choices

Active Benefits

2020 - 2021
Montana University System

MUS_EB
Montana University System
Employee Benefits

MUS Annual Enrollment – April 22, 2020 - May 15, 2020

Visit the MUS *Choices* website Home page at www.choices.mus.edu and click on the Benefits Enrollment button to make your 2020-2021 benefit elections in the Benefitsolver online enrollment system.

All enrollees will be automatically enrolled in the current medical plan coverage level with the new Medical Plan Third-Party Administrator, BlueCross BlueShield of Montana.

If you do not complete the online annual enrollment process between April 22, 2020 – May 15, 2020, you and your dependents will automatically be re-enrolled in your current dental and vision hardware benefits.

To add an eligible dependent child not currently on your plan during annual enrollment you **must** make an active election.

You **must** complete the online annual enrollment process if you wish to re-elect:

- Healthcare Flexible Spending Account
- Dependent Care Flexible Spending Account

During this annual enrollment **only**, employees will have the opportunity to enroll in optional Supplemental Life and AD&D Insurance coverage for themselves, a legal spouse, and dependent children up to the guaranteed issue amounts.
Once annual enrollment ends, this opportunity will close.

Employee Annual Enrollment Benefits Presentation
Live, interactive webcast:
Friday, April 17, 2020, 10:00 a.m.
Access from the MUS *Choices* website Home page at www.choices.mus.edu

On-Demand Benefits Presentation

- Available on April 22, 2020 at www.choices.mus.edu

Questions?

If you have questions about enrolling in the Benefitsolver online enrollment system, please contact your campus Human Resources/Benefits office directly.

Table of Contents

How *Choices* Works

Lake McDonald, MT

Mandatory (must choose) Benefits

Optional (voluntary) Benefits

Yellowstone National Park, MT

Additional Benefit Plan Information

How *Choices* Works

This workbook is your guide to ***Choices*** – The 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 benefit 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, contact your campus Human Resources/ Benefits Office (page 40). This enrollment workbook is not a guarantee of benefits. Consult your enrollment workbook or Summary Plan Description (see page 35 for availability).

Flathead River, MT

1. Who's Eligible

A person employed by a unit of the Montana University System (MUS), 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 MUS Group 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 MUS Group Benefits Plan.

2. Waive coverage:

You can waive coverage: You have the option to waive benefits coverage with the Montana University System Group Benefits Plan. In order to waive coverage, you must actively elect to waive coverage in the online enrollment system by your enrollment deadline verifying you are waiving coverage. If you do not actively elect to waive coverage, certain coverages will continue (existing employees) or you will be defaulted into coverage (new employees) as outlined below. Please note there is no continuing or default coverage for Flexible Spending Accounts (FSAs) as these accounts must be actively elected each plan 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, Vision Hardware, Life/ Accidental Death and Dismemberment (AD&D), Long Term Disability (LTD) and Flexible Spending Accounts.
- You forfeit the monthly employer contribution toward benefits coverage.
- You and your eligible children cannot re-enroll unless and until you have a qualifying event or until the next annual enrollment period.
- Your spouse cannot be added to the Plan unless and until they have a qualifying event.

3. Enrolling family members

Enrollment for FY2021 is Closed Enrollment for legal spouses unless there is a qualifying event (see page 3 for qualifying events). Eligible children under the age of 26 may be added during the annual enrollment period or if there is a qualifying event.

If you're a **new employee**, you may enroll your family for benefits under ***Choices***, including Medical, Dental, Vision Hardware, optional supplemental life and AD&D insurance coverage.

Eligible family members include your:

- **Legal spouse:** Legally married or certified common-law married spouses, as defined under Montana law, will be eligible for enrollment as a dependent on the MUS Plan. Only legally married or common-law spouses with a certified affidavit of common-law marriage will be eligible for enrollment on the Plan during the employees initial enrollment period or within 63 days of a qualifying event.

- **Eligible 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 legal guardianship.

  *Coverage may continue past age 26 for an eligible unmarried dependent child who is mentally or physically disabled and incapable of self-support and is currently on the MUS Plan. Eligibility is subject to review each plan year.

4. How to Enroll

1. New benefits eligible employees have the option of enrolling themselves and any eligible dependents, or waiving all coverages, during a 30-day initial enrollment period, that begins the day following the date of hire or the date of benefits eligibility under the Plan.

2. Employees may make benefit changes from among the benefit plan options during annual enrollment each Plan year or within 63 days of a qualifying event (see page 3 for qualifying events) based on Plan rules.

How to Enroll Cont.

3. Each benefit option in ***Choices*** has a monthly cost associated with it. These costs are shown in the online benefits enrollment system and in this workbook (page 7).

Mandatory (must choose):
Medical pg 6
Prescription Drug (included in Medical) pg 15
Dental pg 17
Basic Life Insurance and AD&D pg 23
Long Term Disability pg 23

Optional (voluntary):
Vision Hardware pg 24
Flexible Spending Accounts pg 28
Supplemental Life Insurance pg 30
Dependent Life Insurance pg 31
Supplemental AD&D Insurance pg 32
Long Term Care pg 34

4. Employees make their benefit elections online in the Benefitsolver online enrollment system. Instructions on how to login and navigate the online Benefitsolver enrollment system are included on the next two pages (4 - 5). The online benefits enrollment system will walk you through your coverage options and monthly costs.

5. Visit **www.choices.mus.edu** and click on the **Benefits Enrollment** button to enroll.
Company Key: musbenefits

If the benefits you choose cost . . .

- The same or less than 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.

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*

Documentation to support the change will be required.

Qualifying events may allow limited benefit changes.

Questions? If you have questions about the enrollment process or enrolling in the Benefitsolver online benefits enrollment system, please contact your campus Human Resources/Benefits Office directly (page 40).

Questions about qualifying events should be directed to your campus Human Resources/Benefits Office or consult the Summary Plan Description (SPD).

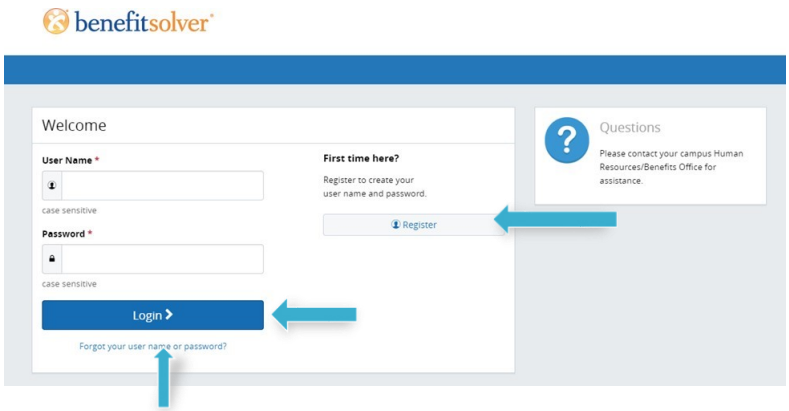
MUS_EB
Montana University System
Employee Benefits

Complete your Montana University System benefits enrollment today!

LOG IN

Visit the MUS *Choices* website Home page at **www.choices.mus.edu** from any computer or smart device, click on the **Benefits Enrollment** button on the *Choices* Home page and **Login** with your **User Name** and **Password**.

New users must **Register** and answer security questions. The case-sensitive Company Key is **musbenefits**.



Need to reset your user name or password?

1. Click **Forgot your user name or password?**
2. Enter your Social Security Number, birth date and the Company Key: **musbenefits.**
3. Answer your security phrase.
4. Enter and confirm your new password, then click **Continue** and **Login** with your new credentials.

GET STARTED

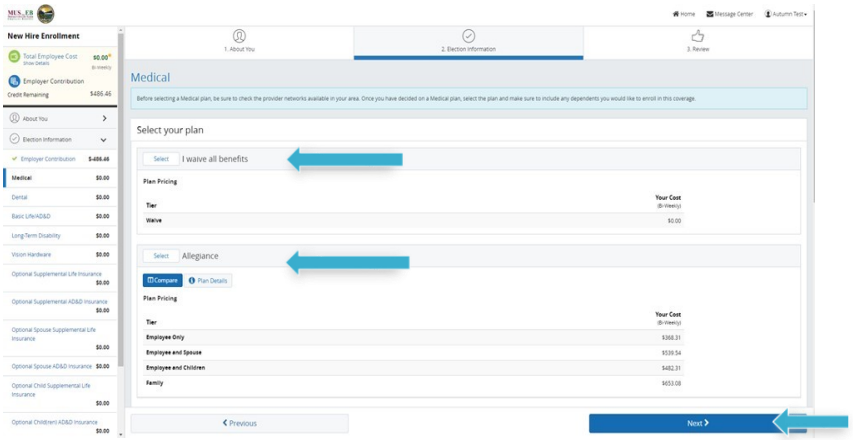
Click **Start Here** and follow the instructions to make your benefit elections by the deadline on the calendar. If you miss the deadline, you will not be able to make any changes to your benefit elections until the next annual enrollment period.

MAKE YOUR ELECTIONS

Using **Previous** and **Next** to navigate, review your options as you move through the enrollment process.

Select plan(s) and what dependent(s) you would like to cover.

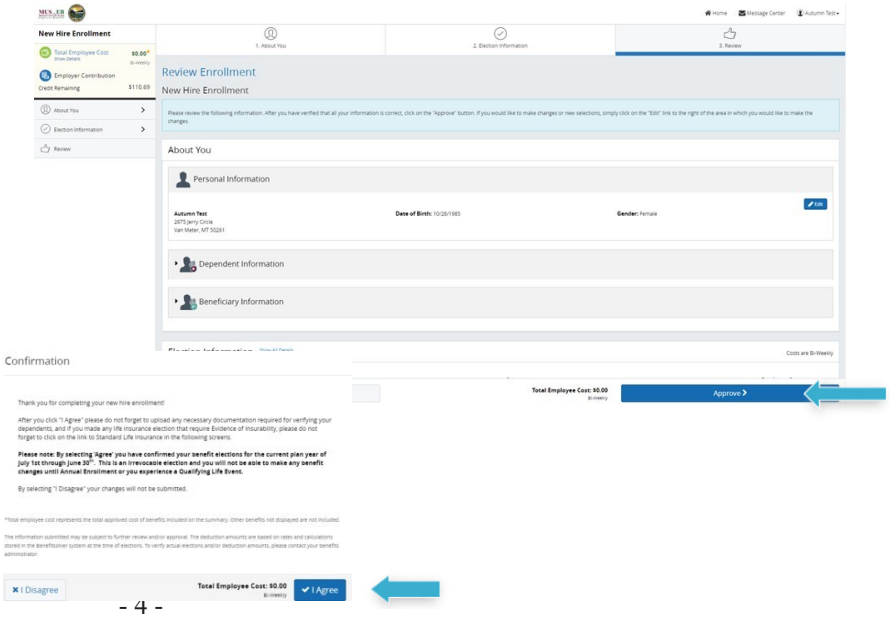
Track your benefit elections and costs along the left side of the page.



REVIEW AND CONFIRM

Make sure your personal information, benefit elections, dependent(s), and beneficiary(ies) are accurate and **Approve** your enrollment.

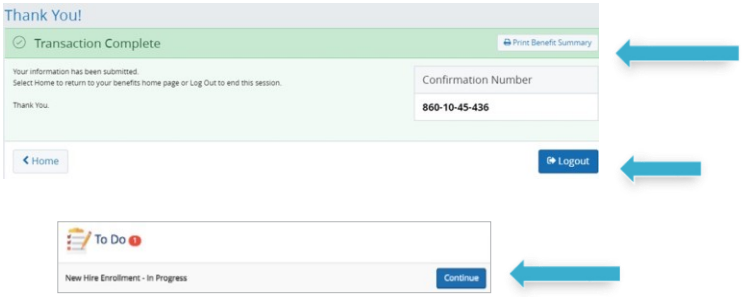
To finalize your enrollment, click **I Agree**.



FINALIZE

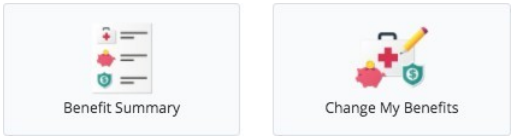
When your enrollment is complete, you will receive a confirmation number and you can also **Print Benefit Summary**.

Your **To Do** list will notify you if you have any additional actions needed to complete your enrollment.



REVIEW YOUR BENEFITS

You have year-round access to a benefits summary that shows your personal benefit selections. Click **Benefit Summary** on the Home page to review your current benefits at any time.



CHANGE YOUR BENEFITS

Once approved, your benefit elections will remain in effect until the end of the plan year, unless you have a qualifying life event, such as marriage, divorce or birth of a child. Find detailed qualifying event information at **www.choices.mus.edu**.

1. Click on **Change My Benefits**.
2. Select **Life Event** and the event type.
3. Review your options and follow the election steps outlined above to complete your changes.

****IMPORTANT:** You must make changes within **63 days** of the qualifying event and provide the required dependent verification documentation.

FIND BENEFIT INFORMATION

View your MUS *Choices* benefit plan information at **www.choices.mus.edu**.

If you have questions about your enrollment, contact your campus Human Resources/Benefits Office directly.

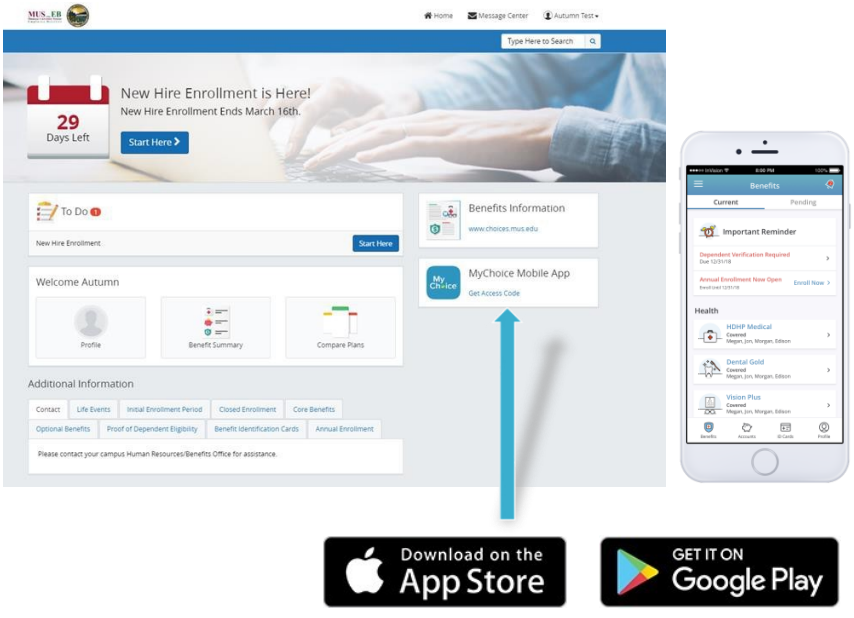
CHANGE YOUR BENEFICIARY(IES)

Beneficiary changes can be made at any time of the year.

1. Click on **Change My Benefits**
2. Select **Basic Info** and **Change of Beneficiary**.
3. Follow the prompts to complete your change.

Download the MyChoice℠ Mobile App

1. Visit your device's app store and download the **MyChoice by Businessolver®** Mobile App.
2. Visit your Benefitsolver Home page to **Get Access Code**.
3. Activate the app with your access code.
   (If you don't use the code within 20 minutes, you'll need to generate a new one.)
4. Follow the instructions within the Mobile App to have easy access to your benefits on the go.



Medical Plan *Choices (mandatory)*

Beginning 7/1/20, the Montana University System will be moving to one Medical Plan option. All enrollees will be automatically enrolled in the current Medical Plan coverage level with the new Medical Plan third-party administrator, BlueCross BlueShield of Montana (BCBSMT). To see if your provider is an In-Network BCBSMT provider, please check their website at www.bcbsmt.com/find-a-doctor-or-hospital. Enrollees who were not enrolled on the BCBSMT Medical Plan prior to 7/1/20, will receive new Medical Plan ID cards. As of 7/1/20, your providers will need a copy of your new Medical Plan ID card to ensure that claims are submitted to the correct plan for processing.

How the Medical Plan works

Plan members receive medical services from a health care provider. If the provider is **In-Network**, the provider will submit a claim for the member. The medical plan claim's administrator processes the claim and sends an Explanation of Benefits (EOB) to the member, showing the member's payment responsibilities (deductible, copayments, and/or coinsurance costs) to the provider. The Plan then pays the remaining allowed amount. The provider will not bill the member the difference between the charge and the allowed amount.

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 medical plan claim's administrator processes the claim and sends an EOB to the member showing the member's payment responsibilities (deductible, coinsurance, and any difference between the charge and the allowed amount (balance billing)).

Definition of Terms

In-Network Providers – Providers who have contracted with the medical plan claim's administrator to manage and deliver care at agreed upon prices. Members may self-refer to In-Network providers and specialists. There is a cost savings for services received In-Network. You pay a $25 copayment for Primary Care Physician (PCP) visits and a $40 copayment for specialty provider visits to In-Network providers (no deductible) and 25% coinsurance (after deductible) for most In-Network hospital/ facility services.

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

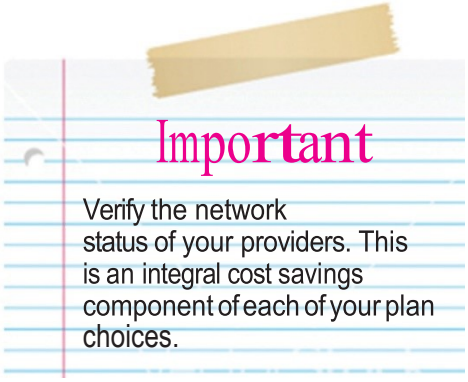
Emergency Services are covered everywhere. However, Out-of-Network providers may balance bill the difference between the allowed amount and the charge.

Deductible – The amount you pay each benefit year before the Plan begins to pay.

Copayment - A fixed dollar amount you pay for a covered service that a member is responsible for paying. The medical plan pays the remaining allowed amount.

Coinsurance – A percentage of the allowed amount for covered charges you pay, after paying any applicable deductible.

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



BlueCross BlueShield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

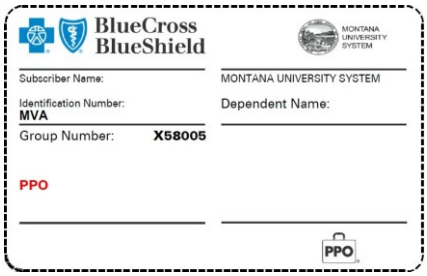
1-800-820-1674 or 447-8747, www.bcbsmt.com

Medical Plan Monthly Rates FY2021

Monthly Premiums	Blue Cross Blue Shield
Employee/Survivor Only	$748
Employee & Spouse	$1,075
Employee & Child(ren)/ Survivor & Childr(ren	$994
Employee & Family	$1,327

The employer contribution for FY2021 is $1,054 per month for eligible active employees (applies to pre-tax benefits only).

Sample Medical card



Medical Plan Costs FY2021

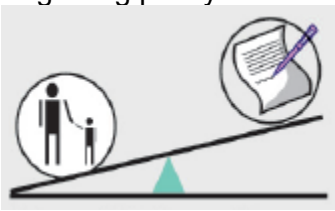
Medical Plan Costs	Medical Plan In-Network	Medical Plan Out-of-Network *
Annual Deductible Applies to all covered services, unless otherwise noted or copayment is indicated.	$750/Person $1,500/Family	Separate $750/Person Separate $1,750/Family
Copayment (outpatient office visits) Primary Care Physician Visit (PCP) Specialty Provider Visit	 $25 copay $40 copay	 N/A N/A
Coinsurance Percentages (% of allowed charges member pays)	25%	35%
Annual Out-of-Pocket Maximum (Maximum paid by member in a benefit year for covered services; includes deductibles, copays and coinsurance)	$4,000/Person $8,000/Family	Separate $6,000/Person Separate $12,000/Family

* Services from an Out-of-Network provider have separate deductibles, % coinsurance, and Out-of-Pocket maximums. An Out-of-Network provider can balance bill the difference between the allowed amount and the charge.

Examples of Medical costs to Plan and Member - Primary Care Physician Visit

(In-Network) Jack's Plan deductible is $750, his coinsurance is 25%, and his out-of-pocket max is $4,000.

July 1
Beginning plan year

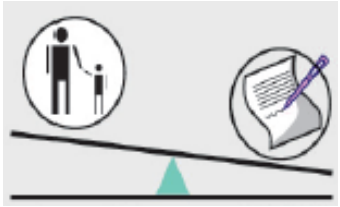


Jack pays $25 office visit copay and 100% of allowed amount for lab charges

Plan pays remainder of office visit

Jack hasn't reached his deductible yet and he visits the doctor and has lab work. He pays $20 for the office visit and 100% of the allowed amount 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 $25 for the office visit and $400 for the labwork. The Plan pays $75 for the office visit and $0 for the labwork. The In-Network provider writes off $500.

more costs



Jack pays $25 office visit copay and 25% of allowed amount for lab charges

Plan pays remainder of office visit and 75% of allowed amount

Jack has seen the doctor several times and reaches his $750 In-Network deductible. His plan pays some of the costs of his next visit. He pays $25 for the office visit and 25% of the allowed amount for labwork and the Plan pays the remainder of the office visit + 75% of the allowed amount. **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 $25 for the office visit and $100 for the labwork. The Plan pays $75 for the office visit and $300 for the labwork. The In-Network provider writes off $500.

June 30
End of plan year

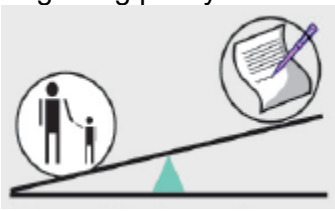
Jack pays 0%

Plan pays 100% allowed amount

Jack reaches his $4,000 out-of-pocket maximum. Jack has seen his doctor often and paid $4,000 total (deductible + coinsurance + copays). The Plan pays 100% of the allowed amount 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 or 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 year

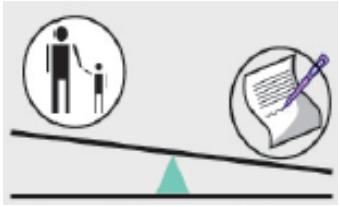


Jack pays 100%

Plan pays 0%

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

more costs



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

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 allowed amount and any difference between the provider charge and the Plan allowed amount. The Plan pays 60% of the allowed amount. **For example**, the provider charges $1,000. The Plan allowed amount is $500. Jack pays 35% of the allowed amount ($175) + the difference between the provider charge and the Plan allowed amount ($500). Jack's total responsibility is $675. The Plan pays 65% of the allowed amount ($325).

June 30
End of plan year

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

Plan pays 100% allowed amount

Jack reaches his $6,000 out-of-pocket maximum. Jack has seen his doctor often and paid $6,000 (deductible + coinsurance). The Plan pays 100% of the allowed amount for covered charges for the remainder of the benefit year. Jack pays the difference between the provider charge and the allowed amount. **For example**, the provider charges $1,000. The Plan allowed amount 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 Outpatient Services		
Outpatient Services	25%	35%
Outpatient Surgi-Center	25%	35%
Physician/Professional Provider Services (not listed elsewhere)		
Primary Care Physician (PCP) Office Visit - Includes Naturopathic visits	$25 copay/visit for office visit only - lab, x-ray & other procedures are subject to deductible/coinsurance	35% **Note:** There is no network for Naturopaths, so they are treated as In-Network, however, the member may be balance billed the difference between the allowed amount and the provider charge.
Specialty Provider Office Visit	$40 copay/visit for office visit only - lab, x-ray & other procedures are subject to deductible/coinsurance	35%
Inpatient/Outpatient Physician Services	25%	35%
Lab/Ancillary/Misc. Charges	25%	35%
Eye Exam (preventive or medical)	0% one/yr	35% one/yr
Second Surgical Opinion	0%/visit for office visit only - lab, x-ray & other procedures are subject to deductible/coinsurance	35%
Emergency Services		
Ambulance Services for Medical Emergency	$200 copay/transport	$200 copay/transport
Emergency Room Facility Charges	$250 copay/visit for room charges only - lab, x-ray & other procedures are subject to deductible/coinsurance (waived if immediately admitted to hospital)	$250 copay/visit for room charges only - lab, x-ray & other procedures are subject to deductible/coinsurance (waived if immediately admitted to hospital)
Professional Charges	25%	25%
Urgent Care Services		
Facility/Professional Charges	$75 copay/visit for room charges only - lab, x-ray & other procedures are subject to deductible/coinsurance	$75 copay/visit for room charges only - lab, x-ray & other procedures are subject to deductible/coinsurance
Lab & Diagnostic Charges	25%	25%

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.

Schedule of Medical Benefits FY2021

Medical Plan Services	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Maternity Services		
Hospital Charges	25%	35%
Physician Charges (delivery & inpatient)	25% (waived if enrolled in WellBaby Program within first trimester)	35%
Prenatal Office Visits	$25 copay/visit (waived if enrolled in WellBaby Program within first trimester)	35%
Preventive Services		
Preventive screenings/immunizations (adult & Well-Child care) Refer to pgs 13 & 14 for listing of Preventive Services covered at 100% of the allowed amount and for age recommendations	0% (Limited to services listed on pgs 13 & 14. Other preventive services subject to deductible and coinsurance)	35%
Mental Health/Chemical Dependency Services		
Inpatient Services (Pre-Certification is recommended)	25%	35%
Outpatient Services (this is a combined max of 4 visits at $0 copay for mental health and chemical dependency services)	First 4 visits $0 copay, then $25 copay/visit	35%
Psychiatrist	$40 copay/visit	35%
Rehabilitative Services Physical, Occupational, Speech, Cardiac, Respiratory, Pulmonary, and Massage Therapy, Acupuncture and Chiropractic		
Inpatient Services (Pre-Certification is recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr
Outpatient Services (This is a combined max of 30 visits for all rehab services)	$25 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr **Note:** There is no network for Acupuncture & Massage Therapy, so they are treated as In-Network, however, the member may be balance billed the difference between the allowed amount and the provider charge.

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
Extended Care Services		
Home Health Care (Prior Authorization is recommended)	$25 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr
Hospice	25% Max: 6 months	35% Max: 6 months
Skilled Nursing Facility (Prior Authorization is recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr
Miscellaneous Services		
Allergy Shots	$40 copay/visit Office visit only. If no office visit, deductible & coinsurance waived	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

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.

Schedule of Medical Benefits FY2021

Medical Plan Services	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Miscellaneous Services cont.		
PKU Supplies (Includes treatment & medical foods)	0% (no deductible)	35%
Dietary/Nutritional Counseling	First 8 visits $0 copay, then $25 copay/visit	35%
Obesity Management (Prior Authorization required)	25% Must be enrolled in Take Control for non-surgical treatment	35%
TMJ (Prior Authorization recommended)	25% Surgical treatment only	35%
Organ Transplants		
Transplant Services (Prior Authorization required)	25%	35%
Travel		
Travel for patient only - If services are not available in local area (Prior Authorization required)	0% up to $1,500/yr. -up to $5,000/transplant	0% up to $1,500/yr. -up to $5,000/transplant
MUS Wellness Program		
Preventive Health Screenings Healthy Lifestyle Ed. & Support	see pg 25	
WellBaby		
Take Control Diabetes, Weight Loss, High Cholesterol, High Blood Pressure, Tobacco User	see pg 26	
Incentive Program		

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.

Preventive Services

Pablo, MT

1. What Services are Preventive

The MUS medical plan provides 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 preventive care is provided by In-Network providers, services are reimbursed at 100% of the allowed amount, without application of deductible, coinsurance, or copay. Services from an Out-of-Network provider have a 35% coinsurance and a separate deductible and out-of-pocket maximum. An Out-of-Network provider can balance bill the difference between the allowed amount and the charge.

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/
CDC: www.cdc.gov
Bright Futures: www.brightfutures.org
Secretary Advisory Committee: www.hrsa.gov/about/organization/committees.html

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 medical 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 and is considered diagnostic.

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 preventive care is provided by In-Network providers, services are reimbursed at 100% of the allowed amount, without application of deductible, coinsurance, or copay. Services from an Out-of-Network provider have a 35% coinsurance and a separate deductible and out-of-pocket maximum. An Out-of-Network provider can balance bill the difference between the allowed amount and the charge.

Periodic Exams Appropriate screening tests per Bright Futures and other sources (previous page)	
Well-Child 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 - 75	• 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 Navitus Pharmacy benefit.** **For recommended immunization schedules for all ages, visit the CDC website at www.cdc.gov/vaccines/index.html**	

Prescription Drug Plan

(Included in Medical Plan)

Your prescription drug coverage is managed by Navitus Health Solutions.

Who is eligible?
The Prescription Drug Plan (PDP) is a benefit for all benefits eligible Montana University System employees, retiree enrollees and their eligible dependents. Any member enrolled in the medical plan will automatically receive Navitus Health Solutions prescription drug coverage. There is no separate premium and no deductible for prescription drugs.

To determine your drug tier level and copay amount before going to the pharmacy, consult the Drug Schedule of Benefits, log into the Navitus Member Portal at www.navitus.com, or call Navitus Customer Care (see next page for numbers).

The Navitus Drug Formulary List and Pharmacy Directory can be found online at www.navitus.com. You will need to register on the Navitus Navi-Gate for Members web portal to access the MUS-specific drug formulary (preferred drug list), drug tier level, and pharmacy directory. If you have questions regarding the drug formulary list or pharmacy directory, please contact Navitus Customer Care.

You can also find a list of Navitus Frequently Asked Questions (FAQs) at www.navitus.com/members.

Sample Pharmacy Card

How do I fill my prescriptions?
Prescription drugs may be obtained through the Plan at either a local retail pharmacy (up to a 34 or 90-day supply) or through a mail order pharmacy (90-day supply). Members who use maintenance medications can experience a significant cost-savings when filling their prescriptions for a 90-day supply.

Mail Order Pharmacies
Ridgeway, Costco, and miRx Pharmacies administer the mail order pharmacy program. If you are new to the mail order program, you can register online (see contact details on next page).

Retail Pharmacy Network
NOTE: CVS/ Target pharmacies are not part of the Montana University System Pharmacy Plan network. If you choose to use these pharmacies, you will be responsible for all charges.

Specialty Pharmacy
The preferred Specialty Pharmacy is Lumicera Health Services. Lumicera helps members who are taking prescription drugs that require special handling and/or administration to treat certain chronic illnesses or complex conditions by providing services that offer convenience and support. Ordering new prescriptions with this specialty pharmacy is simple, just call a Patient Care Specialist to get started at 1-855-847-3553.

You can also find a list of Lumicera specialty pharmacy Frequently Asked Questions (FAQs) at www.lumicera.com/Patients/FAQ.aspx.

Prescription Drug Plan

Drug Schedule of Benefits Tier Level	Retail (up to 34-day supply)	Retail/Mail Order (90-day supply)
Tier $0 (certain preventive medications (ACA, certain statins, metformin and omeprazole))	$0 Copay	$0 Copay
Tier 1 (low cost, high-value generics and select brands that provide high clinical value)	$15 Copay	$30 Copay
Tier 2 (preferred brands and select generics that are less cost effective)	$50 Copay	$100 Copay
Tier 3 (non-preferred brands and generics that provide the least value because of high cost or low clinical value, or both)	50% Coinsurance (Does not apply to the Out-of-Pocket maximum)	50% Coinsurance (Does not apply to the Out-of-Pocket maximum)
Tier 4 (Specialty) (specialty medications for certain chronic illnesses or complex diseases) $200 copay if filled at preferred Specialty pharmacy 50% coinsurance, if filled at a non-preferred Specialty pharmacy (Does not apply to the Out-of-Pocket maximum)	N/A	N/A
Out-of-Pocket Maximum	Individual: $2,150 per year Family: $4,300 per year	

Questions?

Navitus Customer Care
call 24 Hours a Day | 7 Days a Week
1-866-333-2757

Secure Member Portal
www.navitus.com

Specialty Pharmacy
Lumicera Health Services
Customer Care: 1-855-847-3553
Monday - Friday 8 a.m. to 6 p.m. CST
www.lumicera.com

Costco
1-800-607-6861
or go to www.pharmacy.costco.com
Monday - Friday 5 a.m. to 7 p.m. PST

Ridgeway:
1-800-630-3214
or go to www.ridgeway.pharmacy/
Monday -Thursday 9 a.m. to 5 p.m. MST

miRx:
1-866-894-1496
or go to www.mirxpharmacy.com
Monday - Friday 8 a.m. to 6 p.m. MST

Dental Plan *(mandatory)*

Choices offers employees two Dental plan options to choose from:: **Basic Plan** or **Select Plan**.

Review the chart below and pay close attention to the different benefit plan options and the different monthly rates to help you make your benefit selection.

	Basic Plan - Preventive Coverage	Select Plan - Enhanced Coverage
Monthly Dental Rates	• Employee/Survivor Only $18 • Employee & Spouse $34 • Employee/Survivor & Child(ren) $34 • Employee & Family $49	• Employee/Survivor Only $43 • Employee & Spouse $82 • Employee/Survivor & Child(ren) $82 • Employee & Family $116
Maximum Annual Benefit	**$750 per covered individual**	**$2,000 per covered individual**
Diagnostic & Preventive Services	• Twice Per Benefit Period • Initial and Periodic oral exam • Cleaning • Complete series of intraoral X-rays	• Twice Per Benefit Period • Initial and Periodic oral exam • Cleaning • Complete series of intraoral X-rays Note: The above services do not count towards the $2,000 annual maximum (see below).
Basic Restorative Services	• Not covered	• Amalgam filling • Endodontic treatment • Periodontic treatment • Oral surgery • Removal of impacted teeth
Major Dental Services	• Not covered	• Crown • Root canal • Complete lower and upper denture • Dental implant • Occlusal guards
Orthodontia	• Not covered	• Available to covered children and adults • $1,500 lifetime benefit/individual

Select Plan Benefits:

Diagnostic & Preventive Benefit: The ***Choices*** Select Plan allows MUS Plan members to obtain diagnostic & preventive services without those costs applying to the annual $2,000 maximum.

Orthodontic Benefits: The Select Plan allows 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 claims administrator) will establish a monthly reimbursement based on your provider's monthly fee and your prescribed treatment plan.

Sample Dental Card

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

Dental Fee Schedule

Dental claims are reimbursed based on a fee schedule. The following subsets of the **Select** and **Basic Plan** fee 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 treatment.

The fee schedule's dollar amount is the maximum reimbursement for the specified procedure code. Covered participants are responsible for the difference (if any) between the provider's charge and the fee schedule's reimbursement amount. Blue shaded codes are for the **Basic Plan** ONLY. All Codes (shaded and non-shaded) are for the **Select Plan**.

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 listing (see pg 35 for availability).

Procedure Code	Description	Fee Schedule
D0120	Periodic oral evaluation – established patient	$40.00
D0140	Limited oral evaluation – problem focused	$58.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$40.00
D0150	Comprehensive oral evaluation – new or established patient	$65.00
D0160	Detailed and extensive oral evaluation – problem focused, by report	$139.00
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	$44.00
D0180	Comprehensive periodontal evaluation – new or established patient	$72.00
D0190	Screening of a patient	$28.00
D0191	Assessment of a patient	$28.00
D0210	Intraoral – complete series of radiographic images	$110.00
D0220	Intraoral – periapical first radiographic image	$26.00
D0230	Intraoral – periapical each additional radiographic image	$20.00
D0240	Intraoral – occlusal radiographic image	$25.00
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$58.00
D0270	Bitewing – single radiographic image	$22.00
D0272	Bitewings – two radiographic images	$37.00
D0273	Bitewings – three radiographic images	$45.00
D0274	Bitewings – four radiographic images	$53.00
D0277	Vertical bitewings – 7 to 8 radiographic images	$73.00
D0310	Sialography	$411.00
D0320	Temporomandibular joint arthrogram, including injection	$622.00
D0321	Other temporomandibular joint radiographic images, by report	$224.00
D0322	Tomographic survey	$355.00
D0330	Panoramic radiographic image	$91.00
D1110	Prophylaxis – adult	$83.00
D1120	Prophylaxis – child	$58.00
D1206	Topical application of fluoride varnish	$31.00
D1208	Topical application of fluoride – excluding varnish	$28.00
D1351	Sealant – per tooth	$45.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$54.00
D1510	Space maintainer – fixed, unilateral – per quadrant	$239.00
D1516	Space maintainer – fixed – bilateral, maxillary	$388.00
D1517	Space maintainer – fixed – bilateral, mandibular	$388.00

Dental Fee Schedule

Procedure Code	Description	Fee Schedule
D1520	Space maintainer – removable, unilateral – per quadrant	$393.00
D1526	Space maintainer – removable – bilateral, maxillary	$538.00
D1527	Space maintainer – removable – bilateral, mandibular	$538.00
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$63.00
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$63.00
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$63.00
D1556	Removal of fixed unilateral space maintainer – per quadrant	$63.00
D1557	Removal of fixed bilateral space maintainer – maxillary	$63.00
D1558	Removal of fixed bilateral space maintainer – mandibular	$63.00
D1575	Distal shoe space maintainer - fixed, unilateral – per quadrant	$239.00
D2140	Amalgam – one surface, primary or permanent	$93.00
D2150	Amalgam – two surfaces, primary or permanent	$118.00
D2160	Amalgam – three surfaces, primary or permanent	$147.00
D2161	Amalgam – four or more surfaces, primary or permanent	$176.00
D2330	Resin-based composite – one surface, anterior	$98.00
D2331	Resin-based composite – two surfaces, anterior	$132.00
D2332	Resin-based composite – three surfaces, anterior	$156.00
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$192.00
D2391	Resin-based composite – one surface, posterior	$116.00
D2392	Resin-based composite – two surfaces, posterior	$148.00
D2393	Resin-based composite – three surfaces, posterior	$187.00
D2394	Resin-based composite – four or more surfaces, posterior	$220.00
D2510	Inlay – metallic – one surface	$292.00
D2520	Inlay – metallic – two surfaces	$344.00
D2542	Onlay – metallic – two surfaces	$419.00
D2610	Inlay – porcelain/ceramic – one surface	$292.00
D2620	Inlay – porcelain/ceramic – two surfaces	$335.00
D2642	Onlay – porcelain/ceramic – two surfaces	$453.00
D2650	Inlay – resin-based composite – one surface	$292.00
D2651	Inlay – resin-based composite – two surfaces	$335.00
D2662	Onlay – resin-based composite – two surfaces	$371.00
D2740	Crown – porcelain/ceramic substrate	$480.00
D2750	Crown – porcelain fused to high noble metal	$459.00
D2751	Crown – porcelain fused to predominantly base metal	$410.00
D2780	Crown – ¾ cast high noble metal	$516.00
D2783	Crown – ¾ porcelain/ceramic	$477.00
D2790	Crown – full cast high noble metal	$468.00
D2930	Prefabricated stainless steel crown – primary tooth	$186.00
D2931	Prefabricated stainless steel crown – permanent tooth	$222.00
D2932	Prefabricated resin crown	$221.00

Procedure Code	Description	Fee Schedule
D2933	Prefabricated stainless steel crown with resin window	$222.00
D2940	Protective restoration	$70.00
D2950	Core buildup, including any pins when required	$151.00
D3110	Pulp cap – direct (excluding final restoration)	$44.00
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$110.00
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$789.00
D3346	Retreatment of previous root canal therapy – anterior	$747.00
D3347	Retreatment of previous root canal therapy – premolar	$828.00
D3410	Apicoectomy – anterior	$606.00
D3425	Apicoectomy – molar (first root)	$597.00
D3430	Retrograde filling – per root	$148.00
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$358.00
D4249	Clinical crown lengthening – hard tissue	$455.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$784.00
D4270	Pedicle soft tissue graft procedure	$620.00
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$154.00
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$105.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$83.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$93.00
D4910	Periodontal maintenance	$94.00
D5110	Complete denture – maxillary	$608.00
D5120	Complete denture – mandibular	$662.00
D5130	Immediate denture – maxillary	$666.00
D5140	Immediate denture – mandibular	$666.00
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$436.00
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$436.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$690.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$650.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$488.00
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$488.00
D5411	Adjust complete denture – mandibular	$32.00
D5611	Repair resin partial denture base, mandibular	$89.00
D5612	Repair resin partial denture base, maxillary	$89.00
D5640	Replace broken teeth – per tooth	$76.00
D5650	Add tooth to existing partial denture	$114.00
D5660	Add clasp to existing partial denture – per tooth	$160.00
D5710	Rebase complete maxillary denture	$320.00
D5711	Rebase complete mandibular denture	$320.00

Procedure Code	Description	Fee Schedule
D5720	Rebase maxillary partial denture	$314.00
D5721	Rebase mandibular partial denture	$360.00
D2933	Prefabricated stainless steel crown with resin window	$312.30
D2940	Protective restoration	$309.58
D2950	Core buildup, including any pins when required	$306.86
D5851	Tissue conditioning, mandibular	$51.00
D5863	Overdenture – complete maxillary	$930.00
D6010	Surgical placement of implant body: endosteal implant	$855.00
D6210	Pontic – cast high noble metal	$521.00
D6212	Pontic – cast noble metal	$365.00
D6214	Pontic – titanium and titanium alloys	$528.00
D6240	Pontic – porcelain fused to high noble metal	$459.00
D6241	Pontic – porcelain fused to predominantly base metal	$391.00
D6242	Pontic – porcelain fused to noble metal	$463.00
D6740	Retainer crown – porcelain/ceramic	$492.00
D6750	Retainer crown – porcelain fused to high noble metal	$456.00
D6752	Retainer crown – porcelain fused to noble metal	$490.00
D6790	Retainer crown – full cast high noble metal	$498.00
D6791	Retainer crown – full cast predominantly base metal	$402.00
D6794	Retainer crown – titanium and titanium alloys	$548.00
D7111	Extraction, coronal remnants – primary tooth	$65.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$102.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$178.00
D7220	Removal of impacted tooth – soft tissue	$211.00
D7230	Removal of impacted tooth – partially bony	$257.00
D7240	Removal of impacted tooth – completely bony	$316.00
D7850	Surgical discectomy, with/without implant	$1,500.00
D7860	Arthrotomy	$1,500.00
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$217.00
D7971	Excision of pericoronal gingiva	$120.00
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$69.00
D9120	Fixed partial denture sectioning	$86.00
D9222	Deep sedation/general anesthesia – first 15 minutes	$280.00
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$107.00
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$252.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$111.00
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$67.00
D9942	Repair and/or reline of occlusal guard	$38.00
D9944	Occlusal guard – hard appliance, full arch	$254.00
D9945	Occlusal guard – soft appliance, full arch	$64.00
D9946	Occlusal guard – hard appliance, partial arch	$127.00
D9950	Occlusion analysis – mounted case	$187.00
D9951	Occlusal adjustment – limited	$51.00
D9952	Occlusal adjustment – complete	$406.00

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 Plan utilizes a fee schedule 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 fee schedule amount, resulting in balance billing. 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 fee schedule amount in which case, the dentist may balance bill you up to the difference between the allowed fee and the MUS Plan benefit fee schedule 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 example for an adult cleaning demonstrates how lower out-of-pocket patient costs can be achieved when you visit a Delta Dental dentist (**Basic** and Select Plan coverage). The example compares 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 example for a crown demonstrates how lower out-of-pocket patient costs can be achieved when you visit a Delta Dental dentist (**Basic** and Select Plan coverage). The example compares 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

Life Insurance/AD&D & Long Term Disability (*mandatory*)

Basic Life/AD&D Insurance:

Administered by Standard Insurance Co.
1-800-759-8702;
www.standard.com/mybenefits/mus

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

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

Basic Life/AD&D Options & Monthly Rates		
Option1	$15,000	$1.28 for both
Option 2	$30,000	$2.56 for both
Option 3	$48,000	$4.08 for both

Long Term Disability:

Who May Enroll:
Employee only

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

Long Term Disability Options & Monthly Rates		
Option 1	60% of pay/180 day waiting period	$4.54
Option 2	66 2/3% of pay/180 day waiting period	$9.06
Option 3	66 2/3% of pay/120 day waiting period	$11.30

The three LTD plan options differ in the amount of your pay they replace, when benefits become payable, and monthly 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 coverage 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 LTD coverage. Please consult with your campus Human Resources/Benefits Office.

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.

The following applies to both Basic Life/AD&D Insurance and Long Term Disability

- If you are a new employee, you may elect any level of coverage during initial enrollment.
- An employee may increase one level of coverage during annual enrollment.
- An employee may decrease their coverage to any level during annual enrollment.
- An employee may increase or decrease their coverage one level due to a qualifying event, as long as the change is consistent with the event (such as, a dependent is disenrolled, coverage can be decreased one level).

Vision Hardware Plan

(optional)

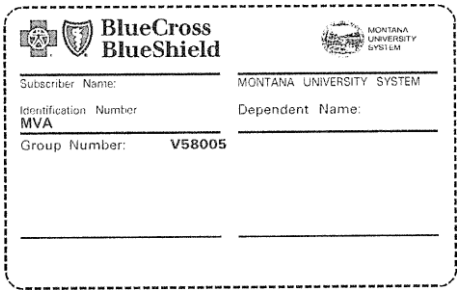
1-800-820-1674 or 447-8747, www.bcbsmt.com

***Choices* offers a Vision Hardware plan for Employees and their eligible dependents.**

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 your claim form to Blue Cross Blue Shield of Montana for processing. The optional vision coverage is a hardware benefit only. Eye Exams, whether preventive or medical, are covered under the medical benefit plan. See pg. 9 Eye Exam (preventive & medical). Please refer to the Summary Plan Description (SPD) for complete vision hardware benefits and plan exclusions (see pg. 35 for availability).

Monthly Vision Hardware Rates	
• Employee/Survivor Only	$10.70
• Employee & Spouse.	$20.20
• Employee/Survivor & Child(ren)	$21.26
• Employee & Family	$31.18

Sample Vision Hardware card



Service/Material	Coverage
Eyeglass Frame and Lenses: **Frame:** One frame per benefit period, in lieu of contact lenses **Lenses:** One pair of lenses per benefit period, in lieu of contact lenses	Up to $300 allowance toward the purchase of an eyeglass frame and prescription lenses, including single vision, bifocal, trifocal, progressive lenses; ultraviolet treatment; tinting; scratch-resistant coating; polycarbonate; anti-reflective coating. The Plan participant may be responsible for charges at the time of purchase.
Contact Lenses: One purchase per benefit period, in lieu of eyeglass frame and lenses	Up to $150 allowance toward contact lens fitting and the purchase of conventional, disposable or medically necessary* contact lenses. The Plan participant may be responsible for charges at the time of purchase.

*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.

Filing a claim:
When a Plan participant purchases vision hardware, a walk-out statement should be provided by the Provider. This walk-out statement should be submitted to Blue Cross Blue Shield of Montana for reimbursement.

Go to: www.choices.mus.edu/forms.html and select the Vision Hardware Claim Form.

MUS Wellness Program *(optional)*

Overview
The Montana University System (MUS) Benefit Plan offers Wellness services to covered adult medical plan members (employees, retirees, spouses, COBRA enrollees, and covered dependent children over the age of 18).

WELLNESS
MONTANA UNIVERSITY SYSTEM

Preventive Health Screenings

WellCheck
Each campus offers preventive health screenings for adult medical 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 medical plan members over the age of 18 are eligible for two free WellChecks per plan year (July 1 - June 30). Go to www.wellness.mus.edu/WellCheck.html for more information regarding WellCheck dates and times in your area.

Online Registration
Online registration is required for all participants for WellCheck appointments. To register go to: **my.itstartswithme.com.**

Lab Tests -
Log on to your It Starts With Me account for a complete listing of tests available at WellCheck: **my.itstartswithme.com.**

Flu Shots
Are offered FREE in the fall, subject to national vaccine availability. Go to **www.wellness.mus.edu/WellCheck.html** for more information.

Healthy Lifestyle Education & Support

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, is intended for general educational purposes only, and does not always address individual circumstances.

WellBaby
WellBaby is a pregnancy benefit designed to help you achieve a healthier pregnancy. Enroll during your first trimester to take advantage of all the program benefits.

For more information
call 406-660-0082 or visit:
wellness.mus.edu/WellBaby.html

Stay Connected

For education and updates visit our Blog: www.montanamovesandmeals.com

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

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

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

MUS Wellness Program *(optional)*

Wellness Incentive Program and Take Control Program

Incentive Program
www.muswell.limeade.com

Discover your own path to wellness with the 2020 Wellness Incentive Program!

Active employees can join exciting new wellness activities that will help you blaze a trail to your best life - all while earning rewards.

When you participate in the MUS incentive program and rack up points, you can move from Scout (1,000 points) up to our fourth level — Expedition (4,060 points) — to earn gift card rewards.

Ready to discover your own path to wellness? Here's how to get started:

1. **Login at** www.muswell.limeade.com
   Haven't registered? Click "get started" on www.muswell.limeade.com and follow the detailed instructions.
2. **Take the Well-Being Assessment:** Your assessment helps you understand the many dimensions of your well-being. Plan on spending approximately 15 minutes to complete.
3. **Complete a WellCheck Health Screening (blood draw and biometric screening) in 2020:** Completing a WellCheck health screening will give you an accurate measure of your health so you can maintain your health and prevent disease. For the Wellcheck schedule go to: www.wellness.mus.edu/WellCheck.html.

- Montana Meals Nutrition Challenges
- Montana Moves Fitness Challenges
- Challenges focusing on stress, sleep, and financial Wellness

If you have any questions about the MUS Wellness incentive program call 866-885-6940 or email support@limeade.com.

Take Control Program

takecontrol
Customized Plans. Individual Results. Real Savings.

Take Control is a healthcare company that believes living well is within everyone's reach. 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)
- **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)
- WellBaby members can join Take Control as part of the WellBaby program

Services Provided:

- Monthly health coaching
- Fitness center or fitness class reimbursement
- Copay waivers for diabetic supplies
- Monthly blog 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:

- Visit with your In-Network primary health care provider (with $0 copay)
- Certified Exercise Specialist (Personal Trainer)
- Sleep Study (deductible/coinsurance waived)
- Additional Counseling Sessions (with $0 copay)

For details, visit wellness.mus.edu/TakeControl.html or contact Take Control at 1-800-746-2970 or visit www.takecontrolmt.com.

Employee Assistance Program (EAP)

An Overview for Employees *(optional)*

Life presents us with challenges at work and at home on a daily basis. You do not have to face these challenges alone, even if you're far away.

The EAP Can Help with Almost Any Issue

EAP benefits are available to all employees and their families at NO COST to you. Help is just a phone call away. The EAP offers confidential advice, support, and practical solutions to real-life issues. You can access these confidential services by calling the toll-free number and speaking with a consultant.

EAP Services for Employees and Families

- 24-hour Crisis Help: toll-free access for you or a family member experiencing a crisis.
- In-person Counseling: up to 4 face-to-face counseling sessions for relationship and family issues, stress, anxiety, and other common challenges.
- RBH eAccess: convenient access to online consultations with licensed counselors.

Online Resources at ibhsolutions.com

- ibhsolutions.com: the EAP includes access to online tools and educational resources to help make life easier.

Webinars	Current health news + movies
Monthly newsletters	Stress tools
Wellness resources	Financial calculators
Assessments	Legal resources
Self-directed courses	Retirement planning resources
Articles	Tip sheets
Healthy recipes	Child/elder care locators

- Lunch & Learn Webinars: free monthly supervisor and employee webinars are followed by a live Q + A. Go to ibhsolutions.com and click the Webinars link to sign up or view past webinars via the RBH YouTube link.\

Access Counseling and Benefit Information

CALL 866-750-1327
WEBSITE ibhsolutions.com
- Select Members from the top right corner
- Click on the RBH logo
- Enter your Access Code: MUS
- Click the My Benefits button

RBH Reliant Behavioral Health | An IBH Company

Flexible Spending Accounts *(optional)*

1-877-WageWorks (1-877-924-3967) www.wageworks.com

Important Reminders:

Health Flexible Spending Account (FSA) FY2020 balance: If an employee doesn't enroll in an FSA for FY2021 and has unused FSA funds in the amount of $50 or less that are not expended by June 30, 2020, the FSA will be closed and the remaining unused funds will be forfeited. Claims must be received by Allegiance Flex Advantage by September 30, 2020 for reimbursement.

No Automatic Enrollment: You must re-enroll each plan year to participate in a Flexible Spending Account (no exceptions can be made on late enrollment).

To be eligible for reimbursement: All claims must be received by WageWorks by September 30, 2021

Account Types	Annual Amount	Qualifying Expense Examples
Health FSA	Minimum Contribution: $120 Maximum Contribution: $2,750	Medical expenses including deductibles, coinsurance, copays, and all dental and vision expenses that are not considered cosmetic.
Dependent Care FSA	Minimum Contribution: $120 Maximum Contribution: $5,000	Costs for day 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.

Health Flexible 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, dental, or vision expenses. The amount you elect for health FSA expenses is not subject to federal, state, Social Security, or Medicare taxes.

When you enroll in the health FSA, you are electing to participate for the entire plan year. No changes to your election may be made during the plan year unless you experience a "qualifying event." Changes must be consistent with the change in status or qualifying event.

Your health FSA will reimburse you for eligible expenses that you, your spouse, and your qualified dependents incur during the plan year. The annual amount you elect will be available on July 1st and can be used at any time during the plan year. Health FSA expenses which are eligible for reimbursement include those defined by IRS Code, Section 213(d). For a comprehensive list of eligible expenses, including a list of expenses that may require a letter of Medical Necessity signed by your doctor or a prescription from your doctor, visit www.wageworks.com/employees/eligible-expenses/.

You can estimate your tax savings by using WageWorks calculators on the WageWorks website at www.wageworks.com/employees/calculators.

If you or your spouse contribute to a Health Savings Account (HSA), you are not eligible to enroll in the MUS health FSA.

$500 rollover from the previous 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 it – or – lose it" rule, any money not used by the end of the plan year will be forfeited. The IRS permits health FSAs to allow $500 to rollover from one plan year to the next. This means that up to $500 from last year's election can be rolled over to the new plan year that begins July 1, 2020. The $500 rollover rule does not apply to dependent care FSAs.

Dependent Care Flexible Spending Account (DCFSA)

If both you and your spouse work or you are a single parent, you may have dependent day care expenses. The Federal Child Care Tax Credit is available to taxpayers to help offset dependent day care expenses. A dependent care FSA often gives employees a better tax benefit. You should consult your tax preparer to determine which option works best for you.

Your dependent care FSA lets you use "before-tax" dollars to pay day care expenses for children under age 13, or individuals unable to care for themselves. A dependent receiving day care must live in your home at least eight (8) hours per day. The day care must be necessary for you and your spouse to remain gainfully employed. Day care may be provided through live-in care, babysitters, licensed day care/preschool centers, and after school care. You cannot use "before-tax" dollars to pay your spouse or one of your children under the age of nineteen (19) for providing day care. Schooling expenses at the kindergarten level and above, overnight camps, and nursing home care are not reimbursable.

Unlike health FSAs, dependent care FSAs may only reimburse expenses up to the amount you have contributed at any time during the year. If you submit a reimbursement request for an amount that is greater than your account balance, that amount will be pended until your next contribution is posted to your account and then any eligible amount(s) will be reimbursed to you.

Continued on next page

Flexible spending account administrative fees will be paid by MUS.

Reimbursement Options:
Claims are normally processed within 2 – 3 business days of receipt. You usually have a check in your mailbox or a direct deposit (if applicable) within 5 business days after WageWorks receives your claim. You may mail (WageWorks, PO Box 14053, Lexington, KY, 40512), fax toll-free (877-353-9236), or scan and send claims electronically at www.wageworks.com or via your mobile device.

Pay Me Back or Pay My Provider:
When filing a request for reimbursement, you may elect to have WageWorks make the payment direct to you **(Pay Me Back)** or you may elect to have WageWorks pay your provider directly **(Pay My Provider)**. You may also elect to have recurring payments for weekly dependent care expenses or recurring medical expenses such as orthodontic claims.

Direct Deposit:
When submitting **Pay Me Back** reimbursement requests, you may elect to receive your reimbursement via check or direct deposit. Sign up online for direct deposit at www.wageworks.com and WageWorks will electronically deposit reimbursements directly into your checking account.

Healthcare Debit Card: WageWorks sends debit cards as part of the Health FSA. One card is issued following enrollment and you may order additional cards, at no cost, by calling WageWorks or requesting online. You may use the Healthcare Debit Card to pay for eligible medical, dental or vision care expenses. Documentation for the expense may be required so it's a good rule of thumb to keep all receipts and other supporting documentation when you use your Healthcare Debit Card.

The WageWorks Healthcare© Card is the quick and easy way to pay for eligible healthcare expenses. You can also request reimbursement on a mobile device, by submitting an online claim, by toll-free fax, or through the mail. If the expense is normally covered by your medical, dental, or vision hardware coverage, please provide the Explanation of Benefits (EOB) as documentation to support your request. If your medical, dental, or vision hardware plan coverage will not cover the expense, an itemized statement from the provider will satisfy documentation requirements.

FSA Store:
Have funds you need to spend before the end of the plan year? WageWorks partners with FSA Store which houses one of the largest selections of guaranteed eligible Health Flexible Spending Account products. And, you can use your Healthcare Debit Card to conveniently order and pay for these items online!

All claims for eligible expenses that were incurred during the plan year (July 1, 2020 - June 30, 2021) must be received by WageWorks by September 30, 2021, 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, 2021, if the claims were incurred during your period of employment, and during the plan year. No exceptions can be made on late claims submissions.

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 or qualifying event. For more information about mid-year election changes, please contact your campus Human Resources/Benefits Office.

Questions? Need Help?

Contact your campus Human Resources Office or WageWorks. WageWorks Customer Service is available 24 hours a day / 7 days a week. Call 1-877-WageWorks (1-877-924-3967) or use the Live Chat function within the participant portal at www.wageworks.com.

Supplemental Life Insurance *(optional)*

Administered by Standard Insurance Co.
1-800-759-8702; www.standard.com/mybenefits/mus

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 a new employee, you may elect up to $300,000 in coverage during initial enrollment without submitting evidence of insurability.
- If a new hire elects $0 in coverage during their initial enrollment, they can add coverage of $25,000 at annual enrollment. If they want to elect more than $25,000 at annual enrollment, they are required to submit evidence of insurability.
- If you are not enrolling for the first time, you may increase one level of coverage during annual enrollment (up to $300,000) without having to submit evidence of insurability. You may also increase coverage more than one level, however, you will need to submit evidence of insurability for the increase above more than one level.
- Elections above $300,000 will always require evidence of insurability.
- An employee may decrease their coverage to any level or drop coverage completely during annual enrollment.
- An employee may increase or decrease their coverage one level or drop completely due to a qualifying event, as long as the change is consistent with the event (such as, a dependent is disenrolled, coverage can be decreased one level).

"The controlling provisions will be in the group policy issued by Standard Insurance Company. Neither the certificate nor the information presented in this booklet modifies the group policy or the insurance coverage in any way."

Optional Supplemental Life Monthly Rates (after-tax) -Employee Benefit (based on age of employee 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	$ 1.50	$ 3.00	$ 4.50	$ 6.00	$ 7.50	$ 9.00	$ 10.50	$ 12.00	$ 13.50	$ 15.00	$ 16.50	$ 18.00
30-34	$ 2.00	$ 4.00	$ 6.00	$ 8.00	$ 10.00	$ 12.00	$ 14.00	$ 16.00	$ 18.00	$ 20.00	$ 22.00	$ 24.00
35-39	$ 2.25	$ 4.50	$ 6.75	$ 9.00	$ 11.25	$ 13.50	$ 15.75	$ 18.00	$ 20.25	$ 22.50	$ 24.75	$ 27.00
40-44	$ 2.50	$ 5.00	$ 7.50	$ 10.00	$ 12.50	$ 15.00	$ 17.50	$ 20.00	$ 22.50	$ 25.00	$ 27.50	$ 30.00
45-49	$ 4.50	$ 9.00	$ 13.50	$ 18.00	$ 22.50	$ 27.00	$ 31.50	$ 36.00	$ 40.50	$ 45.00	$ 49.50	$ 54.00
50-54	$ 6.75	$ 13.50	$ 20.25	$ 27.00	$ 33.75	$ 40.50	$ 47.25	$ 54.00	$ 60.75	$ 67.50	$ 74.25	$ 81.00
55-59	$ 11.00	$ 22.00	$ 33.00	$ 44.00	$ 55.00	$ 66.00	$ 77.00	$ 88.00	$ 99.00	$ 110.00	$ 121.00	$ 132.00
60-64	$ 16.50	$ 33.00	$ 49.50	$ 66.00	$ 82.50	$ 99.00	$ 115.50	$ 132.00	$ 148.50	$ 165.00	$ 181.50	$ 198.00
65-69	$ 31.75	$ 63.50	$ 95.25	$ 127.00	$ 158.75	$ 190.50	$ 222.25	$ 254.00	$ 285.75	$ 317.50	$ 349.25	$ 381.00
70 & over	$ 67.25	$ 134.50	$ 201.75	$ 269.00	$ 336.25	$ 403.50	$ 470.75	$ 538.00	$ 605.25	$ 672.50	$ 739.75	$ 807.00

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	$ 19.50	$ 21.00	$ 22.50	$ 24.00	$ 25.50	$ 27.00	$ 28.50	$ 30.00	$ 31.50	$ 33.00	$ 34.50	$ 36.00
30-34	$ 26.00	$ 28.00	$ 30.00	$ 32.00	$ 34.00	$ 36.00	$ 38.00	$ 40.00	$ 42.00	$ 44.00	$ 46.00	$ 48.00
35-39	$ 29.25	$ 31.50	$ 33.75	$ 36.00	$ 38.25	$ 40.50	$ 42.75	$ 45.00	$ 47.25	$ 49.50	$ 51.75	$ 54.00
40-44	$ 32.50	$ 35.00	$ 37.50	$ 40.00	$ 42.50	$ 45.00	$ 47.50	$ 50.00	$ 52.50	$ 55.00	$ 57.50	$ 60.00
45-49	$ 58.50	$ 63.00	$ 67.50	$ 72.00	$ 76.50	$ 81.00	$ 85.50	$ 90.00	$ 94.50	$ 99.00	$ 103.50	$ 108.00
50-54	$ 87.75	$ 94.50	$ 101.25	$ 108.00	$ 114.75	$ 121.50	$ 128.25	$ 135.00	$ 141.75	$ 148.50	$ 155.25	$ 162.00
55-59	$ 143.00	$ 154.00	$ 165.00	$ 176.00	$ 187.00	$ 198.00	$ 209.00	$ 220.00	$ 231.00	$ 242.00	$ 253.00	$ 264.00
60-64	$ 214.50	$ 231.00	$ 247.50	$ 264.00	$ 280.50	$ 297.00	$ 313.50	$ 330.00	$ 346.50	$ 363.00	$ 379.50	$ 396.00
65-69	$ 412.75	$ 444.50	$ 476.25	$ 508.00	$ 539.75	$ 571.50	$ 603.25	$ 635.00	$ 666.75	$ 698.50	$ 730.25	$ 762.00
70 & over	$ 874.25	$ 941.50	$ 1,008.75	$ 1,076.00	$ 1,143.25	$ 1,210.50	$ 1,277.75	$ 1,345.00	$ 1,412.25	$ 1,479.50	$ 1,546.75	$ 1,614.00

Continued on next page.....

Optional Supplemental Dependent Life Insurance eligibility:

Optional Supplemental Dependent Life Insurance for your spouse and unmarried child(ren) from live birth to age 26 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 MUS employed member. You must enroll in employee optional supplemental life coverage to be eligible for spouse or child(ren) supplemental life coverage elections.

- Spouse elections cannot exceed 100% of the employee election (i.e., employee elects $100,000 for self, spouse maximum is $100,000).
- If you are a new employee, you may elect up to $50,000 in spousal coverage during initial enrollment without submitting evidence of insurability.
- If you are enrolling for the first time and did not elect spousal supplemental life coverage during your new employee initial enrollment and want to add spousal coverage at any level during annual enrollment, you must submit evidence of insurability.
- If a new employee only elects $25,000 in spousal coverage during their initial enrollment and they want to increase their spousal coverage to $50,000 at annual enrollment, you must submit evidence of insurability.
- If you are not enrolling for the first time and want to increase your spousal coverage to or over $50,000 at annual enrollment, you must submit evidence of insurability.
- An employee can add spousal coverage, if adding a spouse due to marriage or due to the spouse losing other insurance eligibility, they can add up to $50,000 without submitting evidence of insurability.
- Evidence of insurability is always required for spouse elections over $50,000.
- Employees may decrease spousal coverage to any level or drop completely during annual enrollment.
- Employees may increase or decrease their spousal coverage one level or drop completely due to a qualifying event, as long as the change is consistent with the event (such as birth of a child, coverage may be increased one level as long as it does not exceed 100% of the employee elected amount).

Optional Supplemental Life Monthly Rates (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	$ 1.50	$ 3.00	$ 4.50	$ 6.00	$ 7.50	$ 9.00	$ 10.50	$ 12.00	$ 13.50	$ 15.00	$ 16.50	$ 18.00
30-34	$ 2.00	$ 4.00	$ 6.00	$ 8.00	$ 10.00	$ 12.00	$ 14.00	$ 16.00	$ 18.00	$ 20.00	$ 22.00	$ 24.00
35-39	$ 2.25	$ 4.50	$ 6.75	$ 9.00	$ 11.25	$ 13.50	$ 15.75	$ 18.00	$ 20.25	$ 22.50	$ 24.75	$ 27.00
40-44	$ 2.50	$ 5.00	$ 7.50	$ 10.00	$ 12.50	$ 15.00	$ 17.50	$ 20.00	$ 22.50	$ 25.00	$ 27.50	$ 30.00
45-49	$ 4.50	$ 9.00	$ 13.50	$ 18.00	$ 22.50	$ 27.00	$ 31.50	$ 36.00	$ 40.50	$ 45.00	$ 49.50	$ 54.00
50-54	$ 6.75	$ 13.50	$ 20.25	$ 27.00	$ 33.75	$ 40.50	$ 47.25	$ 54.00	$ 60.75	$ 67.50	$ 74.25	$ 81.00
55-59	$ 11.00	$ 22.00	$ 33.00	$ 44.00	$ 55.00	$ 66.00	$ 77.00	$ 88.00	$ 99.00	$ 110.00	$ 121.00	$ 132.00
60-64	$ 16.50	$ 33.00	$ 49.50	$ 66.00	$ 82.50	$ 99.00	$ 115.50	$ 132.00	$ 148.50	$ 165.00	$ 181.50	$ 198.00
65-69	$ 31.75	$ 63.50	$ 95.25	$ 127.00	$ 158.75	$ 190.50	$ 222.25	$ 254.00	$ 285.75	$ 317.50	$ 349.25	$ 381.00
70 & over	$ 67.25	$ 134.50	$ 201.75	$ 269.00	$ 336.25	$ 403.50	$ 470.75	$ 538.00	$ 605.25	$ 672.50	$ 739.75	$ 807.00

An employee must enroll in self coverage equal to or greater than the amount elected for child coverage. No evidence of insurability is required for dependent child coverage at any level.

- New employees may elect up to $30,000 in dependent child coverage during initial enrollment.
- If you are enrolling for the first time and did not elect dependent child coverage during initial enrollment, you can add dependent child coverage of $5,000 at annual enrollment.
- Employees may increase or decrease their dependent child coverage one level or drop completely due to a qualifying event, as long as the change is consistent with the event (such as dependent child is disenrolled, coverage may be decreased one level or dropped completely).
- Employees may increase their dependent child coverage one level or decrease their coverage to any level or drop completely during annual enrollment.
- Disabled dependent children over the age of 26 who are covered on the Plan **MAY NOT** be covered on optional supplemental life coverage.

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

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
to age 26	$ .56	$1.12	$1.68	$2.24	$2.80	$3.36

Supplemental AD&D Coverage *(optional)*

Administered by Standard Insurance Co.
1-800-759-8702; www.standard.com/mybenefits/mus

Optional Supplemental AD&D Insurance eligibility:

This is an employee only benefit. If you enroll for Optional AD&D Insurance, your cost depends on the amount of coverage you select, as shown in the following table. No evidence of insurability is required for Optional AD&D coverage at any level. Remember, this cost is paid on an after-tax basis.

- If you are a new employee, you may elect any supplemental AD&D coverage amount during your initial enrollment.
- If you are enrolling for the first time and did not elect supplemental AD&D coverage during your new employee initial enrollment and want to add coverage, you may elect $25,000 in supplemental AD&D coverage at annual enrollment.
- If you are not enrolling for the first time, you may increase one level of coverage (increments of $25,000) during annual enrollment.
- Employees may decrease their coverage to any level or drop completely during annual enrollment.
- Employees may increase or decrease their coverage one level or drop completely due to a qualifying event, as long as the change is consistent with the event (such as increase coverage one level (such as birth of a child, coverage may be increased one level).

“The controlling provisions will be in the group policy issued by Standard Insurance Company. Neither the certificate nor the information presented in this booklet modifies the group policy or the insurance coverage in any way.”

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

$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000	$225,000	$250,000	$275,000	$300,000
$.56	$1.12	$1.68	$2.24	$2.80	$3.36	$3.92	$4.48	5.04	$5.60	6.16	6.72

$325,000	$350,000	$375,000	$400,000	$425,000	$450,000	$475,000	$500,000	$525,000	$550,000	$575,000	$600,000
$7.28	$7.84	$8.40	$8.96	$9.52	$10.08	$10.64	$11.20	11.76	$12.32	12.88	13.44

Paradise Valley, MT

Optional Supplemental Dependent AD&D Insurance eligibility:

Optional Supplemental Dependent AD&D Insurance for your spouse and unmarried child(ren) from live birth to age 26 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 supplemental AD&D coverage in order to elect supplemental AD&D coverage for dependents.

No evidence of insurability is required for spousal or dependent child coverage at any level.

- Spouse elections cannot exceed 100% of the employee election (i.e., employee elects $100,000 for self, spouse maximum is $100,000).
- If you are a new employee, you may elect any supplemental AD&D coverage amount for a spouse during initial enrollment, as long as it does not exceed 100% of the employee election amount.
- If you are enrolling for the first time and did not elect spousal supplemental AD&D coverage during your new employee initial enrollment and want to add spousal coverage, you may elect $25,000 in spousal supplemental AD&D coverage during annual enrollment as long as the employee has elected $25,000 in employee AD&D coverage.
- If you are not enrolling for the first time and want to increase your spousal supplemental AD&D coverage, you may increase one level of coverage (increments of $25,000) during annual enrollment, as long as it does not exceed 100% of the employee election amount.
- Employees may decrease their spousal coverage to any level or drop completely during annual enrollment.
- Employees may increase or decrease their spousal AD&D coverage one level or drop completely due to a qualifying event, as long as the change is consistent with the event (such as birth of a child, coverage may be increased one level as long as it does not exceed 100% of the employee elected amount).
- An employee can add spousal supplemental AD&D coverage in any amount if adding a spouse due to marriage or due to the spouse losing other insurance eligibility, as long as it does not exceed 100% of the employee election amount.

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

$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000	$225,000	$250,000	$275,000	$300,000
$.56	$1.12	$1.68	$2.24	$2.80	$3.36	$3.92	$4.48	5.04	$5.60	6.16	6.72

An employee must enroll in self coverage equal to or greater than the amount elected for dependent child coverage.

- New employees may elect any supplemental AD&D coverage amount for a dependent child during initial enrollment, as long as it does not exceed the employee election amount.
- If you are enrolling for the first time and did not elect dependent child supplemental AD&D coverage during initial enrollment, you can add dependent child coverage of $5,000 during annual enrollment.
- Employees can increase their dependent child coverage one level (increments of $5,000) during annual enrollment, as long as it does not exceed the employee election amount.
- Employees may decrease their dependent child coverage to any level or drop completely during annual enrollment.
- Employees may increase or decrease their dependent child coverage one level or drop completely due to a qualifying event, as long as the change is consistent with the event (such as birth of a child, coverage may be increased one level).
- Disabled dependent children over the age of 26 who are covered on the Plan **MAY NOT** be covered on optional supplemental AD&D coverage

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

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
to age 26	$.06	$.12	$.18	$.24	$.30	$.36

Long Term Care Insurance *(optional)*

Provided by UNUM Life Insurance Co.

1-800-227-4165 www.unuminfo.com/MontanaU/index.aspx

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 medical plan covers long term care situations when, in most cases, it may not, as those plans are designed to pay for specific care for acute conditions, not for long term care for daily living. We may be left thinking we should have planned better. The Long Term Care (LTC) plan is designed to pick up where our medical plan leaves off. You may never need long term care, however, if you experience an unexpected event, it is the type of care you may need if you couldn't independently perform the basic daily activities, such as bathing, dressing, continence and eating, or if you suffered from a cognitive impairment, such as Alzheimer's disease. This year about 12 million men and women will need long term care. A study by the US Department of Health and Human Services indicates that 70% of individuals over age 65 will require some type of long term care during their lifetime. The Montana University System (MUS) offers the opportunity to purchase Long Term Care Insurance from Unum Life Insurance Company of America.

Who is Eligible
Employees, retirees, and all family members are eligible for the Long Term Care Insurance Plan. This plan may be elected, changed, or dropped at any time.

New employees can enroll in LTC within 30 days of employment without demonstrating evidence of insurability. Continuing employees, retirees, and all family members can enroll in the MUS group LTC insurance with medical underwriting at any time.

If you or your family members would like to enroll in the Long Term Care Plan, contact your campus Human Resources/Benefits Office.

Additional Benefit Plan Information

Dependent Hardship Waiver

The MUS Benefit Plan offers a Dependent Premium Hardship Waiver to allow health care coverage for children. The family must first apply for Healthy Montana Kids (HMK) coverage for all children under the age of 19. If HMK denies coverage and the family has a financial hardship, an application may be submitted to MUS Benefits requesting the Dependent Premium 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. The family must re-apply for HMK and the Dependent Premium Hardship Waiver each Plan year in order to be eligible for the waiver. For more information, please contact your campus Human Resources/Benefits office or call MUS Benefits at 1-877-501-1722 or 406-449-9162.

Self Audit Award Program

Be sure to check all bills and EOBs from your medical providers to make sure that 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 MUS 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.

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

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

To receive the Self Audit Award, the member must:

- Notify the medical plan 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 medical plan claims administrator for verification, claims adjustment and calculation of the Self Audit Award.

Summary Plan Description (SPD)

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 contains the full legal description of the Plan's medical, dental, vision hardware, and prescription drug benefits and should always be consulted when a specific question arises about the Plan.

Participants may request a hard copy of the SPD by contacting their campus Human Resources/Benefits Office or the MUS Benefits Office at 1-877-501-1722. The SPD is also available online on the MUS *Choices* website at www.choices.mus.edu.

Summary of Benefits and Coverage (SBC)

The SBC is available on the MUS ***Choices*** website at www.choices.mus.edu/Publication_Notices.html. This document, required by PPACA, will outline what the MUS Medical Plan covers and what the cost share is for the member and the Plan for covered health care services.

Eligibility and enrollment for coverage in the Montana University System Employee Group Benefits Plan for persons (and their dependents) who are NOT active employees within MUS:
Detailed rules are published in the MUS Summary Plan Description in these sections:

- Eligibility
- Enrollment, Changes in Enrollment, Effective Dates of Coverage
- Leave, Layoff, Coverage Termination, Re-Enrollment, Survivors, and Retirement Options
- Continuation of Coverage Rights under COBRA

Each employee and former employee is responsible for understanding rights and responsibilities for themselves and their eligible dependents for maintaining enrollment in the Montana University System Employee Group Benefits Plan.

Coordination of Benefits: Persons covered by a health care plan through the Montana University System AND also by another non-liability health care coverage plan, whether private, employer-based, governmental (including Medicare and Medicaid), are subject to coordination of benefits rules as specified in the Summary Plan Description, Coordination of Benefits section. Rules vary from case to case by the circumstances surrounding the claim and by the active or retiree status of the member. In no case will more than 100% of a claim's allowed amount be paid by the sum of all payments from all applicable coordinated insurance coverages.

Note to Retirees eligible for Medicare coverage: All claims are subject to coordination of benefits with Medicare whether or not the covered person is actually receiving Medicare benefits. Retirees eligible for Medicare and paying Medicare Retiree premium rates as published in the ***Choices*** Retiree Workbook are required to be continuously enrolled in BOTH Medicare Part A and Medicare Part B.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Notice

The Montana University System 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 the Plan.

The HIPAA Notice can be accessed on the MUS Choices website at www.choices.mus.edu/Publication_Notices.html.

The Montana University System Group Benefit Plan contracts with individuals or entities known as Business Associates, who perform various functions on the Plan's behalf such as claims processing and other health-related services associated with the Plan, including claims administration or to provide support services, such as medical review or pharmacy benefit management services, etc.

The Montana University System's self-insured 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, payments, wellness programs (including WellChecks), lifestyle management programs (e.g., Take Control) healthcare operations, claims processing (including review of claims payments or denials, appeals, health care fraud and abuse detection, and compliance). Information concerning these categories may be shared, without a participant's written consent, between authorized MUS Benefits Division employees and MUS Business Associates, the participant's providers or legally authorized governmental entities.

Benefits Worksheet

Monthly Out-of-Pocket Benefit Premium Costs

MANDATORY (must choose) BENEFITS (unless you waive all benefits)			
MEDICAL PLAN	(Pre-Tax)	Medical Plan	(a)
DENTAL PLAN	(Pre-Tax)	Basic or Select	(b)
BASIC LIFE/AD&D INSURANCE	(Pre-Tax)		
		Basic Life/AD&D Insurance $15,000	(c)
		Basic Life/AD&D Insurance $30,000	(c)
		Basic Life/AD&D Insurance $48,000	(c)
LONG TERM DISABILITY	(Pre-Tax)		
		Option 1	(d)
		Option 2	(d)
		Option 3	(d)
TOTAL MANDATORY BENEFITS PREMIUM	**(Pre-Tax)**	**Add lines a,b,c and d**	**(e)**

OPTIONAL (voluntary) BENEFITS (Pre-Tax)	
VISION HARDWARE PLAN	(f)

PRE-TAX PREMIUM TOTALS			
MANDATORY BENEFITS	(Pre-Tax)	Enter amount from line (e)	(g)
OPTIONAL BENEFITS	(Pre-Tax)	Enter amount from line (f)	(h)
TOTAL BENEFITS	**(Pre-Tax)**	**Add lines (g) and (h)**	**(i)**
Employer Contribution for July 1 through June 30			$1,054 (j)

**Employer Contribution applies to medical, dental, basic life/AD&D, LTD and optional vision hardware

TOTAL MONTHLY OUT-OF-POCKET COST (Pre-Tax) **Subtract line (i) from line (j)** **(k)**

If line (k) is a negative amount, this is the left-over employer contribution amount. If line (k) is positive, this amount is your out-of-pocket expense. THIS IS PRE-TAX ONLY

FLEXIBLE SPENDING ACCOUNT ELECTIONS		
MEDICAL (HEALTH) FLEXIBLE SPENDING	(Pre-Tax)	(l)
Minimum $120/year Maximum $2,750/year		
DEPENDENT CARE	(Pre-Tax)	(m)
Minimim $120/year Maximum $5,000/year		
TOTAL FLEXIBLE SPENDING MONTHLY PREMIUM	**Add lines (l) and (m)**	**(n)**

Flexible Spending Account (FSA): Employees have the option to elect an FSA using Pre-Tax employee salary reduction funds. Employer funds (excess employer contribution) are not permitted.

OPTIONAL (voluntary) BENEFITS	**(Post-Tax)**		
SUPPLEMENTAL LIFE (EMPLOYEE)	(Post-Tax)		(o)
SUPPLEMENTAL LIFE (SPOUSE)	(Post-Tax)		(p)
SUPPLEMENTAL LIFE (CHILD(REN))	(Post-Tax)		(q)
SUPPLEMENTAL AD&D (EMPLOYEE)	(Post-Tax)		(r)
SUPPLEMENTAL AD&D (SPOUSE)	(Post-Tax)		(s)
SUPPLEMENTAL AD&D (CHILD(REN))	(Post-Tax)		(t)
TOTAL OPTIONAL BENEFITS	**(Post-Tax)**	**Add lines (o) through (t)**	**(u)**

TOTAL MONTHLY OUT-OF-POCKET COST PRE-TAX and POST-TAX **Add lines (k), (n) and (u)** **(v)**

Glossary

Allowed Amount

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

Balance Billing

This amount is the difference between the actual billed amount and the allowed amount for services provided by an Out-of-Network provider or the billed amount for a non-covered service.

Benefit Plan Year

The period starting July 1 and ending June 30.

Certification/Pre-Certification

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

Coinsurance

A percentage of the allowed amount for covered health care services that a member is responsible for paying, after paying any applicable deductible. For example, if Jack has met his deductible for In-Network medical costs ($1,250), he pays 30% of the allowed amount up to the Out-of-Pocket Maximum and the Plan pays 70%.

Copayment

A fixed dollar amount the member pays for a covered health care service, usually at the time the member receives the service. The Plan pays the remaining allowed amount.

Covered Charges

Charges for health care services that are determined to be medically necessary and are eligible for payment under the Plan.

Deductible

A set dollar amount that a member must pay for covered health care services before the medical plan pays. The deductible applies to the plan year (July 1 through June 30). For example, Jack's deductible is $1,250. Jack pays 100% of the allowed amount until his deductible has been met.

Diagnostic

A type of service that includes tests or exams usually performed for monitoring a disease or condition which you have signs, symptoms, or prevailing medical history for.

Emergency Services

Evaluation and treatment of an emergency medical condition (illness, injury, or serious condition). Emergency Services are covered everywhere; however, Out-of-Network providers may balance bill the difference between the allowed amount and the charge.

Fee Schedule

A fee schedule is a complete listing of fees used by the Plan to reimburse providers and suppliers for providing selected health care services. The comprehensive listing of fee maximums is used to reimburse a provider on a fee-for-service or flat-fee basis.

In-Network Provider

A provider who has a participating contract with the medical plan claims administrator to provide health care services for Plan members and to accept the allowed amount as payment in full. Also called "preferred provider" or "participating provider". Members will pay less out-of-pocket expenses if they see an In-Network provider.

Out-of-Network Provider

Any provider who provides services to a member but does not have a participating contract with the medical plan claims administrator. Also called "non-preferred provider" or non-participating provider". Members will pay more out-of-pocket expenses if they see an Out-of-Network provider.

Out-of-Pocket Maximum

The maximum amount of money a member pays toward the cost of covered health care services. Out-of-pocket expenses include deductibles, copayments, and coinsurance. For example, Jack reaches his $4,350 Out-of-Pocket Maximum. Jack has seen his doctor often and paid $4,350 total (deductible + coinsurance + copays). The Plan pays 100% of the allowed amount for covered charges for the remainder of the plan year. Balance billing amounts (the difference between Out-of-Network provider charges and the allowed amount) do not apply to the Out-of-Pocket Maximum.

Plan

Healthcare benefits coverage offered to members through the employer to assist with the cost of covered health care services.

Preventive Services

Routine health care, including screenings and exams, to prevent or discover illnesses, disease, or other health problems.

Prior Authorization

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

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.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine, nurse practitioner, clinical nurse specialist or physician assistant) who directly provides or coordinates a range of health care services for or helps access health care services for a patient.

Screening

A type of preventive service that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Specialist

A physician specialist who focuses on a specific area of medicine to diagnose, manage, prevent or treat certain types of symptoms and conditions.

CAMPUS Human Resources/Benefits Offices

MSU - Bozeman	920 Technology Blvd, Ste. A, Bozeman, MT 59717	406-994-3651
MSU - Billings	1500 University Dr., Billings, MT 59101	406-657-2278
MSU - Northern	300 West 11th Street, Havre, MT 59501	406-265-3568
Great Falls College - MSU	2100 16th Ave. S., Great Falls, MT 59405	406-268-3701
UM - Missoula	32 Campus Drive, LO 252, Missoula, MT 59812	406-243-6766
Helena College - UM	1115 N. Roberts, Helena MT 59601	406-447-6925
UM - Western	710 S. Atlantic St., Dillon, MT 59725	406-683-7010
MT Tech - UM	1300 W. Park St., Butte, MT 59701	406-496-4380
OCHE, MUS Benefits Office	560 N. Park Ave, Helena, MT 59620	877-501-1722
Dawson Community College	300 College Dr., Glendive, MT 59330	406-377-9430
Flathead Valley Community College	777 Grandview Dr., Kalispell, MT 59901	406-756-3981
Miles Community College	2715 Dickinson St., Miles City, MT 59301	406-874-6292

RESOURCES

Montana University System Benefits Office
Office of the Commissioner of Higher Education
Toll Free 877-501-1722 * Fax (406) 449-9170
www.choices.mus.edu

MEDICAL PLAN & VISION HARDWARE PLAN

BLUE CROSS BLUE SHIELD OF MONTANA
Customer Service 1-800-820-1674 or 406-447-8747
www.bcbsmt.com

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

WAGEWORKS INC
Flex Plan Administrator 1-877-924-3967
www.wageworks.com

Navitus – PRESCRIPTION DRUG PLAN

Customer Service 1-866-333-2757
www.navitus.com

RIDGEWAY MAIL ORDER PHARMACY – www.ridgeway.pharmacy/
Customer Service 1-800-630-3214
Fax: 406-642-6050

COSTCO MAIL ORDER PHARMACY - www.pharmacy.costco.com
Customer Service 1-800-607-6861
Fax: 1-888-545-4615

miRx MAIL ORDER PHARMACY - www.mirxpharmacy.com
Customer Service 1-866-894-1496
Fax: (406) 869-6552

LUMICERA HEALTH SERVICES - www.lumicera.com
Customer Care: 1-855-847-3553

STANDARD LIFE INSURANCE – Life/AD&D & Long Term Disability
Customer Service 1-800-759-8702
www.standard.com/mybenefits/mus

UNUM LIFE INSURANCE – Long Term Care
Customer Service 1-800-227-4165
www.unuminfo.com/MontanaU/index.aspx