choices

Retiree Benefits

2022 - 2023
Montana University System

MUS Annual Enrollment – April 25, 2022 - May 13, 2022

Please Read

Retiree Annual Enrollment
Benefits Presentation
Live, interactive webcast: Friday, April 22, 2022, at 2:00 p.m.
Access from the MUS ***Choices*** website home page at choices.mus.edu

On-Demand Benefits Presentation
Available on April 27, 2022 at choices.mus.edu

• If you do not want to make any enrollment or benefit changes to your Montana University System (MUS) ***Choices*** Retiree Benefit Plan (MUS Plan), you do not need to submit a Retiree Enrollment Form and will automatically be enrolled in your current benefit elections and coverage levels.

• If you are making enrollment or benefit changes to your MUS ***Choices*** Retiree Benefit Plan, you must return your completed Retiree Enrollment Form with your changes to your campus Human Resources/Benefits Office **no later than May 13, 2022.**

• If you choose to waive any of your MUS ***Choices*** Retiree Benefit Plan coverage(s), you **must** return your completed Retiree Enrollment Form declining coverage(s) to your campus Human Resources/Benefits Office **no later than May 13, 2022.**

MUS retirees who pay their monthly premium payments via direct bill will continue to submit their monthly premium payments directly to Businessolver. Businessolver offers online payments (accessed from the MUS ***Choices*** home page at choices.mus.edu), scheduled automated clearing house (ACH) transactions, or physical statement coupons.

MUS retirees who pay their monthly premium payments via the Montana Teachers' Retirement System (TRS) or the Montana Public Employees' Retirement System (PERS) will continue to have their monthly premiums automatically deducted from their pension plan. If you need to change your premium payments from a pension plan deduction to direct bill as of July 1, 2022, please contact your campus Human Resources/Benefits office to assist you with this change.

Campus Human Resources/Benefits Office Contacts		
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, Lommasson, Room 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

Table of Contents

Montana Wildflower

Glacier National Park, MT

Choices Enrollment for a Retiree

Benefit Plan Year July 1 – June 30

To select ***Choices*** benefit options as a Retiree, you must complete and return a Retiree Enrollment Form to your campus Human Resources/Benefits office to make your benefit elections:

- within 63 days of retirement and becoming eligible for Retiree benefits. If you do not enroll within the 63-day enrollment period, you will permanently forfeit your eligibility for all Retiree Choices Benefit Plan coverages.
- during annual enrollment by the stated deadline. **If you do not make any benefit changes, you will automatically be enrolled in your current benefit elections and coverage levels or to the stated default coverage if your existing plan(s) is/are changing.**
- when you have a mid-year qualifying event (marriage, birth or adoption of a child, loss or gain of eligibility for other health insurance coverage - voluntarily canceling other health insurance does not constitute loss of eligibility) and want to make an allowed mid-year change in benefit elections. **This change must be made within 63 days of the event.** Documentation to support the change will be required.

MEDICARE ENROLLMENT: Retirees and/or their covered dependents who are or become Medicare-eligible (age 65) at retirement or after, **must** be enrolled in **BOTH** Medicare Part A and Medicare Part B. If Medicare enrollment is not completed within sixty-three (63) days from the date of the employee's retirement or the retiree's and/or covered dependent's Medicare eligibility date, the individual(s) will be disenrolled from the MUS ***Choices*** Medical and Prescription Drug Plans. Enrollment in the Select Dental Plan and/or Vision Hardware Plan may be continued if the Medicare-eligible Retiree and/or covered dependent is enrolled in those plans at retirement or on the date of Medicare eligibility even if they are disenrolled from the MUS ***Choices*** Medical and Prescription Drug Plans due to not enrolling in Medicare Part A and Part B.

No Retreat Rights:
If you waive Retiree Medical, Dental, and/or Vision Hardware Plan coverage(s), you and your eligible dependents will permanently forfeit your coverage(s) and will **NOT** be allowed to enroll in the future.

If you are waiving coverage for your eligible dependents (including your legal spouse), as those persons are defined by the MUS Summary Plan Description (SPD) because they are currently covered by another health insurance plan, you may be able to enroll your eligible dependents for coverage under the MUS Plan in the future, provided you request such coverage within 63 days after their other coverage ends.

If you acquire an eligible dependent, as defined by the MUS SPD, due to marriage, birth, adoption or placement for adoption of a child under the age of 18, you may enroll your newly acquired dependent child(ren) or legal spouse for coverage under the MUS Plan, provided that such enrollment occurs within 63 days after the event.

Reminder: Enrollment for FY2023 is Closed Enrollment for legal spouses unless there is a qualifying event (see SPD for qualifying events).

Step-by-Step Process for Completing Your *Choices* Retiree Enrollment Form

Step 1: Review this workbook carefully and read the back of the Retiree Enrollment Form:

- Discuss this information with your legal spouse and/or other family members.
- Determine your benefit needs for the coming benefit Plan Year if you are enrolling during annual enrollment or for the remainder of the current benefit Plan Year if a new Retiree.
- This enrollment workbook is not a guarantee of benefits.

Enrollment in Retiree coverage is a one-time opportunity.

Step 2: Complete your Retiree Enrollment Form: Your Retiree Enrollment Form should be included with this workbook. In the event your Retiree Enrollment Form is missing or you need another copy, please contact your campus Human Resources/Benefits Office (see inside cover).

Medical Plan Coverage (includes Prescription Drug Plan): For Medical Plan coverage, you must be qualified to enroll (see back of enrollment form). If you do not make an election to continue your Medical Plan coverage when you first retire, you will permanently forfeit your Medical Plan coverage.

- Choose the coverage level you want.
- Once you have selected a coverage level, fill in the corresponding monthly premium amount in the space provided on the enrollment form, by "Medical Premium".
- **or** check the box that declines Medical Plan coverage entirely.

Medicare Part D Prescription Drug Plan Coverage:

- Medicare primary Retiree Medical Plan enrollees will automatically be enrolled in the Navitus MedicareRx Plan (page 13).
- If you opt out of the Navitus MedicareRx Plan or get another Medicare Part D plan, you will forfeit your Medical Plan coverage.

Dental Plan Coverage: For Dental Plan coverage, you must be qualified to enroll (see back of enrollment form). Retirees are offered enrollment in the Select Dental Plan only. If you do not make an election to continue your Dental Plan coverage when you first retire, you will permanently forfeit your Dental Plan coverage.

- Choose the coverage level you want.
- Once you have selected a coverage level, fill in the corresponding monthly premium amount in the space provided on the enrollment form, by "Dental Premium".
- **or** check the box that declines Dental Plan coverage entirely.

Vision Hardware Plan Coverage: For Vision Hardware Plan coverage, you must be qualified to enroll (see back of enrollment form). You cannot enroll in Vision Hardware Plan coverage as a retiree if you were not enrolled in coverage prior to retirement. If you do not make an election to continue your Vision Hardware Plan coverage when you first retire, you will permanently forfeit your Vision Hardware Plan coverage.

- Choose the coverage level you want.
- Once you have selected a coverage level, fill in the corresponding monthly premium amount in the space provided on the enrollment form, by "Vision Premium".
- **or** check the box that declines Vision Hardware Plan coverage entirely.

Step 3: Total Your Costs:

- Add up the total monthly premium amounts and fill in the corresponding monthly premium amount in the space provided on the enrollment form, by "Total Monthly Premium".
- Arrange with your campus Human Resources/Benefits Office for automatic payment of your premiums through your pension plan or a direct bill payment account.

Step 4: Demographic and Dependent Coverage: Please complete these sections each time you fill out the Retiree Enrollment Form. If you have questions, consult your enrollment workbook, SPD, or contact your campus Human Resources/Benefits Office (see inside cover).

How the *Choices* Medical Plan Works

When a Plan member receives medical services from an **In-Network Provider,** the provider will submit a claim to the Plan claim's administrator for the member. The Plan claim's administrator will process the claim and send an Explanation of Benefits (EOB) to the member and the provider, showing the member's payment responsibilities (deductible, copayments, and/or coinsurance costs). The Plan then pays the remaining allowed amount. The provider **will not** balance bill the member the difference between the billed charge and the allowed amount.

When a Plan member receives medical services from an **Out-of-Network Provider**, the member must verify if the provider will submit the claim to the Plan claim's administrator or if the member must submit the claim. The Plan claim's administrator will process the claim and send an EOB to the member showing the member's payment responsibilities (deductible, coinsurance, and any difference between the allowed amount (balance billing)). The Plan pays the remaining allowed amount. The Out-of-Network Provider may balance bill the member the difference between the billed charge and the allowed amount.

Members may self-refer to any health care provider, however, there is a cost savings for medical services received by an In-Network Provider.

Definition of Terms

In-Network Providers – Providers who have contracted with the Plan claim's administrator to manage and deliver care at agreed upon allowed amounts. You pay a $30 copayment for Primary Care Physician (PCP) office visits and a $50 copayment for Specialty provider office visits to In-Network Providers (no deductible) and 30% coinsurance (after deductible) for most In-Network outpatient/ inpatient services.

Out-of-Network Providers - Providers who do not have a contract with the Plan claim's administrator. You pay 40% of the allowed amount (after a separate deductible) for services received from an Out-of-Network Provider.

Out-of-Network providers **may** balance bill you for any difference between their billed charge and the allowed amount.

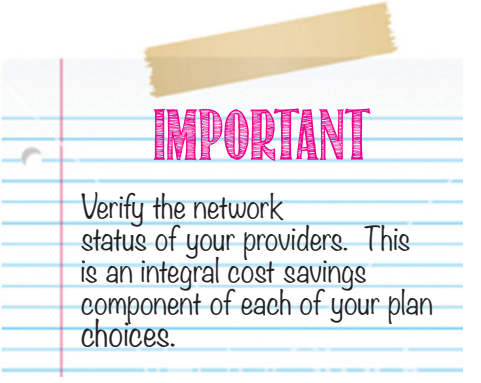
Emergency Services - Emergency services are covered everywhere; however, Out-of-Network Providers **may** balance bill the difference between the allowed amount and the billed charge.

Deductible - The amount you pay each benefit Plan Year before the Plan begins to pay.

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.

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

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



Medical Plan (*optional*)

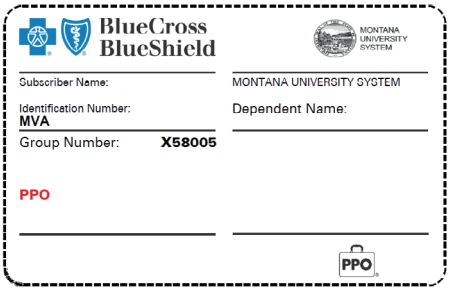
BlueCross BlueShield of Montana
An Independent Licensee of the Blue Cross and Blue Shield Association

Administered by BlueCross BlueShield of Montana, 1-800-820-1674 or 447-8747, bcbsmt.com

Choices offers a Medical Plan for Retirees and their eligible dependents.

Continuation of enrollment in the Medical Plan is a one-time opportunity for Retirees (and their eligible dependents) at retirement. Coverage is permanently forfeited if the Retiree fails to continue enrollment, cancels Medical coverage, or fails to pay premiums. **Note:** A legal spouse reaching age 65 is not a qualifying event for re-enrolling in Medical coverage.

BlueCross BlueShield Medical



Non-Medicare Retirees (generally under age 65)

	Monthly Medical Plan Rates
Retiree/Survivor Only	$981
Retiree + One	$1,962
Retiree + Two or More	$2,452
Retiree + Spouse (Medicare primary)	$1,354
Retiree + Spouse (Medicare primary) + Child(ren)	$1,845
Survivor + Child(ren)	$1,471

Medicare enrolled Retirees (generally 65 and older)

	Monthly Medical Plan Rates
Retiree/Survivor Only	$368
Retiree + One	$1,354
Retiree + Two or More	$1,845
Retiree + Spouse (Medicare primary)	$736
Retiree + Spouse (Medicare primary) + Child(ren)	$1,219
Survivor + Child(ren)	$851

Schedule of Medical Benefits

FY2023

	In-Network	Out-of-Network *
Deductible Applies to all covered services, unless otherwise noted or copayment is indicated.	$1,250/Person $2,500/Family	Separate $2,500/Person Separate $5,000/Family
Copayment (outpatient office visits) Primary Care Physician Visit (PCP) Specialty Provider Visit	$30 copay $50 copay	N/A N/A
Coinsurance Percentage (% of allowed charges member pays)	30%	40%
Out-of-Pocket Maximum (Maximum amount paid by member in a Plan Year for covered services; includes deductibles, copays and coinsurance)	$4,350/Person $8,700/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 **may** balance bill the difference between their billed charge and the allowed amount.

Two Medicine Lake, MT

Churchill, MT

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

(In-Network) **Jack's Plan deductible is $1,250, coinsurance is 30%, and out-of-pocket max is $4,350.**

July 1
Beginning Plan Year

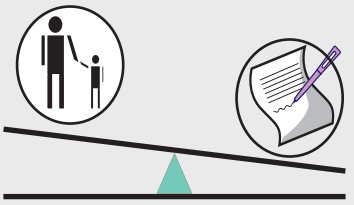
→ more costs → more costs

June 30
End of Plan Year

Jack pays $30 office visit copay and 100% of allowed amount for lab work

Plan pays remainder of office visit

Jack has not reached his deductible yet and he visits the doctor and has lab work. He pays $30 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 lab work is $850. The Plan allows $100 for the office visit and $400 for the lab work. Jack pays $30 for the office visit and $400 for the lab work. The Plan pays $70 for the office visit and $0 for the lab work. The In-Network Provider writes off $500.



Jack pays $30 office visit copay and 30% of allowed amount for lab work

Plan pays remainder of office visit and 70% of allowed amount

Jack has seen the doctor several times and reaches his $1,250 deductible. He pays $30 for the office visit and 30% of the allowed amount for lab work and the Plan pays the remainder of the office visit + 70% of the allowed amount. **For example,** Jack's doctor visit totals $1,000. The office visit is $150 and lab work is $850. The Plan allows $100 for the office visit and $400 for the lab work. Jack pays $30 for the office visit and $120 for the lab work. The Plan pays $70 for the office visit and $280 for the lab work. The In-Network Provider writes off $500.

Jack pays 0%

Plan pays 100% allowed amount

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. **For example**, Jack's doctor visit totals $1,000. The office visit is $150 and lab work is $850. The Plan allows $100 for the office visit and $400 for the lab work. Jack pays $0 and the Plan pays $500. The In-Network Provider writes off $500.

(Out-of-Network) **Jack's Plan deductible is $2,500, coinsurance is 40%, and out-of-pocket max is $6,000.**

July 1
Beginning Plan Year

→ more costs → more costs

June 30
End of 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.

Jack pays 40% + any difference between provider charge and Plan allowed amount.

Plan pays 60% of allowable

Jack has seen the doctor several times and reaches his $2,500 deductible. His Plan pays some of the costs of his next visit. He pays 40% 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 40% of the allowed amount ($200) + the difference between the provider charge and the Plan allowed amount ($500). Jack's total responsibility is $700. The Plan pays 60% of the allowed amount ($300).

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

Plan pays 100% of allowed amount

Jack reaches his $6,000 out-of-pocket maximum. Jack has seen his doctor often and paid $6,000 total (deductible + coinsurance). The Plan pays 100% of the allowed amount for covered charges for the remainder of the Plan 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	Out-of-Network
Hospital Inpatient Services Pre-Certification of non-emergency inpatient hospitalization is strongly recommended		
Room & Board Charges	30%	40%
Ancillary Services	30%	40%
Surgical Services (See Summary Plan Description for surgeries requiring prior authorization)	30%	40%
Hospital Outpatient Services		
Outpatient Services	30%	40%
Outpatient Surgery Center Services	30%	40%
Physician/Professional Provider Services (not listed elsewhere)		
Primary Care Physician (PCP) Office Visit - Includes Telemedicine and Naturopathic visits **Note:** Naturopathic visits are processed In-Network, however, the member may be balance billed the difference between the billed charge and the allowed amount.	$30 copay/visit (for office visit only - lab, x-ray & other procedures are subject to deductible/coinsurance)	40%
Specialty Provider Office Visit - Includes Telemedicine visits	$50 copay/visit (for office visit only - lab, x-ray & other procedures are subject to deductible/coinsurance)	40%
Inpatient/Outpatient Physician Services	30%	40%
Lab/Ancillary/Misc. Services	30%	40%
Eye Exam (preventive or medical)	0% one/Plan Year	40% one/Plan Year
Second Surgical Opinion	0%/visit (for office visit only - lab, x-ray & other procedures are subject to deductible/coinsurance)	40%
Emergency Services		
Ambulance Services for Medical Emergency	$200 copay/transport	$200 copay/transport
Emergency Room 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 Provider Services	30%	30%
Urgent Care Services		
Facility/Professional Services	$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 Services	30%	30%

Schedule of Medical Benefits FY2023

Medical Plan Services	In-Network	Out-of-Network
Maternity Services		
Hospital Services	30%	40%
Physician Services (delivery & inpatient)	30% (waived if enrolled in WellBaby Program within first trimester)	40%
Prenatal Office Visit	$30 copay/visit	40%
Preventive Services		
Preventive screenings/immunizations (adult & Well-Child care) Refer to pages 11 & 12 for listing of In-Network Preventive Services covered at 100% of the allowed amount and age recommendations.	0% (limited to services listed on pgs 11 & 12. Other preventive services subject to deductible and coinsurance)	40%
Mental Health/Chemical Dependency Services		
Inpatient Services (Pre-Certification is recommended)	30%	40%
Outpatient Visit (this is a combined max of 4 visits at $0 copay for mental health and chemical dependency services) - Includes Telemedicine visits	First 4 visits $0 copay, then $30 copay/visit	40%
Rehabilitative Services Physical, Occupational, Speech, Cardiac, Respiratory, Pulmonary, and Massage Therapies; Acupuncture and Chiropractic		
Inpatient Services (Pre-Certification is recommended)	30% Max: 30 days/Plan Year	40% Max: 30 days/Plan Year
Outpatient Services (this is a combined max of 60 visits for all outpatient rehabilitative services) - Includes Telemedicine visits **Note:** Acupuncture & Massage Therapy visits are processed In-Network, however, the member may be balance billed the difference between the billed charge and the allowed amount.	$30 copay/visit Max: 60 visits/Plan Year	40% Max: 60 visits/Plan Year

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

Medical Plan Services	In-Network	Out-of-Network
Extended Care Services		
Home Health Care Visit (Prior Authorization is recommended)	$30 copay/visit Max: 30 visits/Plan Year	40% Max: 30 visits/Plan Year
Hospice Services	30% Max: 6 months	40% Max: 6 months
Skilled Nursing Facility Services (Prior Authorization is recommended)	30% Max: 30 days/Plan Year	40% Max: 30 days/Plan Year
Miscellaneous Services		
Allergy Shots	$50 copay/visit (for office visit only- if no office visit, deductible & coinsurance waived)	40%
Durable Medical Equipment, Prosthetic Appliances & Orthotics (Prior Authorization is recommended for amounts greater than $2,500)	30% Max: $200/Plan Year for foot orthotics	40% Max: $200/Plan Year for foot orthotics

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

Schedule of Medical Benefits …….. FY2023

Medical Plan Services	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Miscellaneous Services cont.		
PKU Supplies (Includes treatment & medical foods)	0% (no deductible)	40%
Hearing Aids Pediatric- 18 years or younger Adult- 19 years or older (See SPD for benefit details) Note: Hearing Aids are processed In-Network	30% Pediatric- 1/ear every 3 years Adult- $2,000/ear lifetime maximum	30% Pediatric- 1/ear every 3 years Adult- $2,000/ear lifetime maximum
Dietary/Nutritional Counseling Visit - Includes Telemedicine visits	First 8 visits $0 copay, then $30 copay/visit	40%
Obesity Management (Prior Authorization required)	30% (must be enrolled in Take Control program for non-surgical treatment)	40%
TMJ (Prior Authorization recommended)	30% (surgical treatment only)	40%
Organ Transplants		
Transplant Services (Prior Authorization required)	30%	40%
Travel Reimbursement		
Travel reimbursement for patient only - If services are not available in your local area (Prior Authorization required) (See SPD for travel reimbursement details)	0% - up to $1,500/Plan Year - up to $5,000/transplant	0% -up to $1,500/Plan Year -up to $5,000/transplant
Wellness Program		
Preventive Health Screenings Healthy Lifestyle Education & Support	see pg 22	
WellBaby Program		
Take Control Lifestyle Management Program Diabetes, Weight Loss, Tobacco Use, High Cholesterol, High Blood Pressure		
Virgin Pulse Incentive Program		

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

Preventive Services

Pine Creek Lake, 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.

Note: When covered preventive care services are provided by In-Network Providers, the services are reimbursed at 100% of the allowed amount, without application of deductible, coinsurance, or copay. Preventive care services provided by an Out-of-Network Provider have a 40% coinsurance and a separate deductible and Out-of-Pocket maximum. An Out-of-Network Provider **may** balance bill the difference between their billed charge and the allowed amount.

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: uspreventiveservicestaskforce.org
Advisory Committee on Immunization Practices (ACIP): cdc.gov/vaccines/acip/
CDC: cdc.gov
Bright Futures: brightfutures.org
Secretary Advisory Committee: 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 the Medical 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 evaluation office visit with the doctor performing the colonoscopy, colonoscopy procedure, the ambulatory facility fee, anesthesiology (if necessary), and pathology will be reimbursed as preventive, provided they are submitted with accurate preventive coding.

See next page for listing of covered Preventive Services.

Covered Preventive Services

Periodic Exams Appropriate screening tests per Bright Futures and other sources (previous page)	
Well-Child Care Infant through age 17	• Age 0 months through 4 years (up to 14 visits) • Age 5 years through 17 years (1 visit/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 years through 65+ (1 visit/Plan Year)
Preventive Screenings	
Anemia Screening	• Pregnant Women
Bacteriuria Screening	• Pregnant Women
Breast Cancer Screening (mammography)	• Women age 40+ (1 per Plan Year)
Cervical Cancer Screening (PAP)	• Women age 21 - 65 (1 per 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 Plan Year OR • Sigmoidoscopy; every 5 years OR • Colonoscopy; every 10 years
Prostate Cancer Screening (PSA) age 50+	• 1 per Plan Year (age 40+ with risk factors)
Osteoporosis Screening	• Post-menopausal women age 65+, or age 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	
Diphtheria, Tetanus, Pertussis (DTaP) (Tdap) (Td); Haemophilus Influenza (Hib); Hepatitis A (HepA) & B (HepB); Human Papillomavirus (HPV); Influenza; Measles, Mumps, Rubella (MMR); Meningococcal (MenACWY) (MenB), Pneumococcal (Pneumonia) (PCV13); Poliovirus (IPV); Rotavirus (RV); Chickenpox (Varicella); Zoster (Shingles); Coronavirus (COVID-19); Tuberculosis testing (TB). **Influenza, Zoster (Shingles), and COVID-19 vaccinations are reimbursed at 100% via the Navitus Prescription Drug Plan.** **For recommended immunization schedules for all ages, visit the CDC website at cdc.gov/vaccines/index.html**	

Prescription Drug Plan

(Included in Medical Plan)

Administered by Navitus Health Solutions

Who is eligible?
All MUS Medical Plan enrollees and their eligible dependents will automatically be enrolled in Navitus Health Solutions Prescription Drug Plan (PDP) coverage (non-Medicare enrollees (Commercial Plan)/Medicare primary enrollees (MedicareRx (Part D) Plan)). There is no separate premium and no deductible for prescription drugs.

How do I access my PDP information? To access more information about the Navitus PDPs, including the MUS-specific participating network pharmacy directory and the complete prescription drug formulary (preferred drug list), you will need to register on the Navitus Member Portal (see next page). If you have questions regarding the drug formulary or pharmacy directory, contact Navitus Customer Care (see next page).

To determine your MUS PDP drug tier level and copay amount before going to the pharmacy, consult the Drug Schedule of Benefits, log into the Navitus Member Portal, or contact Navitus Customer Care (see next page).

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.

Retail Pharmacy Network
NOTE: CVS/Target pharmacies are not part of the MUS PDP participating pharmacy network. If you choose to use these pharmacies, you will be responsible for all charges. This is not applicable to Navitus MedicareRx enrollees.

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 next page).

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, contact Lumicera Customer Care (see next page).

You can access the Lumicera specialty pharmacy Frequently Asked Questions (FAQs) at lumicera.com/Patients/FAQ.aspx.

Medicare Part D Plan
The Medicare PDP, Navitus MedicareRx, is a Medicare Part D prescription drug plan (PDP). Like all Medicare Part D plans, this Medicare PDP is approved by Medicare and run by a private company (Navitus).

- Enrollment in another Medicare Part D drug plan is not permitted.
- MUS Medicare primary Retiree Plan members cannot be covered on another MUS Medicare primary Retiree Plan as a legal spouse (dual enrollment).
- Medicare-eligible Plan members **must** be enrolled in **BOTH** Medicare Part A and B to be eligible for this drug plan and to remain on the MUS Medical Plan.

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/Plan Year Family: $4,300/Plan Year Individual: $2,150/Calendar Year (MedicareRx) Family: $4,300/Calendar Year (MedicareRx)	

Questions?

Navitus Customer Care
call 24 hours/day | 7 days/week
(Closed Thanksgiving and Christmas Day)

Commercial Plan (Non-Medicare)
1-866-333-2757
navitus.com

MedicareRx Plan (Medicare)
1-866-270-3877
medicarerx.navitus.com

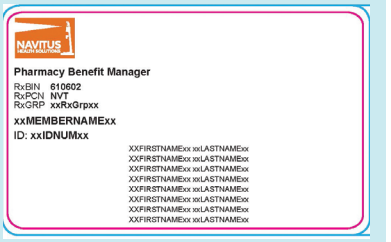
Lumicera Customer Care
1-855-847-3553
Monday - Friday 8 a.m. to 7 p.m. CST
lumicera.com

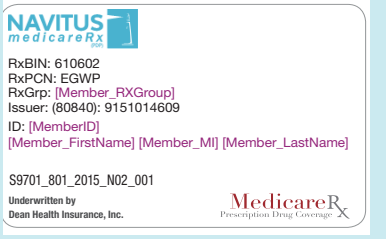
Costco
1-800-607-6861
costco.com/Pharmacy/home-delivery

Ridgeway:
1-800-630-3214
ridgeway.pharmacy

miRx:
1-866-894-1496
mirxpharmacy.com

Sample Pharmacy Cards





Dental Plan (*optional*)

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

Choices offers one Dental Plan option for Retirees and their eligible dependents: **Select Plan**

Continuation of enrollment in the Dental Plan is a one-time opportunity for Retirees (and their eligible dependents)at retirement. Coverage is permanently forfeited if the Retiree fails to continue enrollment, cancels Dental coverage, or fails to pay premiums. **Note:** A legal spouse reaching age 65 is not a qualifying event for re-enrolling in Dental coverage.

Monthly Dental Plan Rates	• Retiree/Survivor Only $52 • Retiree & Spouse $94 • Retiree/Survivor & Child(ren) $94 • Retiree & Family $156
Diagnostic & Preventive Services	Twice/Plan Year: • Initial and periodic oral exam • Cleaning • Complete series of intraoral X-rays • Topical application of fluoride The above services **do not** count towards the $2,000 annual benefit maximum (see below).
Basic Restorative Services	• Amalgam filling • Endodontic treatment • Periodontic treatment • Oral surgery • Removal of impacted teeth
Major Dental Services	• Crown • Root canal • Complete lower and upper denture • Dental implant • Occlusal guards
Orthodontia Services	• $1,500 lifetime benefit/individual

Sample Dental Card

Select Plan Benefit Highlights:

Diagnostic & Preventive Services

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 ***Choices*** Select Plan allows a $1,500 lifetime orthodontic benefit per covered individual. Benefits are paid at 50% of the allowed amount for covered services. Treatment plans usually include an initial down payment and ongoing monthly fees. If an initial down payment is required, the Plan 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.

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

Dental Fee Schedule

Dental claims are reimbursed based on a dental fee schedule. The following subsets of the ***Choices*** **Select Plan** fee schedule includes the most common used procedure codes. The fee schedule's dollar amount is the maximum reimbursement paid by the Plan for the specified procedure code. Covered members are responsible for the difference (if any) between the provider's billed charge and the fee schedule's maximum reimbursement amount.

The dental procedure 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 benefit and fee schedule information (see pg. 23 for availability).

Procedure Code	Description	Fee Schedule
D0120	Periodic oral evaluation – established patient	$44.00
D0140	Limited oral evaluation – problem focused	$59.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$48.00
D0150	Comprehensive oral evaluation – new or established patient	$66.00
D0160	Detailed and extensive oral evaluation – problem focused, by report	$139.00
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	$52.00
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	$124.00
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	$23.00
D0272	Bitewings – two radiographic images	$41.00
D0273	Bitewings – three radiographic images	$49.00
D0274	Bitewings – four radiographic images	$54.00
D0277	Vertical bitewings – 7 to 8 radiographic images	$75.00
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	$97.00
D1110	Prophylaxis – adult	$87.00
D1120	Prophylaxis – child (through age 13)	$58.00
D1206	Topical application of fluoride varnish (Child through age 18)	$31.00
D1208	Topical application of fluoride – excluding varnish (Child through age 18)	$28.00
D1351	Sealant – per tooth (Child through age 15)	$45.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (Child through age 15)	$54.00
D1510	Space maintainer – fixed, unilateral – per quadrant (Child through age 13)	$284.00
D1516	Space maintainer – fixed – bilateral, maxillary (Child through age 13)	$399.00
D1517	Space maintainer – fixed – bilateral, mandibular (Child through age 13)	$395.00
D1520	Space maintainer – removable, unilateral – per quadrant (Child through age 13)	$393.00
D1526	Space maintainer – removable – bilateral, maxillary (Child through age 13)	$538.00
D1527	Space maintainer – removable – bilateral, mandibular (Child through age 13)	$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

Procedure Code	Description	Fee Schedule
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	$112.00
D2331	Resin-based composite – two surfaces, anterior	$143.00
D2332	Resin-based composite – three surfaces, anterior	$174.00
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$214.00
D2391	Resin-based composite – one surface, posterior	$127.00
D2392	Resin-based composite – two surfaces, posterior	$162.00
D2393	Resin-based composite – three surfaces, posterior	$207.00
D2394	Resin-based composite – four or more surfaces, posterior	$241.00
D2510	Inlay – metallic – one surface	$292.00
D2520	Inlay – metallic – two surfaces	$344.00
D2543	Onlay – metallic – three surfaces	$375.00
D2544	Onlay – metallic – four or more surfaces	$545.00
D2620	Inlay – porcelain/ceramic – two surfaces	$335.00
D2642	Onlay – porcelain/ceramic – two surfaces (12 years and older)	$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 (12 years and older)	$371.00
D2740	Crown – porcelain/ceramic substrate	$497.00
D2750	Crown – porcelain fused to high noble metal	$463.00
D2751	Crown – porcelain fused to predominantly base metal	$420.00
D2780	Crown – ¾ cast high noble metal	$516.00
D2783	Crown – ¾ porcelain/ceramic	$488.00
D2790	Crown – full cast high noble metal	$520.00
D2930	Prefabricated stainless steel crown – primary tooth	$186.00
D2931	Prefabricated stainless steel crown – permanent tooth	$222.00
D2932	Prefabricated resin crown	$221.00
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)	$49.00
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$121.00

Procedure Code	Description	Fee Schedule
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$873.00
D3346	Retreatment of previous root canal therapy – anterior	$763.00
D3347	Retreatment of previous root canal therapy – premolar	$850.00
D3410	Apicoectomy – anterior	$776.00
D3425	Apicoectomy – molar (first root)	$801.00
D3430	Retrograde filling – per root	$154.00
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$371.00
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	$1,000.00
D4270	Pedicle soft tissue graft procedure	$620.00
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$173.00
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$117.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$96.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$104.00
D4910	Periodontal maintenance	$99.00
D5110	Complete denture – maxillary	$675.00
D5120	Complete denture – mandibular	$662.00
D5130	Immediate denture – maxillary	$783.00
D5140	Immediate denture – mandibular	$793.00
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$464.00
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$556.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$718.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$715.00
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)	$643.00
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	$102.00
D5650	Add tooth to existing partial denture	$117.00
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
D5720	Rebase maxillary partial denture	$314.00
D5721	Rebase mandibular partial denture	$360.00

Procedure Code	Description	Fee Schedule
D5820	Interim partial denture (maxillary)	$216.00
D5821	Interim partial denture (mandibular)	$233.00
D5850	Tissue conditioning, maxillary	$51.00
D5851	Tissue conditioning, mandibular	$51.00
D5863	Overdenture – complete maxillary	$930.00
D6010	Surgical placement of implant body: endosteal implant	$860.00
D6210	Pontic – cast high noble metal	$622.00
D6212	Pontic – cast noble metal	$365.00
D6214	Pontic – titanium and titanium alloys	$528.00
D6240	Pontic – porcelain fused to high noble metal	$499.00
D6241	Pontic – porcelain fused to predominantly base metal	$425.00
D6242	Pontic – porcelain fused to noble metal	$463.00
D6740	Retainer crown – porcelain/ceramic	$497.00
D6750	Retainer crown – porcelain fused to high noble metal	$507.00
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	$68.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$119.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$204.00
D7220	Removal of impacted tooth – soft tissue	$239.00
D7230	Removal of impacted tooth – partially bony	$283.00
D7240	Removal of impacted tooth – completely bony	$327.00
D7850	Surgical discectomy, with/without implant	$1,500.00
D7860	Arthrotomy	$1,500.00
D7971	Excision of pericoronal gingiva	$120.00
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$73.00
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	$135.00
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	$40.00
D9944	Occlusal guard – hard appliance, full arch	$283.00
D9945	Occlusal guard – soft appliance, full arch	$151.00
D9946	Occlusal guard – hard appliance, partial arch	$320.00
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 network dentist that will best suit your needs and your pocketbook! Understand the difference between a PPO and Premier network dentist.

Finding a Delta Dental Network 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 billed charges may be greater than the MUS Plan benefit fee schedule amount, resulting in balance billing. 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.

While you have the freedom of choice to visit any licensed dentist under the Plan, you may want to consider visiting a Delta Dental network dentist to reduce your Out-of-Pocket costs.

MUS Dental Plan members will usually save when they visit a Delta Dental network dentist. Delta Dental Preferred Provider Organization (PPO) network dentists agree to lower levels of allowed fees and therefore offer the most savings. Delta Dental Premier network dentists also agree to a set level of allowed fees, but not as low as with a PPO network dentist. Therefore, when visiting a Premier network dentist, MUS members may see some savings, just not as much as with a PPO network dentist. The best way to understand the difference in fees is to view the examples below. Visit deltadentalins.com/mus and use the *Find a Dentist* search to help you select a network 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 network dentist. The example compares the patient's share of costs at each network level below:

Adult Cleaning	PPO Network Dentist	Premier Network 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 fee schedule 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 network dentist. The example compares the patient's share of costs at each network level below:

Crown	PPO Network Dentist	Premier Network 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

Vision Hardware Plan *(optional)*

BlueCross BlueShield of Montana

Administered by BlueCross BlueShield of Montana 1-800-820-1674 or 447-8747, bcbsmt.com

Choices offers a Vision Hardware Plan for Retirees and their eligible dependents.

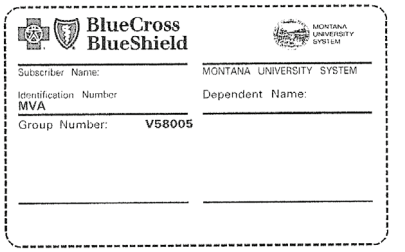
Continuation of enrollment in the Vision Hardware Plan is a one-time opportunity for Retirees (and their eligible dependents) at retirement. Coverage is permanently forfeited if the Retiree fails to continue enrollment, cancels Vision Hardware coverage, or fails to pay premiums. **Note:** A legal spouse reaching age 65 is not a qualifying event for re-enrolling in Vision Hardware coverage.

Using Your Vision Hardware Plan Benefit

Quality vision care is important to your eye wellness and overall health care. Accessing your Vision Hardware Plan benefit is easy. Simply select your provider, purchase your hardware, and submit your claim form to BlueCross BlueShield of Montana (BCBSMT) for processing. The optional Vision Hardware Plan coverage is for hardware only. Eye Exams, whether preventive or medical, are covered under the Medical Plan (see pg. 7 Eye Exam (preventive & medical)). Please refer to the SPD for complete Vision Hardware Plan benefits and plan exclusions (see pg. 23 for availability).

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

Sample Vision Hardware Card



Service/Material	Coverage
Eyeglass Frame and Lenses: **Frame:** One eyeglass frame per Plan Year, in lieu of contact lenses **Lenses:** One pair of prescription lenses per Plan Year, in lieu of contact lenses	Up to $300 allowance toward the purchase of one eyeglass frame and one pair of prescription lenses, including single vision, bifocal, trifocal, progressive lenses; ultraviolet treatment; tinting; scratch-resistant coating; polycarbonate; anti-reflective coating. The Plan member may be responsible for charges at the time of purchase.
Contact Lenses: One purchase per Plan Year, in lieu of eyeglass frame and prescription lenses	Up to $200 allowance toward contact lens fitting and the purchase of conventional, disposable, or medically necessary* contact lenses. The Plan member 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: If your Provider does not bill for vision hardware purchases, the Provider should provide the Plan member with a walk-out statement that can be submitted to BCBSMT for reimbursement, along with a MUS Vision Hardware Claim Form, which can be found at choices.mus.edu/forms.html.

MUS Wellness Program *(optional)*

The MUS Plan offers Wellness programs to covered ***Choices*** Medical Plan enrollees over the age of 18.

Preventive Health Screenings

WellChecks
Each campus offers preventive health screenings (WellChecks) for adult Medical Plan members. 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 wellness.mus.edu/WellCheck.html for more information regarding WellCheck dates and times in your area.

Available to Non-Medicare enrollees only.

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

Lab Tests -
Log into your It Starts With Me account for a complete listing of lab tests available at WellCheck.

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

NEW

Wellness Incentive Program

Retirees and their legal spouses who are covered on the ***Choices*** Medical Plan are eligible to participate in the new Virgin Pulse Wellness Incentive Program!

Build healthy habits, have fun with family and friends, and experience the lifelong rewards of better wellbeing. Earn points by participating in wellness challenges and redeem your points for items in the Virgin Pulse Store.

Here's how to get started: Login at: **join.virginpulse.com/muswell**

Already registered?
Sign in here: **app.member.virginpulse.com**

wellness.mus.edu

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

Healthy Lifestyle Education & Support

WellBaby Program
WellBaby is a pregnancy program designed to help you achieve a healthier pregnancy. Enroll during your first trimester to take advantage of all program benefits. For more information call 406-660-0082 or visit **wellness.mus.edu/WellBaby.html**

Take Control Lifestyle Management Program
Take Control is a health coaching program 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:

- Diabetes: Type I, Type II, Pre-diabetes, or Gestational (Fasting GLUC > 125)
- Weight Loss: 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 participants can join Take Control as part of the WellBaby program

Services provided include monthly health coaching, copay waivers for diabetic supplies, and healthy lifestyle resources.

Benefits Pre-Authorized by your Health Coach may include:
- Visit with your In-Network primary health care provider ($0 copay)
- Sleep study (deductible/coinsurance waived),
- Additional counseling visits ($0 copay).

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

Available to Non-Medicare enrollees only.

For more information about the MUS Wellness programs, contact the MUS Wellness office at 406-994-6111.

Additional Benefit Plan Information

Self-Audit Award Program

Be sure to check all medical health care provider bills and Explanation of Benefits (EOBs) from the Medical Plan claims administrator to ensure charges have not been duplicated or you have been billed for services you did not receive. When you detect billing errors that result in a claims adjustment, the Plan will share the savings with you! You may receive an award of 50% of the savings, up to a maximum of $1,000.

The Self-Audit Award Program is available to all MUS Medical Plan members who identify medical billing errors which:

- Have not already been detected by the Medical Plan claims administrator or reported by the health care provider,
- Involve medical services which are allowable and covered by the MUS Medical 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 claims administrator or the health care provider,
- Contact the health care 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.

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Summary Plan Description (SPD)

All MUS Plan participants have the right to obtain a current copy of the 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.

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 choices.mus.edu.

Eligibility and enrollment rules for coverage in the MUS Plan for participants and their eligible dependents (who are NOT active employees within MUS), are published in the MUS SPD in these sections:

- Eligibility
- Enrollment, Changes in Enrollment, and Effective Dates of Coverage
- Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options
- Continuation of Coverage Rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

Each employee and former employee are responsible for understanding the rights and responsibilities for themselves and their eligible dependents for maintaining enrollment in the MUS Plan.

Retirees eligible for Medicare and paying Medicare Retiree monthly premium rates, as published in the ***Choices*** Retiree Workbook, are required to be continuously enrolled in **BOTH** Medicare Part A and Medicare Part B.

Coordination of Benefits (COB): Persons covered by a health care plan through the MUS AND 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 SPD, COB 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.

Summary of Benefits and Coverage (SBC)

The SBC is available on the MUS ***Choices*** website at 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.

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

The MUS 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 choices.mus.edu/Publication_Notices.html.

The MUS 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 MUS 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 Plan participant's written consent, between authorized MUS Benefits office employees and MUS Business Associates, the participant's providers, or legally authorized governmental entities.

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 provider's billed charge and the allowed amount for covered 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 non-emergency 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 benefit 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 billed charge and the allowed amount.

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 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 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-Network Providers **may** balance bill the difference between the billed charge and the allowed amount.

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 benefit Plan Year. (July 1 - June 30). Balance billing amounts (the difference between Out-of-Network Provider billed charges and the allowed amount) do not apply to the Out-of-Pocket Maximum.

Plan

Healthcare benefits coverage offered to eligible 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 list of health-related provisions that took 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

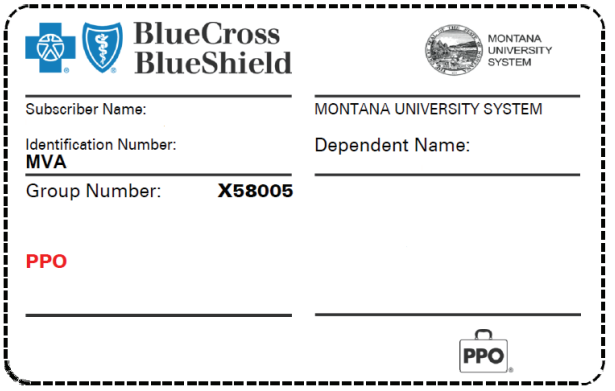
A physician specialist who focuses on a specific area of medicine to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Glacier National Park, MT

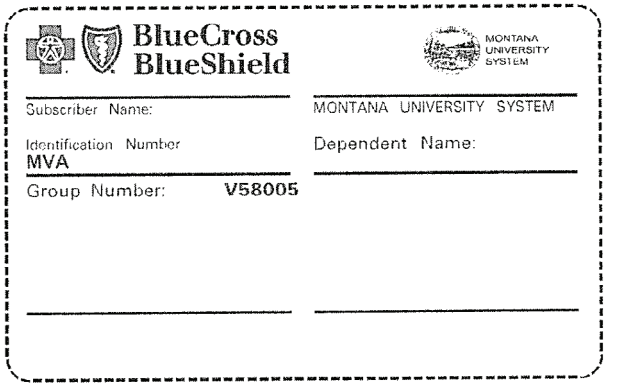
Montana Wildflower

Insurance Card Examples

BlueCross BlueShield Medical

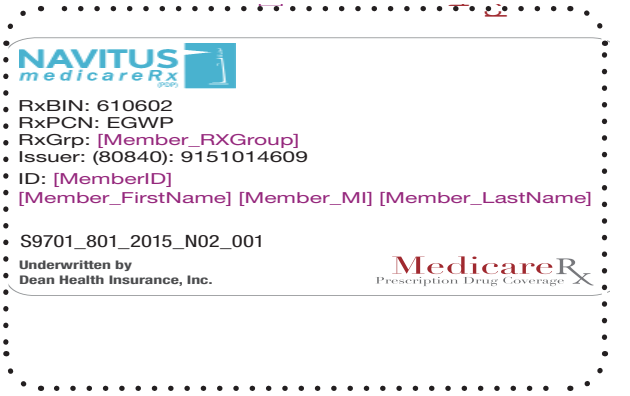


BlueCross BlueShield Vision Hardware



Navitus Pharmacy

Medicare Rx Navitus Pharmacy



Delta Dental

RESOURCES

Montana University System Benefits Office
Office of the Commissioner of Higher Education
1-877-501-1722 * Fax (406) 449-9170
choices.mus.edu

MEDICAL PLAN & VISION HARDWARE PLAN

BLUECROSS BLUESHIELD OF MONTANA
1-800-820-1674 or (406) 447-8747
bcbsmt.com

DENTAL PLAN

DELTA DENTAL
1-866-579-5717
deltadentalins.com/mus

PRESCRIPTION DRUG PLANS

NAVITUS COMMERCIAL PLAN (Non-Medicare)
1-866-333-2757
navitus.com

NAVITUS MEDICARE Rx PLAN (Medicare)
1-866-270-3877
medicarerx.navitus.com

LUMICERA HEALTH SERVICES
1-855-847-3553
lumicera.com

COSTCO MAIL ORDER PHARMACY
1-800-607-6861 * Fax 1-888-545-4615
costco.com/Pharmacy/home-delivery

miRx MAIL ORDER PHARMACY
1-866-894-1496 * Fax (406) 869-6552
mirxpharmacy.com/

RIDGEWAY MAIL ORDER PHARMACY
1-800-630-3214 * Fax (406) 642-6050
ridgeway.pharmacy