choices

Active Benefits

2023 - 2024
Montana University System

MUS Annual Enrollment – April 24, 2023 - May 12, 2023

Please Read

- Visit the MUS ***Choices*** website at choices.mus.edu and click on the **Benefits Enrollment** button or the applicable campus **Net ID** button to make your 2023-2024 ***Choices*** Annual Enrollment benefit elections in the Benefitsolver online enrollment system.

- If you do not complete the online Annual Enrollment process between **April 24 – May 12, 2023**, you and your covered dependents will automatically be re-enrolled in your current benefit plan(s) and coverage levels.

- To add an eligible dependent child not currently on your plan during Annual Enrollment, you **must** make an active election in the Benefitsolver online enrollment system.

- You **must** complete the online Annual Enrollment process if you wish to re-elect a:
  - Health Care Flexible Spending Account
  - Dependent Care (Day Care) Flexible Spending Account

Employee Annual Enrollment Benefits Presentation
Live, interactive webcast: Friday, April 21, 2023, at 10:00 a.m. (MST)
Access from the MUS ***Choices*** website at choices.mus.edu

On-Demand Benefits Presentation
Available by April 26, 2023 at choices.mus.edu

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

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

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Fall in Montana

Bridger Bowl Ski area, MT

Choices Enrollment for an Employee

Benefit Plan Year July 1 – June 30

This workbook is your guide to ***Choices*** – the Montana University System's employee benefits program (MUS Plan) 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 have chosen. Please read the information in this workbook carefully. This enrollment workbook is not a guarantee of benefits.

Montana Wildflower

Who's Eligible

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

2. Temporary faculty or staff members who are scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of six months or more in a 12-month period.

3. Seasonal faculty or staff members who are scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of six months or more in a 12-month period.

4. Academic, professional, or administrative personnel with an individual contract under the authority of the Montana Board of Regents of Higher Education 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.

Waiver of Coverage:

You have the option to waive benefits coverage with the MUS Group Benefits Plan. 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, current coverages will continue (existing employees) or you will be defaulted into coverage (new employees) as outlined on the next page. The cost of default coverage will be within the employer contribution amount. Please note, there is no continuing or default coverage for Flexible Spending Accounts (FSAs), as these accounts must be actively elected each benefit Plan Year.

Waiver of Coverage:

If you waive coverage, **all** of the following will apply:

- You waive coverage for yourself and all eligible dependents.
- You waive all mandatory and optional ***Choices*** coverages, 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 dependent children cannot re-enroll unless you have a qualifying event or until the next Annual Enrollment period.
- Your legal spouse cannot be added to the Plan unless they have a qualifying event.
- If you are enrolling after previously waiving coverage, you will only be allowed to enroll in the lowest benefit plan options available.

If you default coverage, your coverage will be defaulted to Employee only coverage and will consist of:

- Employee Only – Medical Plan
- Employee Only – Basic Dental Plan
- Basic Life/AD&D – Option 1 ($15,000)

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 benefit Plan Year or within 63 days of a qualifying event (see page 3 for qualifying events) based on Plan rules.

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 5).

Ross Peak, Bridger Mountains

How to Enroll Cont.

Mandatory *(must choose or waive)*:

Medical Plan pg 4
Prescription Drug Plan (included in Medical) pg 13
Dental Plans pg 15
Basic Life and AD&D Insurance pg 21
Long Term Disability pg 21

Optional (*voluntary*):

Vision Hardware Plan pg 22
Flexible Spending Accounts pg 25
Supplemental Life Insurance pg 27--28
Supplemental AD&D Insurance pg 29-30

4. Employees make their benefit elections online in the Benefitsolver online enrollment system. The online benefits enrollment system will walk you through your coverage options and monthly costs. Instructions on how to login and navigate the online Benefitsolver enrollment system can be found on the ***Choices*** website at choices.mus.edu.

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

If the benefits you choose cost . . .

- The same or less than the employer contribution, you will not see any change in your paycheck.
- More than the employer contribution, you will pay the difference through automatic payroll deductions.

Your annual ***Choices*** elections remain in effect for the entire benefit Plan Year (July 1 – June 30) following enrollment or unless you have a change in status (qualifying event).

Enrolling Family Members:

MUS has Closed Enrollment for a legal spouse, unless there is a qualifying event (see below 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 are a new employee, you may enroll your eligible dependents for benefits, including Medical, Dental, Vision Hardware, and optional supplemental life/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 employee's initial enrollment period or within 63 days of a qualifying event.

- **Eligible dependent children under age 26*:** Children include your natural children, step-children, and children placed in your home for adoption before age 18 or for whom you have court-ordered permanent legal custody or court-ordered permanent 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 covered on the MUS Plan. Eligibility is subject to review each benefit Plan Year.

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 enrolling in the Benefitsolver online benefits enrollment system, please contact your campus Human Resources/Benefits Office directly (inside cover). Questions about qualifying events should be directed to your campus Human Resources/Benefits Office or consult the Summary Plan Description (SPD) (see page 31 for availability).

How the *Choices* Medical Plan Works

When a Plan member receives covered medical services from an **In-Network Provider,** the provider will submit a claim to the Plan claims administrator for the member. The Plan claims 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 for covered services. The provider **will not** balance bill the member the difference between the billed charge and the allowed amount for covered services.

When a Plan member receives covered medical services from an Out-of-Network Provider, the member must verify if the provider will submit the claim to the Plan claims administrator or if the member must submit the claim. The Plan claims 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 for covered services. 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 covered medical services received by an In-Network Provider.

Definition of Terms

In-Network Providers -
Providers who have contracted with the Plan claims administrator to manage and deliver care at agreed upon allowed amounts. You pay a $25 copayment for Primary Care Physician (PCP) office visits and a $40 copayment for Specialty provider office visits to In-Network Providers (no deductible) and 25% coinsurance (after deductible) for covered In-Network outpatient/inpatient services.

Out-of-Network Providers - Providers who do not have a contract with the Plan claims administrator. You pay 35% of the allowed amount (after a separate deductible) for covered 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 for covered services.

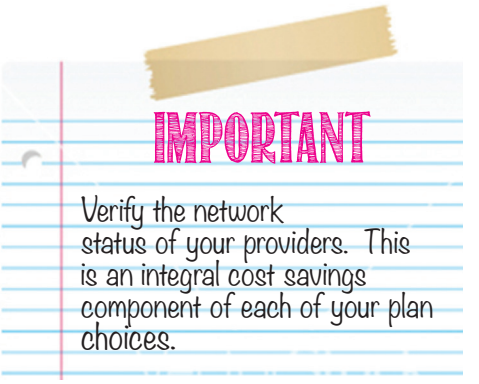
Emergency Services - Emergency services are covered everywhere; however, Out-of-Network Providers may balance bill the difference between the allowed amount and the billed charge for covered services.

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

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

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

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



Medical Plan *(mandatory)*

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

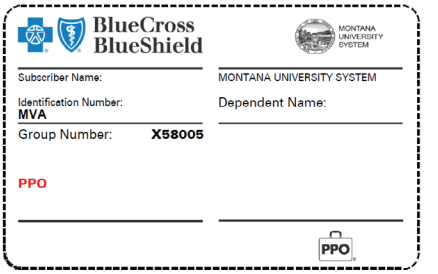
Administered by BlueCross BlueShield of Montana 1-800-820-1674 or 406-447-8747 bcbsmt.com

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

	Medical Plan Monthly Rates
Employee/Survivor Only	$748
Employee & Spouse	$1,075
Employee & Child(ren)/ Survivor & Child(ren)	$994
Employee & Family	$1,327

The employer contribution for FY2024 is $1,054 per month for benefits eligible employees (***applies to pre-tax benefits only***).

Sample Medical card



Schedule of Medical Benefits FY2024

Medical Plan Costs		
	In-Network	**Out-of-Network ***
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 Percentage (% of allowed charges member pays)	25%	35%
Out-of-Pocket Maximum (Maximum amount paid by member in a Plan 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 may balance bill the difference between their billed charge and the allowed amount for covered services.

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

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

July 1
Beginning Plan Year

→ more costs

→ more costs

June 30
End of Plan Year

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

Plan pays remainder of office visit

Jack has not reached his deductible yet and he visits the doctor and has lab work. He pays $25 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 $25 for the office visit and $400 for the lab work. The Plan pays $75 for the office visit and $0 for the lab work. The In-Network Provider writes off $500.

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 deductible. He pays $25 for the office visit and 25% of the allowed amount for lab work 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 lab work is $850. The Plan allows $100 for the office visit and $400 for the lab work. Jack pays $25 for the office visit and $100 for the lab work. The Plan pays $75 for the office visit and $300 for the lab work. The In-Network Provider writes off $500.

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 services 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 $750, coinsurance is 35%, 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 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 65% 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).

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 services 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 recommended		
Room and Board Charges	25%	35%
Ancillary Services	25%	35%
Surgical Services (See SPD for surgeries requiring authorization)	25%	35%
Hospital Outpatient Services		
Outpatient Services	25%	35%
Outpatient Surgery Center Services	25%	35%
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	$25 copay/visit (for office visit only - lab, x-ray & other services subject to deductible/coinsurance)	35%
Specialty Provider Office Visit - Includes Telemedicine visits	$40 copay/visit (for office visit only - lab, x-ray & other services subject to deductible/coinsurance)	35%
Inpatient/Outpatient Physician Services	25%	35%
Lab/Ancillary/Misc. Charges	25%	35%
Eye Exam (preventive or medical)	0% one/Plan Year (additional exams subject to office visit copay)	35%
Hearing Exam (preventive or medical) **Note:** Audiologist exams are processed In-Network, however, the member **may** be balance billed the difference between the billed charge and the allowed amount.	0% one/Plan Year (additional exams subject to office visit copay)	35%
Second Surgical Opinion	0%/visit (for office visit only - lab, x-ray & other services subject to deductible/coinsurance)	35%
Emergency Services Note: Emergency Services are processed In-Network		
Ambulance Services for Medical Emergency (ground or air)	$200 copay/transport (for transport only - other services & supplies are subject to deductible/coinsurance)	$200 copay/transport (for transport only - other services & supplies are subject to deductible/coinsurance)
Emergency Room Charges	$250 copay/visit (for room charges only - lab, x-ray & other services subject to deductible/coinsurance (waived if immediately admitted to hospital))	$250 copay/visit (for room charges only - lab, x-ray & other services subject to deductible/coinsurance (waived if immediately admitted to hospital))
Professional Provider Services	25%	25%

Schedule of Medical Benefits

Medical Plan Services	In-Network	Out-of-Network
Urgent Care Services Note: Urgent Care Services are processed In-Network		
Facility/Professional Services	$75 copay/visit (for room charges only - lab, x-ray & other services subject to deductible/coinsurance)	$75 copay/visit (for room charges only - lab, x-ray & other services subject to deductible/coinsurance)
Lab & Diagnostic Services	25%	25%
Maternity Services		
Hospital Services	25%	35%
Physician Services (delivery & inpatient)	25% (waived if enrolled in WellBaby Program within first trimester)	35%
Prenatal Office Visit	$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 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/coinsurance)	35%
Mental Health/Substance Use Disorder		
Inpatient Services (Pre-Certification is recommended)	25%	35%
Outpatient Visit (this is a combined max of 4 visits at $0 copay for mental health and substance use disorder services) -Includes Telemedicine Visits	First 4 visits $0 copay then $25 copay/visit (other services subject to deductible/coinsurance)	35%
Rehabilitative Services Physical, Occupational, Speech, Cardiac, Respiratory, Pulmonary, and Massage Therapies; Acupuncture and Chiropractic		
Inpatient Services (Pre-Certification is recommended)	25% Max: 30 days/Plan Year	35% Max: 30 days/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 for covered services.

Medical Plan Services	In-Network	Out-of-Network
Rehabilitative Services Cont.		
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.	$25 copay/visit Max: 60 visits/Plan Year (x-ray & other services subject to deductible/coinsurance)	35% Max: 60 visits/Plan Year
Extended Care Services		
Home Health Care Visit (Prior Authorization is recommended)	$25 copay/visit Max: 30 visits/Plan Year	35% Max: 30 visits/Plan Year
Hospice Services	25% Max: 6 months	35% Max: 6 months
Skilled Nursing Facility Services (Prior Authorization is recommended)	25% Max: 30 days/Plan Year	35% Max: 30 days/Plan Year
Miscellaneous Services		
Allergy Shots	$40 copay/visit (for office visit only- if no office visit, deductible/coinsurance waived)	35%
Durable Medical Equipment, Prosthetic Appliances & Orthotics (Prior Authorization is recommended for amounts greater than $2,500)	25% Max: $200/Plan Year for foot orthotics	35% Max: $200/Plan Year for foot orthotics
PKU Supplies - Includes treatment & medical foods	0% (no deductible)	35%

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 for covered services.

Schedule of Medical Benefits

Medical Plan Services	In-Network	Out-of-Network
Miscellaneous Services cont.		
Hearing Aids Pediatric- 18 years or younger Adult- 19 years or older (See SPD for benefit details) Note: Hearing Aids are processed In-Network	25% Pediatric- 1/ear every 3 years (aid only) Adult- $2,000/ear lifetime maximum (aid only)	25% Pediatric- 1/ear every 3 years (aid only) Adult- $2,000/ear lifetime maximum (aid only)
Dietary/Nutritional Counseling Visit - Includes Telemedicine Visits	First 16 visits $0 copay, then $25 copay/visit	35%
Obesity Management (Prior Authorization required)	25% (must be enrolled in Take Control program for non-surgical treatment)	35%
TMJ Services (Prior Authorization recommended)	25% (surgical treatment only)	35%
Organ Transplants		
Transplant Services (Prior Authorization recommended)	25%	35%
Out of Area Travel Reimbursement		
Travel reimbursement for patient only - If services are not available in 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
MUS Wellness Program		
Preventive Health Screenings Healthy Lifestyle Education & Support	see pg 23	
WellBaby Program		
Take Control Lifestyle Management Program- Diabetes, Weight Loss, Tobacco Use, High Cholesterol, High Blood Pressure	see pg 24	
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 for covered services.

Preventive Services

Manhattan, 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 separate deductible, 35% coinsurance, 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 Centers 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, the 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/Plan Year)
Preventive Screenings	
Anemia Screening	• Pregnant Women
Bacteriuria Screening	• Pregnant Women
Breast Cancer Screening (mammography)	• Women age 40+ (1/Plan Year)
Cervical Cancer Screening (PAP)	• Women age 21 - 65 (1/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/Plan Year **or** • Sigmoidoscopy; every 5 years **or** • Colonoscopy; every 10 years
Prostate Cancer Screening (PSA) age 50+	• 1/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)/Plan Year)
Abdominal Aneurysm Screening	• Men age 65 - 75 who have ever smoked (1 screening by ultrasound/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 https://www.cdc.gov/vaccines/index.html	

Prescription Drug Plan

(Included in Medical Plan)

Administered by Navitus Health Solutions

Who is eligible?

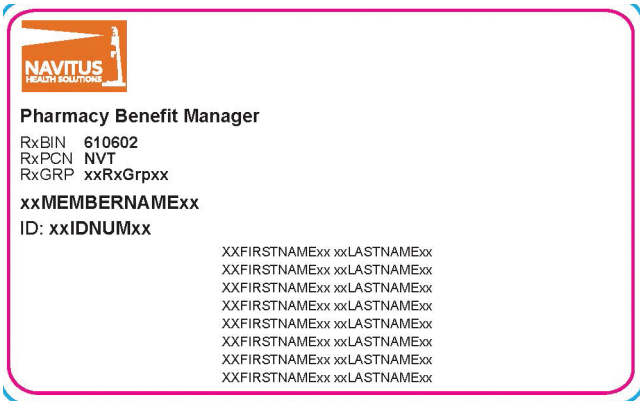
All MUS Medical Plan enrollees and their eligible dependents will automatically be enrolled in the Navitus Health Solutions Prescription Drug Plan (PDP) Commercial Plan coverage. There is no separate premium and no deductible for prescription drugs.

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).

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.

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.

Mail Order Pharmacies

Ridgeway and Costco 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).

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 prescriptions with this specialty pharmacy is simple, contact Patient Customer Care (see next page).

You can acess the Lumicera specialty pharmacy Frequently Asked Questions (FAQs) at 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/Plan Year Family: $4,300/Plan Year	

Questions?

Navitus Customer Care
call 24 hours/day | 7 days/week
(Closed Thanksgiving and Christmas Day)
1-866-333-2757
navitus.com

Lumicera Customer Care
1-855-847-3553
Mon. - Thurs. 7 a.m. - 6 p.m.
Fri. 7 a.m. - 5 p.m. MST
lumicera.com

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

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

Dental Plan *(mandatory)*

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

Choices offers Employees and their eligible dependents two Dental plan options to choose from: **Basic Plan** or **Select Plan**.

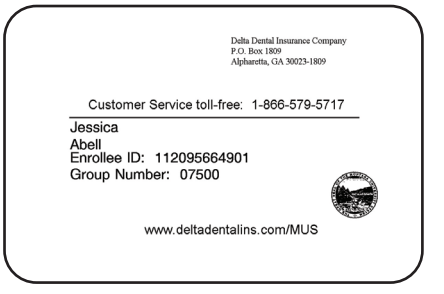
Dental Plan Coverage		
	Basic Plan - Preventive Coverage	**Select Plan - Enhanced Coverage**
Monthly Dental Plan Rates	• Employee/Survivor Only $18 • Employee & Spouse $34 • Employee/Survivor & Child(ren) $34 • Employee & Family $49	• Employee/Survivor Only $43 • Employee & Spouse $82 • Employee/Survivor & Child(ren) $82 • Employee & Family $116
Maximum Annual Benefit	**$750 per covered individual**	**$2,000 per covered individual**
Diagnostic & Preventive Services	Twice per Plan Year: • Initial and periodic oral exam • Cleaning • Complete series of intraoral X-rays	Twice per Plan Year: • Initial and periodic oral exam • Cleaning • Complete series of intraoral X-rays **Note:** The above services do not apply to 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 Services	• Not covered	• $1,500 lifetime benefit/individual

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 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 deltadentalins.com/mus

Dental Fee Schedule

Dental claims are reimbursed based on a dental fee schedule. The following subsets of the **Select Plan** and **Basic Plan** fee schedules include the most common 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 members are responsible for the difference (if any) between the provider's billed 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 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. 31 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 – comprehensive 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
D0321	Other temporomandibular joint radiographic images, by report	$224.00
D0322	Tomographic survey	$355.00
D0330	Panoramic radiographic image	$97.00
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	$88.00
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$33.00
D0601	Caries risk assessment and documentation, with a finding of low risk	$11.00
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$11.00
D0603	Caries risk assessment and documentation, with a finding of high risk	$11.00
D1110	Prophylaxis – adult	$87.00
D1120	Prophylaxis – child (through age 13)	$58.00

Procedure Code	Description	Fee Schedule
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
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$63.00
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
D2543	Onlay – metallic – three surfaces	$375.00
D2544	Onlay – metallic – four or more surfaces	$545.00
D2620	Inlay – porcelain/ceramic – two surfaces	$335.00
D2644	Onlay – porcelain/ceramic – four or more surfaces	$553.00
D2664	Onlay – resin-based composite – four or more surfaces	$440.00
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
D2792	Crown – full cast noble metal	$545.00
D2920	Re-cement or re-bond crown	$63.00
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$252.00
D2930	Prefabricated stainless steel crown – primary tooth	$186.00
D2931	Prefabricated stainless steel crown – permanent tooth	$222.00
D2940	Protective restoration	$70.00

Procedure Code	Description	Fee Schedule
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
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
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$371.00
D4270	Pedicle soft tissue graft procedure	$620.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$703.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$916.00
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 periodontal 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
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$643.00
D5410	Adjust complete denture – maxillary	$32.00
D5421	Adjust partial denture – maxillary	$46.00
D5422	Adjust partial denture – mandibular	$33.00
D5511	Repair broken complete denture base, mandibular	$86.00
D5512	Repair broken complete denture base, maxillary	$86.00
D5640	Replace broken teeth – per tooth	$102.00
D5650	Add tooth to existing partial denture	$117.00
D5711	Rebase complete mandibular denture	$320.00

Procedure Code	Description	Fee Schedule
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	$216.00
D5850	Tissue conditioning, maxillary	$51.00
D5851	Tissue conditioning, mandibular	$51.00
D6010	Surgical placement of implant body: endosteal implant	$860.00
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
D6245	Pontic – porcelain/ceramic	$489.00
D6740	Retainer crown – porcelain/ceramic	$497.00
D6750	Retainer crown – porcelain fused to high noble metal	$507.00
D6751	Retainer crown – porcelain fused to predominantly base metal	$420.00
D6752	Retainer crown – porcelain fused to noble metal	$490.00
D6790	Retainer crown – full cast high noble metal	$498.00
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
D9110	Palliative treatment of dental pain – per visit	$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
D9947	Custom sleep apnea appliance fabrication and placement	$273.00
D9949	Repair of a custom sleep apnea appliance	$40.00
D9950	Occlusion analysis – mounted case	$187.00
D9951	Occlusal adjustment – limited	$51.00
D9952	Occlusal adjustment – complete	$406.00
D9953	Reline custom sleep apnea appliance (indirect)	$40.00

Delta Dental Fee examples

How to select a Delta Dental network dentist that will best suit your needs and your pocket book! 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 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 (**Select Plan** coverage). 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 (**Select Plan** coverage). 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 fee schedule amount	$423	$423	$423
What you pay	$271	$399	$577

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

Basic Life/AD&D Insurance:

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

This is an Employee only benefit.

Basic life insurance coverage under ***Choices*** pays benefits to your beneficiary(ies) if you die from most causes while coverage is in effect. Accidental Death & Dismemberment (AD&D) insurance coverage under ***Choices*** 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. ***Choices*** offers three Basic Life/AD&D plan options to choose from.

No evidence of insurability is required.

Basic Life/AD&D Options & Monthly Rates		
Option 1	$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:

This is an Employee only benefit.

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. The three LTD plan options differ in the amount of your pay they replace, when benefits become payable, and monthly premium costs.

Long Term Disability Options & Monthly Rates		
Option 1	60% of pay/180 day waiting period	$5.40
Option 2	66 2/3% of pay/180 day waiting period	$10.78
Option 3	66 2/3% of pay/120 day waiting period	$13.46

Benefit Options:

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.

Employees increasing coverage one level during annual enrollment or due to a qualifying event 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.

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 coverage level 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)*

BlueCross BlueShield of Montana

Administered by BlueCross BlueShield of Montana 1-800-820-1674 or 1-406-447-8747 bcbsmt.com

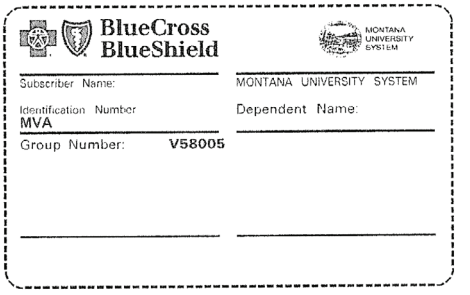
Choices offers a Vision Hardware Plan for Employees and their eligible dependents.

Using Your Vision Hardware Benefit

Quality vision care is important to your eye wellness and overall health care. Accessing your Vision Hardware 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. 31 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 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 pair or one single purchase of a supply of prescription contact lenses per Plan Year, in lieu of an eyeglass frame and prescription lenses	Up to $200 allowance toward contact lens fitting and the purchase of conventional, disposable or medically necessary* prescription contact lenses. The Plan participant may be responsible for charges at the time of purchase.

*Prescripion contact lenses that are required to treat medical or abnormal visual conditions, including but not limited to eye surgery (i.e., cataract removal), when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses, and certain corneal or other eye diseases (i.e., anisometropia, high ametropia, and keratoconus).

Filing a claim:

If the 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 BCBSMT Claim Form, which can be found at https://www.bcbsmt.com/docs/forms/claim/mt/medical-claim-mt.pdf.

MUS Wellness Program *(optional)*

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

WELLNESS
MONTANA UNIVERSITY SYSTEM

Wellness Health Screenings

WellChecks
Each campus location offers two free wellness health screenings (WellChecks) per Plan Year (July 1 - June 30). A free basic blood panel and biometric screening are provided at WellCheck, with additional optional tests available at discounted prices. Representatives from MUS Wellness are also present at most WellChecks to answer wellness related questions. Go to wellness.mus.edu/WellCheck for more information.

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.

Flu Shots
Flu shots are offered FREE in the fall, subject to national vaccine availability. Go to **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 will 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 Program
WellBaby is a pregnancy benefit designed to help you achieve a healthier pregnancy. Enroll during your first trimester to take advantage of all of 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: montanamovesandmeals.com

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

Visit the MUS Wellness website at: wellness.mus.edu

MUS Wellness Program *(optional)*

Wellness Incentive Program

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

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

Get started at: **join.virginpulse.com/muswell**

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

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

Take Control Lifestyle Management Program

takecontrol
Customized Plans. Individual Results. Real Savings.

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)
- **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.

Flexible Spending Accounts *(optional)*

Administered by HealthEquity/WageWorks: 1-877-WageWorks (1-877-924-3967) wageworks.com

This is an Employee only benefit.

Choices offers three optional Flexible Spending Accounts (FSA). These optional reimbursement accounts (FSAs) can work to your advantage by allowing an employee to set aside contributions out of each paycheck (pre-tax), in equal installments throughout the Plan Year (July 1 – June 30), to pay for qualified Out-of-Pocket expenses for health care and dependent care (day care).

No Automatic Enrollment: You must re-enroll each benefit Plan Year to participate in a FSA (no exceptions will be made for late enrollment).

FSA Changes for FY24 (July 1, 2023 – June 30, 2024)

- The HCFSA/LPFSA maximum contribution amount has increased to $3,050.
- HCFSA/LPFSA participants may rollover up to $610 in unused funds from FY24 (July 1, 2023 - June 30, 2024).
- The DCFSA maximum contribution amount will remain $5,000.

Flexible spending account administrative fees are paid by MUS.

FSA Account Options	FSA Annual Contribution Amount	FSA Qualifying Expense Examples
Health Care FSA	Minimum Contribution: $120 Maximum Contribution: $3,050	Health care expenses, including but not limited to, deductibles, coinsurance, copays, dental, vision, and Rx expenses.
Limited Purpose FSA	Minimum Contribution: $120 Maximum Contribution: $3,050	**Dental and Vision expenses only**, including but not limited to, dental exams, dentures, contacts, eyeglass frames and lenses.
Dependent Care FSA (day care)	Minimum Contribution: $120 Maximum Contribution: $5,000	Costs for **dependent** (**day care)** provided to your dependent child(ren) under age 14, or other dependents unable to care for themselves, and is necessary for you to remain employed.

If you enroll in a FSA during your initial enrollment, your account(s) becomes effective the first day of the month following your date of hire. If you enroll in a FSA during annual enrollment, your account(s) becomes effective July 1st. FSA funds may only be used for expenses incurred on or after your FSA effective date and can be used at any time during the benefit Plan Year.

When you enroll in a FSA, you are electing to participate for the entire benefit Plan Year (July 1 – June 30). No changes to your FSA election may be made during the benefit Plan Year, unless you experience a qualifying event. Changes must be consistent with the change in status or qualifying event.

The amount you elect for your FSA expenses are not subject to federal, state, Social Security, or Medicare taxes. You can access tax savings FSA calculators for accurate savings estimates on the HealthEquity/WageWorks website at wageworks.com/employees/calculators/.

Health Care Flexible Spending Account (HCFSA)

A HCFSA allows an employee to set aside contributions (pre-tax) to pay for qualified Out-of-Pocket medical, dental, vision, and/or Rx expenses which are not fully covered by the group health plan. The HCFSA allows the employee to be reimbursed for expenses incurred by the employee and the employee's eligible dependents during the benefit Plan Year. Expenses are considered "incurred" on the date the service was performed, not the date the expense is paid.

HCFSA expenses which are eligible for reimbursement include those defined by IRS Code, Section 213(d). For a comprehensive list of HCFSA eligible expenses, including a list of expenses that may require a letter of Medical Necessity or a prescription from your provider, visit healthequity.com/fsa-qme.

NOTE: If you or your legal spouse contribute to a Health Savings Account (HSA), you are not eligible to participate in a HCFSA; however, you may enroll in a Limited Purpose Flexible Spending Account (LPFSA) (see information below).

Limited Purpose Flexible Spending Account (LPFSA)

The LPFSA guidelines are the same as the HCFSA (see information above), with the exception of eligible expenses. The LPFSA eligible expenses **only** include **dental and vision expenses.** For a comprehensive list of eligible LPFSA expenses, visit healthequity.com/lpfsa-qme.

If you enroll in a FSA during your initial enrollment, your account(s) becomes effective the first day of the month following your date of hire. If you enroll in a FSA during annual enrollment, your account(s) becomes effective July 1st. FSA funds may only be used for expenses incurred on or after your FSA effective date and can be used at any time during the benefit Plan Year.

HCFSA/LPFSA Rollover Funds: The IRS permits health FSAs to rollover a limited amount of unused FSA contributions from one benefit Plan Year to the next. This means that HCFSA/LPFSA balances, up to $610 from the current Plan Year, can be rolled over to the next benefit Plan Year that begins July 1 and runs through June 30. Be sure not to elect more than you will need to cover expenses incurred by you and/or your eligible dependents during the benefit Plan Year. Under the "use it – or – lose it" rule, any remaining contribution balance over $610 not used by the end of the benefit Plan Year will be forfeited.

Important Reminders: If an employee does not enroll in a HCFSA/LPFSA for FY24 and has unused HCFSA/LPFSA funds in the amount of $50 or less that are not expended by June 30, 2024, the FSA will be closed and the remaining unused funds will be forfeited.

Dependent Care (Day Care) Flexible Spending Account (DCFSA)

The DCFSA (day care) is not used for reimbursement of health care expenses. The DCFSA allows an employee to set aside contributions (pre-tax) to pay for qualified Out-of-Pocket dependent day care expenses for children under age 14, or individuals unable to care for themselves. If both you and your legal spouse work or you are a single parent, you may have dependent day care expenses. 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 legal 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 pre-tax dollars to pay your legal 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. For a comprehensive list of eligible DCFSA expenses, visit healthequity.com/dcfsa-qme.

Unlike health FSAs, DCFSAs may only reimburse expenses up to the amount you have contributed at any time during the benefit Plan 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. Unused DCFSA (day care) contribution balances cannot be rolled over to the next benefit Plan Year and will be forfeited.

Mid-Year Election Changes: Mid-year FSA 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.

FSA Questions?

Contact your campus Human Resources/Benefits Office or HealthEquity/WageWorks. HealthEquity/WageWorks Customer Service is available 24/day, 7 days/week at 1-877-WageWorks (1-877-924-3967).

Reimbursement: Claims are usually processed within 2 – 3 business days of receipt and you should receive a check in the mail or via direct deposit (if applicable) within 5 business days after HealthEquity/WageWorks receives your claim. You may submit claims via mail (HealthEquity/WageWorks, PO Box 14053, Lexington, KY, 40512), fax (1-877-353-9236), online (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 HealthEquity/WageWorks make the payment directly to you **(Pay Me Back)** or to pay your provider directly **(Pay My Provider).** You may also elect to have recurring payments for DCFSA (day care) expenses or recurring medical expenses, such as orthodontia.

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 wageworks.com and HealthEquity/WageWorks will electronically deposit reimbursements directly into your account.

Debit Card: The HealthEquity/WageWorks Healthcare© Card is a quick and easy way to pay for eligible HCFSA or LPFSA expenses. You will receive a Health Equity/WageWork debit card as part your enrollment in a HCFSA or LPFSA. You may request additional debit card(s), at no cost, by contacting HealthEquity/WageWorks or requesting online. You may use the debit card to pay for eligible medical, dental or vision care expenses. Documentation for the expense may be required, so keep all FSA receipts, Explanation of Benefits (EOB), and other supporting documentation when you use your debit card.

If the expense is normally covered by your Medical, Dental, or Vision Hardware Plan, you **must** provide an Explanation of Benefits (EOB) as documentation to support your request. If your Medical, Dental, or Vision Hardware Plan will not cover the expense, an itemized statement from the provider will satisfy documentation requirements.

Have funds you need to spend before the end of the benefit Plan Year? HealthEquity/WageWorks partners with the FSA Store (fsastore.com/), an online marketplace which has a large selection of eligible HCFSA and LPFSA products. You can use your Healthcare Debit Card to conveniently order and pay for these products online!

To be eligible for reimbursement: All claims incurred during the FY24 benefit Plan Year (July 1, 2023 – June 30, 2024) must be received by HealthEquity/WageWorks by September 30, 2024 to be eligible for reimbursement. If you terminate employment during the benefit Plan Year, your participation in the FSA ends, subject to COBRA limitations. However, you still may submit claims through September 30, 2024 if the claims were incurred during your period of employment and during the benefit Plan Year. **No exceptions can be made on late claims submissions.**

Supplemental Life Insurance *(optional)*

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

Optional Supplemental Life Insurance:

This is an Employee only benefit. If you enroll in Optional Supplemental Life Insurance, your cost depends on your age as of July 1st and the amount of coverage you select, as shown in the following table. The cost of this benefit is paid on an after-tax basis.

- If you are a new employee, you may elect up to $300,000 in coverage during your 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 add coverage of $25,000, increase or decrease their coverage one level, or drop completely if enrolled in $25,000 due to a qualifying event, as long as the change is consistent with the event (ie., a dependent is disenrolled, coverage can be decreased one level).

"The controlling provisions are 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

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Optional Supplemental Dependent Life Insurance eligibility:

Optional Supplemental Dependent Life Insurance for your legal spouse and unmarried dependent 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. 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 your legal spouse or dependent child(ren) to enroll in supplemental life coverage elections. The cost of this benefit is paid on an after-tax basis.

- Spousal elections cannot exceed 100% of the employee election (i.e., employee elects $100,000 for self, spousal maximum is $100,000).
- If you are a new employee, you may elect up to $50,000 in spousal coverage during your 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 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 legal spouse due to marriage, up to $50,000 without submitting evidence of insurability.
- Evidence of insurability is always required for spousal elections over $50,000.
- Employees may decrease spousal coverage to any level or drop completely during annual enrollment.
- Employees may add coverage of $25,000, increase or decrease their spousal coverage one level or drop completely if enrolled in $25,000 due to a qualifying event, as long as the change is consistent with the event (ie., 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) -Spousal Benefit (based on age of Legal Spouse as of July 1st)

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

- If you are a new employee, you may elect up to $30,000 in dependent child coverage during your initial enrollment.
- If you are enrolling for the first time and did not elect dependent child coverage during your 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 if enrolled in $5,000 due to a qualifying event, as long as the change is consistent with the event (ie., dependent child is disenrolled, coverage may be decreased one level).
- 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 Premium (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 standard.com/mybenefits/mus

Optional Supplemental AD&D Insurance eligibility:

This is an Employee only benefit. If you enroll for Optional Supplemental Accidental Death & Dismemberment (AD&D) Insurance, your cost depends on the amount of coverage you select, as shown in the following table. The cost of this benefit is paid on an after-tax basis.

No evidence of insurability is required for optional supplemental AD&D coverage at any level.

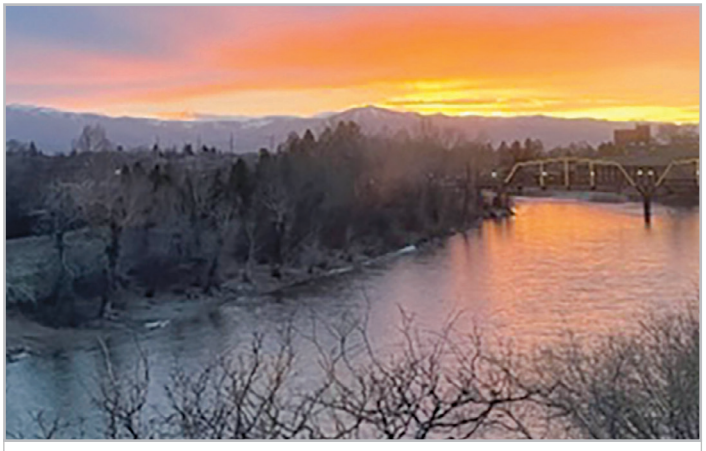
- If you are a new employee, you may elect any supplemental AD&D coverage amount during your initial enrollment.
- If you are enrolling for the first time and did not elect supplemental AD&D coverage during your initial enrollment and want to add coverage, you may elect $25,000 in supplemental AD&D coverage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

"The controlling provisions are 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



Sunset over Clark Fork River, Missoula MT

Optional Supplemental Dependent AD&D Insurance eligibility:

Optional Supplemental Dependent AD&D Insurance for your legal spouse and unmarried dependent child(ren) from live birth to age 26 is designed to protect you against certain financial burdens in the event a covered dependent dies due to an accidental death. You are automatically the beneficiary of any benefits that become payable. 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 to be eligible for your legal spouse or dependent child(ren) to enroll in supplemental AD&D coverage elections. The cost of this benefit is paid on an after-tax basis.

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

- Spousal elections cannot exceed 100% of the employee election (i.e., employee elects $100,000 for self, spousal maximum is $100,000).
- If you are a new employee, you may elect any supplemental AD&D coverage amount for a legal spouse during your 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 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 add coverage of $25,000, increase or decrease their spousal AD&D coverage one level, or drop completely if enrolled in $25,000 due to a qualifying event, as long as the change is consistent with the event (i.e., 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 legal spouse due to marriage, as long as it does not exceed 100% of the employee election amount.

Optional Supplemental AD&D Monthly Rates (after-tax) -Spousal 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 add coverage of $5,000, increase or decrease their dependent child coverage one level, or drop completely if enrolled in $5,000 due to a qualifying event, as long as the change is consistent with the event (i.e., 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 Premium (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

Additional Benefit Plan Information

Dependent Premium Hardship Waiver

The MUS Benefit Plan offers a Dependent Premium Hardship Waiver (DPHW) to assist employees with the cost of medical health care coverage for children covered on the MUS Medical Plan. 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, a DPHW application may be submitted to the MUS Benefits Office requesting the Dependent Premium Hardship Waiver. If the total household income is not more than 125% of the HMK guidelines, covered dependent children will be eligible for the waiver for the benefit Plan Year (July 1 – June 30). The family must re-apply for HMK coverage and the DPHW each benefit Plan Year to be eligible for the waiver. For more information, please contact your campus Human Resources/Benefits Office or the MUS Benefits Office at 1-877-501-1722. The DPHW application is available on the ***Choices*** website at choices.mus.edu/forms.html.

★ 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's 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 provider to verify the error and work out the correct billing, and
- Submit 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 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 Montana University System Group Benefit Plan for participants and their dependents (who are NOT active employees within MUS), are published in the MUS Summary Plan Description 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 retiree is 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 premium rates, as published in the ***Choices*** Retiree Workbook, are required to be continuously enrolled in **BOTH** Medicare Part A and Medicare Part B as their primary coverage.

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. 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 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, 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.

Choices Benefits Spending Worksheet

Monthly Out-of-Pocket Benefit Premium Costs

MANDATORY BENEFITS (must choose) (unless you waive all benefits) (Pre-Tax)

MEDICAL PLAN		Medical Plan	(a)
DENTAL PLAN		Basic or Select Plan	(b)
BASIC LIFE/AD&D			
	Basic Life/AD&D Option 1 $15,000		(c)
	Basic Life/AD&D Option 2 $30,000		(c)
	Basic Life/AD&D Option 3 $48,000		(c)
LONG TERM DISABILITY		Option 1	(d)
(Option 2- No new enrollments are allowed)		Option 2	(d)
		Option 3	(d)
TOTAL MANDATORY BENEFITS MONTHLY PREMIUM	**(Pre-Tax)**	**Add lines a,b,c and d**	**(e)**

OPTIONAL BENEFITS (optional) (Pre-Tax)

VISION HARDWARE PLAN		(f)

PRE-TAX MONTHLY PREMIUM TOTALS

MANDATORY BENEFITS	Enter amount from line (e)	(g)
OPTIONAL BENEFITS	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 only

TOTAL BENEFITS MONTHLY PREMIUM (Pre-Tax)	**Subtract line (j) from line (i)**	**(k)**

If line (k) is a negative amount, the left-over amount is the remaining Employer Contribution amount.
If line (k) is a positive amount, the amount is your Out-of-Pocket expense.

FLEXIBLE SPENDING ACCOUNTS (FSA) (optional) (Pre-Tax)

HEALTH CARE FSA		(l)
Minimum $120/year Maximum $3,050/year		
DEPENDENT CARE (DAY CARE) FSA		(m)
Minimum $120/year Maximum $5,000/year		
TOTAL FSA MONTHLY PREMIUM	**(Pre-Tax) Add lines (l) and (m)**	**(n)**

Employees have the option to elect a FSA using Pre-Tax salary contributions.

OPTIONAL SUPPLEMENTAL BENEFITS (optional) (Post-Tax)

SUPPLEMENTAL LIFE (EMPLOYEE)		(o)
SUPPLEMENTAL LIFE (SPOUSE)		(p)
SUPPLEMENTAL LIFE (CHILD(REN))		(q)
SUPPLEMENTAL AD&D (EMPLOYEE)		(r)
SUPPLEMENTAL AD&D (SPOUSE)		(s)
SUPPLEMENTAL AD&D (CHILD(REN))		(t)
TOTAL OPTIONAL BENEFITS MONTHLY PREMIUM (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 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 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 ($750), he pays 25% of the allowed amount up to the Out-of-Pocket Maximum and the Plan pays 75%.

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

Covered Services
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 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 $750. Jack pays 100% of the allowed amount for covered services 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 a prevailing medical history.

Emergency Services
Evaluation and treatment of a covered 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 for covered services.

Fee Schedule
A fee schedule is a complete listing of fees used by the Plan to reimburse providers and suppliers for providing selected covered 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 services for Plan members and to accept the allowed amount as payment in full for covered services. Also called "Preferred Provider" or "Participating Provider". Members will pay less Out-of-Pocket expenses for covered services if they see an In-Network Provider.

Out-of-Network Provider
A 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 for covered services 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 for covered services.

Out-of-Pocket Maximum
The maximum amount of money a member pays toward the cost of covered services. Out-of-Pocket expenses include deductibles, copayments, and coinsurance. For example, 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 services for the remainder of the benefit Plan Year (July 1 through June 30). Balance billing amounts for covered services (the difference between Out-of-Network Provider billed charges and the allowed amount) do not apply to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum applies to the benefit Plan Year (July 1 through June 30).

Plan
Healthcare benefits coverage offered to eligible members through the employer to assist with the cost of covered 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.

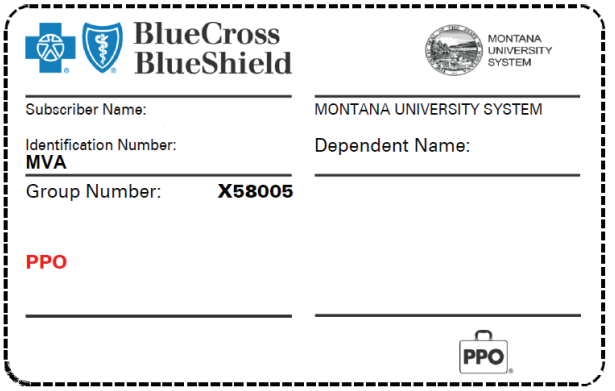
Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine, nurse practitioner, clinical nurse specialist or physician assistant) who directly provides or coordinates a range of health care services for or helps access health care services for a patient.

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 a prevailing medical history of a disease or condition.

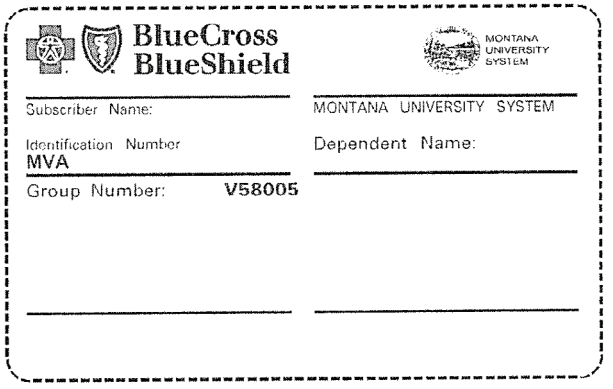
Specialist
A physician specialist who focuses on a specific area of medicine to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Insurance Card Examples

BlueCross BlueShield Medical

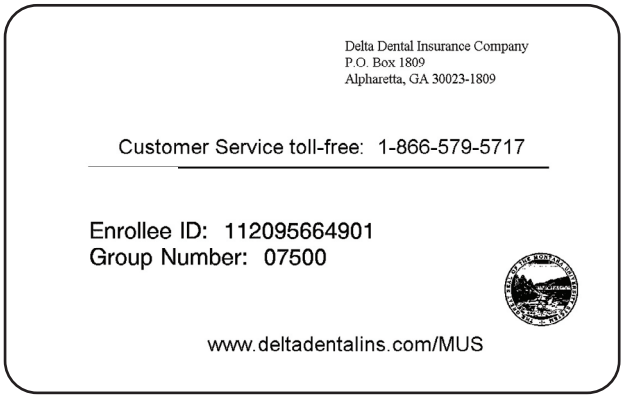


BlueCross BlueShield Vision Hardware

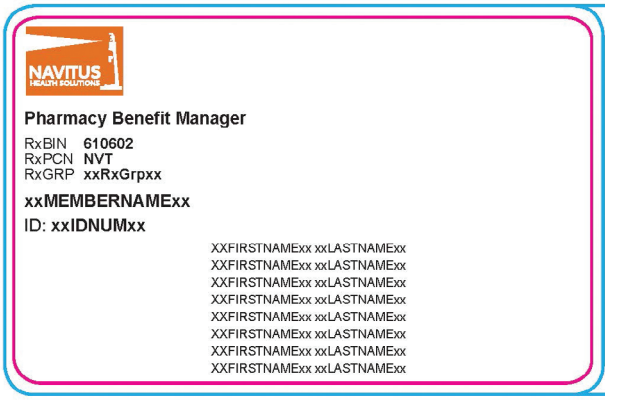


WageWorks Flex card

Delta Dental



Navitus Pharmacy



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 PLANS

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

FLEXIBLE SPENDING ACCOUNTS

HEALTHEQUITY/WAGEWORKS INC
1-877-924-3967
wageworks.com

PRESCRIPTION DRUG PLAN

NAVITUS COMMERCIAL PLAN
1-866-333-2757
navitus.com

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

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

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

LIFE/AD&D & LONG TERM DISABILITY PLANS

STANDARD LIFE INSURANCE
1-800-759-8702
standard.com/mybenefits/mus