choices

Annual Benefits Enrollment Workbook

2014 - 2015

Montana University System Employee Benefits

Please read the following Benefit Information..

1. Summary of Benefits and Coverage (SBC)

SBC forms can be found by visiting the following website:
www.choices.mus.edu/SBC

These forms provide the detailed coverage information required by the Patient Protection and Affordable Care Act (PPACA). If you would like a hard copy, please call toll free 877-501-1722.

2. Waiver of Health Coverage

You have the option to waive coverage with the Montana University System Employee Benefits Plan. In order to waive coverage you must sign a hard-copy enrollment form stating you are waiving coverage and submit the form to your campus Human Resources Department by your enrollment deadline. If you do not sign and submit an enrollment form confirming your intention to waive coverage, certain coverages will continue (existing employees) or default (new employees) as outlined below. **Please note there is no continuing or default coverage for Flexible Spending Accounts (FSAs).** FSAs must be actively elected each benefit year.

If you waive coverage, all of the following apply:

- You waive coverage for yourself and for all eligible dependents.
- You waive all mandatory and optional ***Choices*** coverage including Medical, Dental, Life, Accidental Death and Dismemberment (AD&D), and Long Term Disability (LTD).
- You forfeit the monthly employer contribution toward benefit coverage.
- You and your eligible children cannot re-enroll unless and until you have a qualifying event or until the next re-enrollment period.
- Your spouse cannot re-enroll unless and until they have a qualifying event.

3. Continuing Coverages for Existing Employees

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

- Existing employees default to present elections if continuing benefits in FY 2015 unless currently enrolled in the **Traditional Plan.** Those currently enrolled in the **Traditional Plan** who take no action will default to the Blue Cross Blue Shield plan with current dependent elections.
- New employees who do not enroll during the initial 30 day enrollment period default to all of the following:
  1) Employee Only Blue Cross Blue Shield
  2) Employee Only Basic Dental
  3) $15,000 Basic Life Insurance/AD&D.
  4) Long Term Disability Option 1 (60% of pay/180 day waiting period).

Important Note:

Enrollment for plan year 2014/15 is Closed Enrollment for spouses and adult dependents unless there is a qualifying event (see page 2 qualifying events). See glossary page 37 for definition of adult dependent. Children under age 26 may be added during this enrollment period.

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How *Choices* Works

This workbook is your guide to ***Choices*** – Montana University System's employee 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 booklet (Summary Plan Descriptions - see pg 39 for availability).

1. Who's Eligible

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

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

2. Temporary faculty or professional staff members scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of more than six months in a 12-month period, 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 more than six months in a 12-month period, or who actually do so regardless of schedule.

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

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

Enrolling family members

Important Note: Enrollment for plan year 2014/15 is Closed Enrollment for spouses and adult dependents unless there is a qualifying event (see page 2 qualifying events). Children under the age of 26 may be added during this enrollment period. See below for definition of terms.

If you're a **new employee**, you may enroll your family for certain benefits under ***Choices***, including Medical, Dental, Vision hardware, 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

- Adult Dependent is someone at least 18 yrs of age who does not meet the plan definition of spouse or dependent child, but does meet plan eligibility requirements as defined in the Summary Plan Description - see last page 39 for availability.

- 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 employee receives a monthly employer contribution. This amount is based on the Montana State legislature's funding 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 (included in Medical) pg 14
   Dental pg 17
   Basic Life Insurance and AD&D pg 23
   Long Term Disability pg 23

   Optional (voluntary):
   Supplemental Life Insurance pg 24
   Dependent Life Insurance pg 25
   Supplemental AD&D Insurance pg 25
   Vision hardware pg 28
   Long Term Care pg 28
   Flexible Spending Acct. pg 30

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 35 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 - *voluntarily canceling other health insurance does not constitute loss of eligibility.*

Other life events may allow limited benefit changes. All questions about the enrollment process or qualifying events should be directed to your campus Human Resources Office.

Medical (*must choose*) Choices

Choices gives you the opportunity to choose from three medical plan choices. The next two pages will help explain the medical plans and the corresponding medical rates for each plan.

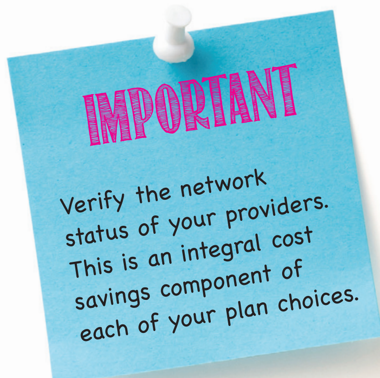
Medical Plan Choices

Allegiance, Blue Cross/Blue Shield, and PacificSource are the medical plan choices. The plans provide the same basic benefits but have differences in provider networks. Check which providers participate on the medical plan administrator's website. See back cover for website addresses.

How The Plan Works

Plan members receive medical services from a health care provider. If the provider is **in-network**, the provider submits a claim for the member. The administrator processes the claim and sends an Explanation of Benefits (EOB) to the member, showing the member's payment responsibilities (deductible, co-pay, and/or coinsurance costs) to the provider. The plan then pays the remaining allowable charges. The provider will not bill the member the difference between charge and allowable (balance billing).

If the provider is **out-of-network**, the member must verify if the provider will submit the claim or if the member must submit the claim. The administrator processes the claim and sends an EOB to the member showing the members payment responsibilities (deductible, co-insurance, and any difference between the charge and allowable (balance billing)).



Definition of Terms

In-Network Providers – Providers who have contracted with the plan to manage and deliver care at agreed upon prices. Members may self-refer to in-network providers and specialists. There are better benefits for services received **In-Network** than for services **Out-of-Network**. You pay a $15 copayment for most visits to In-Network providers (no deductible) and 25% (after deductible) for most In-Network hospital/ facility services.

Out-of-Network Providers – You pay 35% of allowable fees (after a separate deductible) for most services received Out-of-Network. Out-of-network providers can also balance bill you for any difference between their charge and the allowable charge.

Emergency services are covered everywhere. However, out-of-network providers may balance bill the difference between allowance and charge.

An **annual deductible** – the amount you pay each benefit year before the plan begins to pay.

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.

Coinsurance – a percentage of allowable fees you pay until you reach the benefit year's out-of-pocket maximum.

Out-of-Pocket Maximum - The maximum amount of money you pay toward the cost of health care services. Out-of pocket expense include deductibles, copayments, and coinsurance.

Medical Plan Rates for 2014-2015

Monthly Premiums	Allegiance Managed Care	Blue Choice Managed Care	PacificSource Managed Care
Employee Only	$607	$594	$664
Employee & Spouse\AD	$877	$858	$959
Employee & Child(ren)	$850	$832	$929
Employee & Family	$1146	$1122	$ 1254

The employer contribution for 2014-2015 is $887 per month for eligible active employees.

Schedule of Medical Benefits 2014 - 2015

Medical Plan Costs	Managed Care In-Network	Managed Care Out-of-Network *
Annual Deductible Applies to all covered services, unless otherwise noted or copayment is indicated.	$500/Person $1,000/Family	Separate $750/Person Separate $1,750/Family
Copayment (on outpatient visits)	$15 copay	N/A
Coinsurance Percentages (% of allowed charges member pays)	25%	35%
Annual out-of-pocket maximum (Maximum paid by member in a benefit year; includes deductibles, co-pay and coinsurance)	$3,500/Person $7,000/Family	Separate $6,000/Person Separate $12,000/Family

* Services from an **out-of-network** provider have a 35% coinsurance and a separate deductible and annual out-of-pocket maximum. An out-of-network provider can balance bill the difference between the allowance and the charge.

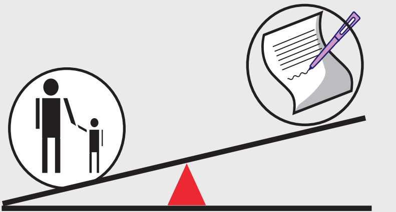
Examples of Medical costs to Plan and Member

(in-network) Jack's Plan Deductible is $500, his coinsurance is 25%, and his out-of-pocket max is $3,500.

July 1
Beginning plan yr

→ more costs → more costs

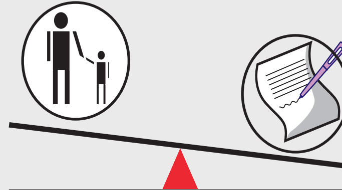
June 30
End of plan yr



Jack pays $15 office visit co-pay and 100% of allowable for lab charges

Plan pays remainder of office visit

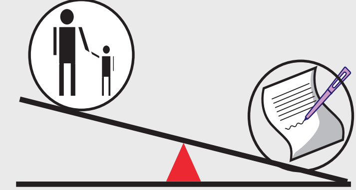
Jack hasn't reached his deductible yet and he visits the doctor and has lab work. He pays $15 for the office visit and 100% of the allowable for covered lab charges. **For example**, Jack's doctor visit totals $1,000. The office visit is $150 and labwork is $850. The plan allows $100 for the office visit and $400 for the labwork. Jack pays $15 for the office visit and $400 for the labwork. The plan pays $85 for the office visit and $0 for the labwork. The in-network provider writes off $500.



Jack pays $15 office visit co-pay and 25% of allowable for lab charges

Plan pays remainder of office visit and 75% of allowable charges

Jack has seen the doctor several times and reaches his $500 in-network deductible. His plan pays some of the costs of his next visit. He pays $15 for the office visit and 25% of the allowable cost for labwork and the plan pays the remainder of the office visit + 75% of the allowable cost. **For example,** Jack's doctor visit totals $1,000. The office visit is $150 and labwork is $850. The plan allows $100 for the office visit and $400 for the labwork. Jack pays $15 for the office visit and $100 for the labwork. The plan pays $85 for the office visit and $300 for the labwork. The in-network provider writes off $500.



Jack pays 0%

Plan pays 100% allowable charges

Jack reaches his $3,500 out-of-pocket maximum. Jack has seen his doctor often and paid $3,500 total (deductible + coinsurance + co-pays). The plan pays 100% of the allowable for covered charges for the remainder of the benefit year. **For example**, Jack's doctor visit totals $1,000. The office visit is $150 and labwork is $850. The plan allows $100 for the office visit and $400 for the labwork. Jack pays $0 and the plan pays $500. The in-network provider writes off $500.

(Out-of-network) Jack's Plan Deductible is $750, his coinsurance is 35%, and his out-of-pocket max is $6,000.

July 1
Beginning plan yr

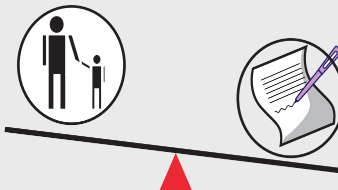
→ more costs → more costs

June 30
End of plan yr

Jack pays **100%**

Plan pays **0%**

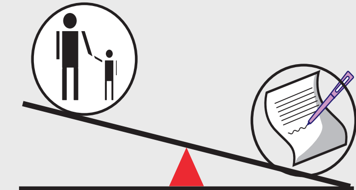
Jack hasn't reached his deductible yet and he visits the doctor. He pays 100% of the provider charge. Only allowable amounts apply to his deductible. **For example**, the provider charges $1,000. The plan allowable is $500. $500 applies to Jack's out-of-network deductible. Jack must pay the provider the full $1,000.



Jack pays 35% + any difference between provider charge and plan allowable.

Plan pays 65% of allowable

Jack has seen the doctor several times and reaches his $750 out-of-network deductible. His plan pays some of the costs of his next visit. He pays 35% of the allowable cost and any difference between the provider charge and the plan allowable. The plan pays 65% of the allowable cost. **For example**, the provider charges $1,000. The plan allowable is $500. Jack pays 35% of the allowable ($175) + the difference between the provider charge and the plan allowable ($500). Jack's total responsibility is $675. The plan pays 65% of the allowable ($325).



Jack pays any difference between provider charge and plan allowable (balance bill)

Plan pays 100% of allowable

Jack reaches his $6,000 out-of-pocket maximum. Jack has seen his doctor often and paid $6,000 total (deductible + coinsurance). The plan pays 100% of the allowable for covered charges for the remainder of the benefit year. Jack pays the difference between the provider charge and the allowable. **For example**, the provider charges $1,000. The plan allowable is $500. Jack pays $500 and the plan pays $500.

Medical Plan Services	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Hospital Inpatient Services Pre-certification of non-emergency inpatient hospitalization is strongly recommended		
Room Charges	25%	35%
Ancillary Services	25%	35%
Surgical Services (see Summary Plan Description for surgeries requiring prior authorization)	25%	35%
Hospital Services (Outpatient facility charges)		
Outpatient Services	25%	35%
Outpatient Surgi-Center	25%	35%
Physician/Professional Provider Services (not listed elsewhere)		
Office visit	$15 copay/visit	35%
Inpatient Physician Services	25%	35%
Lab/Ancillary/Miscellaneous Charges	25%	35%
Eye Exam (preventive & medical)	0% one/yr	35% one/yr
Second Surgical Opinion	$15 copay/visit for room charges only - lab, x-ray & other procedures apply deductible/coinsurance	35%
Emergency Services		
Ambulance Services for Medical Emergency	$200 copay	$200 copay
Emergency Room Facility Charges	$125 copay/visit for room charges only lab, x-ray & other procedures apply deductible/coinsurance (waived if immediately admitted to hospital)	$125 copay/visit for room charges only lab, x-ray & other procedures apply deductible/co-insurance (waived if immediately admitted to hospital)
Professional Charges	25%	25%
Urgent Care Services		
Facility/Professional Charges	$50 copay/visit for room charges only - lab, x-ray & other procedures apply deductible/coinsurance	$50 copay/visit for room charges only - lab, x-ray & other procedures apply deductible/coinsurance
Lab & Diagnostic Charges	25%	25%
Maternity Services		
Hospital Charges	25%	35%
Physician Charges (delivery & inpatient)	25% (waived if enrolled in WellBaby Program within first trimester)	35%
Prenatal Offices Visits	$15 copay/visit (waived if enrolled in WellBaby Program within first trimester)	35%

Schedule of Medical Benefits 2014 - 2015

Medical Plan Services	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Preventive Services		
Preventive screenings/ immunizations/flu shots (adult & child Wellcare) Refer to pages 10 & 11 for listing of Preventive Services covered at 100% allowable and for age recommendations	$0 copay (no deductible) limited to services listed on pg 10 & 11. Other preventive services subject to deductible and co-insurance	35%
Mental Health Services		
Inpatient Services (Pre-certification is strongly recommended)	25%	35%
Outpatient Services	First 4 visits $0 copay then $15 copay/visit	35%
Chemical Dependency		
Inpatient Services (pre-certification is strongly recommended)	25%	35%
Outpatient Services	First 4 visits $0 copay then $15 copay/visit	35%
Rehabilitative Services Physical, Occupational, Cardiac, Respiratory, Pulmonary & Speech Therapy		
Inpatient Services (Pre-certification is strongly recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr
Outpatient Services	$15 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr

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

Medical Plan Services	**In-Network Copay/Coinsurance**	**Out-of-Network Coinsurance**
Complementary Health Care Services		
Acupuncture	Members pay charges over $25/visit Max: 15 visits/yr in combination with Naturopathic	Members pay charges over $25/visit Max: 15 visits/yr in combination with Naturopathic
Naturopathic	Members pay charges over $25/visit Max: 15 visits/yr in combination with Acupuncture	Members pay charges over $25/visit Max: 15 visits/yr in combination with Acupuncture
Chiropractic	$15/visit Max: 20 visits/yr	35% Max: 20 visits/yr
Extended Care Services		
Home Health Care (Prior authorization is strongly recommended)	$15 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr
Hospice	25% Max: 6 months	35% Max: 6 months
Skilled Nursing (Prior authorization is strongly recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr
Miscellaneous Services		
Allergy Shots	$15 copay/visit	35%
Durable Medical Equipment, Prosthetic Appliances & Orthotics (Prior authorization is required for amounts greater than $2,500)	25% Max: $200 for foot orthotics	35% Max: $200 for foot orthotics

Schedule of Medical Benefits ………………….. 2014 - 2015

Medical Plan Service	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Miscellaneous Services cont.		
PKU Supplies (Includes treatment & medical foods)	0% (no deductible)	35%
Dietary/Nutritional Counseling (Prior authorization recommended)	0% (no deductible) Max: 8 visits/yr	Not covered
Obesity Management (Prior authorization required by all plans)	25% Must be enrolled in Take Control for non-surgical treatment	Not covered
TMJ (Prior authorization required)	25% Surgical treatment only	Not covered
Infertility Treatment (biological infertility only) (prior authorization required for all plans providing coverage)	25% Max: 3 artificial inseminations/ lifetime	Not covered
Organ Transplants		
Transplant Services (Prior authorization required)	25%	Not covered
Travel		
Travel for patient only (if services are not available in local community)	0% up to $1,500/yr. with Prior authorization -up to $5,000/yr. in conjunction with transplants only with Prior authorization	Not covered
Get Healthy, Stay Healthy		
Preventive Health Screenings/ Healthy Lifestyle Ed. & Support/ Emotional & Financial Wellness	see pg 12	
Take Control	see pg 13	
Tobacco Cessation, Diabetes, Weight Loss, High Cholesterol, High Blood Pressure		
WellBaby		
Infusion Therapy		

Preventive Services

1. What Services are Preventive

All MUS health options provide preventive care coverage that complies with the federal health care reform law, 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/acip/index.html
CDC: www.cdc.gov/
Bright Future: www.brightfutures.org/
Secretary Advisory Committee: www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/

2. Important Tips

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

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

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

See next page for listing of covered Preventive Services.

Covered Preventive Services

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

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	• Pregnant Women
Bacteriuria Screening	• 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	• 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	• Adults with high blood pressure
HIV Screening	• Pregnant women and others 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) **Influenza and Zoster (Shingles) vaccinations are reimbursed at 100% via the URx Pharmacy benefit.** **If needed, see immunization schedules on CDC website (previous page)**	

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. For more detailed information about your Wellness Program please refer to the Wellness book.

Preventive Health Screenings

WellCheck

Every campus offers health screenings for plan members called WellChecks. A free basic blood panel and biometric screening are provided at WellCheck, with optional additional tests available at discounted prices. Representatives from MUS Wellness are also present at most WellChecks to answer wellness-related questions. Adult plan members are eligible for two free WellChecks per plan year. Go to www.wellness.mus.edu/WellCheck for more information regarding WellCheck dates and times on your campus.

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. Go to www.wellness.mus.edu for more information.

SOCIAL MEDIA

Like us on facebook: www.facebook.com/MUSwellness

For education and Monthly Challenges visit our Blog: www.montanamovesandmeals.com

Check out our Pinterest Page: www.pinterest.com/montanameals

Follow us on Twitter: twitter.com
@montanamoves
@montanameals

Healthy Lifestyle Education & Support

Ask an Expert

This program provides FREE telephone consultation with a registered dietitian and/or exercise specialist. See Wellness website below for an application.

Quick Help Program

If you have a quick question regarding health, fitness, or nutrition related topics, send us an email at: wellness@montana.edu. We'll do our best to provide the information you need, or point you in the right direction if we don't have an answer ourselves!

The information given through the Quick Help Program does not provide medical advice, it is intended for general educational purposes only, and does not always address individual circumstances.

Emotional Wellness

Confidential Counseling

Each plan year you are eligible for four (4) FREE, confidential sessions with an In-Network counselor for any issues that may be causing stress or disruption. This can be for any issue, be it family, personal, work, or other. (Important: These sessions must be with an in-network counselor to be covered by the plan. To find an in-network counselor, contact your insurance administrator or visit their websites. See pg 7 for more information.)

Financial Wellness

Solid Finances Series

Solid Finances is a series of FREE financial education webinars to provide working Montanans high quality unbiased financial education opportunities. Available to anyone. Visit **www.msuextension.org/solidfinances** for more information and to view the webinar schedule.

Visit the Wellness website for more information: www.wellness.mus.edu

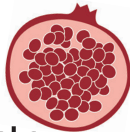
Get Healthy, Stay Healthy

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.

Plan members receive 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. To learn more about the Infusion Program call 1-800-287-8266, or contact MUS Benefits at 1-877-501-1722.

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 the Wellness website below.



Take Control Program
Eat Well. Stay Active. Reduce Your Risks.

Take Control is a healthcare company that believes that living well is within everyone's reach. They provide health coaching services free of charge to anyone covered by the Montana University System health care plan. Take Control offers comprehensive and confidential education and support for the medical conditions listed below. Their unique and convenient telephonic delivery method allows plan members to participate from work or home, and receive individual attention specific to each plan member's needs. Members with any of the following conditions may enroll:

Take Control Program Offerings:
- **Diabetes** -Type I, Type II, Pre-diabetes, or Gestational (Fasting GLUC > 125)
- **Overweight** - High Body Mass Index (BMI > 24.99)

Take Control Program Offerings Cont.
- **Tobacco User** – Smoking, chewing tobacco, cigars, pipe
- **High Blood Pressure** (Hypertension) (Systolic > 140 or Diastolic > 90)
- **High Cholesterol** (Hyperlipidemia) (CHOL > 240 or TRIG > 200 or LDL > 150 or HDL < 40M/50F)

Services Provided:
- Monthly Health Coaching
- Up to three visits with your in-network primary health care provider covered at 100%
- Fitness center or fitness class reimbursement
- Reduced-cost medication waivers for qualifying health conditions
- Assistance with tobacco cessation
- Monthly Newsletter written by Take Control staff, with healthy lifestyle topics
- Website with additional health resources

Additional benefits that can be pre-authorized by your Health Coach:
- Weight Watchers reimbursement
- Certified Exercise Specialist (Personal Trainer)
- Sleep Study
- Additional Counseling Sessions (co-pay free)

Incentives:
- A $100 reimbursement award is available after months 6 and 12 to assist in offsetting expenses related to your life style improvement.

Visit **www.wellness.mus.edu/TakeControl.asp** to complete and submit the Lifestyle Management Application form. If you are applying for the Diabetes Program, please also submit the Diabetes Questionnaire.

What our participants have to say:
"It helped keep me on track. Suggestions on nutrition were helpful in lowering my blood glucose. Keeping in touch every 30 days kept me accountable. Now I know what is expected of me and I can keep it up." – V.H.

"I am feeling so good with all the exercise and diet changes I have been able to make – more energy, less fatigue, I am sleeping better, I can climb stairs and am not short of breath." – J.S.

Wellness Website: www.wellness.mus.edu/DiseaseManagement.asp

Prescription Drug Choices

(Included in Medical plan)

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

URx is your Pharmacy Plan:

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

What is URx?
URx is a prescription drug management program developed by the Montana University System. URx uses 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, C, S $50, and S $200 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 members may have regarding 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.choices.mus.edu/urx.asp

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

Specialty Drug copays are $50 and $200.

URx Specialty Drug Program

Administered by Diplomat: 1-877-319-6337

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 $50 copay. Other specialty drugs are available through the **URx** Specialty Program with a $200 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 through Diplomat. For these prescriptions, Diplomat will transfer them to specialty pharmacies that are able to dispense these drugs.

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

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

Agents to Treat Multiple Sclerosis	
S-$50	Copaxone , Rebif(PA)
S-$200	Avonex, Betaseron, Extavia, Gilenya(PA),Aubagio (PA),Tecfidera(PA), Ampyra (PE)
Anti-Hemophilic Factors	
S-$50	All Factors including: Alphanate, Alphanine SD, Bebulin VH, Feiba/-VH, Helixate FS, Hemofil-M, Humate-P, Hyate:C, Kogenate FS, Monoclate P, Mononine, Novoseven, Recombinate, Refacto
Anti-Inflammatory (Rheumatoid Arthritis/Psoriasis)	
S-$50	Humira (PA), Enbrel (PA)
S-$200	Cimzia (PA), Enbrel (PA), gold sodium thiomalate, Myochrysine, Orencia(PA), Raptiva (PA), Remicade(PA), Stelara (PA)
Anti-Inflammatory (Anti-Arthritics)	
S-$200 all PA	Euflexxa, Orthovisc, Synvisc,Hyalgan, Supartz
Antineoplastics	
S-$50	Revlimid, Gleevec,Nexavar, Tarceva
S-$200	All antineoplastics including: Afinitor, Alkeran, Aromasin, Avastin, Bicnu, Busulfex, carboplatin, Ceenu, cisplatin, Campath, cyclophosphamide, Depocyt, Eligard, Erbitux, etoposide, Gemar, Herceptin, Iressa, Lupron/- Depot, mercaptopurine, Sprycel, Sutent, Trelstar Depot/-LA, Tykerb, Vectibix, Vumon, Xeloda, Zolinza
Growth Hormones/Insulin-Like Growth Factor Hormones	
S-$50	Norditropin (PA), Tev-Tropin (PA)
S-$200 (all PA)	Genotropin, Humatrope , Nutropin/-AQ, Omnitrope, Saizen, Serostim, Zorbtive
Hepatitis Agents	
S-$50 all PA	Copegus , Infergen, Peg-Intron, Pegasys, Rebetol, Rebetron, Roferon-A, Sovaldi
S-$200 all PA	Intron-A (PA), Incivek, Olysio, Victrelis
Immunosuppressive Agents	
S-$50	cyclosporine (oral and inj), Neoral, Gengraf, Rapamune, Sandimmune
S-$200	Simulect, Zenapax
Osteoporosis	
S-$200 (all PA)	Aredia, Boniva, Forteo , Miacalcin, pamidronate, Zometa, Reclast
Pulmonary Arterial Hypertension	
S-$200	Flolan, Letairis, Remodulin, Tyvaso, Ventavis, Tracleer, Opsumit, Adempas, Adcirca

URx Drug Classification

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

URx Drug Classification (Based on medical evidence of impact to health and overall net cost)	Drug Class	Deductible	Retail Rx (30-day supply)	Mail Rx (90-day supply)
Excellent level of value based on best medical evidence, best opportunity for improved health outcomes via disease management, and best overall net cost.	Tier A	$0	$0 Copayment †	$0 Copayment †
High level of value based on medical evidence of outcomes and lower overall net cost savings. Includes generic and brand drugs compared to higher cost brand name counterparts.	Tier B	$0	$15 Copayment †	$30 Copayment †
Good level of value based on fair medical evidence grading, but displaying higher overall net cost relative to generic counterparts and less expensive brand name drug or clinical alternatives.	Tier C	$0	$40 Copayment †	$80 Copayment †
Lower level of value based on evidence of outcomes relative to other clinical alternatives. Generally have much higher overall net costs. *[Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most drugs purchased through URx.]*	Tier D	$0	50% Coinsurance †* (You will pay half of the discounted price)	50% Coinsurance †* (You will pay half of the discounted price)
These drugs have the lowest level of value (based on clinical evidence) or the highest overall net cost in relation to generic or other brand alternatives. Tier F drugs may also include drugs that were not previously covered, allowing members to purchase them at a substantial discount. *[Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most.]*	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 $50 or $200 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.	Tier S	$0	50% Coinsurance †* if purchased through standard retail pharmacy	Not Covered

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

† A copayment is a flat dollar amount you pay for Rx services. Coinsurance is a percentage of the total discounted cost you pay for Rx services.

Interesting Facts:
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 a lot of money! Currently the Montana University System Employee Benefits Plan spends more on prescription drugs than on doctor visits.

How do I determine what my drug tier is?
You can look up which tier your drug is at **www.choices.mus.edu/urx.asp** or by calling Montana University System Employee Benefits at 1-877-501-1722. If you are unsatisfied with the tier 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 Employee Benefits Plan.

Dental *(must choose)* Choices

Because dental coverage is an annual required benefit choice, you can choose from two options: **Basic Plan** and **Select 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	Select Plan - Enhanced Coverage
Who May be Enrolled & Monthly Rates	• Employee Only $16 • Employee & Spouse/Adult Dep. $31 • Employee & Child(ren) $31 • Employee & Family $43	• Employee Only $42 • Employee & Spouse/Adult Dep. $80 • Employee & Child(ren) $80 • Employee & Family $113
Maximum Annual Benefit	**$750 per covered individual**	**$1,500 per covered individual**
Preventive and Diagnostic Services	• Twice Per Benefit Year • Initial and Periodic oral exam • Cleaning • Complete series of intraoral X-rays	• Twice Per Benefit Year • Initial and Periodic oral exam • Cleaning • Complete series of intraoral X-rays **Note:** the above services do not count towards the $1,500 annual maximum and include the Diagnostic & Preventive (D&P) Maximum Waiver feature. See below
Basic Restorative Services	• Not covered	• Amalgam filling • Endodontic treatment • Periodontic treatment • Oral surgery
Major Dental Services	• Not covered	• Crown • Root canal • Complete lower and upper denture • Dental implant • Occlusal guards
Removal of impacted teeth	• Not covered	• Covered benefit

Select Plan Benefit Highlight Features:

Diagnostic & Preventive Maximum Waiver Benefit
The Choices Select Plan includes the D&P Maximum waiver benefit allowing MUS plan members to obtain diagnostic & preventive services without those costs applying to the annual $1,500 maximum.

Orthodontic Benefits
The ***Choices*** Select 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 (the dental plan administrator) will establish a monthly reimbursement based on your provider's monthly fee and your prescribed treatment plan.

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

Delta Dental Fee examples

How to select a Delta Dental Dentist that will best suit your needs and your pocket book! Understand the difference between a PPO and Premier Dentist.

Finding a Delta Dental Dentist:

The MUS dental program utilizes schedules of benefits so you know in advance exactly how much the plan will pay for each covered service. It is important to understand that a dentist's charges may be greater than the plan benefit, resulting in balance billing to you. While you have the freedom of choice to visit any licensed dentist under the plan, you may want to consider visiting a Delta Dental dentist to reduce your out of pocket costs.

When a dentist contracts with Delta Dental, they agree to accept Delta Dental's allowed fee as full payment. This allowed fee may be greater than the MUS plan benefit in which case, the dentist may balance bill you up to the difference between the allowed fee and the MUS benefit amount.

Montana University System plan members will usually save when they visit a Delta Dental dentist. Delta Dental Preferred Provider Organization (PPO) dentists agree to lower levels of allowed fees and therefore offer the most savings. Delta Dental Premier dentists also agree to a set level of allowed fees, but not as low as with a PPO dentist. Therefore, when visiting a Premier dentist, MUS members usually see some savings, just not as much as with a PPO dentist. The best way to understand the difference in fees is to view the examples below. Then go to: www.deltadentalins.com/MUS and use the *Find a Dentist* search to help you select a dentist that is best for you!

The following claim examples for an adult cleaning demonstrate how lower out-of-pocket patient costs can be achieved when you visit a Delta Dental dentist (**Basic** and Select Plan coverage). The examples compare the patient's share of costs at each network level below:

Adult Cleaning	PPO Dentist	Premier Dentist	Out-of-Network Dentist
What the Dentist Bills	$87	$87	$87
Dentists allowed fee with Delta Dental	$57	$71	No fee agreement with Delta Dental
MUS Plan Benefit allowed amount	$83	$83	$83
What you pay	$0	$0	$4

The following claim examples for a crown demonstrate how lower out-of-pocket patient costs can be achieved when you visit a Delta Dental dentist (**Basic** and Select Plan coverage). The examples compare the patient's share of costs at each network level below:

Crown	PPO Dentist	Premier Dentist	Out-of-Network Dentist
What the Dentist Bills	$1,000	$1,000	$1,000
Dentists allowed fee with Delta Dental	$694	$822	No fee agreement with Delta Dental
MUS Plan Benefit allowed amount	$423	$423	$423
What you pay	$271	$399	$577

Dental Codes

Dental claims are reimbursed based on a Schedule of Benefits. The following subsets of the **Select** 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 and preventive. The Schedule's 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's reimbursement amount.

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

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

.... Dental Codes Schedule of Benefits

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

Dental Codes Schedule of Benefits ....

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

Dental Codes Schedule of Benefits

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

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

The 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 MUS-Delta Dental contract and Delta Dental processing policies. These allowances may be further reduced due to maximums, limitations, and exclusions. Please refer to the SPD for complete information.

Life Insurance/AD&D & Long Term Disability

(must choose)

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

Basic Life/AD&D Insurance:

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

Who is Eligible:
An employee may increase one level of coverage during annual benefit enrollment, if eligible and in an active work status.

Basic Life/AD&D Monthly Premiums		
Basic Life/AD&D	$15,000	$ 1.49 for both
Basic Life/AD&D	$30,000	$2.97 for both
Basic Life/AD&D	$48,000	$4.75 for both
If you are enrolling in *Choices* you must select a Basic Life Insurance		

Long Term Disability (LTD):

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

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

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

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

Who May Enroll:
Employee Only

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

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

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

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

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

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

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

Supplemental Life Insurance *(voluntary)*

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

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 (up to $300,000) 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. Elections above $300,000 will always require evidence of good health.

Optional Supplemental Life Monthly Premium (after tax) -Employee Benefit

Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000	$225,000	$250,000	$275,000	$300,000
under 30	$ 1.15	$ 2.30	$ 3.45	$ 4.60	$ 5.75	$ 6.90	$ 8.05	$ 9.20	$ 10.35	$ 11.50	$ 12.65	$ 13.80
30-34	$ 1.60	$ 3.20	$ 4.80	$ 6.40	$ 8.00	$ 9.60	$ 11.20	$ 12.80	$ 14.40	$ 16.00	$ 17.60	$ 19.20
35-39	$ 1.80	$ 3.60	$ 5.40	$ 7.20	$ 9.00	$ 10.80	$ 12.60	$ 14.40	$ 16.20	$ 18.00	$ 19.80	$ 21.60
40-44	$ 2.48	$ 4.95	$ 7.43	$ 9.90	$ 12.38	$ 14.85	$ 17.33	$ 19.80	$ 22.28	$ 24.75	$ 27.23	$ 29.70
45-49	$ 4.25	$ 8.50	$ 12.75	$ 17.00	$ 21.25	$ 25.50	$ 29.75	$ 34.00	$ 38.25	$ 42.50	$ 46.75	$ 51.00
50-54	$ 6.43	$ 12.85	$ 19.28	$ 25.70	$ 32.13	$ 38.55	$ 44.98	$ 51.40	$ 57.83	$ 64.25	$ 70.68	$ 77.10
55-59	$ 10.75	$ 21.50	$ 32.25	$ 43.00	$ 53.75	$ 64.50	$ 75.25	$ 86.00	$ 96.75	$ 107.50	$ 118.25	$ 129.00
60-64	$ 13.20	$ 26.40	$ 39.60	$ 52.80	$ 66.00	$ 79.20	$ 92.40	$ 105.60	$ 118.80	$ 132.00	$ 145.20	$ 158.40
65-69	$ 26.00	$ 52.00	$ 78.00	$ 104.00	$ 130.00	$ 156.00	$ 182.00	$ 208.00	$ 234.00	$ 260.00	$ 286.00	$ 312.00
over 70	$ 60.00	$ 120.00	$ 180.00	$ 240.00	$ 300.00	$ 360.00	$ 420.00	$ 480.00	$ 540.00	$ 600.00	$ 660.00	$ 720.00

Age	$ 325,000	$ 350,000	$ 375,000	$ 400,000	$ 425,000	$ 450,000	$ 475,000	$ 500,000	$ 525,000	$ 550,000	$ 575,000	$ 600,000
under 30	$ 14.95	$ 16.10	$ 17.25	$ 18.40	$ 19.55	$ 20.70	$ 21.85	$ 23.00	$ 24.15	$ 25.30	$ 26.45	$ 27.60
30-34	$ 20.80	$ 22.40	$ 24.00	$ 25.60	$ 27.20	$ 28.80	$ 30.40	$ 32.00	$ 33.60	$ 35.20	$ 36.80	$ 38.40
35-39	$ 23.40	$ 25.20	$ 27.00	$ 28.80	$ 30.60	$ 32.40	$ 34.20	$ 36.00	$ 37.80	$ 39.60	$ 41.40	$ 43.20
40-44	$ 32.18	$ 34.65	$ 37.13	$ 39.60	$ 42.08	$ 44.55	$ 47.03	$ 49.50	$ 51.98	$ 54.45	$ 56.93	$ 59.40
45-49	$ 55.25	$ 59.50	$ 63.75	$ 68.00	$ 72.25	$ 76.50	$ 80.75	$ 85.00	$ 89.25	$ 93.50	$ 97.75	$ 102.00
50-54	$ 83.53	$ 89.95	$ 96.38	$ 102.80	$ 109.23	$ 115.65	$ 122.08	$ 128.50	$ 134.93	$ 141.35	$ 147.78	$ 154.20
55-59	$ 139.75	$ 150.50	$ 161.25	$ 172.00	$ 182.75	$ 193.50	$ 204.25	$ 215.00	$ 225.75	$ 236.50	$ 247.25	$ 258.00
60-64	$ 171.60	$ 184.80	$ 198.00	$ 211.20	$ 224.40	$ 237.60	$ 250.80	$ 264.00	$ 277.20	$ 290.40	$ 303.60	$ 316.80
65-69	$ 338.00	$ 364.00	$ 390.00	$ 416.00	$ 442.00	$ 468.00	$ 494.00	$ 520.00	$ 546.00	$ 572.00	$ 598.00	$ 624.00
over 70	$ 780.00	$ 840.00	$ 900.00	$ 960.00	$ 1,020.00	$ 1,080.00	$ 1,140.00	$ 1,200.00	$ 1,260.00	$ 1,320.00	$ 1,380.00	$ 1,440.00

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Optional Supplemental Dependent Life Insurance eligibility:

Your spouse and unmarried child(ren) from live birth to age 26. 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. You must enroll in employee supplemental life to be eligible for spouse or child/ren supplemental life elections.

Other than new employees, you may increase one level of coverage for child/ren without evidence of good health. Evidence of good health is always required for spouse elections over $50,000. Spouse elections cannot exceed 50% of the employee election (i.e., employee elects $100,000 for self, spouse maximum is $50,000).

Optional Supplemental Life Monthly Premium (after tax) -Spouse Benefit
Based on age of spouse as of July 1

Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000	$225,000	$250,000	$275,000	$300,000
under 30	$ 1.15	$ 2.30	$ 3.45	$ 4.60	$ 5.75	$ 6.90	$ 8.05	$ 9.20	$ 10.35	$ 11.50	$ 12.65	$ 13.80
30-34	$ 1.60	$ 3.20	$ 4.80	$ 6.40	$ 8.00	$ 9.60	$ 11.20	$ 12.80	$ 14.40	$ 16.00	$ 17.60	$ 19.20
35-39	$ 1.80	$ 3.60	$ 5.40	$ 7.20	$ 9.00	$ 10.80	$ 12.60	$ 14.40	$ 16.20	$ 18.00	$ 19.80	$ 21.60
40-44	$ 2.48	$ 4.95	$ 7.43	$ 9.90	$ 12.38	$ 14.85	$ 17.33	$ 19.80	$ 22.28	$ 24.75	$ 27.23	$ 29.70
45-49	$ 4.25	$ 8.50	$ 12.75	$ 17.00	$ 21.25	$ 25.50	$ 29.75	$ 34.00	$ 38.25	$ 42.50	$ 46.75	$ 51.00
50-54	$ 6.43	$ 12.85	$ 19.28	$ 25.70	$ 32.13	$ 38.55	$ 44.98	$ 51.40	$ 57.83	$ 64.25	$ 70.68	$ 77.10
55-59	$ 10.75	$ 21.50	$ 32.25	$ 43.00	$ 53.75	$ 64.50	$ 75.25	$ 86.00	$ 96.75	$ 107.50	$ 118.25	$ 129.00
60-64	$ 13.20	$ 26.40	$ 39.60	$ 52.80	$ 66.00	$ 79.20	$ 92.40	$ 105.60	$ 118.80	$ 132.00	$ 145.20	$ 158.40
65-69	$ 26.00	$ 52.00	$ 78.00	$ 104.00	$ 130.00	$ 156.00	$ 182.00	$ 208.00	$ 234.00	$ 260.00	$ 286.00	$ 312.00
over 70	$ 60.00	$ 120.00	$ 180.00	$ 240.00	$ 300.00	$ 360.00	$ 420.00	$ 480.00	$ 540.00	$ 600.00	$ 660.00	$ 720.00

Optional Supplemental Life Monthly Premium (after tax) -Child Benefit

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
to age 26	$ 0.50	$ 1.00	$ 1.50	$ 2.00	$ 2.50	$ 3.00

Supplemental AD&D Coverage *(voluntary)*

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

Optional AD&D Insurance eligibility:

This is an employee only benefit. If you enroll for Optional AD&D 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.

You may elect any AD&D amount in increments of $25,000.

Optional Supplemental AD&D Monthly Premium (after tax) -Employee Benefit

Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000	$225,000	$250,000	$275,000	$300,000
All Adults	$ 0.50	$ 1.00	$ 1.50	$ 2.00	$ 2.50	$ 3.00	$ 3.50	$ 4.00	$ 4.50	$ 5.00	$ 5.50	$ 6.00

Age	$ 325,000	$ 350,000	$ 375,000	$ 400,000	$ 425,000	$ 450,000	$ 475,000	$ 500,000	$ 525,000	$ 550,000	$ 575,000	$ 600,000
All Adults	$ 6.50	$ 7.00	$ 7.50	$ 8.00	$ 8.50	$ 9.00	$ 9.50	$ 10.00	$ 10.50	$ 11.00	$ 11.50	$ 12.00

Optional Dependent AD&D Insurance eligibility:

Your spouse and unmarried child(ren) from live birth to age 26. Optional Dependent AD&D Insurance is designed to protect you against certain financial burdens in the event a covered dependent dies of an accidental death. 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. You must enroll in employee optional AD&D in order to elect AD&D for dependents.

You may elect any amount for your spouse in $25,000 increments and any amount for your children in $5,000 increments.

Optional Supplemental AD&D Monthly Premium (after tax) -Spouse Benefit

Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000	$225,000	$250,000	$275,000	$300,000
All Adults	$ 0.50	$ 1.00	$ 1.50	$ 2.00	$ 2.50	$ 3.00	$ 3.50	$ 4.00	$ 4.50	$ 5.00	$ 5.50	$ 6.00

Optional Supplemental AD&D Monthly Premium (after tax) -Child Benefit

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
to age 26	$ 0.05	$ 0.10	$ 0.15	$ 0.20	$ 0.25	$ 0.30

Long Term Care Insurance *(voluntary)*

Provided by UNUM Life Insurance Co.

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

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

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

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

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

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

Vision hardware *(voluntary)*

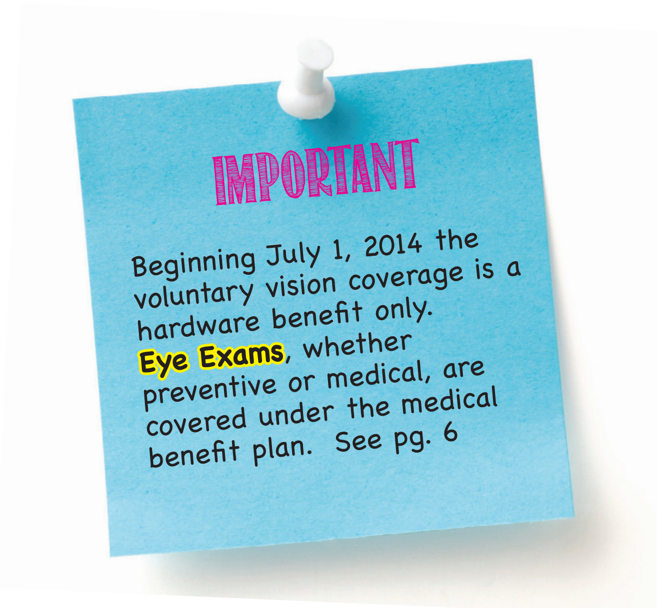
Administered by Blue Cross Blue Shield:

Customer Service 1-800-820-1674 or 447-8747
www.bcbsmt.com

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 Vision Hardware Benefit
Quality vision care is important to your eye wellness and overall health care. Accessing your Vision Hardware benefit is easy. Simply select your provider, purchase your hardware and submit to Blue Cross Blue Shield (BCBS) for processing.



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Vision hardware *(voluntary)* cont.

Monthly Vision Hardware Rates	
• Employee Only	$7.11
• Employee & Spouse/Adult Dep.	$13.42
• Employee & Child(ren)	$14.13
• Employee & Family	$20.73

Note: Beginning July 1, 2014 the voluntary vision coverage is a hardware benefit only. Eye Exams, whether preventive or medical, are covered under the medical benefit plan. See pg. 6

Service/Material	Coverage
Frames: Once every two years	$175 allowance
Single Vision Bifocal Trifocal Standard Progressives Once every benefit year in lieu of contacts	$5 copay $5 copay $5 copay $25 copay
Lens Options: UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard A/R	 $5 copay $5 copay $5 copay $20 copay $25 copay
Contact Lens Materials: Conventional & Disposable *Medically Necessary Once every benefit year in lieu of eyeglass lenses	 $150 allowance $150 allowance paid in full
Contact Lens Exam Fees: Standard Contact Lens Fit & Follow-up Premium Contact Lens Fit & Follow-up Once every benefit year	 $5 copay, paid in full fit and two follow up visits $5 copay

* 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.

Flexible Spending Account *(voluntary)*

Great News! This year, flexible spending account administrative fees will again be paid by MUS!

Administered by Allegiance Benefit Plan Management, Inc.

1-877-778-8600 - www.askallegiance.com

Account Types	Annual Amount	Qualifying Expense Examples
Medical FSAs	Minimum Contributions: $120 Maximum Contributions: $2,500	Medical expenses including deductibles, co-insurance, co-pays, Rx expenses, chiropractic and naturopathic care. All dental and vision expenses that are not considered cosmetic.
FSA for WellCheck program	Minimum Award: $250 Maximum Award: $500	Same as Medical FSA Qualifying Expenses above.
Dependent Care FSAs	Minimum Contribution: $120 Maximum Contribution: $5,000	Costs for care provided to your child(ren) under age 13, or other dependents unable to care for themselves, and necessary for you to remain gainfully employed.
Adoption Assistance (Maximum listed is a lifetime maximum)	Minimum Contribution: $120 Maximum Contribution: $13,190	Adoption fees, court costs, attorney fees, medical examination costs, and related travel expenses.

Health Flex Spending Account (FSA)

During the annual enrollment period, you may elect amounts to be withheld from your earnings to pay for your out-of-pocket medical expenses. Eligible health FSA expenses include those defined by IRS Code, Section 213(d). For a list of examples, go to www.askallegiance.com

The amount you elect to set aside for Health FSA expenses is not subject to federal income, state income, or Social Security/Medicare taxes.

Your health FSA election will reimburse you for eligible expenses that you, your spouse, and your qualified dependents incur during the plan year. The entire annual amount you elect can be used at any time during the plan year.

You can request reimbursement on-line, by toll-free fax, or through the mail. If the expense may be covered through your health coverage, please provide the coverage explanation of benefits as documentation. If coverage will not consider the expense, an itemized statement from the provider will satisfy documentation requirements.

Some expenses are considered to be “dual purpose.” These expenses are for items or services that are sometimes for purposes other than to treat a medical condition. In order to be reimbursed for a “dual purpose” expense, or over the counter drugs and medicines, a diagnosis and recommendation for treatment from a medical professional is required.

If you or your spouse contribute to a Health Savings Account (HSA), you are not eligible to participate in a general purpose health FSA.

You can access a tax savings calculator for accurate savings estimates under Tax Calculators on the Allegiance flex website www.askallegiance.com.

FSA for WellCheck program

Individual contributions to FSA accounts will be funded by the MUS on July 1, 2014, for qualifying employees based on WellCheck completion in fall 2013 and spring 2014, as outlined below.

- $250 for the active employee plan member who completes a WellCheck
- An additional $250 for any adult dependent age 18 or older enrolled in the plan (spouse, domestic partner, or adult child) who also completes a WellCheck
- The total amount, per household, cannot exceed $500.
- Effective July 1 you will have access to the money in your FSA account (see health FSA information) to pay for qualified medical expenses in accordance with plan rules.
- If your spouse has a Health Savings Account (HSA) you may elect a Limited Purpose FSA for dental and vision reimbursements. Call Allegiance for information on how to elect a Limited Purpose FSA.

Continued on next page

Important:

- Left-over employer contributions can be deposited in a medical flex account only
- You must re-enroll each year to participate in a Flexible Spending Account (NOT automatic!)
- All claims must be received by Allegiance by September 30, 2015 to be eligible for reimbursement

Dependent Care
If both you and your spouse work or you are a single parent, you may have dependent care expenses. The Federal Child Care Tax Credit is available to taxpayers to help offset dependent care expenses. A dependent care FSA often gives employees a better tax benefit. You can complete a worksheet that compares the Federal Child Care Tax Credit to the dependent care FSA by clicking on Tax Calculators on the Allegiance flex website.

Your dependent care FSA lets you use “before-tax” dollars to pay care expenses for children under age 13, or individuals unable to care for themselves. A dependent receiving care must live in your home at least eight (8) hours per day. The care must be necessary for you and your spouse to remain gainfully employed. Care may be provided through live-in care, baby sitters, and licensed day care centers. You cannot use “before-tax” dollars to pay your spouse or one of your children under the age of nineteen (19) for providing care. Schooling expenses at the kindergarten level and above are not reimbursable. Neither overnight camp nor nursing home care is reimbursable.

Unlike health FSAs, dependent care FSAs may only reimburse expenses up to the amount you have contributed at any time during the year.

$500 Rollover from one plan year to the next
When you enroll in the flexible spending accounts, you are electing to participate for the entire plan year. Be sure not to elect more than you will need to cover expenses incurred by you and/or your family members during the plan year. Under the “use-or-lose” rule, any money not used by the end of the plan year cannot be returned to you. However, the IRS recently modified the “use-or-lose” rules to allow $500 to rollover from one plan year to the next. This means that up to $500 from this plan election can be rolled over to the FY16 plan year that begins July 1, 2015. In addition, no changes to your election may be made during the plan year unless you experience a “qualifying event.”

Mid-Year Election Changes
Mid-year election changes must be made within 63 days of a qualifying event. Changes are limited and differ for each pre-tax option. Changes must be consistent with the change in status. For more information about mid-year election changes, please contact your campus Human Resources Department or Allegiance.

Reimbursement
You may mail, fax toll-free, or scan and send claims electronically at www.askallegiance.com.

Check Payment: Allegiance authorizes reimbursement and prints checks each business day. Claims are normally processed within five business days of receipt. You usually have a check in your mailbox within a week after Allegiance receives your claim.

Direct Deposit: Send in the Direct Deposit form with a voided check, or sign up online at www.askallegiance.com and Allegiance will electronically deposit reimbursements directly into your checking account.

Debit Card: Your employer offers debit cards as part of the Flex Plan at a cost of $10.00 per year. That fee will be paid by MUS for the July 1, 2014-June 30, 2015 plan year. You may use the debit card to pay for medical and/or dependent care expenses. Documentation for the expense may be required, and should be saved for all debit card transactions.

Claims for eligible expenses that were incurred during the plan year (July 1, 2014 - June 30, 2015) must be received by Allegiance by September 30, 2015, to be eligible for reimbursement. If you terminate employment during the plan year, your participation in the plan ends, subject to COBRA limitations. However, you still may submit claims through September 30, 2015, if the claims were incurred during your period of employment, and during the plan year.

Questions

Customer Service Representatives are available to answer questions each business day between 7:00 a.m. and 6:00 p.m. Mountain time. After hours, and on weekends, you can access your account information online or through the toll-free automated voice-response system.
Call toll free at 1-877-778-8600.

Directors Note

Dear Montana University System Employees and Family Members:

Recent years have been very eventful in the health care world. During the last year you have been inundated with all kinds of information and stories about health care in the media. For most of us it is hard to know what is fact and what is "spin" and how that relates to our health and our families.

We are fortunate because we have access to health care coverage and other benefits by virtue of our employment relationship through the Montana University System. We cover over 18,000 people for services including medical, pharmacy, dental, vision, life insurance, long-term care and disability coverage, and provide the ability to put money aside to pay for health care and child care on a pre-tax basis.

The good news is that those programs and benefits continue and we are able to manage them within the challenging environment of health care change. **We continue to be focused on ways to empower members to maintain and improve their health and quality of life**. Here are a few of the ways we are doing so:

- ***WellCheck Wellness Incentive*** In our upcoming benefit year, we are rewarding members who utilize our WellChecks to learn about and monitor their health. We will provide $250 for plan members who participated in a WellCheck in fall of 2013 or spring of 2014 (up to a maximum of $500 for a household). These funds will be in a flexible spending account and can be used to pay for eligible out-of-pocket costs for medical expenses. If you are willing to do the work to learn about and manage your health, and attend a MUS WellCheck, we can help to reduce your out-of-pocket costs for health care.

- ***Transparency in Health Care Purchasing*** One of the biggest problems in the health care system is the lack of transparency in health care costs and purchasing. I expect that very few of us know how to find out the cost of a health care service before it is billed and comes to us on an Explanation of Benefits. That lack removes any ability for us to function as informed consumers and shop for quality and price in health care. We recently went through a bid process for our medical vendor services and as a result many of our members will have access to new pricing and transparency tools where they can begin to learn about and compare prices and quality for health care.

- ***Facilitating Choice and Access to Other Programs*** When employees transition to retirement, one of the biggest concerns and financial burdens is planning for health care costs among both pre-65 and Medicare eligible retirees. To help, we have looked at innovative ways to coordinate with other programs that may provide significant financial advantages to retirees who chose these options. For our Medicare retirees, we provide a *Medicare Advantage Plan* option through New West Health Services. For our non-Medicare retirees, we developed a process to permit people to try the new *HealthCare Marketplace* in Montana. By permitting retirees to try these programs and then have the ability to come back to the MUS benefit plan under the criteria in a Retreat Right, we provide the security of knowing they are always covered.

Please plan to attend a benefits presentation in your area and learn about your benefits. Stay tuned throughout the year as we continue to inform you about new programs and services available to you and your family!

• • • • • • • • • • • • • • • • *Connie Welsh, MUS Benefits Director*

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.

★ 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.

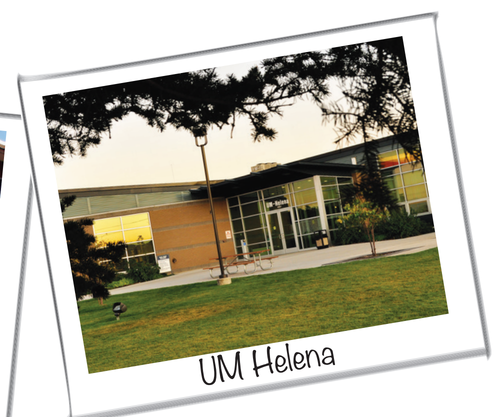
The Self Audit Award Program is available to all plan members who identify medical billing errors which:

- 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, and
- Have copies of the correct billing sent to the claims administrator for verification, claims adjustment and calculation of the self-audit award.

Great Falls College



UM Helena

Resources

35....Medical Spending Worksheet

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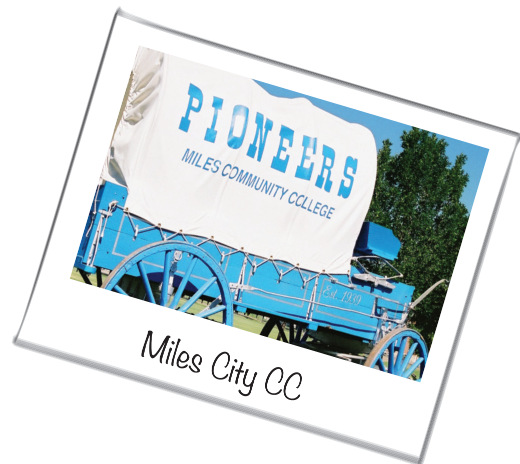
MSU Billings

MSU Northern

Flathead Valley CC



Miles City CC

Medical Spending Worksheet

Monthly Out-of-Pocket Benefit Premium Costs

Active Employees Employer Contribution for July 2014 through June 2015		$ 887	(a)
MANDATORY (must choose) BENEFITS (unless you waive all benefits)			
MEDICAL PLAN (rates on page 4)	Allegiance Managed Care	$ ______	(b)
	BCBS Managed Care	$ ______	(b)
	PacificSource Managed Care	$ ______	(b)
DENTAL PLAN (rates on page 17)	Basic	$ ______	(c)
	Select	$ ______	(c)
LIFE INSURANCE (rates on page 23)	Basic Life/AD&D $15,000	$ ______	(d)
	Basic Life/AD&D $30,000	$ ______	(d)
	Basic Life/AD&D $48,000	$ ______	(d)
LONG TERM DISABILITY (rates on page 23)	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 HARDWARE PLAN (rates on page 29)		$ ______	(g)
FLEXIBLE SPENDING ACCOUNT (FSA) (page 30)	Medical	$ ______	(h)
	Dependent	$ ______	(i)
TOTAL OPTIONAL BENEFITS PREMIUM (Pre-Tax)	add lines g, h, and i	$ ______	(j)

TOTAL MONTHLY OUT-OF-POCKET COSTS FOR BENEFITS JULY 2014-JUNE 2015

MANDATORY BENEFITS		Enter amount from line (f)	$ ______	(k)
OPTIONAL BENEFITS	(Pre-Tax)	Enter amount from line (j)	$ ______	(l)
TOTAL BENEFITS	(Pre-Tax)	Add lines (k) and (l)	$ ______	(m)
EMPLOYER CONTRIBUTION		Amount from line (a)	$ 887	(n)
TOTAL MONTHLY OUT-OF-POCKET COST (Pre-Tax)		Subtract line (m) from line (n)	$ ______	(o)

If line (0) is a negative amount, this is the left-over amount from state share.
If line (0) is positive, this amount is your out-of-pocket expense.
***Note:** the amount in line (0) reflects pre-tax expenses only.*

OPTIONAL (voluntary) BENEFITS (Post-tax)				
SUPPLEMENTAL LIFE (page 24 & 25)			$ ______	(p)
SUPPLEMENTAL AD&D (rates on page 26)			$	(q)
OPTIONAL BENEFITS	(Post-Tax)	Add lines (p) and (q)	$ ______	(r)

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

Privacy Rights & Plan Documents

Under a federal privacy law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 benefits provided through a fully insured health insurance policy. The Montana University System 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 pre-existing 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 this plan year. 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 Employee Group 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 MUS's control.

The Montana University System Employee Group Benefit 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. These Business Associates and health care provider(s) must also, under HIPAA, protect a plan member's personally identifiable health information from inadvertent, improper or illegal disclosure.

The Montana University System Employee Group Benefit 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) 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 without a member's written consent between MUS authorized benefit employees, their supervisors and our Business Associates, members' providers or legally authorized governmental entities.

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.

Adult Dependent

Adult Dependent is someone at least 18 yrs of age who does not meet the plan definition of spouse or dependent child, but does meet plan eligibility requirements as defined in the Summary Plan Description.

Benefit Year/Plan Year

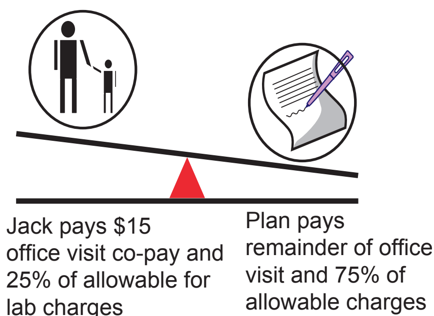
The period starting July 1 and ending June 30.

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 Jack has met his deductible for the In-Network medical costs ($500), he pays 25% of additional allowable charges and the plan pays 75%.



Copayment

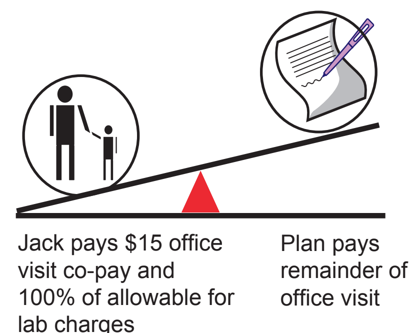
A fixed dollar amount for allowable and covered charges that a member is responsible for paying. The medical plan pays the remaining allowable charges. This type of cost-sharing method is typically used by managed care medical plans.

Covered Charges

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

Deductible

A set dollar amount that a member and family must pay before the medical plan begins to share the costs. The deductible applies to the plan July 1 through June 30. For example, Jack's deductible is $500. Jack pays 100 percent of allowable charges until his deductible has been met.



In-Network Providers

Providers who have contracted with the plan to manage and deliver care at agreed upon prices. Members may self-refer to in-network providers and specialists. There are better benefits for services received **In-Network** than for services **Out-of-Network**. You pay a $15 copayment for most visits to In-Network providers (no deductible) and 25% (after deductible) for most In-Network hospital/facility services.

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Managed Care Medical Plan

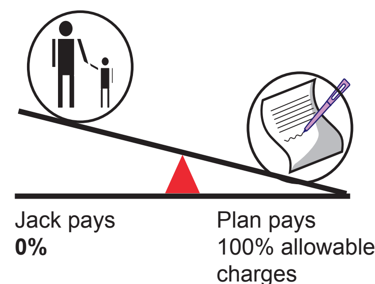
Plans that offer first dollar coverage for services such as office visits that are exempt from deductible. These plans also provide differing levels of benefits for in-network and out-of-network providers.

Out-of-Network Provider

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

Out-of-pocket Maximum

The maximum amount of money you pay toward the cost of health care services. Out-of pocket expense include deductibles, copayments, and coinsurance. For example, Jack reaches his $3,500 out-of-pocket maximum. Jack has seen his doctor often and paid $3,500 total (deductible + coinsurance + co-pays). The plan pays 100% of the allowable for covered charges for the remainder of the benefit year.



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.

PPACA

The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will continue to be rolled out through 2018.

URx

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

Availability of the MUS Summary Plan Description

All Montana University System (MUS) plan participants have the right to obtain a current copy of the Summary Plan Description (SPD). Despite the use of "summary" in the title, this document is the full legal description of the Plan's 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.choices.mus.edu. Using the FIND function on your computer will help you to locate the section you need quickly.

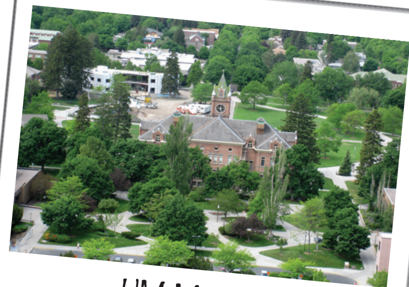
All participants are given or mailed a copy of the ***CHOICES*** Annual Benefits Enrollment Workbook or Retiree Workbook each spring during the annual enrollment period. These workbooks list the various required and optional programs available, and their premiums. We encourage participants to retain 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.

Don't Forget:

Summary of Benefits and Coverage (SBC) forms can be found by visiting the following website: www.choices.mus.edu/SBC These forms, required by PPACA, detail what each plan covers.

Scratch Paper

MSU Bozeman



UM Missoula

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.choices.mus.edu

HEALTH PLANS

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
Allegiance Managed Care Plan
Customer Service 1-877-778-8600
Precertification 1-800-342-6510
www.abpmtpa.com/mus

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

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

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

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

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC. - Flex Plan Administrator
Customer Service 1-877-778-8600
www.askallegiance.com

URx – PRESCRIPTION DRUG PROGRAM

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

MEDIMPACT
Customer Service 1-888-648-6764

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

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

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

STANDARD LIFE INSURANCE – Life and Disability
Customer Service 1-800-759-8702
www.standard.com

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