up to $52</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Single Vision</td>
<td>$20 copay</td>
<td>Up to $45</td>
<td>Up to $45</td>
</tr>
<tr>
<td>Bilical</td>
<td>$20 copay</td>
<td>$10 off balance over $20</td>
<td>Up to $45</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$20 copay</td>
<td>Up to $55</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Standard Progressives</td>
<td>$80 copay</td>
<td>Up to $55</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Contacts Lens in lieu of contacts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lens Materials:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>$125 allowance, 15% off balance over $125</td>
<td>Up to $80</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Disposable</td>
<td>$125 allowance paid in full</td>
<td>Up to $80</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td></td>
<td>Up to $200</td>
<td>Up to $200</td>
</tr>
<tr>
<td>Once every benefit year in lieu of eyeglass lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lens Exam Fees:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Contact Lens Fit &amp; Follow-up</td>
<td>$20 copay, paid in full fit and two follow up visits</td>
<td>Up to $40</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Premium Contact Lens Fit &amp; Follow-up</td>
<td>$20 copay, 10% off retail price, then apply $30 allowance</td>
<td>Up to $40</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Once every benefit year</td>
<td>$20 copay</td>
<td>Up to $40</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Lens Options:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV Coating</td>
<td>$15 copay</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Thin (Solid and Gradient)</td>
<td>$15 copay</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Standard Scratch Resistance</td>
<td>$15 copay</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>$40 copay</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Standard A/R</td>
<td>$45 copay</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

* 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.
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 Lasky 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:
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.

Out-of-Network Providers
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.

URX is your Pharmacy Plan:
- Any member enrolled in a medical insurance plan will automatically receive URXs. 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. URXs 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 $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 URXs. 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.

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.

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.

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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.

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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. Specialty Drugs are available through the URx Specialty Drug 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 medications, 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.
Supplemental Life Insurance (voluntary)

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 table below. Remember, this cost is paid on a 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 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.

URx Drug Classification

URx Drug Classification (Based on medical evidence of impact to health and overall net cost)

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Deductible</th>
<th>Retail Rx (30-day supply)</th>
<th>Mail Rx (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier A</td>
<td>$0</td>
<td>$0 Copayment †</td>
<td>$0 Copayment †</td>
</tr>
<tr>
<td>Tier B</td>
<td>$15</td>
<td>$15 Copayment</td>
<td>$30 Copayment</td>
</tr>
<tr>
<td>Tier C</td>
<td>$40</td>
<td>$40 Copayment</td>
<td>$80 Copayment</td>
</tr>
<tr>
<td>Tier D</td>
<td>$0</td>
<td>50% of coinsurance †</td>
<td>50% of coinsurance †</td>
</tr>
<tr>
<td>Tier F</td>
<td>$0</td>
<td>100% of coinsurance †</td>
<td>100% of coinsurance †</td>
</tr>
<tr>
<td>Tier S</td>
<td>$50</td>
<td>50% of coinsurance †</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

What Class are you in?
What grade would you get if 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 Pharmacy 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.

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

<table>
<thead>
<tr>
<th>Age</th>
<th>$25,000</th>
<th>$50,000</th>
<th>$75,000</th>
<th>$100,000</th>
<th>$125,000</th>
<th>$150,000</th>
<th>$175,000</th>
<th>$200,000</th>
<th>$225,000</th>
<th>$250,000</th>
<th>$275,000</th>
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<tr>
<td>0-9</td>
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<td>$2.00</td>
<td>$3.00</td>
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<td>$6.00</td>
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<tr>
<td>10-14</td>
<td>$1.30</td>
<td>$2.60</td>
<td>$3.90</td>
<td>$5.20</td>
<td>$6.50</td>
<td>$7.80</td>
<td>$9.10</td>
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<td>$11.70</td>
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<td>15-19</td>
<td>$1.50</td>
<td>$3.00</td>
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<td>20-24</td>
<td>$1.70</td>
<td>$3.40</td>
<td>$5.10</td>
<td>$6.80</td>
<td>$8.50</td>
<td>$10.20</td>
<td>$11.90</td>
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<td>$15.30</td>
<td>$17.00</td>
<td>$18.70</td>
<td>$20.40</td>
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<tr>
<td>25-29</td>
<td>$1.90</td>
<td>$3.80</td>
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<td>$15.20</td>
<td>$17.10</td>
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<td>$22.80</td>
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<td>30-34</td>
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<td>$6.30</td>
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<td>$12.60</td>
<td>$14.70</td>
<td>$16.80</td>
<td>$18.90</td>
<td>$21.00</td>
<td>$23.10</td>
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<tr>
<td>35-39</td>
<td>$2.30</td>
<td>$4.60</td>
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<td>$16.10</td>
<td>$18.40</td>
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<td>40-44</td>
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<tr>
<td>45-49</td>
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<td>60-64</td>
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<td>$23.90</td>
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<td>$30.10</td>
<td>$33.20</td>
<td>$36.30</td>
<td>$39.40</td>
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<tr>
<td>over 64</td>
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<td>$9.50</td>
<td>$12.70</td>
<td>$15.90</td>
<td>$19.10</td>
<td>$22.30</td>
<td>$25.50</td>
<td>$28.70</td>
<td>$31.90</td>
<td>$35.10</td>
<td>$38.30</td>
<td>$41.50</td>
</tr>
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</table>

Optional Dependent Life

Monthly Premiums

<table>
<thead>
<tr>
<th>Child(ren)</th>
<th>$2,500</th>
<th>$5,000</th>
<th>$10,000</th>
<th>$15,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,500</td>
<td>$8.77</td>
<td>$1.54</td>
<td>$3.08</td>
<td>$7.71</td>
</tr>
<tr>
<td>$5,000</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>$10,000</td>
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<tr>
<td>$15,000</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Who May be Enrolled &amp; Monthly Rates</th>
<th>Basic Plan</th>
<th>Premium Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$17</td>
<td>$44</td>
</tr>
<tr>
<td>Employee &amp; Spouse/Adult Dep.</td>
<td>$32</td>
<td>$84</td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>$32</td>
<td>$84</td>
</tr>
<tr>
<td>Employee &amp; Family</td>
<td>$46</td>
<td>$119</td>
</tr>
</tbody>
</table>

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

### Basic Restorative Services

- Covered benefit
  - 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.


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.

### Basic Life/AD&D Monthly Premiums

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life/AD&amp;D</td>
<td>$10,000</td>
</tr>
<tr>
<td>Basic Life/AD&amp;D</td>
<td>$10,000</td>
</tr>
<tr>
<td>Basic Life/AD&amp;D</td>
<td>$10,000</td>
</tr>
<tr>
<td>Basic Life/AD&amp;D</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

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).

### 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 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 the greater of $100 or 10% of your LTD benefit before reduction by deductible income.

### Who is Eligible:

- Employee Only

### 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. 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

<table>
<thead>
<tr>
<th>Option</th>
<th>Monthly Benefit</th>
<th>Waiting Period</th>
<th>Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>60% of pay/180 days</td>
<td>5.90</td>
<td></td>
</tr>
<tr>
<td>Option 2</td>
<td>66-2/3% of pay/180 days</td>
<td>11.75</td>
<td></td>
</tr>
<tr>
<td>Option 3</td>
<td>66-2/3% of pay/120 days</td>
<td>14.66</td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6241</td>
<td>Pontic – porcelain fused predominantly base metal</td>
<td>$391</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic – porcelain fused to noble metal</td>
<td>$408</td>
</tr>
<tr>
<td>D6245</td>
<td>Pontic – porcelain/ceramic</td>
<td>$429</td>
</tr>
<tr>
<td>D6750</td>
<td>Crown – porcelain fused to high noble metal</td>
<td>$423</td>
</tr>
<tr>
<td>D6751</td>
<td>Crown – porcelain fused to predominately base metal</td>
<td>$410</td>
</tr>
<tr>
<td>D6752</td>
<td>Crown – porcelain fused to noble metal</td>
<td>$414</td>
</tr>
<tr>
<td>D6790</td>
<td>Crown – full cast high noble metal</td>
<td>$410</td>
</tr>
<tr>
<td>D6791</td>
<td>Crown – full cast predominately base metal</td>
<td>$402</td>
</tr>
<tr>
<td>D6792</td>
<td>Crown – full cast noble metal</td>
<td>$406</td>
</tr>
<tr>
<td>D6794</td>
<td>Crown – titanium</td>
<td>$410</td>
</tr>
<tr>
<td>D6973</td>
<td>Core build up for retainer, including any pins</td>
<td>$92</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>$94</td>
</tr>
<tr>
<td>D7210</td>
<td>Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
<td>$160</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
<td>$176</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth - partially bony</td>
<td>$215</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth - completely bony</td>
<td>$255</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth - completely bony, with unusual surgical complications</td>
<td>$305</td>
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<tr>
<td>D7850</td>
<td>Surgical disectomy, with/without implant</td>
<td>$1,500</td>
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<tr>
<td>D8660</td>
<td>Arthroscopy</td>
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<tr>
<td>D880</td>
<td>Occlusal orthotic device, by report</td>
<td>$469</td>
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<tr>
<td>D960</td>
<td>Frenuloplasty (frenectomy or frenotomy) - separate procedure</td>
<td>$210</td>
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<tr>
<td>D971</td>
<td>Excision of pericondental gingiva</td>
<td>$120</td>
</tr>
<tr>
<td>D9110</td>
<td>Palatal (emergency) treatment of dental pain - minor procedure</td>
<td>$69</td>
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<tr>
<td>D9220</td>
<td>Deep sedation/general anesthesia - first 30 minutes</td>
<td>$219</td>
</tr>
<tr>
<td>D9221</td>
<td>Deep sedation/general anesthesia - each additional 15 minutes</td>
<td>$105</td>
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<tr>
<td>D9241</td>
<td>Intravenous conscious sedation/analgesic - first 30 minutes</td>
<td>$199</td>
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<tr>
<td>D9242</td>
<td>Intravenous conscious sedation/analgesic - each additional 15 minutes</td>
<td>$81</td>
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<tr>
<td>D9310</td>
<td>Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
<td>$67</td>
</tr>
<tr>
<td>D9940</td>
<td>Occlusal guards, by report</td>
<td>$245</td>
</tr>
</tbody>
</table>

The CDT codes and nomenclature are copyright of the American Dental Association. 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.

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.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient</td>
<td>$40</td>
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<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused</td>
<td>$58</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient</td>
<td>$65</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient</td>
<td>$72</td>
</tr>
<tr>
<td>D0210</td>
<td>Introral - complete series (including bitewings)</td>
<td>$110</td>
</tr>
<tr>
<td>D0220</td>
<td>Introral - periapical first film</td>
<td>$26</td>
</tr>
<tr>
<td>D0230</td>
<td>Introral - periapical each additional film</td>
<td>$20</td>
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<tr>
<td>D0240</td>
<td>Introral - occlusal film</td>
<td>$25</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - first film</td>
<td>$58</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewings - one film</td>
<td>$22</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two films</td>
<td>$37</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings - three films</td>
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<td>D0274</td>
<td>Bitewings - four films</td>
<td>$53</td>
</tr>
<tr>
<td>D0320</td>
<td>TMJ arthrogram including injection</td>
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</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
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</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis - Adult</td>
<td>$83</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis - Child</td>
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</tr>
<tr>
<td>D1203</td>
<td>Topical application of fluoride (prophylaxis not included) child (through age 13)</td>
<td>$27</td>
</tr>
<tr>
<td>D1204</td>
<td>Topical application of fluoride (prophylaxis not included) adult (ages 14 through 18)</td>
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<tr>
<td>D1351</td>
<td>Sealent – per tooth (through age 15)</td>
<td>$45</td>
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<tr>
<td>D1510</td>
<td>Space maintainer - fixed - unilateral</td>
<td>$239</td>
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<tr>
<td>D1515</td>
<td>Space maintainer - fixed - bilateral</td>
<td>$588</td>
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<tr>
<td>D1520</td>
<td>Space maintainer - removable - unilateral</td>
<td>$393</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer - removable - bilateral</td>
<td>$538</td>
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<tr>
<td>D2140</td>
<td>Amalgam - one surface, primary or permanent</td>
<td>$93</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two surfaces, primary or permanent</td>
<td>$118</td>
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<tr>
<td>D2160</td>
<td>Amalgam - three surfaces, primary or permanent</td>
<td>$147</td>
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<tr>
<td>D2161</td>
<td>Amalgam - four or more surfaces, primary or permanent</td>
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<td>D2330</td>
<td>Resin-based composite – one surface, anterior</td>
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<td>D2331</td>
<td>Resin-based composite – two surfaces, anterior</td>
<td>$125</td>
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<td>D2332</td>
<td>Resin-based composite – three surfaces, anterior</td>
<td>$156</td>
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<tr>
<td>D2335</td>
<td>Resin-based composite – root or more surfaces involving incisal angle (anterior)</td>
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<tr>
<td>D2391</td>
<td>Resin- based composite – one surface, posterior</td>
<td>$116</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Description</td>
<td>Maximum Benefits</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite - two surfaces, posterior</td>
<td>$148</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite - three surfaces, posterior</td>
<td>$184</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite - four or more surfaces, posterior</td>
<td>$220</td>
</tr>
<tr>
<td>D2543</td>
<td>Onlay - metallic - three surfaces</td>
<td>$373</td>
</tr>
<tr>
<td>D2544</td>
<td>Onlay - metallic - four or more surfaces</td>
<td>$440</td>
</tr>
<tr>
<td>D2643</td>
<td>Onlay - porcelain/ceramic - three surfaces</td>
<td>$375</td>
</tr>
<tr>
<td>D2644</td>
<td>Onlay - porcelain/ceramic - four or more surfaces</td>
<td>$440</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown - porcelain/ceramic substrate</td>
<td>$453</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown - porcelain fused to high noble metal</td>
<td>$423</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown - porcelain fused to predominately base metal</td>
<td>$410</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porcelain fused to noble metal</td>
<td>$414</td>
</tr>
<tr>
<td>D2780</td>
<td>Crown - 3/4 cast high noble metal</td>
<td>$406</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown - 3/4 porcelain/ceramic</td>
<td>$410</td>
</tr>
<tr>
<td>D2790</td>
<td>Crown - full cast high noble metal</td>
<td>$410</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown - primary tooth</td>
<td>$148</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown - permanent tooth</td>
<td>$222</td>
</tr>
<tr>
<td>D2932</td>
<td>Prefabricated resin crown</td>
<td>$222</td>
</tr>
<tr>
<td>D2933</td>
<td>Prefabricated stainless steel crown with resin window</td>
<td>$222</td>
</tr>
<tr>
<td>D2940</td>
<td>Sedative filling</td>
<td>$70</td>
</tr>
<tr>
<td>D2950</td>
<td>Core buildup, including any pins</td>
<td>$95</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention - per tooth, in addition to restoration</td>
<td>$38</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated post and core in addition to crown</td>
<td>$127</td>
</tr>
<tr>
<td>D3110</td>
<td>Pulp cap - direct (excluding final restoration)</td>
<td>$43</td>
</tr>
<tr>
<td>D3310</td>
<td>Root canal - Anterior (excluding final restoration)</td>
<td>$489</td>
</tr>
<tr>
<td>D3320</td>
<td>Root canal - Bicuspid (excluding final restoration)</td>
<td>$566</td>
</tr>
<tr>
<td>D3330</td>
<td>Root canal - Molar (excluding final restoration)</td>
<td>$695</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy - anterior</td>
<td>$592</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy - bicuspid</td>
<td>$674</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy - molar</td>
<td>$814</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy/periradicular surgery - anterior</td>
<td>$435</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy/periradicular surgery - bicuspid (first root)</td>
<td>$480</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy/periradicular surgery - molar (first root)</td>
<td>$520</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrgrade filling - per root</td>
<td>$116</td>
</tr>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$358</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$113</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical crown lengthening - hard tissue</td>
<td>$455</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including flap entry and closure) four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$672</td>
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<tr>
<td>D4261</td>
<td>Osseous surgery (including flap entry and closure) one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$511</td>
</tr>
<tr>
<td>D4271</td>
<td>Free soft tissue graft procedure (including donor site surgery)</td>
<td>$632</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Complete denture - maxillary</td>
<td>$608</td>
</tr>
<tr>
<td>D5120</td>
<td>Complete denture - mandibular</td>
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</tr>
<tr>
<td>D5130</td>
<td>Immediate denture - maxillary</td>
<td>$666</td>
</tr>
<tr>
<td>D5140</td>
<td>Immediate denture - mandibular</td>
<td>$666</td>
</tr>
<tr>
<td>D5211</td>
<td>Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>$436</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>$436</td>
</tr>
<tr>
<td>D5213</td>
<td>Axillary partial denture - cast framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$650</td>
</tr>
<tr>
<td>D5214</td>
<td>Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$650</td>
</tr>
<tr>
<td>D5225</td>
<td>Maxillary partial denture - flexible base (including any clasps, rests and teeth)</td>
<td>$488</td>
</tr>
<tr>
<td>D5226</td>
<td>Mandibular partial denture - flexible base (including any clasps, rests and teeth)</td>
<td>$488</td>
</tr>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
<td>$86</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken teeth - complete denture (each tooth)</td>
<td>$76</td>
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<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
<td>$89</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth - per tooth</td>
<td>$76</td>
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<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
<td>$114</td>
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<tr>
<td>D5660</td>
<td>Add clasps to existing partial denture</td>
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<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
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</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
<td>$274</td>
</tr>
<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
<td>$263</td>
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<tr>
<td>D5820</td>
<td>Interim partial denture (maxillary)</td>
<td>$216</td>
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<tr>
<td>D5821</td>
<td>Interim partial denture (mandibular)</td>
<td>$216</td>
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<tr>
<td>D5850</td>
<td>Tissue conditioning, maxillary</td>
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<tr>
<td>D6210</td>
<td>Pontic - cast high noble metal</td>
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<td>D6212</td>
<td>Pontic - cast noble metal</td>
<td>$365</td>
</tr>
<tr>
<td>D6240</td>
<td>Pontic - porcelain fused to high noble metal</td>
<td>$424</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Description</td>
<td>Maximum Benefits</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite - two surfaces, posterior</td>
<td>$148</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite - three surfaces, posterior</td>
<td>$184</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite - four or more surfaces, posterior</td>
<td>$220</td>
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<tr>
<td>D2395</td>
<td>Onlay - metallic - three surfaces</td>
<td>$375</td>
</tr>
<tr>
<td>D2434</td>
<td>Onlay - metallic - four or more surfaces</td>
<td>$490</td>
</tr>
<tr>
<td>D2643</td>
<td>Onlay - porcelain/ceramic - three surfaces</td>
<td>$375</td>
</tr>
<tr>
<td>D2644</td>
<td>Onlay - porcelain/ceramic - four or more surfaces</td>
<td>$440</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown - porcelain/ceramic substrate</td>
<td>$453</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown - porcelain fused to high noble metal</td>
<td>$423</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown - porcelain fused to predominately base metal</td>
<td>$410</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porcelain fused to noble metal</td>
<td>$414</td>
</tr>
<tr>
<td>D2780</td>
<td>Crown - 3/4 cast high noble metal</td>
<td>$406</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown - 3/4 porcelain/ceramic</td>
<td>$410</td>
</tr>
<tr>
<td>D2790</td>
<td>Crown - full cast high noble metal</td>
<td>$410</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown - primary tooth</td>
<td>$148</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown - permanent tooth</td>
<td>$222</td>
</tr>
<tr>
<td>D2932</td>
<td>Prefabricated resin crown</td>
<td>$222</td>
</tr>
<tr>
<td>D2933</td>
<td>Prefabricated stainless steel crown with resin window</td>
<td>$222</td>
</tr>
<tr>
<td>D2940</td>
<td>Sedative filling</td>
<td>$70</td>
</tr>
<tr>
<td>D2950</td>
<td>Core buildup, including any pins</td>
<td>$95</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention - per tooth, in addition to restoration</td>
<td>$38</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated post and core in addition to crown</td>
<td>$127</td>
</tr>
<tr>
<td>D3110</td>
<td>Pulp cap - direct (excluding final restoration)</td>
<td>$43</td>
</tr>
<tr>
<td>D3310</td>
<td>Root canal - Anterior (excluding final restoration)</td>
<td>$489</td>
</tr>
<tr>
<td>D3320</td>
<td>Root canal - Bicuspid (excluding final restoration)</td>
<td>$566</td>
</tr>
<tr>
<td>D3330</td>
<td>Root canal - Molar (excluding final restoration)</td>
<td>$695</td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy - anterior</td>
<td>$592</td>
</tr>
<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy - bicuspid</td>
<td>$674</td>
</tr>
<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy - molar</td>
<td>$814</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy/periradicular surgery - anterior</td>
<td>$435</td>
</tr>
<tr>
<td>D3421</td>
<td>Apicoectomy/periradicular surgery - bicuspid (first root)</td>
<td>$480</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy/periradicular surgery - molar(first root)</td>
<td>$520</td>
</tr>
<tr>
<td>D3430</td>
<td>Rerotide filling - per root</td>
<td>$116</td>
</tr>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$358</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$113</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical crown lengthening - hard tissue</td>
<td>$455</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery (including flap entry and closure) four or more contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$672</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous surgery (including flap entry and closure) one to three contiguous teeth or bounded teeth spaces per quadrant</td>
<td>$511</td>
</tr>
<tr>
<td>D4271</td>
<td>Free soft tissue graft procedure (including donor site surgery)</td>
<td>$632</td>
</tr>
</tbody>
</table>
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.

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

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.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient</td>
<td>$40</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused</td>
<td>$58</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation -new or established patient</td>
<td>$65</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation -new or established patient</td>
<td>$72</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral - complete series (including bitewings)</td>
<td>$110</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first film</td>
<td>$26</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional film</td>
<td>$20</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal film</td>
<td>$25</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - first film</td>
<td>$58</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewings - one film</td>
<td>$22</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two films</td>
<td>$37</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings - three films</td>
<td>$45</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - four films</td>
<td>$53</td>
</tr>
<tr>
<td>D0320</td>
<td>TMJ arthogram including injection</td>
<td>$622</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
<td>$91</td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis - Adult</td>
<td>$83</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis - Child</td>
<td>$58</td>
</tr>
<tr>
<td>D1203</td>
<td>Topical application of fluoride (prophylaxis not included) child (through age 13)</td>
<td>$27</td>
</tr>
<tr>
<td>D1204</td>
<td>Topical application of fluoride (prophylaxis not included) adult (ages 14 through 18)</td>
<td>$28</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant – per tooth (through age 15)</td>
<td>$45</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer - fixed - unilateral</td>
<td>$239</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer - fixed - bilateral</td>
<td>$588</td>
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<tr>
<td>D1520</td>
<td>Space maintainer - removable -unilateral</td>
<td>$393</td>
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<tr>
<td>D1525</td>
<td>Space maintainer - removable -bilateral</td>
<td>$538</td>
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<tr>
<td>D2140</td>
<td>Amalgam - one surface, primary or permanent</td>
<td>$93</td>
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<tr>
<td>D2150</td>
<td>Amalgam - two surfaces, primary or permanent</td>
<td>$118</td>
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<tr>
<td>D2160</td>
<td>Amalgam - three surfaces, primary or permanent</td>
<td>$147</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - four or more surfaces, primary or permanent</td>
<td>$176</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite - one surface, anterior</td>
<td>$98</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite - two surfaces, anterior</td>
<td>$125</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite - three surfaces, anterior</td>
<td>$156</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite - four or more surfaces involving incisal angle (anterior)</td>
<td>$190</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin- based composite -one surface, posterior</td>
<td>$116</td>
</tr>
</tbody>
</table>

The CDT codes and nomenclature are copyright of the American Dental Association. 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.
Dental (must choose)

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.

<table>
<thead>
<tr>
<th>Basic Plan - Preventive Coverage</th>
<th>Premium Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who May be Enrolled &amp; Monthly Rates</strong></td>
<td><strong>Who May be Enrolled &amp; Monthly Rates</strong></td>
</tr>
<tr>
<td>Employee Only</td>
<td>Employee Only</td>
</tr>
<tr>
<td>Employee &amp; Spouse/Adult Dep.</td>
<td>Employee &amp; Spouse/Adult Dep.</td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>Employee &amp; Child(ren)</td>
</tr>
<tr>
<td>Employee &amp; Family</td>
<td>Employee &amp; Family</td>
</tr>
</tbody>
</table>

| Maximum Annual Benefit | $750 per covered individual | $1,500 per covered individual |
| Preventive and Diagnostic Services | Preventive and Diagnostic Services |
| Twice Per Benefit Year | Twice Per Benefit Year |
| Initial and Periodic oral exam | Cleaning |
| 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 | Basic Restorative Services |
| Not covered | Amalgam filling |
| Endodontic treatment | Periodontic treatment |
| Oral surgery | |

| Major Dental Services | Major Dental Services |
| Not covered | Crown |
| Root canal | Complete lower and upper denture |
| Dental implant | Occlusal guards |

| Removal of impacted teeth | 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.


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.

Long term disability coverage provides some protection of your income if you become unable to work due to an illness or injury. Choose the level of coverage to best suit your family’s needs. The total combined income will equal the benefit level you select.

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.

**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 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.

**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
Optional 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.

<table>
<thead>
<tr>
<th>Optional Supplemental Life Monthly Premium</th>
<th>$25,000-$300,000 (increments of $25,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>$25,000</td>
</tr>
<tr>
<td>under 30</td>
<td>$1.43</td>
</tr>
<tr>
<td>30-34</td>
<td>$2.00</td>
</tr>
<tr>
<td>35-39</td>
<td>$2.25</td>
</tr>
<tr>
<td>40-44</td>
<td>$3.10</td>
</tr>
<tr>
<td>45-49</td>
<td>$5.30</td>
</tr>
<tr>
<td>50-54</td>
<td>$8.03</td>
</tr>
<tr>
<td>55-59</td>
<td>$13.43</td>
</tr>
<tr>
<td>60-64</td>
<td>$16.50</td>
</tr>
<tr>
<td>65-69</td>
<td>$32.50</td>
</tr>
<tr>
<td>over 70</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

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.

URx Drug Classification

What Class are you in?
What grade would you get if 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.

URx Drug Classification (Based on medical evidence of impact to health and overall net cost)

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Deductible</th>
<th>Retail Rx (30-day supply)</th>
<th>M all Rx (90-Rx supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent level of value based on best medical evidence, best pharmaceutical and most improved health outcomes via disease management, and best overall net cost.</td>
<td>Tier A</td>
<td>$0</td>
<td>$0 Copayment †</td>
</tr>
<tr>
<td>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.</td>
<td>Tier B</td>
<td>$0</td>
<td>$15 Copayment †</td>
</tr>
<tr>
<td>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.</td>
<td>Tier C</td>
<td>$0</td>
<td>$40 Copayment †</td>
</tr>
</tbody>
</table>

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 100% of 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 15% 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 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. The percentage of the 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.

Optional Dependent Life Insurance

| Optional Dependent Life | $2,500 Spouse/$1,250 Child(ren) | $0.77 |
| Monthly Premiums | $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 |
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.

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.

Preventative Gastrointestinal Agents

- Copaxone, Rebif
- Avonex, Betaseron, Extavia, Ampyra

Antihypertensives

- Flolan, Letairis, Remodulin, Tyvaso, Ventavis
- Tracleer, Revatio

Anticoagulants

- Aredia, Boniva, Forteo (PA), Miacalcin, Reclast
- Simulect, Zenapax
- Sandimmune
- Myfortic, Prograf (oral and inj), Rapamune, Cellcept, cyclosporine (oral and inj), Gengraf, Intron-A
- Roferon-A
- Intron, Pegasys (PA), Rebetol (PA), Rebetron
- Epivir HBV, Copegus (PA), Infergen (PA), Peg-Interferon alpha-2b, Peginterferon alpha-2a
- Gleevac, Herceptin, Iressa, Lupron/Depot, Depo-Testosterone, Estroprovera, Medroxyprogesteroneacetate, waste of body growth, Xeloda, Zolendrinc

Proteinase Inhibitors

- Virazole, Trizivir
- Atripla, Truvada

Supplemental AD&D Coverage (voluntary)

Who May Be Enrolled

Employee only or Employee and Family (employee, spouse, and child(ren) to age 25)

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.

Who May Be Enrolled

Employee only or Employee and Family (employee, spouse, and child(ren) to age 25)

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.

- Employee Only
- Employee & Family

Who May Be Enrolled

Employee only or Employee and Family (employee, spouse, and child(ren) to age 25)

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.
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.

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

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
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 $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.
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 medical plans.

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.

Vision (voluntary) cont.

Monthly Vision Rates

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

* 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.

- 13 -
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 that we should have planned better.

The Montana University System offers the opportunity to purchase Long Term Care Insurance from Unum Provident, a subsidiary of Unum Provident. Long Term Care Insurance is designed to pick up where our health insurance leaves off. You may never need long term care. However, this year about nine million men and women will need long term care. By 2020, 12 million Americans will need long term care. Most will be cared for at home. A study by the US Department of Health and Human Services indicates that people who reach age 65 have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home stay there five years or longer. The Montana University System offers the opportunity to purchase Long Term Care Insurance from Unum Life Insurance Company of America, a subsidiary of Unum Provident.

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

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

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

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

Preventive Health Screenings
WellCheck
Every campus conducts health 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, acupuncture, 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, 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.
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
  - Pregnant women and others at risk

- STD screening
  - 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)

Flexible Spending Account (voluntary)

Administered by Flex Connect - Insurance Coordinators of Montana: 1-866-640-FLEX (3539) - www.insurancecoordinators.com - flex@icmont.com

<table>
<thead>
<tr>
<th>Account Types</th>
<th>Annual Amount</th>
<th>Qualifying Expense Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Minimum: $120 Max: $2,500/Employee</td>
<td>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</td>
</tr>
<tr>
<td>Dependent Care</td>
<td>Minimum: $120 Max: $5,000/Employee</td>
<td>Day care centers (must comply with state and local law), babysitters, preschools, and general-purpose day camps</td>
</tr>
<tr>
<td>Administration Fee</td>
<td>$30.00 ($2.50 per month)</td>
<td>For one or both Medical and Dependent Care FSAs</td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>Minimum: $120 Max: $12,650 (total max-NOT annual max)</td>
<td>Adoption fees, court costs, attorney fees, related travel expenses</td>
</tr>
</tbody>
</table>

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, if you experience an increase in your household size, the Medical FSA will not be decreased. 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 paycheck and deposited into your Medical FSA.

If you receive a qualified 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.

Get 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 debit card to pay for services at the “point of sale”. Participants in the Medical FSA may now choose to use a Benny™ Debit Card

Ineligible Health Care Expenses
• Please see the website below

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.
• 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.

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

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/mchb/advisory/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, anesthesia fee (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.
## Medical Plan Service

<table>
<thead>
<tr>
<th>Medical Plan Service</th>
<th>Traditional Plan In-Network Coinsurance</th>
<th>Traditional Plan Out-of-Network Coinsurance</th>
<th>Managed Care In-Network Coinsurance</th>
<th>Managed Care Out-of-Network Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous Services cont.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PKU Supplies (Includes treatment &amp; medical foods)</td>
<td>25%</td>
<td>25%</td>
<td>0% (no deductible)</td>
<td>35%</td>
</tr>
<tr>
<td>Education Programs on Disease Processes (when ordered by a physician) and Dietary/Nutritional Counseling (When medically necessary &amp; physician ordered. Prior authorization required for managed care plans and strongly recommended for traditional plans.)</td>
<td>0% (no deductible) Max: 8 visits/yr</td>
<td>0% (no deductible) Max: 8 visits/yr</td>
<td>0% (no deductible) Max: 8 visits/yr</td>
<td>Not covered</td>
</tr>
<tr>
<td>Obesity Management (Prior authorization required by all plans)</td>
<td>25%</td>
<td>Not covered</td>
<td>25% OON not covered. Must be enrolled in WellWeight for non-surgical treatment</td>
<td>Not covered</td>
</tr>
<tr>
<td>TMJ (Prior authorization required by managed care plans &amp; strongly recommended for traditional plans)</td>
<td>25% Surgical treatment only</td>
<td>35% Surgical treatment only</td>
<td>25% Surgical treatment only</td>
<td>35% Surgical treatment only</td>
</tr>
<tr>
<td>Infertility Treatment (Biological infertility only) (prior authorization required for all plans providing coverage)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Organ Transplants (Prior authorization required for managed care plans &amp; strongly recommended for traditional plans)</td>
<td>25%</td>
<td>35%</td>
<td>25%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Travel for patient only (if services are not available in local community)</td>
<td>25% up to $1,500/yr. with Prior authorization</td>
<td>25% up to $1,500/yr. with Prior authorization</td>
<td>25% up to $1,500/yr. with Prior authorization up to $5,000/yr. with Prior authorization in conjunction with transplants only with Prior authorization</td>
<td>Not covered</td>
</tr>
<tr>
<td>Get Healthy Stay Healthy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Health Screenings/Healthy Lifestyle Ed. &amp; Support</td>
<td>see pg 12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WellBaby</td>
<td>see pg 13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td></td>
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<tr>
<td>Take Control (Diabetes Support Prg.)</td>
<td></td>
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<tr>
<td>Tobacco Cessation</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>WellHeart</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WellWeight</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

## 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, biopsedance (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.
- (RX) 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 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.

The table below provides a summary of the medical care services covered, the percentage of charges paid, and the amount you will pay. Please refer to the Plan Descriptions for details.

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Coinsurance</td>
<td>0% (no deductible)</td>
<td>$0 copay (no deductible)</td>
</tr>
<tr>
<td>Out-of-Network Coinsurance</td>
<td>35%</td>
<td>35%</td>
</tr>
</tbody>
</table>

## 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)

<table>
<thead>
<tr>
<th>Service</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>25% Max: 30 days/yr</td>
<td>35% Max: 30 days/yr</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>35% Max: 30 days/yr</td>
<td>25% Max: 30 days/yr</td>
</tr>
</tbody>
</table>

Outpatient Services  
No maximum for Severe Mental Illness diagnosis (SMI)

<table>
<thead>
<tr>
<th>Service</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>25% Max: 30 days/yr</td>
<td>35% Max: 30 days/yr</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>35% Max: 30 days/yr</td>
<td>25% Max: 30 days/yr</td>
</tr>
</tbody>
</table>

## Chemical Dependency

Inpatient Services  
(Pre-certification is strongly recommended)

<table>
<thead>
<tr>
<th>Service</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>25% Max: 30 days/yr</td>
<td>35% Max: 30 days/yr</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>35% Max: 30 days/yr</td>
<td>25% Max: 30 days/yr</td>
</tr>
</tbody>
</table>

Outpatient Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>25% Max: 30 days/yr</td>
<td>35% Max: 30 days/yr</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>35% Max: 30 days/yr</td>
<td>25% Max: 30 days/yr</td>
</tr>
</tbody>
</table>

## Rehabilitative Services  
Physical, Occupational, Cardiac, Respiratory, Pulmonary & Speech Therapy

Inpatient Services  
(Pre-certification is strongly recommended)

<table>
<thead>
<tr>
<th>Service</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>25% Max: 30 days/yr</td>
<td>35% Max: 30 days/yr</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>35% Max: 30 days/yr</td>
<td>25% Max: 30 days/yr</td>
</tr>
</tbody>
</table>

Outpatient Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>25% Max: 30 days/yr</td>
<td>35% Max: 30 days/yr</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>35% Max: 30 days/yr</td>
<td>25% Max: 30 days/yr</td>
</tr>
</tbody>
</table>

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.
**Monthly Out-of-Pocket Benefit Premium Costs**

Employer Contribution for July 2012 through June 2013

<table>
<thead>
<tr>
<th>Active Employees</th>
<th>$733 (a)</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Traditional Plan</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL PLAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(rates on page 4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PacificSource Managed Care</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>BCBS Managed Care</td>
<td>$200</td>
<td>$200</td>
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<td>$200</td>
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<tr>
<td>Allegiance Managed Care</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>DENTAL PLAN</td>
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<td></td>
</tr>
<tr>
<td>(rates on page 17)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Premium</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>LIFE INSURANCE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(rates on page 22)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Life/AD&amp;D $10,000</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Basic Life/AD&amp;D $20,000</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>LONG TERM DISABILITY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(rates on page 22)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 1</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Option 2</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Option 3</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td><strong>TOTAL MANDATORY BENEFITS PREMIUM</strong></td>
<td>$733 (a)</td>
<td>$733 (a)</td>
<td>$733 (a)</td>
<td>$733 (a)</td>
</tr>
<tr>
<td>OPTIONAL (voluntary) BENEFITS - Pre tax</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VISION PLAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(rates on page 26)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUPPLEMENTAL ADD&amp;D</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(rates on page 24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FLEXIBLE SPENDING ACCOUNT (FSA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>$2.50 +</td>
<td>$2.50 +</td>
<td>$2.50 +</td>
<td>$2.50 +</td>
</tr>
<tr>
<td>Dependent</td>
<td>$2.50 +</td>
<td>$2.50 +</td>
<td>$2.50 +</td>
<td>$2.50 +</td>
</tr>
<tr>
<td><strong>TOTAL OPTIONAL BENEFITS PREMIUM (Pre-Tax)</strong></td>
<td>$2.50 +</td>
<td>$2.50 +</td>
<td>$2.50 +</td>
<td>$2.50 +</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Traditional Plan</th>
<th>Traditional Plan</th>
<th>Managed Care</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANDATORY BENEFITS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter amount from line (f)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPTIONAL BENEFITS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter amount from line (m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL BENEFITS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add lines (l) and (m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMPLOYER CONTRIBUTION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount from line (a)</td>
<td>$733 (o)</td>
<td>$733 (o)</td>
<td>$733 (o)</td>
<td>$733 (o)</td>
</tr>
<tr>
<td>TOTAL MONTHLY OUT-OF-POCKET COST (Pre-Tax)</td>
<td>$733 (o)</td>
<td>$733 (o)</td>
<td>$733 (o)</td>
<td>$733 (o)</td>
</tr>
<tr>
<td>SUPPLEMENTAL LIFE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(rates on page 23)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEPENDENT LIFE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(rates on page 23)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OPTIONAL BENEFITS</strong> (Post-Tax)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add lines p,q and r</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medical Plan Costs</th>
<th>Traditional Plan In-Network</th>
<th>Traditional Plan Out-of-Network*</th>
<th>Managed Care In-Network</th>
<th>Managed Care Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$1,000/Person</td>
<td>$1,000/Person</td>
<td>$500/Person</td>
<td>Separate $750/Person</td>
</tr>
<tr>
<td></td>
<td>$2,250/Family</td>
<td>$2,250/Family</td>
<td>$1,000/Family</td>
<td>Separate $1,750/Family</td>
</tr>
<tr>
<td>Coinsurance Percentages</td>
<td>25%</td>
<td>35%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Coinsurance Maximum</td>
<td>$5,000/Person</td>
<td>$5,000/Person</td>
<td>$2,500/Person</td>
<td>Separate $4,250/Person</td>
</tr>
<tr>
<td></td>
<td>$11,250/Family</td>
<td>$11,250/Family</td>
<td>$5,000/Family</td>
<td>Separate $9,500/Family</td>
</tr>
<tr>
<td>Copayment (on outpatient visits)</td>
<td>N/A</td>
<td>N/A</td>
<td>$15 copay</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* 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.

**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.

<table>
<thead>
<tr>
<th>July 1</th>
<th>Beginning plan yr</th>
<th>more costs</th>
<th>June 30</th>
<th>End of plan yr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jane pays 100%</td>
<td>Plan pays 0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>more costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jane reaches her $5,000 coinsurance maximum. Jane has seen her 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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jane hasn’t reached her deductible yet and she visits the doctor. She pays 100% of the allowable for covered charges.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 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.

**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.

*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.

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

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

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).

Managed Care

Medical Rates for 2012-2013

<table>
<thead>
<tr>
<th></th>
<th>Traditional Plan</th>
<th>PacificSource Managed Care</th>
<th>Blue Cross Managed Care</th>
<th>Allegiance Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Premiums</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$673</td>
<td>$591</td>
<td>$575</td>
<td>$612</td>
</tr>
<tr>
<td>Employee &amp; Spouse/AD</td>
<td>$905</td>
<td>$795</td>
<td>$774</td>
<td>$823</td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>$882</td>
<td>$774</td>
<td>$754</td>
<td>$802</td>
</tr>
<tr>
<td>Employee &amp; Family</td>
<td>$1137</td>
<td>$998</td>
<td>$972</td>
<td>$1033</td>
</tr>
</tbody>
</table>

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

Important!
Verify the network status of your providers. This is an integral component of each of your plan choices.

• 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.

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.
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.

Availability of the MUS Summary Plan Description

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

- Which medical plan participants have the right to obtain a current copy of the Summary Plan Description (SPD).

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Availabil
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 or 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 less than six months or more, 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 or 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 employees 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
In-Network Hospitals Managed Care Plan

Plentywood
Polson
Ronan
Roundup
Socobey
Shilby
Sidney
Superior
Terry
Townsend
Whitefish
White Sulphur Spr

Traditional Plan

Anaconda
Big Sandy
Big Timber
Billings
Bozeman
Butte
Chester
Choteau
Columbus
Conrad
Cutbank
Dorr Lodge
Dillon
Forsyth
Fort Benton
Glasgow
Glendive
Great Falls
Hamilton
Harlowton
 Havre
Helena
Kalispell
Libby
Livingston
Malta
 Miles City
Missoula
Philipsburg
Plains
Plentywood
Polson
Red Lodge
 Ronan
Roundup
Socobey
Shilby
Sheridan
Sidney
Superior
Terry
Townsend
Whitefish
White Sulphur Springs

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.

Choices

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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
ALLEGIANCES - 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 1-800-620-1674 or 447-8747
www.bcbsmt.com

PACIFICSOURCE HEALTH PLAN - Managed Care Plan
Customer Service 406-442-6596 or 1-877-590-1596
Pre-Authorization: 406-442-6595 or 877-570-1563
www.PacificSource.com/MUS

DELTA DENTAL INSURANCE COMPANY
Customer Service 1-888-579-5717
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 1-888-527-5879
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 Service 1-800-759-8702
www.standard.com

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