**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

Allegiance: MUS Choices Retiree Benefit Plan

Coverage Period: 07/01/2019 – 06/30/2020
Coverage for: Individual/Family | Plan Type: PPO

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The Summary of Benefits and Coverage (SBC) document will help you choose a health **plan**. The SBC shows you how you and the **plan** would share the cost for covered health care services. **NOTE:** Information about the cost of this **plan** (called the **premium**) will be provided separately.

This is only a summary. For more information about your coverage or costs, visit www.choices.mus.edu or call 1-877-501-1722. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms, visit www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-877-501-1722 to request a copy.

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<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$1,250/Individual or $2,500/Family <strong>In-Network</strong></td>
<td>You must pay all of the costs from providers up to the <strong>deductible</strong> amount before the <strong>plan</strong> begins to pay for these services. <strong>Deductible</strong> applies to all services, unless otherwise indicated, or a copayment applies.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. <strong>Preventive care</strong>, primary care, and <strong>specialist</strong> office visit services are covered before you meet your deductible.</td>
<td>The <strong>plan</strong> covers some services even if you haven’t yet met the <strong>deductible</strong> amount. But a <strong>copayment</strong> or <strong>coinsurance</strong> may apply. For example, this <strong>plan</strong> covers certain <strong>preventive services</strong> without cost-sharing and before you meet your <strong>deductible</strong>. See a list of covered <strong>preventive services</strong> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>$2,500/Individual or $5,000/Family <strong>Out-of-Network</strong></td>
<td>You must pay all of the costs from <strong>out-of-network providers</strong> up to the <strong>deductible</strong> amount before the <strong>plan</strong> begins to pay for these services.</td>
</tr>
</tbody>
</table>
| **What is the out-of-pocket limit for this plan?** | $4,350/Individual or $8,700/Family **In-Network**
$6,000/Individual or $12,000/Family **Out-of-Network** | The **out-of-pocket limit** is the most you could pay in a benefit period for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met. |
| **What is not included in the out-of-pocket limit?** | **Premiums**, **balance-billing** charges, and health care this **plan** doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. |
| **Will you pay less if you use a network provider?** | Yes. Visit www.abpmta.com/mus or call 1-877-778-8600 for a list of network providers. | You will pay less if you use a **network provider**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider’s charge and what your **plan** pays (balance billing). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see a **specialist** without a **referral** or permission from the plan. |
All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary Care Provider (PCP) office visit to treat an injury or illness, includes Naturopathic.</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> office visit</td>
<td>$30 copay/office visit; 30% <strong>coinsurance</strong> for other outpatient services; <strong>deductible</strong> applies</td>
<td>40% <strong>coinsurance</strong>; <strong>deductible</strong> applies</td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/screening/Immunization</strong></td>
<td>0%</td>
<td>40% <strong>coinsurance</strong>; <strong>deductible</strong> applies</td>
</tr>
<tr>
<td></td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>30% <strong>coinsurance</strong>; <strong>deductible</strong> applies</td>
<td>40% <strong>coinsurance</strong>; <strong>deductible</strong> applies</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% <strong>coinsurance</strong>; <strong>deductible</strong> applies</td>
<td>40% <strong>coinsurance</strong>; <strong>deductible</strong> applies</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Certain Preventive Drugs- (Tier $0)</td>
<td>Retail (34-day supply)</td>
<td>Retail or Mail Order (90-day supply)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs- (Tier 1) (Tier 2)</td>
<td>Retail or Mail Order (90-day supply)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$50 copay</td>
<td>$100 copay</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.navitus.com](http://www.navitus.com).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Non-preferred brand drugs- (Tier 3)</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs (Tier 4)</td>
<td>$200 copay (preferred specialty pharmacy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Limit- $2,150/Individual or $4,300/Family</td>
<td>50% coinsurance (retail or out-of-network pharmacy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance; deductible applies</td>
<td>40% coinsurance; deductible applies</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>30% coinsurance; deductible applies</td>
<td>40% coinsurance; deductible applies</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency Room care</td>
<td>$250 copay/visit; 30% coinsurance for other outpatient services; deductible applies</td>
<td>$250 copay/visit; 25% coinsurance for other outpatient services; deductible applies</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>$200 copay/transport</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75 copay/visit; 30% coinsurance for other outpatient services; deductible applies</td>
<td>$75 copay/visit; 25% coinsurance for other outpatient services; deductible applies</td>
<td></td>
</tr>
<tr>
<td>50% coinsurance does not apply to annual prescription out-of-pocket limit.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>All other charges are subject to deductible and coinsurance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit limited to evaluation and management charges. All other charges are subject to deductible and coinsurance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
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<td>What You Will Pay</td>
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</tr>
<tr>
<td>---------------------------------------------</td>
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<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>In-Network Provider (You will pay the least)</td>
<td>In-Network Provider (You will pay the least)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30% coinsurance; deductible applies</td>
<td>40% coinsurance; deductible applies</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>30% coinsurance; deductible applies</td>
<td></td>
</tr>
<tr>
<td>If you need mental health or chemical dependency services</td>
<td>Outpatient services</td>
<td>1st 4 visits at $0, then $30 copay/visit</td>
<td>1st 4 visits at $0 copay/visit- mental health and chemical dependency combined visits (excludes psychiatrist).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychiatrist- $50 copay/visit</td>
<td></td>
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<tr>
<td></td>
<td>Inpatient services</td>
<td>30% coinsurance; deductible applies</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$40 copay/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance; deductible applies</td>
<td></td>
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<tr>
<td></td>
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</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Childbirth/delivery facility services</td>
<td>30% coinsurance; deductible applies</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home Health Care</td>
<td>$30 copay/visit</td>
<td></td>
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<tr>
<td></td>
<td>Outpatient Rehabilitative services visit</td>
<td>$30 copay/visit</td>
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<tr>
<td></td>
<td>physical, speech, occupational, pulmonary,</td>
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<tr>
<td></td>
<td>cardiac, respiratory, and medical massage</td>
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<tr>
<td></td>
<td>therapies; chiropractic; acupuncture</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient Rehabilitative services</td>
<td>30% coinsurance; deductible applies</td>
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<td>Prior authorization is recommended/max 30 visits/year.</td>
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<tr>
<td></td>
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<td></td>
<td>Outpatient maximum 30 visits/year- all outpatient rehabilitative services combined.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Massage therapy and Acupuncture services- You may be responsible for balance billing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inpatient maximum 30 days/year.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
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<td>----------------------</td>
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<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>30% coinsurance; deductible applies</td>
<td>40% coinsurance; deductible applies</td>
<td>Prior authorization is recommended/max 30 days/year.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>30% coinsurance; deductible applies</td>
<td>40% coinsurance; deductible applies</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>30% coinsurance; deductible applies</td>
<td>40% coinsurance; deductible applies</td>
<td>Maximum is 6 months.</td>
</tr>
<tr>
<td>If you need dental or eye care</td>
<td>Eye exam ***covered by medical plan</td>
<td>0%</td>
<td>40% coinsurance; deductible applies</td>
</tr>
<tr>
<td>Optional Vision Hardware *** BCBSMT</td>
<td></td>
<td></td>
<td>Up to $300- 1 pair of eyeglass frames and lenses, in lieu of contact lenses/year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Up to $150- 1 purchase of contact lenses, in lieu of eyeglass frames and lenses/year.</td>
</tr>
<tr>
<td>Dental *** Delta Dental</td>
<td>Fee schedule payment.</td>
<td>Fee schedule payment.</td>
<td>Select Plan covers up to $1,500/individual</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):**
- Cosmetic Surgery
- Infertility Treatment
- Hearing Aids
- Private Duty Nursing
- Work related accident/illness
- Routine Foot Care

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):**
- Acupuncture
- Organ transplant
- Chiropractic Care
- Preventive Services
- Medically necessary travel with prior authorization- $1,500 max/year
Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

You can keep this coverage as long as your premiums are paid, unless your employment terminates, or hours worked drop below 20. If you have no other coverage, you can choose to keep this coverage by electing COBRA (Consolidated Omnibus Budget Reconciliation Act). See your campus Human Resources/Benefits office for rules regarding election of COBRA benefits and making premium payments.

For more information on your rights to continue coverage, contact the plan at 1-877-501-1722.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Allegiance at 1-877-778-8600 or MUS Employee Benefits at 1-877-501-1722.

Does this plan provide Minimum Essential Coverage? Yes.
The Affordable Care Act requires people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide Minimum Essential Coverage.

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. This health coverage does meet the Minimum Value Standards for the benefits it provides.

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Please note these coverage examples are based on self-only coverage.

**Having a Baby**
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $1250
- Primary Care office visit copayment: $30
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

This EXAMPLE event includes services like:
- Primary Care physician office visit (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Other services (anesthesia)

**Total Example Cost:** $12,800

In this example, patient would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
<tr>
<td>Primary Care Office Visit Copayment</td>
<td>$30</td>
<td>Emergency Room Copayment</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$3,070.00</td>
<td>Physical Therapy Visit Copayment</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
<td>What isn’t covered</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
<td>Limits or exclusions</td>
</tr>
<tr>
<td>The total patient would pay is</td>
<td>$4,350.00</td>
<td>The total patient would pay is</td>
</tr>
</tbody>
</table>

**Managing Type 2 Diabetes**
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $1250
- Specialist copayment: $50
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

This EXAMPLE event includes services like:
- Specialist office visit (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs

**Total Example Cost:** $7,400

In this example, patient would pay:

<table>
<thead>
<tr>
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<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
<tr>
<td>Specialist Office Visit Copayment</td>
<td>$50</td>
<td>Emergency Room Copayment</td>
</tr>
<tr>
<td>Prescription Copayment</td>
<td>$50</td>
<td>Physical Therapy Visit Copayment</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,845.00</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
<td>What isn’t covered</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
<td>Limits or exclusions</td>
</tr>
<tr>
<td>The total patient would pay is</td>
<td>$3,195.00</td>
<td>The total patient would pay is</td>
</tr>
</tbody>
</table>

**Simple Fracture**
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $1250
- Emergency Room deductible: $250
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

This EXAMPLE event includes services like:
- Emergency Room care (including medical supplies)
- Diagnostic test (x-ray)
- Outpatient Rehabilitative services (physical therapy)

**Total Example Cost:** $1,900

In this example, patient would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
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<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
<tr>
<td>Emergency Room Copayment</td>
<td>$250</td>
<td>Physical Therapy Visit Copayment</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$195.00</td>
<td>Coinsurance</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
<td>What isn’t covered</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
<td>Limits or exclusions</td>
</tr>
<tr>
<td>The total patient would pay is</td>
<td>$1,725.00</td>
<td>The total patient would pay is</td>
</tr>
</tbody>
</table>