MONTANA UNIVERSITY SYSTEM

SUMMARY PLAN DESCRIPTION

EFFECTIVE JULY 1, 2026

THE MONTANA UNIVERSITY SYSTEM

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To: MUS Plan Participants

The Montana University System (MUS) offers a comprehensive Group Benefits Plan referred to as "*Choices*" or "the Plan." The Plan offers the following mandatory benefits: Medical, Prescription Drug (included with Medical Plan), Basic Dental (preventive) or Select Dental (enhanced), Basic Life and Accidental Death & Dismemberment Insurance (AD&D), and Long-Term Disability Insurance (LTD). The Plan also offers the following optional benefits: Vision Hardware, Supplemental Life Insurance (Employee and Dependent), Supplemental AD&D Insurance (Employee and Dependent), and Health Care and Dependent Care (day care) Flexible Spending Accounts (FSA).

This is the Summary Plan Description (SPD) for the Medical, Prescription Drug, Dental, and Vision Hardware Plans. There are separate Life Insurance, AD&D Insurance, LTD Insurance, and FSA Plan Documents.

The SPD explains the benefits Plan Participants may receive as a member of the Plan. The Plan provides coverage for MUS benefits Eligible Employees, Retirees, Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualified Beneficiaries, and Eligible Dependents.

The SPD will help the Plan Participant understand and use their benefits, including coverage provided, the steps to follow to access Plan benefits, specific Plan exclusions, benefit limitations or maximums under the Plan, how the Plan is funded, and a Plan Participant's rights and responsibilities. Plan Participants should review the SPD before incurring any health care expenses.

Federal Health Care Reform

The federal Patient Protection and Affordable Care Act (ACA) and its requirements affect how employers provide health care coverage. The Plan implements many key ACA provisions, such as the elimination of lifetime limits on essential health benefits, Dependent coverage for children *(Refer to Section 1 – Eligibility, provision B. – Eligible Dependents)*coverage for preventive health services, and other patient protections. The "employer mandate," also referred to as the "employer shared responsibility" or "pay or play," affects employers when: (1) they do not offer health care coverage to all full-time Employees; or (2) the coverage they offer is not affordable or does not provide a certain minimum level of benefits.

To comply with the employer mandate, the MUS offers coverage to an Employee who works an average of thirty (30) or more hours per week (or an average of one-hundred thirty (130) hours per month). For employment categories, such as adjunct faculty, coaches, and certain other seasonal or temporary Employees, the MUS must track actual hours worked or create a reasonable method for crediting hours worked. The MUS will credit an adjunct faculty member with three (3) hours of service per week for every credit hour taught per week.

The definitions provided in the SPD defining Plan provisions and eligibility requirements are the rules that govern the Plan.

Final Internal Revenue Service (IRS) regulations under the ACA allow employers to identify full-time Employees by calculating Employees' hours during a specified period of months (a measurement period) while the employment status remains fixed (full-time or not) for a separate specified period (a stability period). Following this regulation will allow the MUS to comply with the employer mandate.

The IRS 'safe harbors' regulations define the following terms:

> A "measurement period" is the look-back period over which hours are calculated to determine whether an Employee has averaged at least thirty (30) hours per week. There are two (2) types of measurement periods:
>
> 1. The "initial measurement period" is used for new Employees.
>
> 2. The "standard measurement period" is used for ongoing Employees.
>
> The "stability period" is the look-forward period for which an Employees employment status (determined during the measurement period as full-time or not) is fixed, regardless of the Employee's actual hours during this period (provided the Employee continues to be an Employee during the stability period). The stability period begins at the end of the measurement period and any administrative period.
>
> The "administrative period" is a period after the end of a measurement period, and before the beginning of the next stability period, during which an employer can perform administrative tasks, such as calculating the hours for the measurement period and determining eligibility for an offer of coverage.
>
> An "ongoing Employee" is an Employee who has been employed for at least one complete standard measurement period.
>
> An Employee is a "variable-hour Employee" if it cannot be determined on the Employees start date that the Employee is reasonably expected to work an average of at least thirty (30) hours per week during the initial measurement period (based on the known information on the Employee's start date).
>
> An "hour of service" means: (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the employer; and (2) each hour for which an Employee is paid, or entitled to payment, by the employer for a period where no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Hours of service for all Employees are credited using actual hours of service from records of hours worked and hours for which payment is made or due. Three (3) hours of service will be applied for each credit taught by adjunct faculty. For example, six (6) credits taught equals eighteen (18) hours of service.

With respect to all Employees, the Plan uses the look-back measurement method to identify full-time benefits Eligible Employees.

The Plan defines the MUS standard measurement period as a twelve-month (12-month) period beginning June 1st each year and ending the following May 31st.

The Plan defines the stability period as a twelve-month (12-month) period that an Employee has health care coverage based on the requirements of ACA.

The Plan defines the administrative period as the thirty-day (30-day) period beginning on June 1st each year and ending June 30th each year.

The MUS is required to file an annual informational return with the IRS about the offer of health insurance coverage made to Plan Participants and their covered Eligible Dependents. The MUS also provides an annual offer of coverage statement to Employees and Retirees covered on the Plan. Compliance with employer reporting requirements is mandatory.

Plan Funding
The MUS Medical Plan, Prescription Drug Plan, Dental Plan(s), and the Vision Hardware Plan are self-insured (self-funded) plans. Premium contributions go directly into a Plan fund, which is used to pay the cost of benefits for Plan Participants who experience Illness or Injury. To keep the Plan financially sound and affordable, all Plan Participants must use their benefits responsibly. Plan Participants are expected to pay a portion of their medical costs in the form of annual Deductibles, percentage Coinsurance, and/or flat dollar Copayments. These cost containment features are part of the MUS Plan design to ensure Plan funds will be available should a Plan Participant incur expenses for a high-cost Medical Emergency or a catastrophic Illness.

Plan Participants should consider the following ways to help reduce costs for both the Participant and the Plan:

1. **Make sure planned (non-emergency) services are covered**. Plan Participants should review the SPD for what services are covered and what services have benefit limitations or maximums and/or require Prior Authorization from the Medical Plan Claims Administrator. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits.)* It is important to Prior Authorize services that are new and could be considered Experimental, Investigational, or services that may be considered Cosmetic. The Plan Participant should contact the Medical Plan Claims Administrator for Pre-Certification of a planned inpatient admission to a Hospital or facility or within twenty-four hours (24-hours) of a Medical Emergency admission. The Plan Participant is responsible for non-covered billed charges and should make sure the inpatient stay meets the Plan's criteria for coverage.

   The Plan Participant may review MUS Plan benefits online on the MUS *Choices* website at choices.mus.edu or contact the Medical Plan Claims Administrator.

2. **Use the Medical Plan's In-Network Providers (Participating or Preferred Providers).** In-Network Providers accept the Allowed Amount for Covered Medical Expenses as their full reimbursement, saving the Plan Participant costs above the Allowed Amount (no balance billing). Using In-Network Providers provides the best benefit for Covered Medical Expenses (Copayments for office visits and the lowest Deductible, Coinsurance percentage, and Out-of-Pocket Maximum).

   If the Plan Participant chooses to use an Out-of-Network Provider (non-Participating or non-Preferred Provider), the participant may want to ask the Provider in advance to accept the Allowed Amount as payment in full.

3. **Ask the Hospital and/or Physician to use In-Network Providers (Participating or Preferred Providers) for ancillary services**. This includes, but is not limited to, Covered Services of a referring Provider, anesthesiologist, radiologist, or independent laboratory.

4. **Consider using public health services for immunizations**.

5. **Consult with a Provider by phone when the Plan Participant is uncertain if a medical symptom is serious enough to justify a visit.**

6. **Use emergency rooms only for Medical Emergencies.** On weekends or evenings when Providers offices are closed, Plan Participants should use a freestanding clinic or urgent care center, where available, for urgent or emergency care.

7. **Discuss with the Provider the risks, alternatives, and fees before treatment or drugs are prescribed.** The Plan Participant should ask enough questions to assure: (1) the treatment is necessary and appropriate for the condition; (2) the treatment does not involve unacceptable risks; and (3) no equally effective or less costly option exists.

8. **Consider seeking a second opinion for non-emergency surgical procedures.** For non-emergency surgery, the Plan Participant should know if another qualified medical specialist would advise against surgery or would recommend another type of surgery.

9. **Request generic drug prescriptions when possible**. Generic drugs are usually less expensive than comparable brand name drugs.

10. **Review medical bills**. Plan Participants should ensure that their medical bills are correct, and they are only billed for services received. If there is an error, the Plan Participant should contact the Provider's billing office and bring the error to their attention.

11. **Finally, the most important thing the Plan Participant can do is guard their health**. Plan Participants are encouraged to eat right, exercise, stop smoking, limit alcohol consumption, and participate in the MUS Wellness Programs. A healthy lifestyle can prevent or mitigate many common Illnesses. Only the Plan Participant can make the choices that will improve their lifestyle and their health.

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Section 1
ELIGIBILITY

A. ELIGIBLE EMPLOYEE

An individual employed by the MUS is eligible to enroll in the Plan under the provisions of Section 2 – *Enrollment, Changes in Enrollment, Effective Dates of Coverage*, if qualified under one of the following categories:

1. **Permanent faculty or staff members** who are scheduled to work at least twenty (20) hours per week or forty (40) hours over two (2) weeks for a continuous period of six (6) months or more in a twelve (12) month period.

2. **Temporary faculty or staff members** who are scheduled to work at least twenty (20) hours per week or forty (40) hours over two (2) weeks for a continuous period of six (6) months or more, or who do so regardless of schedule.

3. **Seasonal faculty or staff members** who are scheduled to work at least twenty (20) hours per week or forty (40) hours over two (2) weeks for six (6) months or more per year, or who do so regardless of schedule.

4. **Employees with an individual contract under the authority of the Montana Board of Regents** which provides for eligibility under one of the above requirements.

NOTE: MUS student Employees who occupy positions designated as student positions are not eligible to join the Plan.

Important: The above categories set forth the definitions to follow for Plan and eligibility requirements.

B. ELIGIBLE DEPENDENTS

NOTE: The Plan has a "closed enrollment" for a legal spouse for Medical and Dental Plan coverage, which means that a legal spouse may not be enrolled in the Plan unless it is during the Eligible Employee's initial benefits enrollment period or there is a Qualifying Change in Status, also known as a Qualifying Event or Qualifying Life Event.

An Eligible Employee who enrolls in the Plan as a Subscriber may also enroll the following Eligible Dependents according to the terms of Section 2 – *Enrollment, Changes in Enrollment, Effective Dates of Coverage.* An Eligible Employee may continue coverage of some or all Dependents, along with continuation of the Employee's coverage under Retiree or COBRA provisions of Sections 3 – *Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options* or 4 – *Continuation of Coverage Rights Under COBRA*.

1. **Legal Spouse** – The person to whom the Subscriber is legally married or certified common-law married to (**must** be filed with the County Clerk and Recorder's office), as defined by Montana state law.

   An Eligible Dependent does not include a legal spouse who is currently legally separated or divorced from the Subscriber and has a legal court order or decree stating such from a court of competent jurisdiction.

2. **Child(ren)** – A Subscriber's child will be an Eligible Dependent if the child meets the following criteria:

Is a natural child, stepchild, legally adopted child (under age 26), or a child placed for adoption (prior to age 18) with the Subscriber or the Subscriber's legal spouse, or a child who has one of the following relationships with the Subscriber or the Subscriber's legal spouse:

1) Court-ordered permanent legal custody of the child (until reaching age 18, unless otherwise specified in the court order) by the Subscriber or the Subscriber's legal spouse; or
2) Court-ordered permanent legal guardianship of the child (until reaching age 18, unless otherwise specified in the court order) by the Subscriber or the Subscriber's legal spouse; or
3) Child for whom the Subscriber or the Subscriber's legal spouse is responsible for medical insurance under a Qualified Medical Child Support Order.

Court-ordered conservatorship of a child by the Subscriber or the Subscriber's legal spouse <u>does not</u> qualify a child as an eligible dependent.

A Subscriber's child will be an Eligible Dependent until reaching the ages referenced above without regard to student status, marital status, financial dependency, or residency status with the Subscriber or another individual. When a Dependent Child reaches the ages referenced above, coverage will terminate on the last day of the child's birthday month.

Proof of the above relationships <u>must</u> be provided in writing to your campus Human Resources (HR)/Benefits Representative or the Plan Administrator.

C. DISABLED DEPENDENT CHILD

An unmarried Dependent Child who is mentally or physically impaired and enrolled in the Plan when they reach age twenty-six (26) may continue coverage (Medical, Dental, and/or Vision Hardware) on the Plan after age twenty-six (26), provided the child is incapable of self-supporting employment and is chiefly dependent upon the Subscriber for support and maintenance. Proof of incapacity **<u>must</u>** be submitted in writing to the Plan Administrator within thirty-one (31) days of the child's twenty-sixth (26^{th}) birthday.

For a disabled dependent child, proof of incapacity **<u>must</u>** be submitted to the Plan Administrator as follows:

1. Proof the child is dependent on the benefits eligible Subscriber for support and maintenance within the current meaning of the COBRA disability continuation criteria. Specifically, the Social Security Administration (SSA) **<u>must</u>** have determined that the child is disabled and qualifies for disability benefits through Social Security Disability Insurance (SSDI) or Supplemental Security Insurance (SSI).

2. The benefits eligible Subscriber **<u>must</u>** submit the most recent tax return indicating the disabled child is a qualified tax dependent of the Subscriber.

3. SSA documentation and tax documentation **<u>must</u>** be received by the Plan Administrator within thirty-one (31) days of the child's twenty-sixth (26^{th}) birthday.

Re-certification of the disability is required by the MUS Plan for review each Benefit Plan Year.

The right to continue coverage under the Plan, for Medical, Dental, and/or Vision Hardware, is a one-time opportunity.

<u>NOTE</u>: A disabled dependent child, age twenty-six (26) or older, **<u>may not</u>** be newly enrolled or re-enrolled in MUS Plan coverages.

D. RESCISSION OF COVERAGE

The Plan cannot rescind coverage for Plan Participants covered under the Plan, except where: (1) the Plan Participant has engaged in fraud or made an intentional misrepresentation of material fact; and (2) the Plan Administrator provides advanced notice.

The term "Rescission" means a cancellation or discontinuance of coverage with a retroactive effect. Retroactive cancellation of coverage may occur with enrollment of a Dependent who is not eligible for coverage under the Plan's terms. Enrolling an ineligible Dependent or otherwise failing to comply with the Plan's requirements will constitute fraud or an intentional misrepresentation of a material fact that will trigger Rescission. The Subscriber is responsible for providing accurate information and making accurate and truthful statements, including information and statements regarding family status, age, and relationships. The Subscriber is responsible for updating previously provided information and statements. If the Subscriber covers an ineligible Dependent, the Subscriber may be liable for benefits already paid. All claims for health care benefits incurred on or after the Rescission date will be rejected. The Rescission of coverage constitutes an Adverse Benefit Determination, and the Subscriber may file a claim under the Plan's internal claim and appeal procedures to challenge the Rescission.

E. ENROLLMENT AND RESPONSIBLITY FOR REMOVING INELIGIBLE DEPENDENTS

1. When a Subscriber enrolls a Dependent in the Plan, they represent that the Dependent is eligible under the terms of the Plan.
2. The Subscriber **must** provide evidence of Dependent eligibility in writing.
3. The Subscriber understands:
    a. The Plan relies on the Subscriber's representation of eligibility in accepting the enrollment of the Dependent.
    b. Failure to provide required evidence of Dependent eligibility is evidence of fraud and material misrepresentation; and
    c. Failure to provide evidence of Dependent eligibility will result in disenrollment of the Dependent, which may be retroactive to the date as of which the Dependent became ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan's provisions on Rescission of coverage.
4. The Subscriber is responsible for removing from coverage a Dependent who ceases to be an eligible Dependent within thirty (30) days of the loss of eligibility due to a change in Dependent status (death or divorce). *(Refer to provisions B. – Eligible Dependents and C. – Disabled Dependent Child of this Section.)* Failure to notify of a Dependent's loss of Dependent status within sixty (60) days will result in the Dependent's loss of COBRA rights. COBRA Subscribers should contact the COBRA Administrator directly to report a Dependent's loss of Dependent status. *(Refer to Section 4 – Continuation of Coverage Rights Under COBRA.)* **After the Dependent's coverage ends, the Subscriber will be responsible for repayment of claim amounts paid for an ineligible Dependent's claims for billed expenses.**

PREMIUM ADJUSTMENT: Premiums paid pre-tax for a Dependent who is no longer eligible **may not** be retroactively adjusted more than thirty (30) days or beyond the start of the calendar year, whichever comes first.

NOTE: An MUS Plan Subscriber **MAY NOT** be covered on another MUS Subscriber's coverage **and** Dependent children **MAY NOT** be covered by more than one MUS Subscriber (dual benefits coverage).

The MUS Plan defines dual benefits coverage as follows:

1. An MUS Plan member (Subscriber or Dependent) who is enrolled in more than one MUS plan; or
2. An MUS Plan Eligible Employee who is enrolled in waived MUS coverage (waives **all** MUS Plan coverages) and is enrolled as a Dependent (legal spouse or child(ren)) on another MUS Subscriber's coverage.

Section 2
ENROLLMENT, CHANGES IN ENROLLMENT, EFFECTIVE DATES OF COVERAGE

A. NEW EMPLOYEE BENEFITS ENROLLMENT

ENROLLMENT OPTIONS: New benefits Eligible Employees have the option of enrolling themselves and any Eligible Dependents as Plan Participants or waiving **all** coverage during a thirty (30) day initial benefits enrollment period that begins the day following the date of hire or the first date of eligibility under the Plan. If the Eligible Employee chooses to enroll, the Employee **must** enroll in the mandatory Plan benefits (Medical, Dental (Basic or Select plan), Basic Life/AD&D Insurance, and LTD Insurance). During this initial benefits enrollment period, the Eligible Employee may also enroll in optional benefits (Vision Hardware, Supplemental Life Insurance, Supplemental AD&D Insurance, or FSAs) according to the provisions of those plans. Eligible Dependents may enroll in the Medical Plan, selected Dental Plan, and/or the optional benefits. **All benefit elections are irrevocable and may not be changed until the next annual benefits enrollment period or the Plan Participant experiences a Qualifying Event, subject to Plan restrictions.**

PREMIUM PAYMENT: The MUS provides a monthly employer contribution toward benefits for enrolled Eligible Employees and their covered Dependents. The monthly employer contribution amount applies to Medical, Dental, Basic Life/AD&D Insurance, LTD Insurance, and optional Vision Hardware coverage (payroll deductions for these elections are pre-tax under IRS Code Section 125, unless the Employee opts out of pre-tax premium payment. Opting out precludes participation in an FSA *(Refer to Section 11 – Flexible Spending Accounts).)* Enrollment in benefits with monthly premium costs exceeding the employer contribution amount authorizes the MUS to deduct the extra monthly premium costs from the Employee's earnings through payroll deduction through the end of the month in which the Employee and their Dependents are covered.

EFFECTIVE DATE: Benefits coverage will be effective on the enrollment date, which is the date of hire or the first date of eligibility under the Plan. **Benefits enrollment for new benefits Eligible Employees and their Eligible Dependents must be completed within the thirty (30) day initial benefits enrollment period.**

Dependent verification documentation to support adding Eligible Dependents to the Plan is required as evidence of Dependent eligibility and must be received within the thirty (30) day initial benefits enrollment period.

NOTE: The Plan has a "closed enrollment", which means that a legal spouse may not be enrolled in the Medical or Dental Plans after the thirty (30) day initial benefits enrollment period, unless there is a Qualifying Event or Qualifying Life Event.

WAIVER OF COVERAGE: If a benefits Eligible Employee chooses to waive coverage, the Employee waives **all** mandatory and optional benefit coverages for themself and any Eligible Dependents and forfeits the monthly employer contribution toward benefits until later enrollment. It is recommended the Employee discuss the implications of waiving coverage with their campus HR/Benefits Representative to better understand the benefits of the employer contribution before making their decision to waive **all** coverages. If a benefits Eligible Employee waives coverage under the Plan, the monthly employer contribution **must** continue to be paid to the Plan by the campus employer to be used for the group benefit cost (§ 2-18-703, MCA).

A benefits Eligible Employee may choose to waive coverage or re-enroll in Employee **only** coverage at any time during the Benefit Plan year, subject to Plan restrictions. If enrolling after previously waiving **all** coverages, the Employee will **only** be allowed to enroll in the lowest benefit plan options

available and **will not** be allowed to enroll in an FSA until the next annual benefits enrollment period.

A benefits Eligible Employee who waives coverage during their initial benefits enrollment period or during the Benefits Plan Year **may not** enroll a Dependent Child(ren) in the Plan until the next annual benefits enrollment period or unless there is a Qualifying Event, subject to Plan restrictions.

A benefits Eligible Employee who waives coverage during their initial benefits enrollment period or during the Benefit Plan Year **may not** enroll a legal spouse in the Medical or Dental Plans unless there is a Qualifying Event, subject to Plan restrictions.

DEFAULT COVERAGE: If a new benefits Eligible Employee neither enrolls nor waives coverage within the thirty (30) day initial benefits enrollment period, the Employee will default to Employee-only coverage, as defined in the current MUS *Choices* Enrollment Workbook. The cost of default coverage will be within the monthly employer contribution amount. This coverage will consist of:

1. Employee Only – Medical Plan
2. Employee Only – Basic Dental Plan
3. Basic Life/AD&D – Option 1 ($25,000)
4. LTD – Option 1 (60% of pay/180-day waiting period)

B. ANNUAL BENEFITS ENROLLMENT

Each year, the MUS will designate an annual benefits enrollment period during which the Subscriber may choose to waive **all** coverages, change their benefit elections and enroll/disenroll Dependents, subject to Plan restrictions. **All** enrollments and benefit election changes are irrevocable and will be effective for the new Benefit Plan Year beginning July 1st. *Refer to the current MUS Choices Enrollment Workbook for Plan options and monthly premium costs.*

NOTE: The Plan has a "closed enrollment", which means that a legal spouse may not be enrolled in the Medical or Dental Plans during the annual benefits enrollment period, unless there is a coinciding Qualifying Event or Qualifying Life Event.

PREMIUM PAYMENT: Enrolling in benefits commits the Subscriber to paying the required Out-of-Pocket monthly premiums for benefit elections through the end of the month in which the Subscriber and their Dependents are covered. For Eligible Employees, it authorizes the MUS to deduct monthly premium costs that exceed the employer contribution amount through payroll deduction through the end of the month in which the Employee and their Dependents are covered. *(Refer to provision A. – New Employee Benefits Enrollment of this Section.)*

C. SPECIAL ENROLLMENT (MID-YEAR CHANGE)

Subscribers on the Plan may make benefit election changes mid-year, subject to Plan restrictions, if:

1. they have a qualifying change in status (as described below).
2. the requested change in benefit elections is consistent with the change in status; and
3. the request for a change in benefit elections is made within sixty-three (63) days of the event or as specifically indicated below.

An Eligible Dependent may be enrolled in the Plan during a sixty-three (63) day Special Enrollment period as provided by the Health Insurance Portability and Accountability Act (HIPAA) when one of the Special Enrollment events (Qualifying Event or Qualifying Life Event) occurs. The sixty-three (63) day Special Enrollment period begins on the date of the Special Enrollment event. A request for Special Enrollment **must** be made through the online benefits enrollment system during the sixty-three (63) day Special Enrollment period. The Subscriber **must** submit all required evidence of Dependent eligibility documentation within the sixty-three (63) day Special Enrollment period.

Documentation provided as evidence of a Dependent's eligibility to support the Special Enrollment request (mid-year change) will be required as proof of eligibility and must be received within the sixty-three (63) day Special Enrollment period.

QUALIFYING EVENTS AND PERMITTED BENEFIT ELECTION CHANGES: The following are Qualifying Event changes in status and permitted changes in benefit elections:

1. **Marriage** – An Eligible Employee who marries but is not enrolled in the Plan may enroll and may enroll their new legal spouse and Eligible Dependents. A Subscriber who marries may enroll their new legal spouse and Eligible Dependents and change benefit elections, subject to Plan restrictions.

   Benefits enrollment **must** be completed within the sixty-three (63) day Special Enrollment period, including submission of documented evidence of Dependent eligibility. Benefit elections may be changed to reduce coverage if a Plan Participant becomes eligible for and moves to the new legal spouse's health plan. Coverage will be effective on the first day of the month following receipt of the request for Special Enrollment.

2. **Birth** – The birth of a newborn child of an Employee who is eligible but not enrolled in the Plan allows the Employee to enroll and to enroll the child and other Eligible Dependents. The birth of a child of a Subscriber allows the Subscriber to enroll the child and other Eligible Dependents and change benefit elections, subject to Plan restrictions.

   Automatic coverage of a child born to a Subscriber, covered legal spouse, or covered Adult Dependent, begins on the date of birth, and continues for a thirty-one (31) day period. Automatic coverage for a thirty-one (31) day period **does not** apply to a newborn grandchild of a Subscriber or the Subscriber's legal spouse. To permanently add the child beyond the first thirty-one (31) days, the Subscriber **must** affirmatively enroll the child and pay the required Subscriber contribution toward premiums paid for coverage to continue beyond thirty-one (31) days. The request for Special Enrollment **must** be completed within the sixty-three (63) day Special Enrollment period, including submission of documented evidence of Dependent eligibility. Coverage will be effective on the child's date of birth.

3. **Adoption or Placement for Adoption** – The adoption of a child (under age 18) by, or placement for adoption of a child (prior to age 18) with, an Employee who is eligible but not enrolled in the Plan allows the Employee to enroll and to enroll the adopted child and other Eligible Dependents. The adoption of a child by, or placement for adoption of a child with, a Subscriber allows the Subscriber to enroll the adopted child and other Eligible Dependents and change benefit elections, subject to Plan restrictions. This provision applies only to children under the age of eighteen (18). The request for Special Enrollment **must** be completed within the sixty-three (63) day Special Enrollment period, including submission of evidence of Dependent eligibility documentation. Coverage will be effective on the date of the qualifying adoption or placement for adoption.

4. **Divorce, legal separation, marriage annulment, dissolution of an Adult Dependent, death of a covered legal spouse or covered Adult Dependent** – Benefit elections may be changed for Special Enrollment for a Dependent Child who loses eligibility for coverage under a former legal spouse's plan, subject to Plan restrictions. Benefit elections may be changed to drop coverage on a deceased covered Dependent and on Dependents who are no longer eligible under the Plan, subject to Plan restrictions.

   An ex-spouse, legally separated spouse or Adult Dependent (and associated Dependents) **must** be removed from coverage within thirty (30) days of the date of the event, i.e., date of divorce decree, date of legal separation decree, or date of dissolution of Adult Dependent. The Subscriber **must** provide notification and event verification documentation within thirty (30) days of the date of the event to enable the Plan to remove the ex-spouse, legally separated spouse or Adult Dependent (and associated Dependents) from coverage. **An ineligible Dependent should be removed from**

coverage within thirty (30) days of the event to avoid paying premiums that cannot be refunded. Coverage will terminate on the last day of the month in which the event occurred. *(Refer to Effective Dates and Retroactive Premium Adjustments below, Section 4 – Continuation of Coverage Rights Under COBRA, and separate Life and AD&D Insurance Plan Descriptions for claims procedures.)*

5. **A Dependent Child dies or ceases to meet the Plan's criteria as an Eligible Dependent** – Benefit elections **must** be changed within thirty (30) days of the event to remove an ineligible Dependent Child. **A Dependent Child should be removed from coverage within thirty (30) days of the event to avoid paying premiums that cannot be refunded. Coverage will terminate on the last day of the month in which the event occurred.** *(Refer to Effective Dates and Retroactive Premium Adjustments below, Section 4 – Continuation of Coverage Rights Under COBRA, and separate Life and AD&D Insurance Plan Descriptions for claims procedures.)*

6. **Loss of Eligibility for other health insurance coverage** – If an Eligible Employee who is not enrolled in the Plan loses other health insurance coverage for one of the following reasons, the Eligible Employee may enroll in the Plan, along with any Eligible Dependents who have also lost eligibility for other health insurance coverage. Loss of other health insurance coverage by an Eligible Dependent of a Subscriber for one of the following reasons allows the Subscriber to enroll the Eligible Dependent and to change benefit elections, subject to Plan restrictions. Reasons for loss of health insurance coverage that trigger this provision are:

    a. The Eligible Employee or Eligible Dependent loses eligibility for other health insurance coverage (i.e., HMK, Medicaid).
    b. Employment events, such as termination of employment or reduction in work hours resulting in a loss of eligibility for other health insurance coverage.
    c. A life event change in status resulting in loss of eligibility for other health insurance coverage (i.e., divorce or death).
    d. Loss of eligibility under other health insurance coverage due to no longer residing, living, or working in the plan's service area.
    e. The Eligible Employee or Eligible Dependent loses COBRA insurance coverage under another plan due to the COBRA continuation period is exhausted.
    f. The Eligible Employee or Eligible Dependent loses other employer insurance coverage due to the plan is terminated by the employer.

    Benefits enrollment **must** be completed within the sixty-three (63) day Special Enrollment period, including submission of documented loss of eligibility for other coverage and evidence of Dependent eligibility. Coverage will be effective on the first day of the month following the receipt of the request for Special Enrollment.

    Loss of eligibility for other coverage when coverage was terminated due to failure of the Enrollee or Eligible Dependent to pay premiums or when coverage was terminated for cause does not constitute a Qualifying Event.

    Voluntary cancellation of other insurance coverage does not constitute a Qualifying Event.

    Certificates of Creditable Coverage do not provide proof of loss of eligibility for other health insurance coverage and are not accepted as documentation for a Qualifying Event enrollment.

7. Eligible Dependents may enroll when coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA/Healthy Montana Kids (HMK)) is terminated due to loss of eligibility (i.e., age or income qualifications). Benefits enrollment **must** be completed within the sixty-three (63) day Special Enrollment period, including submission of documented evidence of loss of eligibility for other

coverage and evidence of Dependent eligibility. Coverage will be effective on the first day of the month following the receipt of the request for Special Enrollment.

Voluntary cancellation of or failure to re-apply for Medicaid or CHIPRA insurance coverage does not constitute a Qualifying Event.

8. Eligible Dependents may enroll when they become entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement will be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (HMK or Medicaid). Benefits enrollment **must** be completed within the sixty-three (63) day Special Enrollment period, including submission of documented evidence of Dependent eligibility. Coverage will be effective on the first day of the month following the Plan's receipt of the request for Special Enrollment.

9. **Court-ordered permanent legal custody or court-ordered permanent legal guardianship of a child** – A court order awarding permanent legal custody or permanent legal guardianship of a child (until reaching age 18, unless otherwise specified in the court order) to a Subscriber or a Subscriber's legal spouse allows the Subscriber to enroll the child, provided the child is an Eligible Dependent as defined in Section 1 – *Eligibility*. Coverage will be effective on the date of the court order provided the Subscriber enrolls the child within sixty-three (63) days of the date of the court order and provides a copy of the court order.

   A court order awarding conservatorship of a child to a Subscriber or the Subscriber's legal spouse is not a Qualifying Event and cannot be used for dependent verification. A court-ordered conservatorship of a child does not qualify a child as an eligible dependent.

10. **Qualified Medical Child Support Order** – A Qualified Medical Child Support Order (QMCSO) requiring a Subscriber or a Subscriber's legal spouse to provide medical insurance for the child allows the Subscriber to enroll the child within sixty-three (63) days of the Order, provided the child is an Eligible Dependent as defined in Section 1 – *Eligibility*. Coverage will be effective on the first day of the month following the date of the Order provided the child is enrolled within sixty-three (63) days of the Order and a copy of the Order is provided.

11. **Gains Eligibility for other health insurance coverage** – Gaining new eligibility for other health insurance coverage by a Subscriber and/or an Eligible Dependent due to one of the following causes allows the Subscriber and/or Eligible Dependent to disenroll from the Plan and/or to change benefit elections, subject to Plan restrictions:

    a. Employment events, such as new employment or newly eligible for benefits due to an increase in work hours.
    b. A change in status resulting in gaining new eligibility for other health insurance coverage (i.e., HMK, Medicaid, Medicare).

    Benefits disenrollment **must** be completed within the sixty-three (63) day Special Enrollment period, including submission of proof of new eligibility for other health insurance coverage from the new employer or from HMK, Medicaid, or Medicare. Coverage will terminate on the last day of the month following the receipt of the request for Special Enrollment.

    Certificates of Creditable Coverage, copies of health insurance ID cards, and benefits enrollment summaries do not provide proof of gaining eligibility for other health insurance coverage and are not accepted as documentation for a Qualifying Event enrollment.

    Voluntary enrollment in health insurance coverage during an employer's annual or open enrollment period does not constitute a Qualifying Event.

RETROACTIVE PREMIUM ADJUSTMENTS: Benefit election changes for Special Enrollment are effective on the dates indicated, subject to Plan restrictions. *(Refer to provision C. – Special Enrollment of this Section.)* Premiums paid pre-tax **may not** be retroactively adjusted to provide a refund more than thirty (30) days or beyond the start of the calendar year, whichever comes first.

PREMIUM PAYMENT: Enrolling in benefits commits the Subscriber to paying the required Out-of-Pocket monthly premiums for benefit elections through the end of the month in which the Subscriber and their Dependents are covered. For Eligible Employees, it authorizes the MUS to deduct monthly premium costs that exceed the employer contribution amount through payroll deduction through the end of the month in which the Employee and their Dependents are covered. *(Refer to provision A. – New Employee Benefits Enrollment of this Section.)*

D. IRREVOCABLE BENEFIT ELECTIONS

Enrolling in benefits commits the Plan Participant to irrevocable benefit elections and monthly premium payments for the Benefit Plan Year. A Plan Participant **may not**, under IRS regulations, start, stop, or amend benefit elections during the Benefit Plan Year without experiencing a Qualifying Event, subject to Plan restrictions.

E. CREDITABLE COVERAGE PROCEDURES

This provision advises Plan Participants of their Creditable Coverage rights under the federal Health Insurance Portability and Accountability Act (HIPAA). Certificates of Creditable Coverage are not required for proof of continuous health care coverage for determining pre-existing condition exclusion rules.

CREDITABLE COVERAGE/MEDICARE PART D/COB: To provide an end date for previous health insurance coverage, a Plan Participant may submit Certification of Creditable Coverage from prior health insurance under which the Plan Participant had coverage. Establishing end dates is important for Medicare Part D or Coordination of Benefits (COB). Certificates of Creditable Coverage do not provide proof of loss of eligibility for other health insurance coverage and are not accepted as documentation of a Qualifying Event.

F. ADDRESS CHANGES

To protect the Subscriber's family's rights, the Subscriber should keep their campus HR/Benefits Representative informed of changes in the Subscriber's and covered Dependents' addresses.

Section 3
LEAVES, LAYOFF, COVERAGE TERMINATION, RE-ENROLLMENT, SURVIVING DEPENDENT, AND RETIREMENT OPTIONS

A. SICK AND WORKERS' COMPENSATION LEAVE

An Employee enrolled in the Plan who (a) is on approved sick leave under a Montana Board of Regents personnel policy or labor contract or (b) is on approved leave and is receiving Workers' Compensation benefits for an Injury sustained during MUS employment may remain covered under the Plan for up to one (1) year provided the required monthly premium contributions are paid. After sick leave pay and applicable vacation or MUS compensatory pay is exhausted, the Employee will be responsible for paying the entire monthly premium, except for months of leave for which the monthly employer contribution is required by Union contract.

The Employee may change enrollment benefit elections *(Refer to Section 2 – Enrollment, Change in Enrollment, Effective Dates of Coverage.)* to drop some or all optional benefits and/or Dependent

coverage within sixty-three (63) days of the date leave begins or of the date applicable benefits (sick leave, vacation, MUS compensatory pay, or Workers' Compensation pay) cease.

Refer to provision F. – Coverage Termination of this Section and Section 4 – Continuation of Coverage Rights Under COBRA.

B. FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act (FMLA) requires Employers who are subject to FMLA to allow Eligible Employees to take unpaid, job-protected leave. The Employer may also require or allow the Employee to substitute appropriate paid leave, including, but not limited to, vacation and sick leave if the Employee has earned or accrued it. The maximum leave required by FMLA is twelve (12) workweeks during a twelve (12) month period for certain family and medical reasons and a maximum combined total of twenty-six (26) workweeks during a twelve (12) month period for certain family and medical reasons and for a serious Injury or Illness of a member of the Armed Forces to allow the Employee, who is the legal spouse, child, parent, or next of kin to the member of the Armed Forces, to care for that member of the Armed Forces. In certain cases, this leave may be taken on an intermittent basis rather than all at once, or the Employee may work a part-time schedule.

For these FMLA provisions only, the following definitions apply:

1. "Member of the Armed Forces" includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation, or therapy.

2. "Next of Kin" means the nearest blood relative to the member.

3. "Parent" means Employee's biological parent or an individual who has functioned as the Employee's parent in place of Employee's biological parent.

4. "Serious health condition" means an Illness, Injury impairment, or physical or mental health condition that involves:

    a. Inpatient care in a Hospital, hospice, or residential medical facility; or

    b. Continuing treatment by a health care Provider (a Doctor of Medicine or Osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the Provider practices or any other individual determined by the Secretary of Labor, and to provide health care services).

5. "Serious Injury or illness" means an Injury or Illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform their military duties.

6. "Child" means Employee's biological child, adopted child, stepchild, foster child, a child placed in Employee's legal custody, or a child for which Employee is acting as the parent in place of the child's biological parent. The child **must** be:

    a. Under the age of eighteen (18); or
    b. Over the age of eighteen (18), but incapable of self-care due to a mental or physical disability.

7. "Legal spouse" means Employee's spouse as defined or recognized under State law in the State where the Employee resides.

In general, FMLA applies to an employer engaged in interstate commerce or in an industry or activity affecting interstate commerce who employs fifty (50) or more Employees for each working day during

each of twenty (20) or more calendar work weeks in the current or preceding calendar year. FMLA also applies to Employees as described in Section 3(d) of the Fair Labor Standards Act, 29 U.S.C. 203(d). The FMLA applies to government entities, including branches of the United States (U.S.) government, state governments and political subdivisions thereof.

Generally, an Employee is eligible for FMLA leave only if the Employee satisfies all of the following requirements as of the date on which a requested FMLA leave is to begin: (1) the Employee has been employed by the Employer for a total of at least twelve (12) months (whether consecutive or not); (2) the Employee has worked (as defined under the Fair Labor Standards Act) at least 1,250 hours during the twelve (12) month period immediately preceding the date the requested leave is to begin; (3) the Employee is employed in any state of the U.S., the District of Columbia or any Territories or possession of the U.S.; and (4) when leave is requested, the Employee is employed at a work site where fifty (50) or more Employees are employed by the Employer within seventy-five (75) surface miles of the work site.

FMLA leave **must** be granted: (1) to care for the Employee's newborn child; (2) to care for a child placed with the Employee for adoption or foster care; (3) to care for the Employee's spouse, child, or parent, who has a serious health condition; (4) when the Employee's own serious health condition prevents the Employee from performing their job; or (5) when a qualifying exigency, as determined by the Secretary of Labor, arises out of the fact that a spouse, child, or parent of the Employee is on active duty or has been called to active duty in the Armed Forces in support of a contingency operation (i.e., a war or national emergency declared by the President or Congress).

Ordinarily, an Employee **must** provide thirty (30) days advanced notice when the requested leave is "foreseeable." If the leave is not foreseeable, the Employee **must** notify the Employer as soon as is practicable, generally within one (1) to two (2) working days. The Employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee's serious health condition, the Employer may require second or third opinions, at the Employer's expense, and a certification of fitness to return to work before allowing the Employee to return to work.

During FMLA leave, the Employer **must** maintain the Employee's health coverage under a group health plan on the same conditions as coverage would have been provided if the Employee had been in Active Service during FMLA leave period. Taking FMLA leave **cannot** result in the loss of any employment benefit that accrued before the start of an Employee's leave unless the loss would have occurred even if the Employee had been in Active Service.

Employers **may not** interfere with, restrain, or deny the exercise of any right provided under the FMLA or manipulate circumstances to avoid responsibilities under the FMLA. Employers **may not** discharge or discriminate against an Employee who opposes any practice made unlawful by the FMLA or who may be involved in a proceeding under or relating to the FMLA.

The U.S. Department of Labor (DOL) is authorized to investigate and resolve complaints of FMLA violations. An Eligible Employee may also bring a civil action against an employer for FMLA violations. The FMLA does not supersede any federal or state law prohibiting discrimination and does not supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights. For additional information, contact the nearest office of the DOL Wage and Hour Division.

C. EXTENDED LEAVE OF ABSENCE

An Employee enrolled in the Plan who is approved for an extended leave of absence under a Montana Board of Regents personnel policy or labor contract may remain covered under the Plan for up to two (2) years provided required monthly premium contributions are paid, except for the following:

1. Basic Life/AD&D, LTD, and Supplemental Life and AD&D coverages **may not** be continued beyond one (1) year (12 months) from the date the leave begins. *(Refer to the Life, AD&D, and LTD Plan Descriptions.)* After applicable vacation or MUS compensatory pay is exhausted, the Employee will be responsible for paying the entire monthly premium, either the full monthly employer contribution amount or the full cost of elected coverages, whichever is greater. Coverage will terminate for non-payment if the required monthly premium is not received by the due date established by the Plan.

2. The Employee may change enrollment benefit elections *(Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage)* to drop optional and/or Dependent coverage within sixty-three (63) days of the date leave begins. *(Refer to provision F. – Coverage Termination of this Section and Section 4 – Continuation of Coverage Rights Under COBRA.)*

D. STATE AND FEDERAL COVERED MILITARY LEAVE

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA): When an Employee enrolled in the Plan is absent from employment with the MUS due to service in the uniformed services and such absence or leave is subject to USERRA requirements, the Employee may elect to continue Medical, Dental, and Vision Hardware coverage under the Plan for self and covered Eligible Dependents. The maximum period of coverage is the period of service and subsequent time USERRA provides for reporting back to work, not to exceed a twenty-four (24) month period beginning on the date the Employee's absence begins.

PREMIUM PAYMENT: An Employee who elects to continue coverage will not be required to pay more than 102% of the full premium associated with the same coverage for the Employer's other Employees. After accumulated vacation or MUS compensatory pay, which the Employee chooses to have applied to premiums, the Employee will be responsible for paying the entire monthly premium contribution, except that an Employee who is called to service for less than thirty-one (31) days will only be responsible for the Employee monthly premium contribution made before such service. *(Refer to provision F. – Coverage Termination of this Section.)*

MT MILITARY SERVICE EMPLOYMENT RIGHTS ACT (MMSERA): When an Employee enrolled in the Plan is absent from employment with the MUS due to State Active Duty service and such leave is subject to MMSERA requirements, the Employee may elect to continue Medical. Dental, and Vision Hardware coverage under the Plan for self and their Eligible Dependents. The maximum period of coverage is the period beginning on the thirty-first (31st) consecutive day of State Active Duty and ending on the day immediately before the day the Employee returns to a position of employment with the MUS, provided the Employee returns to employment in a timely manner, or ending on the day immediately after the day the Employee fails to return to employment in a timely manner.

"**A timely manner**" means the following:
1. For a State Active Duty period of thirty (30) days through one-hundred eighty (180) days, the next regularly scheduled day of Active Service follows fourteen (14) days after the termination of State Active Duty.
2. For a State Active Duty period of more than one-hundred eighty (180) days, the next regularly scheduled day of Active Service follows ninety (90) days after the termination of State Active Duty.

"State Active Duty" means services performed by a Montana National Guard member when a disaster is declared by the proper State authority and includes the period of recovery certified by a licensed Provider to recover from an Illness or Injury incurred while performing State Active Duty.

PREMIUM PAYMENT: An Employee who elects to continue Plan coverage **may not** be required to pay more than 102% of the full Plan monthly premium contribution associated with such coverage for the Employer's other Employees, except that if an Employee performs State Active Duty for less than one-

hundred eighty-one (181) days, such Employee **may not** be required to pay more than the regular Employee share.

EXCEPTION TO USERRA AND MMSERA: These provisions will not apply to coverage of any Illness or Injury determined by the Secretary of Veterans Affairs or the Montana Department of Military Affairs to have been caused by or aggravated during performance of service in the uniformed services.

(Refer to provision F. – Coverage Termination of this Section and Section 4 – Continuation of Coverage Rights Under COBRA.)

E. LAYOFF

A classified staff member enrolled in the Plan who is placed on layoff under the provisions of a Montana Board of Regents personnel policy or labor contract may remain covered under the Plan for six (6) months, provided required monthly premium contributions are paid as provided under the State Employee Protection Act, § 2-18-1205, MCA.

The Employee may change enrollment benefit elections (*Refer to Section 2, provision E*.) to drop optional and/or Dependent coverage within sixty-three (63) days of the date layoff begins or of the date any applicable vacation or compensatory pay ceases. *(Refer to provision F – Coverage Termination of this Section and Section 4 – Continuation of Coverage Rights Under COBRA.)*

REDUCTION IN FORCE CONTINUATION COVERAGE

Under the State Employee Protection Act (§§ 2-18-1201 through 2-18-1206, MCA), an Employee whose position is eliminated as a result of a reduction in force (RIF) is entitled to remain covered by the Plan and to the continuation of the employer's contribution to the Employee's group health insurance for a period of six (6) months following the termination due to a RIF or until the Employee becomes employed, whichever occurs first. (§ 2-18-1205, MCA). The Employee's Medical, Dental, and Vision Hardware (if enrolled at the time of the RIF), will remain intact for the Employee and covered eligible Dependents during the six (6) month period.

Reduction in force continuation of coverage is subject to the following requirements:

1. The Employee's position must fall within the definition of RIF under the State Employee Protection Act.
2. The Employee must remain in the current position until the RIF date.
3. The Employee must continue to pay the Out-of-Pocket contribution amount.

If the Employee obtains another position with the employer and becomes eligible for benefits, the Employee's coverage will automatically continue as an active Employee under the new position.

In the event the Employee is eligible for retirement at the end of the six (6) month period, the following conditions will apply *(Refer to provision I. – Retiree Coverage of this Section.)*:

Retirement before age sixty-five (65):

1. The Employee may continue coverage under the Plan as a Non-Medicare Retiree. The Employee will not receive the employer contribution. The Employee may continue coverage until age sixty-five (65) and will be enrolled in Medicare Retiree coverage; or
2. The Employee may terminate coverage and enroll in other health insurance coverage.

Retirement after age sixty-five (65):

1. The Employee may enroll in Medicare and continue coverage on the MUS Plan as a Medicare Retiree. The Employee will not receive the Employer contribution; or
2. The Employee may terminate coverage and enroll in Medicare Part A, Part B, or Part D, a Medicare Supplement Plan, or a Medicare Advantage Plan.

The following rule applies immediately following the six (6) month period of time in which the Employee is entitled to continue on the MUS Plan and receive the employer contribution:

1. A 1985 federal law (P.L. 99-272, Title X), the Consolidated Omnibus Budget Reconciliation Act (COBRA), modified by the 1996 Health Insurance Portability and Accountability Act (HIPAA), gives Employees and all covered Dependents who are losing eligibility for employer group health care benefits the right to continue certain coverage by self-paying the entire monthly benefits payment *(Refer to Section 4 – Continuation of Coverage Rights Under COBRA.*).

F. COVERAGE TERMINATION

Subscriber coverage for Medical, Dental, Prescription Drug, Vision Hardware, and FSA Plans will terminate upon the earliest of the following dates, except as provided in any COBRA continuation of coverage provision *(Refer to Section 4 – Continuation of Coverage Rights Under COBRA.*) or as specifically indicated:

1. The last day of the month in which an Employee terminates employment, or they have a reduction in work hours and are no longer eligible for benefits.

2. The last day of the month in which the Subscriber's coverage terminates under the Plan.

3. The last day of the month for which the Subscriber fails to make timely monthly premium payment contributions required under the Plan.

4. The last day of the month after the Employee enters active duty (defined as more than thirty (30) days of full-time service) with the Armed Forces of any country. *(Refer to provision C. – Extended Leave of Absence of this Section.).*

5. The day the Plan is terminated by the Montana Board of Regents and benefits coverage is no longer offered.

6. The last day of the month in which the Subscriber ceases to be eligible for coverage.

7. The last day of the month following the date on which the Subscriber dies.

8. The day in which an Employee terminates employment, or they have a reduction in work hours and are no longer eligible for benefits, the day in which the Subscriber ceases to be eligible for coverage, or the day the Subscriber dies for Basic Life/AD&D, LTD, Supplemental Life, and Supplemental AD&D Plans.

Dependent coverage for Medical, Dental, Prescription Drug, Vision Hardware Plans will terminate upon the earliest of the following dates, except as provided in any COBRA continuation of coverage provision *(Refer to Section 4 – Continuation of Coverage Rights Under COBRA.*) or as specifically indicated:

1. The last day of the month following the date in which the Dependent ceases to be an Eligible Dependent as defined by the Plan.

2. The last day of the month in which the Subscriber's coverage terminates, or the Employee has a reduction in work hours and is no longer eligible for benefits.

3. The last day of the month for which the Subscriber fails to make timely monthly premium payment contributions for Dependent coverage required under the Plan.

4. The day the Plan is terminated by the Montana Board of Regents and benefits coverage is no longer offered.

5. The last day of the month following the date the Employer terminates the Dependent's coverage.

6. The last day of the month following the date on which the Subscriber or Dependent dies.

7. The last day of the month after the Dependent enters active duty (defined as more than thirty (30) days of full-time service) with the Armed Forces of any country.

8. The day in which an Employee terminates employment, or they have a reduction in work hours and are no longer eligible for benefits, the day in which the Subscriber ceases to be eligible for coverage, or the day the Employee or Dependent dies for Supplemental Life and Supplemental AD&D Plans.

9. The last day of the month following the receipt of the request for Special Enrollment for a Dependent who experiences a Qualifying Event that qualifies for a Special Enrollment period. Benefits disenrollment **must** be completed within the sixty-three (63) day Special Enrollment period, including submission of proof of new eligibility for other health insurance coverage.

(Refer to Section 1 – Eligibility, provision E. – Enrollment and Responsibility For Removing Ineligible Dependents.)

PREMIUM PAYMENT: Enrolling in benefits commits the Subscriber to paying the required Out-of-Pocket monthly premiums for benefit elections through the end of the month in which the Subscriber and their Dependents are covered. For Eligible Employees, it authorizes the MUS to deduct monthly premium costs that exceed the employer contribution amount through payroll deduction through the end of the month in which the Employee and their Dependents are covered. *(Refer to Section 2, provision A. – New Employee Benefits Enrollment.)*

G. RE-ENROLLMENT IN LAPSED, CANCELLED, OR TERMINATED BENEFITS

FOLLOWING APPROVED LEAVE OR LAYOFF: Employees who cancel or let their Medical, Dental, and/or Vision Hardware Plan coverages lapse, or who cancel coverage on their Eligible Dependents during one (1) of the above approved leaves or during a layoff of no more than six (6) months, may re-enroll themselves and their formerly covered Eligible Dependents on return to benefits-eligible employment. On re-enrollment, Employees and their formerly covered Eligible Dependents will be reinstated to the same benefit elections as before the approved leave or layoff.

REINSTATEMENT OF COVERAGE: Benefits Eligible Employees who have been rehired within thirteen (13) weeks from their last day of MUS Plan coverage may re-enroll in the Plan and will be reinstated to the same benefit elections as before their termination. Eligible Dependents can only be enrolled in the Plan if there has been a Special Enrollment or Mid-Year Change Qualifying Event. *(Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage and separate Life, AD&D, and LTD insurance Plan Descriptions on the contracted vendor's website for re-enrollment requirements and restrictions.)*

Benefits Eligible Employees who have been rehired after thirteen (13) weeks from their last day of MUS Plan coverage may enroll in the Plan the same as a new benefits Eligible Employee and may make new benefit elections and may enroll Eligible Dependents. *(Refer to separate Life, AD&D, and LTD insurance Plan Descriptions on the contracted vendor's website for re-enrollment requirements and restrictions.)*

H. SURVIVING DEPENDENT CONTINUATION OF COVERAGE

Pursuant to § 2-18-704, MCA, a surviving Dependent of a Subscriber (Employee or Retiree) may continue certain Plan benefits (as described below).

A surviving legal spouse or Adult Dependent covered by the Plan at the time of the Subscriber's death, and any Dependent Children also covered at the time of death, may remain on the Plan and continue the Plan coverage options (Medical, Dental, and/or Vision Hardware Plans) they were enrolled in at the time of the Subscriber's death through self-payment of Plan monthly premiums, provided enrollment and monthly premium payment as a surviving legal spouse or Adult Dependent occurs within sixty-three (63) days from the date of death. A child born to the covered surviving legal spouse or Adult Dependent that was conceived before the Subscriber's death or a child (prior to age 18) for whom adoption proceedings were initiated before the Subscriber's death may be enrolled in the Plan, provided the child is enrolled within sixty-three (63) days of birth or of the adoption event. A new legal spouse of a survivor is not eligible to be enrolled in survivor coverage. Dependent Children of a survivor not covered at the time of death are not eligible to be enrolled in survivor coverage.

A covered surviving legal spouse or Adult Dependent may continue coverage indefinitely if they make the required self-payment of Plan monthly premiums as a survivor only or survivor and child(ren).

Surviving Dependent Child(ren) covered by the Plan at the time of the Subscriber's death may independently remain on the Plan and continue the Plan coverage options (Medical, Dental, and/or Vision Hardware) they were enrolled in at the time of the Subscriber's death through self-payment of Plan monthly premiums as a survivor only until they cease to meet Dependent Child eligibility criteria *(Refer to Section 1 – Eligibility, provision B. – Eligible Dependents)*, provided enrollment and monthly premium payment as a surviving Dependent occurs within sixty-three (63) days of the death.

Surviving Dependent coverage becomes effective on the first day of the month following the Subscriber's death, provided required self-payment of Plan monthly premiums is paid.

There is no Employer monthly premium contribution toward survivor benefits.

The right to continue coverage under the Plan, for Medical, Dental, and/or Vision Hardware, is a one-time opportunity.

EXCEPTION: A surviving Dependent who is Medicare-eligible **must** be enrolled in **BOTH** Medicare Part A and Medicare Part B if continuing coverage on the Medical and Prescription Drug Plans. The surviving Dependent will be enrolled in the Medicare Retiree Plan coverage option(s) and will be required to self-pay the Medicare Retiree Plan monthly premiums as a survivor or survivor and child(ren). A surviving Dependent who is Medicare-eligible and is continuing coverage on the Dental Plan will be enrolled in the Retiree Select Dental Plan coverage and will be required to self-pay the Retiree Plan monthly premiums as a survivor or survivor and child(ren).

SURVIVORS WHO FAIL TO CONTINUE COVERAGE WITHIN SIXTY-THREE (63) DAYS OF THE DEATH OR WHO ALLOW COVERAGE TO LAPSE DUE TO NON-PAYMENT OF MONTHLY PREMIUMS MAY NOT LATER REJOIN THE PLAN.

COBRA ALTERNATIVE: Alternatively, a surviving legal spouse or Adult Dependent may elect to continue current coverage(s) (Medical, Dental, and/or Vision Hardware) for self and covered Eligible Dependents (or a Dependent Child could independently elect to continue coverage on self) under COBRA. *(Refer to Section 4 – Continuation of Coverage Rights Under COBRA.)* The surviving legal spouse's COBRA rights are waived if the surviving legal spouse elects surviving Dependent coverage. Similarly, a Dependent Child's COBRA rights are waived if the Dependent Child independently elects to continue surviving Dependent coverage.

I. RETIREE COVERAGE

ELIGIBILITY: An Eligible Employee retiring from the MUS may continue certain MUS Plan health care benefits as a Retiree (as described below) if they have been employed with the MUS for five (5) years or more **and** are fully benefits eligible and are enrolled in MUS Plan mandatory coverages when the Employee leaves employment with the MUS. To be eligible as a Retiree, the Employee **must** be eligible to receive benefits from their mandatory retirement plan (as specified below) when the Employee leaves employment with the MUS. To continue certain Plan benefits at the time they leave employment with the MUS, Retirees who are in the Montana University System Retirement Plan (MUS-RP) (with investment options through TIAA), the Public Employees' Retirement System (PERS), the Teachers' Retirement System (TRS), or any other defined contribution plan sponsored by the MUS or the State of Montana, **must** meet the following criteria for their specific retirement plan:

1. MUS-RP: The Retiree **must** be at least age fifty (50) and have completed five (5) years of membership service.

2. PERS Defined Benefit Plan:
    a. For members hired before July 1, 2011: The Retiree **must** be at least age fifty (50) with five (5) years of membership service or under age sixty (60) with twenty-five (25) years of membership service.
    b. For members hired on or after July 1, 2011: The Retiree **must** be at least age fifty-five (55) with five (5) years of membership service.

3. PERS Defined Contribution Plan: The Retiree **must** be at least age fifty (50) and have completed five (5) years of membership service.

4. TRS:
    a. For Tier 1 members (hired before July 1, 2013): The Retiree **must** be at least age fifty (50) with five (5) years of membership service or under age sixty-five (65) with twenty-five (25) years of membership service.
    b. For Tier 2 members (hired after July 1, 2013): The Retiree **must** be at least age fifty-five (55) with five (5) years of membership service.

CONTINUATION OF BENEFITS COVERAGE AND COVERAGE OPTIONS: An Eligible Retiree **must** arrange with their campus HR/Benefits Representative to continue coverage as a Retiree on a self-pay basis within sixty-three (63) days of retirement. All Retiree status changes **must** be reported to the campus HR/Benefits Representative to facilitate premium and enrollment adjustments. A covered Retiree may continue coverage, as well as coverage for their covered Dependents on the Medical Plan, the Select Dental Plan, and/or the Vision Hardware Plan. If a Retiree **does not** make a benefit election to continue enrollment in the Medical, Select Dental, and/or Vision Hardware coverage when they first retire, the Retiree and their Dependents will permanently forfeit eligibility for these coverages. (*Refer to the Plan benefit options available to Retirees in the current MUS Choices Retiree Enrollment Workbook.)* ***The right to continue coverage under the Plan, for Medical, Select Dental, and/or Vision Hardware, is a one-time opportunity.***

RETIREES WHO FAIL TO CONTINUE COVERAGE WITHIN SIXTY-THREE (63) DAYS OF RETIREMENT OR WHO ALLOW COVERAGE TO LAPSE DUE TO NON-PAYMENT OF MONTHLY PREMIUMS MAY NOT LATER REJOIN THE PLAN.

EXCEPTION: A Retiree with the right to continue coverage under the MUS Plan, who chooses to continue coverage under spousal coverage in the MUS Plan at retirement, may be reinstated to the MUS Plan with Retiree coverage upon ineligibility for MUS spousal coverage due to the spouse waiving MUS retiree coverage at retirement, death, or divorce. This exception applies only to a Retiree who has maintained continuous coverage as a dependent under the MUS Plan.

PREMIUM PAYMENT: An Eligible Retiree may apply payout from their final paycheck toward Retiree premiums through the end of the calendar year or the Benefit Plan Year, whichever comes first, on a pre-tax basis. The Retiree should discuss this option with their campus HR/Benefits Representative. New Retirees are required to pay a minimum of two (2) months of premiums at retirement, prior to being enrolled in Retiree coverage. Ongoing monthly premium payment options include:

1. **Automatic Deductions** – When possible, the Retiree should arrange monthly automatic deductions from their retirement plan with their campus HR/Benefits Representative or directly from a checking or savings account via scheduled monthly automated clearing house (ACH) transactions with the MUS Direct Bill Administrator (ACH form required).
2. **Online Payments** – Submit monthly one-time premium payments ($2 administrative fee applies) **or** enroll in automatic recurring payments (auto-pay) (no administrative fee applies after the first payment) from a checking or savings account online on the MUS *Choices* website at choices.mus.edu.
3. **Manual Payments** – Submit monthly premium payments with a manual check to MUS by mailing payments to the MUS Direct Bill Administrator, with the provided monthly billing statement.

Monthly premium rates vary depending on the number of covered Plan Participants, the benefit plans selected, and whether the Eligible Retiree and/or their covered Eligible Dependent(s) are enrolled in Medicare. Payment of claims while covered under Retiree coverage will be contingent on the receipt by the MUS of the applicable monthly premium payment for such coverage. Monthly premium payments are due on the first of the month for each month of coverage. A grace period of **ten (10) days** from the first of the month will be allowed for payment. Failure to submit the monthly premium payment within the allotted time will cause coverage to be canceled. ***Canceled or lapsed coverage cannot be reinstated***.

Enrolling in benefits commits the Subscriber to paying the required Out-of-Pocket monthly premiums for benefit elections through the end of the month in which the Subscriber and their Dependents are covered.

There is no Employer monthly premium contribution toward Retiree benefits.

MEDICARE ENROLLMENT STATUS: Retirees and/or their covered Dependents who are or become Medicare-eligible at retirement or after **must** be enrolled in **BOTH** Medicare Part A and Medicare Part B. All Medicare status changes **must** be reported to the campus HR/Benefits Representative to facilitate monthly premium and enrollment adjustments. A Retiree Plan Participant not enrolled in Medicare Part A and Medicare Part B has sixty-three (63) days from the date of retirement or Medicare eligibility to obtain the missing coverage and will pay the non-Medicare Retiree monthly premiums until Medicare enrollment is obtained. Changes to Retiree monthly premiums will occur on the first of the month following receipt of proof of Medicare enrollment. If Medicare enrollment is not completed within sixty-three (63) days from the date of retirement or the Plan Participant's Medicare eligibility date, the Plan Participant(s) will be disenrolled from the MUS *Choices* Medical and Prescription Drug Plans. Enrollment in the Select Dental Plan and/or Vision Hardware Plan may be continued if the Medicare-eligible Retiree Plan Participant(s) is enrolled in those plans at retirement or on the date of Medicare eligibility even if they are disenrolled from the MUS *Choices* Medical and Prescription Drug Plans due to not enrolling in Medicare Part A and Medicare Part B.

PLAN BENEFITS COORDINATED WITH MEDICARE BENEFITS: *(Refer to Section 13 – Coordination of Benefits, provision B. – Coordination with Medicare.)*

COBRA ALTERNATIVE: At retirement, an Eligible Retiree and/or their covered Dependent(s) may choose to continue their current Plan coverage(s) (Medical, Dental, and/or Vision Hardware) under

COBRA. An Eligible Retiree and/or their covered Dependent(s) who are Medicare-eligible and choose to continue their current Medical and Prescriptions Drug Plan coverages under COBRA at retirement **must** be enrolled in **BOTH** Medicare Part A and Medicare Part B to enroll in COBRA. The Retiree and/or covered Dependent's COBRA rights are waived if the Retiree and their covered Dependent(s) elect to enroll in Retiree Plan coverage. If an Eligible Retiree chooses to enroll in COBRA coverage at retirement, the Retiree will permanently forfeit eligibility for **all** Retiree Plan coverages. At retirement, an Eligible Retiree **may not** elect Retiree Plan coverage for some benefits and COBRA coverage for other benefits. *(Refer to Section 4 – Continuation of Coverage Rights Under COBRA.)*

Section 4
CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

A. CONTINUATION RIGHTS – COBRA

Under the Public Health Service Act, as amended, covered Eligible Employees and their covered Eligible Dependents may have the right to continue coverage beyond the time coverage would otherwise terminate due to a Qualifying Event. **Only covered Eligible Employees and their covered Eligible Dependents are Qualified Beneficiaries.** The Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation of coverage under this provision will begin on the first day of the month immediately following the date the Employee's and/or their covered Eligible Dependents' coverage terminates.

COBRA continuation of coverage for the Medical Dental, and Vision Hardware Plans is administered by the MUS COBRA administrator. The Plan Administrator is the Office of the Commissioner of Higher Education. COBRA elections may be completed online from the MUS *Choices* website at choices.mus.edu or by submitting a completed COBRA paper election form to the MUS COBRA administrator.

Qualifying Events for Eligible Employees are the following events, if such an event results in a loss of coverage under the Plan:

1. Termination (other than for gross misconduct) of the Employee's employment (including retirement).
2. Involuntary reduction in hours of the Employee's employment and are no longer eligible for benefits.

Qualifying Events for covered Eligible Dependents are the following events, if such an event results in a loss of coverage under the Plan:

1. Death of the Employee.
2. Termination (other than for gross misconduct) of the Employee's employment (including retirement).
3. Involuntary reduction in hours of the Employee's employment and are no longer eligible for benefits.
4. Divorce or legal separation of the legal spouse from the Employee.
5. A covered Dependent Child ceases to be eligible as a Dependent.

An Eligible Employee and/or their covered Dependent(s) who are Medicare-eligible and choose to continue their current Medical and Prescription Drug Plan coverages under COBRA at employment termination or retirement, **must** be enrolled in **BOTH** Medicare Part A and Medicare Part B prior to enrolling in COBRA or will not be eligible to enroll in COBRA Medical and Prescription Drug Plan coverages.

If an Eligible Retiree chooses to enroll in COBRA coverage at retirement, the Retiree will permanently forfeit eligibility for **all** Retiree Plan coverages.

NOTIFICATION RESPONSIBILITIES: An Employee **must** notify their employer of a Qualifying Event within **sixty (60) days** of the date of the Qualifying Event.

Campus HR/Benefits Representatives **must** terminate the enrollment of the Plan Participant(s) within thirty (30) days of the applicable event or within thirty (30) days of the campus HR/Benefits Representative receiving notice of the applicable event, whichever occurs later. Termination of the Plan Participant(s) will automatically generate a COBRA Qualifying Event Notice to the Plan Participant to offer continuation of coverage under the Plan.

ELECTION OF COVERAGE: When the COBRA Administrator is notified of a Qualifying Event, the COBRA Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. A Qualified Beneficiary may continue their current Medical, Dental, and/or Vision Hardware coverage. Notice of the right to COBRA continuation of coverage will be sent to the Plan Participant(s) by the COBRA Administrator on behalf of the Plan no later than fourteen (14) days after the COBRA Administrator is notified of the Qualifying Event.

During the annual benefits enrollment period, COBRA enrollees may drop some or all benefit elections and/or Dependent coverage, enroll Dependent Children, change Dental Plan options, or enroll in Vision Hardware coverage (if not previously enrolled), subject to Plan restrictions. COBRA enrollees **may not** enroll in Medical or Dental coverage during the annual benefits enrollment period if coverage was previously waived. COBRA enrollees **may not** enroll a legal spouse in Medical or Dental coverage during the annual benefits enrollment period if coverage was previously waived, unless the legal spouse experiences a Qualifying Event within 63 days prior to July 1st.

A Qualified Beneficiary has **sixty (60) days** from the date coverage would otherwise be lost or **sixty (60) days** from the date of notification from the COBRA Administrator, whichever is later, to notify the COBRA Administrator that they elect to continue coverage under the Plan. Failure to elect continuation within that period will cause benefits coverage to end.

MONTHLY PREMIUM PAYMENTS: A Qualified Beneficiary is responsible for the full cost of continuation of coverage(s). ***There is no Employer monthly premium contribution toward COBRA benefits.*** Monthly premiums for continuation of coverage **must** be paid in advance each month to the COBRA Administrator (on behalf of the Plan Administrator).

COBRA premium payment options for a Qualified Beneficiary include:

1. **Automatic Deductions** – Directly from a checking or savings account via scheduled monthly automated clearing house (ACH) transactions with the MUS COBRA Administrator (ACH form required).
2. **Online Payments** – Submit monthly one-time premium payments ($2 administrative fee applies) **or** enroll in automatic recurring payments (auto-pay) (no administrative fee applies after the first payment) from a checking or savings account online on the MUS *Choices* website at choices.mus.edu.
3. **Manual Payments** – Submit monthly premium payments with a manual check to MUS by mailing payments to the MUS COBRA Administrator, with the provided monthly billing statement.

Monthly premium rates vary depending on the number of covered Plan Participants and the benefit plans selected. Payment of claims while covered under COBRA continuation coverage will be contingent on the receipt by the MUS of the applicable monthly premium payment for such coverage. Monthly premium payments are due on the first of the month for each month of coverage. A grace period of **ten (10) days** from the first of the month will be allowed for payment. Failure to submit the monthly premium payment within the allotted time will cause coverage to be canceled. ***Canceled or lapsed coverage cannot be reinstated***.

Enrolling in benefits commits the Subscriber to paying the required Out-of-Pocket monthly premiums for benefit elections through the end of the month in which the Subscriber and their Dependents are covered.

The monthly premium required under the provisions of COBRA is as follows:

1. **For a Qualified Beneficiary continuing coverage for eighteen (18) months or less,** the monthly premium is the same as for a similarly situated non-COBRA Subscriber, plus an additional administrative fee of two percent (2%).

2. **For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration (SSA)** within sixty (60) days of becoming covered under COBRA, the monthly premium will be 150% of the applicable monthly premium.

3. **For a Qualified Beneficiary with a qualifying Social Security Disability (SSD) who experiences a second Qualifying Event**:

    a. If another Qualifying Event, such as a death, divorce, legal separation, or Medicare entitlement, occurs during the initial eighteen (18) months of COBRA coverage, the monthly premium for a qualified disabled Dependent will be 102% of the applicable monthly premium.
    b. If the second Qualifying Event occurs during the nineteenth (19^{th}) through the twenty-ninth (29^{th}) month (the Disability Extension Period), the monthly premium for a Qualified Beneficiary will be 150% of the applicable monthly premium.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE: If a Qualified Beneficiary who is covered under the Plan is determined by the SSA to be disabled at any time before the Qualifying Event or within sixty (60) days after the Qualifying Event and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The Plan Administrator **must** be provided with a copy of the SSA's disability determination letter within **sixty (60) days** of the date of the determination and before the end of the original eighteen-month (18-month) period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE: If another Qualifying Event occurs while a former Employee is receiving COBRA continuation coverage, Eligible Dependents of the former Employee can receive additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to Eligible Dependents if the former Employee dies or becomes divorced or legally separated from the legal spouse. The extension is also available to a Dependent Child when that child is no longer eligible under the Plan as a Dependent Child *(Refer to Section 1 – Eligibility, provision B. – Eligible Dependents)*. In all cases, the COBRA Administrator (on behalf of the Plan Administrator) **must** be notified of the second Qualifying Event within **sixty (60) days** of the second Qualifying Event.

Failure to provide notice within sixty (60) days of a Qualifying Event will result in loss of eligibility for an extension of COBRA Continuation Coverage.

WHEN COBRA CONTINUATION COVERAGE ENDS: COBRA continuation coverage will end for the Qualified Beneficiary upon the earliest of the following:

1. On the last day of the month following the receipt of written notice that a Qualified Beneficiary becomes covered under another health insurance plan.

2. On the last day of the month prior to a Qualified Beneficiary becoming Medicare-eligible for

Medicare Part A and Medicare Part B if enrolled in the MUS COBRA Medical and Prescription Drug Plans. COBRA enrollment in the Select Dental Plan and/or Vision Hardware Plan may be continued if a Medicare-eligible Qualified Beneficiary is enrolled in those plans during the Qualified Beneficiary's COBRA election period.

3. On the last day of the month for which the Subscriber fails to make timely monthly premium payments required under the Plan with respect to COBRA continuation coverage for a Qualified Beneficiary is not made to the COBRA Administrator.

4. The day the Plan is terminated by the Montana Board of Regents and benefits coverage is no longer offered.

5. On the last day of the month following the receipt of written notice that a Qualified Beneficiary wishes to terminate COBRA continuation coverage.

6. On the last day of the month in which the maximum coverage period for COBRA continuation coverage ends, as follows:
   a. Eighteen (18) months for a former Employee who is a Qualified Beneficiary due termination of employment, or a reduction in hours of the Employee's employment and is no longer eligible for benefits.
   b. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen (18) month period entitling that Dependent to an additional eighteen (18) months.
   c. On the last day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the SSA if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA continuation coverage. COBRA continuation coverage will also terminate on such day for all Dependents who are Qualified Beneficiaries' due to the Qualifying Event unless that Dependent is entitled to a longer period of COBRA continuation coverage without regard to disability.
   d. Twenty-nine (29) months for a Qualified Beneficiary if a disability extension period of COBRA continuation coverage has been granted for the Qualified Beneficiary; or
   e. Thirty-six (36) months for all other Qualified Beneficiaries.

7. On the same basis the Plan can terminate for cause the coverage of a similarly situated non-COBRA Subscriber.

QUESTIONS: Questions about COBRA Continuation Coverage should be directed to the MUS COBRA Administrator or contact the nearest Regional or District Office of the U.S. DOL's Employee Benefits Security Administration (EBSA).

Section 5
HIPAA PRIVACY AND SECURITY

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of the Health Insurance Portability and Accountability Act (HIPAA), as stated in 45 CFR Parts 160, 162 and 164 and the "Final Rules" under the Health Information Technology for Economic and Clinical Health Act HITECH Act).

A. COMPLIANCE WITH HIPAA PRIVACY AND RECOVERY STANDARDS

Certain Authorized MUS Employees perform services relating to administration of the Plan. To perform these services, these Authorized MUS Employees must, at times, have access to Protected Health Information (PHI) (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Authorized MUS Employees are permitted to have such access subject to the following:

General. Authorized MUS Employees cannot have access to PHI unless each of the conditions set out in this HIPAA Privacy and Security Section is met. "Protected Health Information" or "PHI" will have the same definition as set out in the Privacy Standards and generally will mean individually identifiable health information about the past, present, or future physical or mental health or condition of a Plan Participant, including information about treatment or payment for treatment. PHI does not include employment records held by the MUS in its role as an employer.

Permitted Uses and Disclosures. PHI disclosed to Authorized MUS Employees will be used or disclosed by them only for the purposes of Plan administrative functions. The Plan's administrative functions will include all Plan payment and health care operations. The terms "payment" and "health care operations" will have the same definitions as set out in the Privacy Standards. Generally, "payment" is defined as an activity undertaken by the Plan to collect money due to it or to determine or fulfill its responsibility for payment of benefits under the Plan. "Health care operations" include activities related to payment and Plan administration. Plan administration functions do not include employment-related functions or functions with other benefit plans.

Authorized MUS Employees. Only Authorized MUS Employees will receive PHI, and only to the extent and in the minimum amount necessary for these Employees to perform Plan administrative functions. For purposes of this HIPAA Privacy and Security Section, "Authorized MUS Employees" include the following:

1. Employees of the MUS Employee Benefits office.
2. MUS campus HR/Benefits Representatives.
3. MUS employees in the Information Technology department who support the MUS staff referenced above.

Updates Required. The Plan Administrator will amend the Plan promptly with respect to changes in the Authorized MUS Employees who are authorized to receive PHI.

Use and Disclosure Restricted. An Authorized MUS Employee who receives PHI will use or disclose the PHI only to the extent necessary to perform their duties with respect to the Plan's administrative functions.

Resolution of Issues of Non-compliance. If Authorized MUS Employees use or disclose PHI other than as permitted by the Privacy Standards, the incident will be reported to the MUS privacy official. The privacy official will take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately, whether there is a pattern of breaches, and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the Employee(s) causing the breach, depending upon the nature of the breach, including oral or written reprimand, additional training, or termination of employment, mitigating harm caused by the breach, to the extent practicable, and documenting the incident and all actions taken to resolve the issue and mitigate damages.

"Summary Health Information" means information summarizing claims history, expenses, or types of claims by Plan Participants enrolled in a group health plan and with the following identifiers removed: names; addresses, except for the first three digits of the zip code; dates related to the Plan Participant (e.g., birth date); phone numbers; e-mail addresses and related identifiers; Social Security numbers; medical record numbers; account or Subscriber numbers; vehicle identifiers; and photo or biometric identifier.

B. PRIVACY CERTIFICATION

The MUS certifies to Plan Participants that it agrees to:

1. Not use or further disclose the PHI other than as permitted or required by the Plan documents or as required by law. Such uses or disclosures may be for the purposes of Plan administration, including, but not limited to, the following:
   a. Operational activities, such as: (1) quality assurance or assessment and Utilization Management, credentialing, and certification or licensing activities; (2) underwriting, premium

rating or other activities related to creating, renewing, or replacing health benefit contracts (including reinsurance or stop loss); (3) compliance programs; (3) business planning; (4) responding to appeals, external reviews, and arranging for medical reviews; (5) legal services or auditing functions; and (6) business planning, management, and general administrative activities or customer service activities. Plan administration includes management of the Dental and Vision Hardware Plans. Genetic information will not be used or disclosed for underwriting purposes.

b. Payment activities, such as: (1) determining eligibility or coverage; (2) COB; (3) determination of cost-sharing amounts; (4) adjudicating claims; (5) claims management and collection activities; (6) obtaining payment under a contract for reinsurance or stop-loss coverage and related data-processing activities; and (7) reviewing health care services for Medical Necessity, benefits coverage, appropriateness of care, justification of billed charges, or utilization review activities.

c. For purposes of this certification, Plan administration does not include disclosing Summary Health Information to help the MUS obtain premium bids or to modify, amend, or terminate group health plan coverage. Plan administration does not include disclosure of information to the MUS as to whether the individual is a participant in, is an enrollee of, or has disenrolled from the Plan.

2. Ensure that an agent or subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the MUS with respect to such information.
3. Not use or disclose PHI for employment-related actions and decisions or for any other benefit or Employee benefit plan of the MUS.
4. Report to the Plan Administrator any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law.
5. Make available PHI to individual covered Plan Participants in accordance with Article 164.524 of the Privacy Standards.
6. Make available PHI for amendment by individual covered Plan Participants and incorporate amendments to PHI in accordance with Article 164.526 of the Privacy Standards.
7. Make available the PHI required to provide accounting of disclosures to individual covered Plan Participants in accordance with Article 164.528 of the Privacy Standards.
8. Make available the PHI required to provide accounting of disclosures to individual covered Plan Participants in accordance with Article 164.528 of the Privacy Standards.
9. Make its internal practices, documents, and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services (DHHS) for purposes of determining compliance with the Privacy Standards.
10. If feasible, return or destroy all PHI received from the Plan and retained by the MUS in any form, and return no copies of such information when the information is no longer needed for the purpose for which the disclosure was made, except when such return or destruction of the information is unfeasible, and ensure the adequate separation between the Plan (including Authorized MUS Employees) and the MUS, as required by Article 164.504(f)(2)(iii) of the Privacy Standards.
11. To fulfill this requirement, MUS will restrict access to non-public personal information to the Plan Administrator designated in the SPD or Employees designated by the Plan Administrator as needing to know that information to perform Plan administration and healthcare operations functions or assist eligible Plan Participants enrolling and dis-enrolling from the Plan. The MUS will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator and an Employee so designated must maintain the confidentiality of non-public personal information and follow MUS policies to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities must adhere to procedures and practices that maintain the confidentiality of the Plan

Participant's non-public personal information, use the information only for the limited purpose for which it was shared, and abide by all applicable privacy laws.

C. SECURITY CERTIFICATION

The MUS certifies that it will comply with the Security Standards for the Protection of Electronic PHI (45 CFR Part 164.300 et. seq., the "Security Standards"). Specifically, the MUS will:

1. Implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic PHI the MUS creates, maintains, or transmits on behalf of the Plan. "Electronic Protected Health Information" will have the same definition as set out in the Security Standards but will generally mean PHI that is transmitted by or maintained in an electronic media.

2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that Electronic PHI is used and disclosed only as stated in the Privacy Certification section above.

3. Ensure that an agent or subcontractor to whom it provides Electronic PHI agrees, in writing, to the same restrictions and conditions that apply to the MUS with respect to Electronic PHI including, but not limited to, direct liability for breach involving unsecured Electronic PHI.

4. Report to the Plan Administrator any attempted breach or breach of security measures, as described in this certification and any disclosure or attempted disclosure of Electronic PHI of which the MUS becomes aware.

Section 6
HOW TO OBTAIN BENEFITS

This Section describes how to obtain benefits for Plan Participants enrolled in the Plan. This Section also describes the Medical Plan claims appeal process for Plan Participants.

Payment of benefits will be made based on the submission of required information to the Plan Claims Administrators. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for Plan Claims Administrator contact information.)*

A. PRIOR TO RECEIVING SERVICES

1. **OBTAIN AN IDENTIFICATION CARD.** Subscribers will receive an Identification (ID) card and should ensure the card has the Subscriber's name, Dependent name(s), and Effective Date. Plan Participants will receive separate ID cards for the Medical Plan, Prescription Drug Plan, Dental Plan, and Vision Hardware Plan.

   If a new Plan Participant needs to utilize services before they receive an ID card or if their ID card is lost, the Provider's office may contact the Plan Claims Administrator to verify coverage. Replacement ID cards may be requested by contacting the Plan Claims Administrator.

2. **CHOOSE A PARTICIPATING IN-NETWORK PROVIDER FOR MEDICAL CARE WHEN POSSIBLE**. Participating In-Network Providers will accept the Allowed Amount and not balance bill Plan Participants for billed charges that exceed the Allowed Amount for Covered Medical Expenses. For most Covered Medical Services (Covered Services without a specified benefit limitation or maximum), a Plan Participant who uses a Participating In-Network Provider will only be responsible for their portion of the Allowed Amount (Deductible, Coinsurance, and/or Copayments), not for billed charges that exceed the Allowed Amount. A Plan Participant who uses a Participating In-Network Provider will pay a lower Coinsurance percentage. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits.)*

3. **DETERMINE IF A PLANNED NON-EMERGENCY SERVICE REQUIRES PRIOR AUTHORIZATION.**

Prior Authorization **is required** to receive benefits for:

a. Organ or Tissue Transplant
b. Out-of-Area Medical Travel Expenses; and
c. Bariatric Surgery

If prior authorization is not obtained for the Covered Services listed above, billed charges connected with, or related to, these services will be denied. Adverse prior authorization determinations cannot be appealed.

Prior Authorization is strongly recommended for the following services to determine if a planned procedure or service meets criteria for benefits coverage under the Medical Plan:

a. Surgery that could be considered Cosmetic.
b. A procedure or service that could be considered Experimental or Investigational.
c. Surgical treatment of Temporomandibular Joint Syndrome (TMJ).
d. Durable Medical Equipment that costs more than $2,500.
e. Home Health Care or Skilled Nursing services.
f. Gender Identity Disorder/Gender Dysphoria treatment and services.

Prior Authorization may be obtained from Utilization Management at the Medical Plan Claims Administrator by submitting:

a. A written request from the Provider explaining the proposed service and/or the functional aspects of a surgery and why it is being performed.
b. A complete diagnosis and all medical records regarding the condition for which the requested procedure(s) or treatment(s) will be utilized, including, but not limited to, informed consent form(s), all diagnostic studies.
c. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding procedure codes.
d. The attending Provider's prescription, referral letter, or letter of Medical Necessity, if applicable.
e. A written treatment plan or other information deemed necessary to evaluate the Prior Authorization request.

The Plan Participant's name, address, and the Identification Number **must** be submitted with the above documentation to the Medical Plan Claims Administrator.

A request for Prior Authorization **must** be submitted in writing. A copy of the written approval of available benefits should be attached to all related claims at the time of submittal to expedite processing of the claim.

If the Plan Participant chooses not to request Prior Authorization for recommended services, the billed charges could be denied if the service, treatment, or supply is **not** found to be Medically Necessary when the claim is submitted. Transplant services, bariatric surgery, and Out-of-Area medical travel expenses are **not covered** without Prior Authorization.

4. **PRE-CERTIFICATON FOR NON-EMERGENCY ADMISSIONS AND NOTIFICATION OF EMERGENCY ADMISSIONS.**

Before a planned Inpatient Admission for a non-emergency Illness or Injury, and within seventy-two (72) hours after admission for a Medical Emergency, it is recommended that the Plan Participant or the Participant's attending Provider contact Utilization Management at the Medical Plan Claims Administrator for Pre-Certification review.

Pre-Certification and notification do the following:

a. Optimize efficient resource utilization.
b. Ensure that patients have equitable access to care.
c. Provide collaboration and communication among all members of the health care team to enhance Medically Necessary care in a cost-effective manner.
d. Assist in identifying ways to reduce Out-of-Pocket expenses.
e. Help avoid reductions in benefits which may occur if the services are not Medically Necessary, or the setting is not appropriate; and
f. If appropriate, refer a Case Manager to work with the Plan Participant and Providers. *(Refer to provision 5 – Case Management Services and Focused Case Management, Disease Management, and Health Coaching of this Section.)*

All admissions to an Inpatient facility are subject to a review for Medical Necessity by Utilization Management at the Medical Plan Claims Administrator. All denials of an admission or portion thereof by Utilization Management at the Medical Plan Claims Administrator on behalf of the Plan will result in the denial of all benefits and reimbursements related to the denied admission or the applicable portion of the denied admission.

A benefit determination on whether a claim is eligible for coverage under applicable terms and conditions of the Plan will be rendered only after the claim has been submitted to adjudicate (*see note below)*. If the claim is determined not to be eligible, the Plan Participant will be responsible to pay for all billed charges determined to be ineligible for payment under the Plan. Therefore, although not required, Pre-Certification and Plan notification of emergency admissions are strongly recommended to obtain coverage information prior to incurring expenses.

Once a final decision is made, a written notice of the number of Pre-Certified days will be sent to the Providers and the Plan Participant. Pre-Certification is not required and therefore **cannot** be appealed. However, a Plan Participant may submit a pre-service claim for Prior Authorization. *(Refer to Section 6 – How to Obtain Benefits, provision C. – Claims and Eligibility Procedures).*

NOTE: Pre-Certification of benefits is not a guarantee of payment of the claim(s). Eligibility for claim payments is determined when claims are adjudicated by the Medical Plan Claims Administrator since the amount of benefit coverage is subject to all applicable Plan provisions including, but not limited to, Medical Necessity, patient eligibility, Deductibles, Copayments, Coinsurance, and exclusions, limitations, or maximums in effect when the services are provided.

CONTINUED STAY CERTIFICATION: At the time of initial Pre-Certification, Utilization Management at the Medical Plan Claims Administrator will certify a certain number of days for the Inpatient stay. If the stay exceeds the number of days certified, certification for additional days should be obtained in the same manner as the pre-admission certification.

Charges incurred for Inpatient days in a Hospital or other facility exceeding days previously certified by Utilization Management at the Medical Plan Claims Administrator are subject to all terms, conditions, and exclusions of the Medical Plan.

5. CASE MANAGEMENT SERVICES

Case Management services are provided by the Plan to Medical Plan Participants with major, long-term or high risk Illnesses, Injuries, or pregnancy who can benefit from the services. Appropriate candidates are primarily identified through the Pre-Certification process or through review of large claims. The Case Manager will contact Case Management candidates. Case Management services:

a. Interface with the attending Provider and the patient so that a care plan can be coordinated with all parties.

b. Educate patients about their condition, treatment options, and benefit plan.
c. Assist the Provider with monitoring compliance and patient progression along the recovery continuum.
d. Assist with arrangements for home health services, Durable Medical Equipment, or therapies as needed by individual patients.

6. **FOCUSED CASE MANAGEMENT, DISEASE MANAGEMENT, AND HEALTH COACHING**

Focused Case Management, disease management, and health coaching services are provided by MUS care professionals (Benefits Department and Wellness Programs) or contracted vendors. These professionals work with Plan Participants who can benefit from these services, as well as their attending Provider, and/or their family to identify and arrange the most appropriate, effective, and cost-efficient treatment possible. Services focus on Plan Participants identified as having:

a. a catastrophic Illness or Injury.
b. significant medical risks.
c. chronic health care needs, which can be reduced through prevention or disease management; or
d. a need for wellness promotion and/or health coaching.

Plan Participants will be identified through analysis of information, such as medical/pharmaceutical claims data, and/or wellness screening results to determine who is most likely to benefit from these services. Qualifying adult Plan Participants enrolled in the Medical Plan may be individually contacted by a care professional. The care professional who provides these services must keep all claims data and other medical information confidential. When offered focused Case Management, disease management, or health coaching services, Plan Participants are encouraged to carefully consider the benefit offerings but can reject some or all recommendations or advice. The use of these services is voluntary and offered at no additional cost to Plan Participants. The services are helpful in several ways:

a. These services can permit treatment options not normally available under the Plan through Plan exceptions. The Plan may, at its sole discretion, make payment for medical or dental services that are not listed as Covered Services or benefits of the SPD to provide quality care at a lesser cost. Such payments will be made only upon agreement by the Plan Participant and the Plan; and
b. Participation may save both the Plan and its Plan Participants money by providing a third party to help identify the more efficient/lower cost suppliers of medical goods and services, coordinate services, work out cost reductions, and by making arrangement for special treatment plans.

B. FILING A CLAIM (DOMESTIC OR INTERNATIONAL)

Claims (domestic or international) for Covered Services **must** be received by the Medical Plan Claims Administrator within twelve (12) months from the date the service(s) or treatment(s) is received or completed. A Plan Participant becomes a Claimant when they make a request for Plan benefits in accordance with these claim's procedures. Claims must be submitted on an approved claim form, available from the Provider, on the Plan Claims Administrator's website or the MUS *Choices* website at choices.mus.edu. Claim forms **must** be completed with all requested information, including:

1. Name, address, and Identification Number of the Subscriber.
2. Name and date of birth of the Patient receiving the service or treatment.
3. Date of service(s) or treatment(s).
4. Diagnosis [code] for each condition being treated.
5. Description of each type of service(s) or treatment(s) [code] performed.

6. Amount charged by the Provider for each Covered Service or treatment (in local currency). Charges for Covered international (out of country) Medical Services or treatments **may** require payment upfront to the Provider.
7. Name, address, and phone number of the Provider providing the service(s) or treatment(s).
8. Appropriate documentation, as determined by the Plan Claims Administrator, to support the Medical Necessity of the service(s) or treatment(s) being provided that is sufficient to enable the Plan Claims Administrator to adjudicate the claim pursuant to applicable terms and conditions of the Plan.

When completed, the claim (domestic or international) **must** be sent to the Plan Claims Administrator.

Claims (domestic or international) are processed in the order in which they are received by the Medical Plan Claims Administrator and **must** be received within twelve (12) months from the date services were incurred or treatment is received. Benefits will be applied to the first claim received and will not be changed if additional claims are received during the Benefit Plan Year.

On termination of the Plan, final claims (domestic or international) **must** be received within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

CLAIMS (DOMESTIC OR INTERNATIONAL) WILL NOT BE DEEMED SUBMITTED UNTIL RECEIVED BY THE PLAN CLAIMS ADMINISTRATOR.

At no expense to the Claimant, a Claimant may be required to undergo a medical examination, when and as often as may be reasonable, and to submit all medical and other relevant records necessary to properly adjudicate the claim.

C. CLAIMS AND ELIGIBILITY PROCEDURES

Claims will be considered for payment according to the Plan's applicable terms and conditions, industry-standard claims processing guidelines, and administrative practices not inconsistent with the terms of the Plan. The Plan Claims Administrator may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims determinations will be made within the time periods stated below. For purposes of this section, a Plan Participant will include the Claimant and the Claimant's authorized representative; however, a Plan Participant does not include a Health Care Provider or other assignee. A Health Care Provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply because of the assignment of benefits. A Claimant, for purposes of appeals regulations, is a Plan Participant who makes a claim under the following rules for internal claims and appeals and external review procedures or a Claimant's authorized representative, as defined below. A Plan Participant becomes a Claimant when making a request for a Plan benefit or benefits in accordance with these claims procedures.

Claimants are entitled to receive a full and fair review of claims denied under the Plan. The procedures described in the SPD are intended to comply with U.S. DOL claims procedure regulations by providing reasonable procedures governing the filing of claims for Plan benefits, notification of benefit determinations, right to review information relevant to a claim, opportunity to present evidence and testimony, and further requirements governing appeals of adverse benefit determinations.

"Authorized Representative" means a representative authorized by the Claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant **must** authorize the representative in writing, and this written authorization **must** be provided to the Plan Claims Administrator. The Authorized Representative will only be recognized after the Plan Claims Administrator receives the written authorization.

INFORMATION REGARDING URGENT CARE CLAIMS IS PROVIDED TO THE CLAIMANT UNDER THE DISCLOSURE REQUIREMENTS OF THE APPLICABLE LAW. THE PLAN DOES NOT MAKE TREATMENT DECISIONS. A DECISION TO RECEIVE TREATMENT MUST BE MADE BY THE CLAIMANT AND THE HEALTHCARE PROVIDER. HOWEVER, THE PLAN WILL ONLY PAY BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS, AND EXCLUSIONS OF THE SPD.

Types of Medical Claims

Claims are classified by type of claim and the timeline in which a decision **must** be determined. The notice timeline provided depends on the type of claim. The initial benefit determination notice will be included in the Plan Participant's Explanation of Benefits (EOB) from the Medical Plan Claims Administrator or in a letter from the Plan. There are five (5) types of claims:

1. **Pre-Service Claim** – A claim that **must** be submitted to the Medical Plan Claims Administrator before the Plan Participant receives medical treatment or service. A Pre-Service Claim under the Plan requires a Prior Authorization determination before a Plan Participant obtains medical care or treatment.

2. **Urgent Care Claim** – A claim involving urgent care for medical care or treatment which may seriously jeopardize the Claimant's life, health, or the ability to regain maximum function or may, in the opinion of a Provider with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. **There are no pre-service urgent care requirements under the Plan, and therefore, there are no rights to appeal a pre-service urgent care claim denial.**

3. **Post-Service Claim** – A claim for a medical benefit under the Plan that is not a pre-service claim, an urgent care claim, or a concurrent care claim.

4. **Rescission of Coverage** – A cancellation or discontinuation of coverage that has a retroactive effect based upon a Claimant's fraud or intentional misrepresentation of a material fact. A cancellation or discontinuance of coverage that has a retroactive effect is not a Rescission if and to the extent that it is attributable to a failure to timely pay required monthly premiums or contributions toward the cost of coverage.

5. **Concurrent Care Claim** – A determination made by the Medical Plan Claims Administrator approving an ongoing course of medical treatment for the Claimant to be provided over time or for a specific number of treatments. A concurrent care claim is a claim that relates to the ongoing course of medical treatment (and the basis of the approved concurrent care determination), such as a request by the Claimant for an extension of the number of treatments or the termination by the Plan of the previously approved time for medical treatment.

Initial Claim Determination by Type of Claim and Notice

In most cases, initial claims determinations on Post-Service Claims will occur within thirty (30) days of the Medical Plan Claims Administrator's receipt of the claim and sufficient information on which to make an initial determination on the claim(s).

The Medical Plan Claims Administrator may extend time for the initial claims determination of both Pre-Service and Post-Service Claims by fifteen (15) days, if the extension is reasonably necessary for reasons beyond the Medical Plan Claims Administrator's control and the Medical Plan Claims Administrator gives written notice to the Plan Participant of the reasons for the extension and the date by which the Medical Plan Claims Administrator expects a determination. If an extension is necessary because the Claimant did not submit the information necessary for the Medical Plan Claims Administrator to make an initial claim(s) determination, the extension notice will specifically describe the information needed. The Claimant will have forty-five (45) days from receipt of the notice to provide the specified information to the Medical Plan Claims Administrator. The Medical Plan Claims Administrator will notify the Claimant of the initial claim determination no later than fifteen (15) days

after the date the Medical Plan Claims Administrator receives the specific information requested or the due date for the requested information, whichever is earlier.

Urgent Care Claim Determination and Notice

a. **Designation of Claim**
After receiving a pre-service claim, the Medical Plan Claims Administrator will determine if the claim involves urgent care. If a Provider with knowledge of the Claimant's medical condition determines that the claim involves urgent care, the Medical Plan Claims Administrator will treat the claim as an urgent care claim.

b. **Notice of Determination**
If the claim is an urgent care claim, the Medical Plan Claims Administrator will provide the Claimant with notice of the determination, either verbally or in writing, as soon as possible consistent with the medical exigencies but no later than seventy-two (72) hours from the Medical Plan Claims Administrator's receipt of the claim. If verbal notice is provided, the Medical Plan Claims Administrator will provide a written notice within three (3) days of the date the Medical Plan Claims Administrator notified the Claimant.

c. **Notice of Incomplete or Improperly Submitted Claim**
If an urgent care claim is incomplete or not properly submitted, the Medical Plan Claims Administrator will notify the Claimant about the incomplete or improper submission no later than twenty-four (24) hours from the Medical Plan Claims Administrator's receipt of the claim. The Claimant will have at least forty-eight (48) hours to provide the necessary information. The Medical Plan Claims Administrator will notify the Claimant of the initial claim determination no later than forty-eight (48) hours after the earlier of the date the Medical Plan Claims Administrator receives the specific information requested or the due date for the requested information.

Post-Service Claim Determination and Notice

a. **Notice of Determination**
In response to a post-service claim, the Medical Plan Claims Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim.

b. **Notice of Extension**
1. If an extension is reasonably necessary for reasons beyond the control of the Medical Plan Claims Administrator, the Medical Plan
Claims Administrator may extend the thirty (30) day timeframe for an additional fifteen (15) days. The Medical Plan Claims Administrator will notify the Claimant in writing of the reasons for the extension and the date by which the Medical Plan Claims Administrator expects to render a determination.
2. For receipt of information from the Claimant to decide the claim if the extension is necessary due to the Claimant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed. The Claimant has forty-five (45) days from receipt of the notice to provide the information. The Medical Plan Claims Administrator will notify the Claimant of the initial claim determination no later than fifteen (15) days after the date the Medical Plan Claims Administrator receives the specific information requested or the due date for the information, whichever is earlier.

Concurrent Care Determination and Time Frame for Decision and Notice

a. **Request for Extension of Previously Approved Time or Number of Treatments**
1. In response to the Claimant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Claimant's claim involves urgent care, the Medical Plan Claims Administrator will review the claim and notify the Claimant of its determination within twenty-four (24) hours of receiving the Claimant's claim, provided the Claimant's claim was filed at least twenty-four (24) hours before the end of the approved time

period or number of treatments.

2. If the Claimant's claim was not filed at least twenty-four (24) hours before the end of the approved time or number of treatments, the Claimant's claim will be decided within the timeframes for an urgent care claim. *(Refer to Initial Claim Determination by Type of Claim and Notice of this Section.)*
3. If the Claimant's claim did not involve urgent care, the time periods for deciding pre-service claims and post-service claims, as applicable, will govern.

b. **Reduction or Termination of Ongoing Course of Treatment**
Other than through a Plan amendment or termination, the Medical Plan Claims Administrator **may not** subsequently reduce or terminate an ongoing course of treatment for which the Claimant has received prior approval unless the Medical Plan Claims Administrator provides the Claimant with written notice. The written notice will include the scheduled date of the reduction or termination and will be issued with sufficient time for the Claimant to appeal the determination and obtain a decision before the reduction or termination occurs.

Rescission of Coverage Determination and Notice of Intent to Rescind

The Plan Administrator will provide a Claimant whose coverage is being rescinded due to fraud or an intentional misrepresentation of fact, with a Notice of Intent to Rescind at least thirty (30) days before rescinding coverage. The Notice of Intent to Rescind will include the following:

1. The factual basis for the finding of fraud or intentional misrepresentation of a material fact.
2. Notice that the Claimant may appeal a final determination by the Plan Administrator to rescind coverage after the thirty (30) day period.
3. A reference to the Plan provision(s) on which Rescission is based; and
4. A statement that the Claimant is entitled to receive (upon request and at no cost), reasonable access to and copies of all documents and records and other information relevant to the Rescission.

D. NOTICE OF AN ADVERSE BENEFIT DETERMINATION

A determination on a claim is "adverse" if it is a Rescission, a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Plan benefit. If a claim is denied, in whole or in part, the Claimant will receive written notice of the Adverse Benefit Determination. The Medical Plan Claims Administrator will provide a claim EOB including:

1. An explanation of the claim denial. If the adverse benefit determination is a Rescission, the notice will include the factual basis for the finding of fraud and/or intentional misrepresentation of a material fact.
2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the determination was based.
3. If applicable, a description of additional material or information needed to process the claim and why such information is necessary.
4. A description of the Plan internal and external review procedures (and for urgent care claims only, a description of the expedited review process applicable to such claims) and time limits for appeal of the determination and, if applicable, a statement of the Claimant's right to file a civil action.
5. If applicable, an offer to provide (upon request and at no cost) any internal rule, guidelines, protocol or similar criterion, Medical Policy, or other medical information relied on in making the Adverse Benefit Determination.
6. If applicable, an offer to provide (upon request and at no cost) an explanation for an Adverse Benefit Determination based on a medical necessity standard or an Experimental or Investigational treatment or similar exclusion or limitation.
7. If applicable, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances or an offer to provide (upon request and at no cost) such an explanation.
8. An offer to provide (upon request and at no cost) reasonable access to and copies of all documents and records and other information or materials relevant to the Adverse Benefit Determination.

If a Claimant does not understand the reason for an Adverse Benefit Determination, they should contact the Medical Plan Claims Administrator.

E. APPEALING AN ADVERSE BENEFIT DETERMINATION

The Claimant has the right to appeal an Adverse Benefit Determination under these claims procedures.

Important Appeal Deadline
If a Claimant disagrees with an Adverse Benefit Determination (including a Rescission), the Claimant may appeal the determination in writing to the Medical Plan Claims Administrator. The Claimant **must** appeal within one hundred-eighty (180) days from receipt of the Adverse Benefit Determination. Except for urgent care claims, the Claimant's appeal **must** state why the Claimant does not agree with the Adverse Benefit Determination.

How the Appeal Will Be Determined
As the Plan's named fiduciary, the MUS will review and decide any appeal of an Adverse Benefit Determination. The decisionmaker on appeal will be a different individual than the individual who made the initial benefit determination and will not be a subordinate of the individual who made the initial benefit determination. The decisionmaker on appeal will give no deference to the initial Adverse Benefit Determination and will look at the issues anew. MUS will not make decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to the decisionmaker on appeal based on the outcome of the appeal.

Consideration of Comments
Upon appeal, the decisionmaker will consider all evidence, testimony, records, documents, or other information the Claimant submitted relating to the claim, even if the information was not submitted to or considered by the Medical Plan Claims Administrator.

If the Plan Administrator considers, relies on, or generates new or additional evidence regarding its review of the Claimant's claim, the Plan Administrator will provide the Claimant with the new or additional evidence (at no cost) as soon as possible and with adequate time to respond before a final determination must be provided by the Plan Administrator.

Consultation with An Expert
In the case of a claim denied, in whole or in part, on grounds of medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional who consulted on appeal will not be the same individual who was consulted regarding the initial Adverse Benefit Determination or a subordinate of that individual.

Access to Relevant Information
A Claimant will (upon request and at no cost) be provided reasonable access to, and copies of, all documents, records, and other information relevant to the Adverse Benefit Determination. If the advice of a medical or vocational expert was obtained regarding the initial Adverse Benefit Determination, the names of each such expert will be provided on the Claimant's request, regardless of whether the advice was relied on by the Plan Administrator.

Expedited Methods for Urgent Care Claims
Considering the expedited timeframes for determination of urgent care claims, an urgent care appeal may be submitted to the Medical Plan Claims Administrator. The claim should include at least the following information:

1. The identity of the Claimant.
2. A specific medical condition or symptom.
3. A specific treatment, service, or product for which approval or payment is requested.

4. The reasons why the appeal should be processed on an expedited basis.

The Medical Plan Claims Administrator will decide the appeal of an urgent care claim as soon as possible but no later than seventy-two (72) hours after receipt of the appeal.

F. TIMEFRAMES FOR DECIDING AN APPEAL OF ADVERSE BENEFIT DETERMINATION

The timeframe for the Plan Administrator to decide an appeal of an Adverse Benefit Determination and to notify the Medical Plan Claims Administrator, who will notify the Claimant of the final internal Adverse Benefit Determination, depends on the type of claim on appeal.

1. **Urgent Care Claim** – No later than seventy-two (72) hours from the date the Medical Plan Claims Administrator received the Claimant's appeal.
2. **Pre-Service Claim** – No later than thirty (30) days from the date the Medical Plan Claims Administrator received the Claimant's appeal.
3. **Post-Service Claim** – No later than sixty (60) days from the date the Medical Plan Claims Administrator received the Claimant's appeal.
4. **Concurrent Care Claim** – If the claim involves urgent care, no later than seventy-two (72) hours from the date the Medical Plan Claims Administrator received the Claimant's appeal. If the claim does not involve urgent care, the time for deciding a pre-service (non-urgent care) claim and a post-service claim, as applicable, will govern.
5. **Rescission of Coverage** – No later than sixty (60) days from the date the Plan Administrator received the Claimant's appeal.

These rules require the Claimant to initiate the appeal within the timeframe applicable to the claim at issue. Failure to submit a written appeal or request for review within the relevant time may cause the Claimant to forfeit any right to further review of an Adverse Benefit Determination under these procedures or in court and will render the determination final. An untimely appeal will not be considered.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Medical Plan Claims Administrator in writing, and supporting materials may be submitted via mail, facsimile (fax), or electronic mail (e-mail).

G. FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

If the Plan Administrator upholds the initial Adverse Benefit Determination, in whole or in part, the final internal Adverse Benefit Determination notice will include the following information:

1. The specific reason(s) for the final internal Adverse Benefit Determination. If the final internal Adverse Benefit Determination upholds a Rescission, the notice will include the factual basis for the finding of fraud or intentional misrepresentation of a material fact.
2. A reference to the specific Plan provision(s) or rule(s) on which the final internal Adverse Benefit Determination is based.
3. The standard the Plan Administrator relied on to deny the claim (such as a medical necessity standard).
4. If applicable, a statement describing the Claimant's right to request an external review and the time limits for requesting an external review.
5. If applicable, an offer to provide (upon request and at no cost) any internal rule, guidelines, protocol or similar criterion, Medical Policy, or other medical information relied on in making the final internal Adverse Benefit Determination.
6. If applicable, an offer to provide (upon request and at no cost) an explanation for a final internal Adverse Benefit Determination that is based on a medical necessity standard or an Experimental or Investigational treatment or similar exclusion or limitation.
7. If applicable, an explanation of the scientific or clinical judgment applying the terms of the Plan to

the Claimant's medical circumstances or an offer to provide such a statement (upon request and at no cost).

8. An offer to provide reasonable access to and copies of all documents and records and other information or materials relevant to the final internal Adverse Benefit Determination.

The Plan Administrator will review the claim, and any additional information submitted by the Claimant. The Plan Administrator will conduct a full and fair review of the claim. The Plan Administrator is neither the original decisionmaker nor the decisionmaker's subordinate. The Plan Administrator **cannot** give deference to the initial benefit determination. The Plan Administrator may consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental Treatment, the Plan Administrator will consult with a health care professional with appropriate training. Neither that health care professional nor their subordinate will be the medical professional consulted in the initial determination.

The Plan Administrator will provide written or electronic notice to the Medical Plan Claims Administrator of the final benefit determination. For a Pre-Service Claim, such notice **must** be provided no later than thirty (30) days from the date the Medical Plan Claims Administrator receives the appeal. For a Post-Service Claim, such notice **must** be provided no later than sixty (60) days from the date the Medical Plan Claims Administrator receives the appeal. The Medical Plan Claims Administrator will provide this notice to the Claimant within the relevant timeframe specified above. Such notice will contain the same information as notices for the initial determination.

All claim payments are based on the terms contained in the SPD on file with the Plan Administrator and the Medical Plan Claims Administrator. The Claimant may also request more detailed information, including the names of medical professionals consulted, and copies of relevant documents used by the Medical Plan Claims Administrator to adjudicate the claim. Such information will be provided at no cost.

Right to Request an External Review:

Standard External Review

A Claimant (or an individual acting on the Claimant's behalf) may request external review of an Adverse Benefit Determination by filing a request for external review within four (4) months of the date of receipt of a notice of an Adverse Benefit Determination. The request for external review **must** be made in writing to the Medical Plan Claims Administrator. Within five (5) business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether:

1. The Claimant is (or was) covered under the Plan at the time the health care item or service was requested, or, in the case of a retrospective review, the Claimant was covered under the Plan at the time the health care item or service was provided.
2. The Adverse Benefit Determination is based on the fact the Claimant was not eligible for coverage under the Plan.
3. The Claimant has exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required).
4. The Claimant has provided all the information and forms required to process an external review.

The Claimant will be notified of the results of the preliminary review within one business day of completion of the preliminary review. If the request is incomplete, the notice **must** describe the information or documentation needed to complete the request. In addition, the notice **must** state the time limit for the Claimant to provide the additional information (the initial four-month period within which to request an external review or forty-eight (48) hours after the receipt of this notice, whichever comes later).

If the claim is eligible for external review, an Independent Review Organization (IRO) will be assigned to conduct the external review.

Expedited External Review
A Claimant may seek an expedited external review when:

1. An Adverse Benefit Determination involves a medical condition where the timeframe for completing an expedited internal appeal would seriously jeopardize the Claimant's life, health, or ability to regain maximum function, and a request for an internal appeal has been filed; or
2. A final internal Adverse Benefit Determination involves: (a) a medical condition where the timeframe for completing an expedited internal appeal would seriously jeopardize the Claimant's life, health, or ability to regain maximum function; or (b) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

The request for an expedited external review **must** be made in writing to the Medical Plan Claims Administrator. Immediately on receipt of the request for an expedited review, the Medical Plan Claims Administrator will decide whether the request meets the requirements (as described above) for a standard external review, the Claimant will be notified of the determination, and an IRO will be assigned (as described above) for a standard external review.

External Review by IRO
The Medical Plan Claims Administrator will timely (in the case of an expedited external review, expeditiously) provide to the IRO documents and information considered in making the Adverse Benefit Determination. The Claimant may submit additional information in writing to the IRO within ten (10) business days of the IRO's notification that it has been assigned the request for external review. The IRO will review all information and documents timely received. In making its decision, the IRO is not bound by the Plan's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

1. The Claimant's medical records.
2. The attending health care professional's recommendation.
3. Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating Health Care Provider.
4. The terms of the Claimant's SPD.
5. Evidence-based practice guidelines.
6. Applicable clinical review criteria developed and used by the Plan; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

Notice of Final External Review Decision
The IRO will provide written notice of the final external review decision to the Claimant and the Medical Plan Claims Administrator within forty-five (45) days of the IRO receiving the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the Adverse Benefit Determination, the final external review decision of the IRO controls.

In the case of an expedited external review, the IRO will provide the notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO **must** provide written confirmation of the decision within forty-eight (48) hours.

Compliance with IRO Decision
If the IRO reverses the Plan's Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan Administrator will immediately provide coverage or issue payment according to the terms of the Plan.

Section 7
MEDICAL PLAN DESCRIPTION

This Section describes the Medical Plan benefits for Plan Participants. *(Refer to Section 6 – How to Obtain Benefits*. *Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for Medical Plan contact information.)*

A. COVERED MEDICAL EXPENSES

The following are Covered Medical Expenses of the Medical Plan offered by the MUS Benefits Plan:

1. Expenses within the Allowed Amount (Plan Participants are responsible for Covered Medical Expenses by Out-of-Network Providers which exceed the Allowed Amount (balance billing)).

2. Expenses within the specified benefit limitations and maximums contained in this Section and the current MUS *Choices* Enrollment Workbook Schedule of Benefits, and which meet other requirements of the SPD.

3. Expenses for Covered Medical Services defined in provisions E. and F. of this Section; and

4. Expenses for Covered international (out of country) Medical Services when the Plan Participant is traveling or living outside of the U.S.

A benefit determination on a claim will be rendered only after the claim has been submitted to adjudicate whether it is eligible for coverage under the terms and conditions of the Plan. If the claim is determined to be not eligible, the Plan Participant will be responsible for paying all billed charges that are determined to be ineligible.

Covered Medical Expenses are paid or applied to the Plan Participant's Deductible, Coinsurance, Copayment, and Out-of-Pocket Maximum obligations (as described below).

B. DEDUCTIBLE

DEDUCTIBLE – The dollar amount each Plan Participant must pay for Covered Medical Expenses incurred during the Benefit Plan Year before the Plan will make payment for any Covered Medical Services to which the Deductible applies. Only the Allowed Amount for Covered Medical Expenses is applied toward the annual Deductible. The annual Deductible has been reached when either: (a) a Plan Participant accrues the maximum amount toward the individual Deductible or (b) two (2) or more Plan Participants accrue the maximum amount toward the family Deductible during the Benefit Plan Year. Coinsurance, Copayments, expenses for non-Covered Services, and balance billing amounts do not apply to the annual Deductible and are the Plan Participant's responsibility.

Covered Medical Expenses from an Out-of-Network Provider have a separate annual Deductible and annual Out-of-Pocket Maximum. An Out-of-Network Provider can balance bill the difference between the Allowed Amount and the billed charge. Review the current MUS *Choices* Enrollment Workbook Schedule of Benefits for specific In-Network and Out-of-Network Deducible amounts.

If a Plan Participant is inpatient in a Hospital or other facility on the day their coverage begins, the Plan will pay benefits for Covered Expenses the Plan Participant incurs beginning on the date the coverage

becomes effective, subject to the annual Deductible, Coinsurance percentage, and Out-of-Pocket Maximum as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

If a Plan Participant is inpatient in a Hospital or other facility on the last day of the Benefit Plan Year and continuously confined through the first day of the next Benefit Plan Year, only one Deductible will be applied to that inpatient Hospital stay (facility charges only). If the Plan Participant satisfied the annual Deductible prior to that inpatient Hospital stay, no Deductible will be applied to that stay.

If a Plan Participant is inpatient in a Hospital or other facility on the day their coverage terminates, the Plan will pay benefits for Covered Medical Expenses the Plan Participant incurs through the date the coverage terminates, subject to the annual Deductible, Coinsurance percentage, and Out-of-Pocket Maximum as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

EXEMPTIONS FROM DEDUCTIBLE – Certain Covered Medical Expenses are exempt from the annual Deductible. Review the current MUS *Choices* Enrollment Workbook Schedule of Benefits for specific exemptions.

C. COINSURANCE AND COPAYMENT

COINSURANCE – After a Plan Participant has satisfied the annual Deductible, the Plan Participant pays a Coinsurance percentage of the Covered Medical Expenses incurred until the Out-of-Pocket Maximum is reached. The annual Out-of-Pocket Maximum has been reached when either: (a) a Plan Participant accrues the maximum amount toward the individual Out-of-Pocket Maximum or (b) two (2) or more Plan Participants accrue the maximum amount toward the family Out-of-Pocket Maximum during the Benefit Plan Year. The Plan pays any remaining Covered Medical Expenses the Plan Participant incurs in the Benefit Plan Year.

Covered Medical Expenses from an Out-of-Network Provider have a separate Coinsurance percentage and annual Out-of-Pocket Maximum. An Out-of-Network Provider can balance bill the difference between the Allowed Amount and the billed charge. Review the current MUS *Choices* Enrollment Workbook Schedule of Benefits for specific In-Network and Out-of-Network coinsurance percentage amounts.

If a Plan Participant is inpatient in a Hospital or other facility on the day their coverage begins, the Plan will pay benefits for Covered Expenses the Plan Participant incurs beginning on the date the coverage becomes effective, subject to the annual Deductible, Coinsurance percentage, and Out-of-Pocket Maximum, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

If a Plan Participant is inpatient in the Hospital on the last day of the Benefit Plan Year and continuously confined through the first day of the next Benefit Plan Year, the Deductible and applicable Coinsurance for the entire inpatient Hospital stay (facility charges only) will only apply to the Out-of-Pocket Maximum of the Benefit Plan Year in which the inpatient Hospital stay began. If the Plan Participant satisfied the annual Out-of-Pocket Maximum prior to that inpatient Hospital stay, no Deductible or applicable Coinsurance will be applied to that stay.

If a Plan Participant is inpatient in a Hospital or other facility on the day their coverage terminates, the Plan will pay benefits for Covered Medical Services that the Plan Participant received through the date the coverage terminates, subject to the annual Deductible, Coinsurance percentage, and Out-of-Pocket Maximum as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

EXEMPTIONS FROM COINSURANCE – Certain Covered Medical Expenses are exempt from Coinsurance or Copayments. Review the current MUS *Choices* Enrollment Workbook for specific exemptions.

PRIMARY CARE PROVIDER /SPECIALTY PROVIDER COPAYMENT – A fixed dollar Copayment, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, applies to Covered Medical Expenses for an In-Network office visit for evaluation and management of the patient (consultation and examination by a Provider in an office, clinic, telemedicine, or other outpatient setting). All other Covered Medical Expenses for Covered Medical Services rendered during the office visit are subject to the annual Deductible and Coinsurance. The Copayment is not applied toward the annual Deductible; however, it does apply toward the annual Out-of-Pocket Maximum.

EMERGENCY ROOM COPAYMENT – A fixed dollar Copayment, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, applies to Covered Medical Expenses for the emergency room visit only. The Copayment is waived if the emergency room visit is immediately followed by a Hospital Inpatient Admission. All other Covered Medical Expenses for Covered Medical Services rendered at the emergency room are subject to the annual Deductible and Coinsurance. The Copayment is not applied toward the annual Deductible; however, it does apply toward the annual Out-of-Pocket Maximum.

URGENT CARE COPAYMENT – A fixed dollar Copayment, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, applies to Covered Medical Expenses for the urgent care visit only. All other Covered Medical Expenses for Covered Medical Services rendered at the urgent care are subject to the annual Deductible and Coinsurance. The Copayment is not applied toward the annual Deductible; however, it does apply toward the annual Out-of-Pocket Maximum.

D. BENEFIT MAXIMUMS

Certain Covered Medical Expenses include benefit maximums in the form of annual limitations on the number of allowed visits or dollar amounts payable for Covered Services. For the Medical Plan, these benefit maximums are indicated in the description of the specific Covered Medical Services below and/or in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

E. COVERED MEDICAL SERVICES

Covered Medical Services are visits, treatments, procedures, or supplies:

1. Listed in this Section as Covered Medical Services, and not specified as exclusions in this Section or in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

2. Either Medically Necessary for the diagnosis or treatment of Injury, Illness, or maternity, or services specified as covered preventive services in this Section.

3. Provided to a Plan Participant by a covered Licensed Health Care Provider practicing within the scope of their license; and

4. Provided and coded in accordance with applicable standard medical and insurance practice.

F. SPECIFIC COVERED MEDICAL SERVICES

Expenses for the following Covered Services, which meet the above definition of Covered Medical Services, are covered by this Medical Plan *(Refer to provision E. – Definition of Covered Medical Services of this Section.)*:

1. **Inpatient Hospital Services** – ***The Plan strongly recommends all Inpatient care be Pre-Certified by Utilization Management at the Medical Plan Claims Administrator.*** *(Refer to Section 6 - How to Obtain Benefits.)* Inpatient Hospital services are Covered Medical Services when a Plan Participant is confined to a licensed Hospital for Medically Necessary treatment of an Injury or Illness requiring Inpatient care. Hospital confinement with a primary purpose of obtaining

diagnostic tests, examination, Custodial Care, place of rest, nursing home, or rehabilitation will not be considered a Covered Medical Service, except as otherwise provided in the SPD.

Inpatient Hospital Covered Services include, but are not limited to, the following (other Hospital services are covered in other provisions):

a. Daily room and board in a semi-private room or private room and general nursing services, or confinement in an intensive care unit. If private room accommodations are used, the daily room and board Allowed Amount will not exceed the facility's average semi-private room billed charge.
b. Medically Necessary Hospital expenses for miscellaneous services and supplies furnished by the Hospital, including hemodialysis and diagnostic services.
c. Nursery neonatal unit services, including general nursing services, Physical Therapy, care or treatment of Injury or Illness, congenital defects, birth abnormalities of a newborn Dependent, or premature birth of a newborn Dependent.

Although not required, Pre-Certification of an Inpatient Admission is strongly recommended to obtain coverage information before incurring expenses.

2. **Inpatient Professional Care** – **(*Pre-Certification of all Inpatient Admissions is strongly recommended.)*** Health care services performed, prescribed, or supervised by a Licensed Health Care Provider, including diagnostic, therapeutic, medical, referral, and consultative health care services. *(Refer to Surgical Services in provision 8 of this Section for surgical services.)*

3. **Outpatient Hospital Services** – Outpatient Hospital services rendered to a Plan Participant who has not been admitted for Inpatient care, including, but not limited to, treatments for chronic conditions, Emergency Room services for emergent care or treatment only, Physical Therapy, and diagnostic services.

4. **Emergency Room Services** – Hospital emergency room services for care or treatment of a Medical Emergency only. Emergency room benefits are subject to a Copayment *(Refer to provision C. – Coinsurance and Copayment of this Section and the current MUS Choices Enrollment Workbook Schedule of Benefits)* and the annual Deductible and Coinsurance.

5. **Outpatient Office and Urgent Care Clinic Services** – Coverage includes health care services for the evaluation and management of the patient (consultation and examination by a provider in an office, urgent care clinic, telemedicine, or other outpatient setting) by a Physician, Naturopath, or Licensed Health Care Provider, or by other office/clinic staff under a Physician's direction. These services include, but are not limited to: (a) office visits, telemedicine visits, diagnostic services; (b) treatment services, including minor surgery, radiation and or chemotherapy services provided within the office or clinic; and (c) referral services. These services are subject to a Copayment *(Refer to provision C. – Coinsurance and Copayment of this Section and the current MUS Choices Enrollment Workbook Schedule of Benefits)*, and the annual Deductible and Coinsurance.

   Prescription drugs intended for use in a Provider's office or setting, other than home use, are covered when provided during an evaluation or management encounter, subject to the annual Deductible and Coinsurance.

6. **Ambulatory Surgical Center Services –** Ambulatory Surgical Center (same-day surgery center or Outpatient surgery center) means a licensed facility with a staff of Physicians, other Licensed Health Care Providers, and permanent facilities, either freestanding or as a part of a Hospital, that is equipped and operated solely for performing Outpatient surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities **must** provide continuous Physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center **must** meet requirements for certification or licensing for Ambulatory Surgery Centers in the state in which the facility is located.

The facility **must** have the following:

a. Staffing, which includes:
   1) Direction by a staff of Physicians or surgeons (MD or DO).
   2) Presence of a Physician or surgeon during each surgical procedure and recovery period (including presence of a certified anesthesiologist when general or spinal anesthesia is required).
   3) Provision of full-time skilled nursing services in the operating and recovery rooms (under the direction of RNs); and
   4) Extension of staff privileges to Physicians or surgeons who perform surgery in an area Hospital.

b. Facilities and equipment, which includes:
   1) At least two (2) operating rooms and one (1) recovery room (but not a place for patients to stay overnight).
   2) Diagnostic x-ray and lab equipment (or a contract to use such equipment at an area medical facility); and
   3) Emergency equipment (including a defibrillator, a tracheotomy set, and a blood volume expander).

c. Policies and procedures by which the facility:
   1) Regularly charges patients for services and supplies; and
   2) Contracts with an area Hospital and displays written procedures for immediate transfer of emergency cases.

Ambulatory Surgical Center does not include an office or clinic maintained by a Dentist or Physician for the practice of dentistry or medicine, Hospital emergency room, or trauma center.

7. **Diagnostic Services** – X-rays, laboratory tests, tissue exams, medical diagnostic procedures (e.g., magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, electrocardiogram (EKG), or electroencephalogram (EEG)) ordered by a Physician or other Provider licensed to order the services for the treatment or care of an Illness or Injury and that are provided by an independent lab, other Outpatient facility, or the Physician's or other Provider's office or clinic.

8. **Surgical Services** – **(*Pre-Certification of all Inpatient Admissions is strongly recommended.)*** Surgical procedures provided in a licensed facility are covered (as described below) *(Refer to provision 39 – Bariatric Surgery of this Section.)*:

   a. If more than one (1) surgical procedure is performed during the same operating session, billed charges up to the Allowed Amount for the major procedure will be covered, plus one-half (1/2) of the billed charges up to the Allowed Amount for each of the lesser procedures. When two (2) surgeons of different specialties perform distinctly different procedures in one (1) operating session, claims will be reviewed before determination on coverage is made. There is no additional coverage for incidental surgical procedures. "Incidental surgery" is a procedure that is an integral part of, or incidental to, the primary surgical service and performed during the same operative session. Surgery is not incidental if:

      1. It involves a major body system different from the primary surgical services, or
      2. It adds significant time and complexity to the operating session and amount of patient care.

   b. If two (2) or more surgeons acting as co-surgeons perform the same operations or procedures other than as an Assistant at Surgery, the Allowed Amount will be divided between them. This provision is subject to the limitations listed above.

c. "Assistant at Surgery" is a Physician or non-Physician assistant who actively assists the operating Physician in the performance of covered Medically Necessary surgery. The Assistant at Surgery will be allowed if:

   1. The Assistant at Surgery is a Physician; the Allowed Amount will be twenty (20) percent of the Allowed Amount for the surgical procedure or the assistant's billed charge, whichever is less.
   2. The Assistant at Surgery is a non-Physician assistant or surgical technician; the Allowed Amount will be ten (10) percent of the Allowed Amount for the surgical procedure or the assistant's billed charge, whichever is less.
   3. Benefits are not available when the Assistant at Surgery is present only because the facility requires such services.
   4. Two (2) surgeons are paid as primary surgeons or co-surgeons for their multiple surgeries, no allowance as an Assistant at Surgery will be made to either of the surgeons. Billed charges for an additional Assistant at Surgery will be subject to review.

9. **Second Surgical Opinion (voluntary)** – If a Plan Participant is advised by a Physician to have a surgical procedure performed, the Plan will pay up to the Allowed Amount for an office visit for a second opinion on the need for surgery. Deductible and Coinsurance do not apply to the office visit, and all other services are subject to the annual Deductible and Coinsurance.

   If the second surgical opinion does not agree that the proposed surgery is medically advisable, the Plan will pay up to the Allowed Amount for a third opinion.

   Benefits will be payable only if:
   a. The surgical opinion is provided by a specialist who is:
      1) Certified by the American Board of Medical Specialties in a field related to the proposed surgery; and
      2) Independent of the Physician who first advised the surgery.

   b. The specialist makes a personal examination of the Plan Participant.

10. **Post-Mastectomy Care** – Inpatient care will be covered for the time that is determined to be Medically Necessary by the attending Physician and in consultation with the patient following a mastectomy, a lumpectomy, or a lymph node(s) dissection for the treatment of breast cancer.

11. **Reconstructive Breast Surgery** – Reconstructive breast surgery after a mastectomy is covered, including, but not limited to, the following:
    a. Reconstructive breast surgery performed due to a mastectomy to re-establish symmetry between the breasts. Services include, but are not limited to, augmentation mammoplasty, reduction mammoplasty, and mastopexy.
    b. All stages of reconstruction of the breast, including re-pigmentation of the areola, on which a mastectomy has been performed.
    c. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
    d. Chemotherapy and/or radiation therapy following surgical procedures.
    e. Prostheses and treatment of physical complications at all stages of a mastectomy and breast reconstruction, including lymphedemas.

    Specifically excluded from this benefit are expenses for the following if they are unrelated to producing a symmetrical appearance:
    a. Solely Cosmetic procedures.
    b. Breast augmentation procedures.
    c. Implants for the non-affected breast.
    d. Non-surgical prostheses or any other procedure.

12. **Voluntary Sterilization** – Expenses for female (tubal ligation, tubal implant, hysterectomy) and male (vasectomy) sterilization procedures are covered for Plan Participants. Expenses resulting from or related to the reversal of a sterilization procedure are **not** covered.

13. **Nursing Services** – Private duty nursing services of a Registered Nurse (RN) for skilled care, with a treatment plan determined by a Physician.

14. **Ambulance Services** – Medically Necessary ambulance services are covered to the nearest facility where care or treatment of a Medical Emergency can be rendered or from one facility to another for a higher level of care. Expenses resulting from or related to non-emergent transport or transport for the patient's or family's convenience or comfort are not covered.

15. **Travel Expenses for Out-of-Area Medical Care** – If a Plan Participant's Covered Medical Expenses for an Illness or Injury requires treatment services that are not available in the area in which the Plan Participant resides, the Plan may reimburse travel expenses to seek services rendered by an Out-of-Area In-Network Provider. The Plan will reimburse travel expenses for the Patient for meals, lodging, and transportation (commercial and personal automobile, commercial airline, train, or bus) to and from the nearest licensed medical facility that is equipped to provide the necessary treatment services. Travel expenses for Covered Medical Out-of-Area treatment Services are reimbursed at the State reimbursement rates and are limited to a maximum of $1,500 per Benefit Plan Year or $5,000 per transplant.

The travel benefit is for travel expenses for the patient only.

OUT-OF-AREA MEDICAL TRAVEL PRIOR AUTHORIZATION

Out-of-Area travel expenses must be Prior Authorized by the MUS Benefits office. If Prior Authorization is not obtained prior to travel, Out-of-Area travel expenses will not be reimbursed. *(Refer to Section 6 - How to Obtain Benefits.)*

Plan Participants **must** complete an Out-of-Area Medical Travel Prior Authorization Application and submit the completed application to the MUS Benefits office **prior** to travel. ***Prior Authorizations will not be approved retroactively and no exceptions to the Prior Authorization requirement will be considered.*** The Out-of-Area Travel Prior Authorization Application is available on the MUS *Choices* website at choices.mus.edu.

Travel reimbursement requests **must** be received within twelve (12) months from the date the expenses were incurred.

Travel reimbursement will not be considered for payment if submitted more than twelve (12) months from the date the expenses were incurred.

On termination of the Plan, final reimbursement requests **must** be received within three (3) months from the date of termination, unless otherwise established by the Plan Administrator.

16. **Dental Services (Accidental Injury or Disease)** – The Medical Plan will cover billed charges up to the Dental Fee Schedule Allowed Amount for:

    a. Medically Necessary services of a dentist or an oral surgeon licensed to practice in the state where services are provided if payment were made under this Medical Plan for the same services provided by a Physician.
    b. Services of a dentist or oral surgeon for treatment required due to an accidental Injury to sound natural teeth, diseased teeth, or supporting bone or tissue. Services **must** be completed within twelve (12) months from the date of the accident or diagnosis of disease.

Orthodontics, dentofacial orthopedics, or related appliances are not covered.

17. **Durable Medical Equipment and Orthopedic Appliances** – Expenses up to the Allowed Amount for the following services and supplies requiring a Provider's written prescription are covered:

    a. Purchase of Orthopedic Appliances, including, but not limited to, casts, splints, braces, trusses, crutches, and other Medically Necessary rigid or semi-rigid supports used to restrict or eliminate motion in a diseased, injured, weak, or deformed body part. *(Refer to Section 7, provision F (47 & 48) for Pediatric and Adult Hearing Aid benefits.)*
    b. Rental (up to the purchase price) of a Hospital-type bed, wheelchair, or other durable therapeutic equipment (provided the equipment is designed for prolonged use over a period of time, serves a specific therapeutic purpose in the treatment of an Injury or Illness, is primarily and customarily used for a medical purpose, and is appropriate for use in the home) or the purchase of this equipment if economically justified.
    c. For Durable Medical Equipment for which purchase is not feasible, reasonable rental expenses will be allowed. The Plan Case Manager may determine a reasonable rate.
    d. Replacement or repair of Durable Medical Equipment or Orthopedic Appliances. Durable Medical Equipment will not be considered a replacement if the current equipment no longer meets the medical needs of the patient due to physical or a deteriorating medical condition.

    Prior Authorization of expenses that may exceed $2,500 is strongly recommended. *(Refer to Section 6 – How to Obtain Benefits.)*

    The Plan will not pay for the following items:

    a. Exercise equipment
    b. Car lifts or stair lifts
    c. Biofeedback equipment
    d. Self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition
    e. Whirlpools, hot tubs, or saunas
    f. Waterbeds
    g. Computer-assisted communication devices
    h. Replacement of lost or stolen Durable Medical Equipment
    i. Repair to rental equipment
    j. Duplicate equipment purchased primarily for the patient's convenience when the need for duplicate equipment is not medical in nature.

18. **Prosthetic Appliances** – Purchase of prosthetic appliances, defined as devices that are designed to replace a natural body part lost or damaged due to Illness or Injury to restore full or partial bodily function or appearance, including, but not limited to, artificial limbs, eyes, and larynx, and replacement or repair of such prosthetic appliances.

19. **Miscellaneous Supplies for Use Outside of a Hospital** – Specialized medical supplies: (1) ordered by a Provider for the Medically Necessary treatment of Injury or Illness obtained from a Provider's office, Urgent Care Clinic, Hospital (or other Inpatient facility licensed to provide skilled twenty-four (24) hour medical care), Ambulatory Surgical Center, or medical supply company; and (2) not covered by the Prescription Drug Plan *(Refer to Section 9- Prescription Drug Plan Description)*. This includes specialized dressings, catheters, and supplies for renal dialysis equipment. Dental braces and corrective shoes are specific exclusions of the Plan.

20. **Inborn Errors of Metabolism** – Treatment of inborn errors of metabolism that involve amino acid, carbohydrates, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist.

21. **Blood Transfusion Services** – Blood transfusions, including the cost of blood, blood plasma, blood plasma expanders, and packed cells. Storage charges for blood are covered when the patient has blood drawn and stored for the patient's own use for a planned surgery. Credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Covered Medical Expenses.

22. **Radiation Therapy and/or Chemotherapy Services.**

23. **Oxygen, other gases, and their administration.**

24. **Anesthetics and administration of an anesthetic.**

25. **Medical Records Services** – Reasonable services for producing medical records only if incurred for utilization review, audits, or investigating a claim for benefits if requested and approved by the Plan Administrator. Services that exceed limits imposed by applicable law will not be deemed to be reasonable.

26. **Home Health Care Services** – Care provided for Medically Necessary services and supplies furnished by a home health agency in a covered Plan Participant's home in accordance with a home health care plan as prescribed by a Physician. A home health agency is a public agency or a private organization that is licensed as a home health agency by a state or is certified to participate as such under Title XVIII of the Social Security Act. A home health care plan is a treatment plan for the continued care and treatment of the Plan Participant while under the care of a Physician. The Physician **must** approve the home health care plan in writing and certify the home health care is Medically Necessary. The home health care benefit is limited, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

    Prior Authorization for home health care is strongly recommended. *(Refer to Section 6 – How to Obtain Benefits.)*

    Home health care services provided by a Home Health Agency include:
    a. Nursing services by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN.
    b. Physical, Speech, or Occupational Therapy.
    c. Skilled Nursing Care services.
    d. Medical supplies and equipment for use in the home.

    Home health care services exclude the following:
    a. Services that are primarily for the convenience of the covered Plan Participant's family.
    b. Transportation services.
    c. Respite Care.
    d. Services that consist primarily of Custodial Care, even if Medically Necessary. Custodial Care includes services or treatment that, regardless of where it is provided:
        1) Could be rendered safely by an individual without medical skills; and
        2) Is designed mainly to help the patient with daily living activities, including, but not limited to:
            a) Personal care, such as assistance walking and getting in and out of bed, bathing, eating by spoon, tube, or gastrostomy, exercising, dressing, enema, and using the toilet.
            b) Homemaking, such as preparing meals or special diets.
            c) Moving the patient.
            d) Acting as companion or sitter.
            e) Supervising medication that can be self-administered.
            f) Oral hygiene; and
            g) Ordinary skin and nail care.

An independent medical review staff contracted by the Plan may, if necessary, determine whether services are Custodial Care. When a confinement or visit is found to be mainly for Custodial Care, services, such as prescription drugs and diagnostic services, may still be covered. All bills should be submitted for review and consideration.

27. **Hospice Care** – The Hospice Care benefit is limited, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits. Hospice care services provide a coordinated set of services that:
    a. Arranges, coordinates, and/or provides hospice care services for terminally ill patients and their families through a hospice care team.
    b. Is licensed, accredited, or approved by the state to establish and manage hospice care programs; and
    c. Maintains records of hospice care services provided and bills for such services on a consolidated basis.

    A Hospice care team is an interdisciplinary group of personnel that provides hospice care services and may include:
    a. A Physician.
    b. A patient care coordinator (Physician, RN or LPN who serves as an intermediary between the hospice care program and the attending Physician).
    c. A RN or LPN.
    d. A mental health specialist; and
    e. Lay volunteers.

    Benefits for hospice care are subject to the following conditions:
    a. The services are Medically Necessary.
    b. A Physician orders the services.
    c. The patient is terminally ill; and
    d. The patient is expected to live no more than six (6) months.

    Hospice Care Services – Services that are designed to meet the physical, psychological, spiritual, and social needs of the terminally ill Plan Participant and their family by providing palliative (pain controlling) and supportive medical, nursing, and other health services during the sickness or bereavement. Covered Services include, but are not limited to, the following:

    a. Room and board, including charges by the facility as a condition of occupancy, or on a regular daily or weekly basis, such as general nursing services. If private room accommodations are used, the daily room and board Allowed Amount will not exceed the facility's average semi-private billed charges or an average semi-private rate made by a representative cross section of similar institutions in the area.
    b. Nursing care by a RN, LPN, or a public health Nurse who is under the direct supervision of a RN.
    c. Physical and Speech Therapy, when rendered by a licensed therapist.
    d. Medical supplies, including drugs, biologicals, and medical appliances.
    e. Physician's services.
    f. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.
    g. Counseling and other support services provided to meet the physical, psychological, spiritual, and social needs of the terminally ill patient; and
    h. Instructions for care of the patient, such as counseling and other support services for the patient's immediate family. A patient's immediate family means the patient's legal spouse and children, or when assuming responsibility for patient care, the patient's parents, and siblings.

28. **Care by a Skilled Nursing Facility (Extended Care Unit or Facility, or Transitional Care Unit)** – If, due to an Injury or Illness, a Plan Participant requires Skilled Nursing Care confinement in a

licensed Skilled Nursing Facility (defined below), expenses will be Covered Medical Expenses for the period of such confinement, but not to exceed the limits, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

Pre-Certification of all Inpatient Admissions is strongly recommended *(Refer to Section 6 – How to Obtain Benefits).*

Skilled Nursing Facility Services include the following:

a. Room and board, including charges by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily room and board Allowed Amount will not exceed the facility's average semi-private billed charges or an average semi-private rate made by a representative cross section of similar institutions in the area.
b. Medical services customarily provided by the Skilled Nursing Care Facility, except for private duty or special nursing services and Physicians' fees; and
c. Drugs, biologicals, solutions, dressings, and casts, furnished for use during confinement in a Skilled Nursing Care Facility, but no other supplies.

A **Skilled Nursing Facility** is an institution, or distinct part thereof, which meets the following conditions:

a. Is a licensed long-term care facility or Skilled Nursing Facility in the state in which the facility is located.
b. Is not, other than incidentally, a place for rest, the aged, substance use disorders, individuals with intellectual disabilities, Custodial or educational Care, or care of mental health disorders; and
c. Is certified by Medicare.

29. **Maternity and Routine Newborn Care** – If a Medical Plan Participant incurs expenses due to a pregnancy, including elective abortion, benefits will be payable in the same manner and subject to the same limitations and conditions as other medical conditions.

Pre-Certification of all Inpatient Admissions is strongly recommended. *(Refer to Section 6 – How to Obtain Benefits.)*

Coverage includes:

a. Prenatal office visits.
b. Services of a Physician or other licensed Provider, Hospital, Physician Staffed Birthing Center, or licensed Certified Nurse Midwife (CNM) for maternity care.
c. Nursery and Physician's services for newborn well-baby care, including circumcision, hearing and vision screenings, and phenylketonuria (PKU) testing, while both the Plan Participant and the newborn child are Inpatient due to the child's birth.
d. Breastfeeding equipment and related supplies *(Refer to Section 7 – Medical Plan Description, provision 44 – Breast Pump)*; and
e. Comprehensive lactation support and counseling by a certified lactation consultant, under the general supervision of a licensed Physician (Medical Doctor (MD) or Doctor of Osteopathy (DO)) or a licensed mid-level practitioner (Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), or licensed Certified Nurse Midwife (CNM)) during pregnancy and/or during the postpartum period.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT – Under federal law, group health plans **<u>may not</u>** restrict benefits for a Hospital length of stay related to childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following delivery by cesarean section. However, Federal law does not prohibit the mother's or child's attending Provider, after consulting with the mother, from discharging the mother or her child earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable).

Plans **cannot** require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay that does not exceed forty-eight (48) hours (or ninety-six (96) hours).

THE MUS WELLBABY MATERNITY PROGRAM is voluntary and offered at no cost to all pregnant Medical Plan Participants. Services are designed to monitor the expectant mother's progress, respond to questions, and help ensure a healthy, full-term delivery. These services are available to all pregnant Medical Plan Participants who notify the MUS WellBaby Program Coordinator of the pregnancy. Notification should occur when the pregnancy is diagnosed or as soon after as possible. **To receive the full benefits of this program, notification is required within the first trimester.**

30. **Preventive Care Benefits**

a. **Well-Child Preventive Health Care**
If a Dependent Child on the Medical Plan incurs a routine physical examination, developmental assessment, anticipatory guidance, hearing and vision screenings, and laboratory test expenses for preventive well-child health care, the Plan will pay up to the Allowed Amount for the Dependent Child (up to age nineteen (19). Deductible, Copayment, and Coinsurance do not apply when utilizing an In-Network Provider.

b. **Preventive Immunizations for Adults and Children**
If a Medical Plan Participant receives services from a Physician or other Licensed Health Care Provider for preventive immunizations, the Plan will pay up to the Allowed Amount for the adult or Dependent Child. Deductible, Copayment, and Coinsurance do not apply when utilizing an In-Network Provider.

Preventive immunizations include, but are not limited to diphtheria, chicken pox, tetanus, hepatitis A & B, pertussis, oral polio vaccine, measles, mumps, rubella, rotavirus, human papillomavirus (HPV), shingles, pneumonia, influenza, coronavirus disease (COVID), and tests for tuberculosis.

For recommended immunization schedules for all ages, visit the Centers for Disease Control (CDC) website.

NOTE: These immunizations may be available through public health clinics at a lower cost.

c. **Preventive Health Care for Adults (age nineteen (19) and older)**
If a Medical Plan Participant receives services for the following preventive health screenings, as recommended by a Physician or Licensed Health Care Provider, the Plan will pay in full up to the Allowed Amount. Deductible, Copayment, and Coinsurance do not apply when utilizing an In-Network Provider *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for benefit guidelines):*

1) Pap smear and/or routine pelvic exam.
2) Routine mammogram.
3) Routine breast cancer susceptibility gene (BRCA) testing, including genetic counseling and evaluation for the routine BRCA test, for a woman as determined by a Licensed Health Care Provider or Physician.
4) Routine prostate exam.
5) Routine colonoscopy, proctoscopy, sigmoidoscopy, or fecal occult blood screen.
6) Routine lab work; and
7) Prescribed female contraceptives.

For a complete list of recommended preventive services, as set forth in the recommendations of the U.S. Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the CDC and Prevention, and the guidelines supported by the

Health Resources and Services Administration, visit the U.S. Preventive Services Task Force website.

d. **Disease Management Education Programs**
Programs conducted by Licensed Health Care Providers are covered for prescribed Outpatient self-management training and education (such as dietary and nutritional counseling) for treatment of diabetes or other diseases. A registered dietician or other Licensed Health Care Provider **must** provide the education. This coverage applies to covered Medical Plan Participants to help manage and monitor the care of the covered Plan Participant(s) in the family with the disease. Claims should be submitted to the Medical Plan Claims Administrator in the name of the patient with the disease. Benefits are specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

e. **Preventive Health Screenings (WellChecks) available through the MUS Wellness Program**
Adult Medical Plan Participants over the age of eighteen (18) are eligible for two (2) WellCheck screenings per Benefit Plan Year (July 1st – June 30th). These health screenings, which are voluntary and offered at no cost to the Plan Participant when obtained through the MUS Wellness Program, include:
1) Blood pressure tests; and
2) Basic blood panel and biometric screenings.

31. **Orthotic Devices** – Impression casting and orthotic devices for treatment of malformation or structural weakness of the foot provided the device is prescribed by a Provider and custom fitted for the covered Plan Participant. Benefits are limited to a dollar amount per Benefit Plan Year, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

32. **Rehabilitative Care** – Includes: (a) Medically Necessary Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), and Medical Massage Therapy (MMT); (b) cardiac, respiratory, and pulmonary rehabilitation; (c) Acupuncture; and (d) Chiropractic services.

INPATIENT BENEFITS – Inpatient benefits for all rehabilitative care, except cardiac, respiratory, or pulmonary rehabilitative care, are limited to the number of days of Inpatient rehabilitative care per Benefit Plan Year, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits. Inpatient care **must** be under the direction of a licensed Physician. The nature of the treatment (frequency, duration and/or variety) or the physical condition of the patient **must** be such that Outpatient treatment is not an alternative.

Pre-Certification of all Inpatient Admissions is strongly recommended. *(Refer to Section 6 – How to Obtain Benefits.)*

OUTPATIENT BENEFITS – Outpatient benefits are limited to Medically Necessary services outlined in a rehabilitation treatment plan, not to exceed the benefit maximums, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits. Outpatient benefits apply to rehabilitative therapy services provided when the Plan Participant is not a registered bed patient of a rehabilitation unit. A licensed therapist **must** provide the services, and the services **must** be Medically Necessary for an acute condition, with continuing, measurable progress in restoring body function and/or preventing disability following Illness, Injury, or loss of body part.

Outpatient rehabilitation therapy visits will not be covered when the therapy is directed at the maintenance of the current level of functioning, chronic conditions, over-use conditions, musculoskeletal aches/pains, prevention of future injury, recreation (spa therapy), sports conditioning, and/or stress reduction.

The limitations below apply to all rehabilitative care services:

a. The number of visits in a Benefit Plan Year for all Outpatient professional rehabilitative are limited, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.
b. Ancillary diagnostic services are covered like other diagnostic services and not subject to the per visit limit.

Rehabilitative Care <u>does not</u> include: Custodial Care, diagnostic admissions, maintenance therapy, non-medical self-help therapy, sports conditioning, vocational education therapy, learning or developmental disabilities (including speech delays), social or cultural rehabilitation, visual or auditory disorders, or treatment for Substance Use Disorder or Mental Health.

33. **Prescription Drugs** – Prescription drugs dispensed by a medical facility as part of Inpatient Covered Medical Services are covered under the Medical Plan. Other prescription drugs and diabetic supplies are covered under the Prescription Drug Plan. *(Refer to Section 9 – Prescription Drug Plan Description.)*

34. **Mental Health Treatment** – Benefits for the treatment of Mental Health will be paid like treatment for any other medical condition. If a Plan Participant incurs expenses for the treatment of Mental Health, the Plan will pay as follows:

    a. **INPATIENT TREATMENT** – Services for Medically Necessary confinement as an Inpatient in a licensed Hospital, Mental Health Treatment Center, Psychiatric Hospital or Freestanding Inpatient Facility for the treatment of Mental Health (including in Hospital/facility services of a Physician or other Licensed Health Care Provider) are Covered Medical Expenses, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

    Inpatient services **<u>must</u>** be provided under a program in which a Physician directly supervises the staff or approves individual client treatment plans. All facilities **<u>must</u>** be fully licensed by the state in which the services are performed.

    Medically monitored and medically managed intensive Inpatient care services and clinically managed high-intensity residential services provided at a Residential Treatment Center are benefits of this Plan.

    Pre-Certification of all Inpatient Admissions and Residential Treatment Center services is strongly recommended. *(Refer to Section 6 – How to Obtain Benefits.)*

    b. **PARTIAL HOSPITALIZATION TREATMENT** – For treatment of conditions that qualify for Inpatient Mental Health benefits, a Plan Participant may exchange one (1) day of Inpatient Hospitalization for two (2) days of partial Hospitalization. Two (2) days of Partial Hospitalization count as one (1) day toward the maximum number of Inpatient days covered per Benefit Plan Year.

    Partial Hospitalization is a time-limited ambulatory (Outpatient) program offering active treatment that is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening, and/or weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

    A partial Hospitalization program should offer four (4) to eight (8) hours of therapy five (5) days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each patient.

c. **OUTPATIENT TREATMENT** – Outpatient services for Mental Health treatment are Covered Medical Services, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, when provided by one of the following licensed Providers:

1) Hospital
2) Mental Health Treatment Center; or
3) Physician, psychiatrist, clinical psychologist, psychiatric nurse, clinical social worker, or professional counselor.

d. **SEVERE MENTAL HEALTH TREATMENT** – Expenses covered up to the Allowed Amount for Medically Necessary Outpatient and Inpatient services, as referenced above in provision a., b., and c., for the treatment of Severe Mental Health.

The American Psychiatric Association defines the following disorders as Severe Mental Health:

1) Schizophrenia
2) Schizoaffective disorder
3) Bipolar disorder
4) Major depression
5) Panic disorder
6) Obsessive-compulsive disorder
7) Autism.

A Mental Health Treatment Center is a facility which provides a program for the treatment of mental health by multiple techniques, pursuant to a written treatment plan, approved by and monitored under the direct supervision of a Physician, a psychiatric social worker, and a psychologist, and the facility is:

a. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
b. Licensed, certified, or approved as a Mental Health treatment facility by the Montana Department of Public Health and Human Services (DPHHS) or by the appropriate authority within the state where services are provided.

35. **Substance Use Disorder Treatment** – If a Plan Participant incurs expenses for the treatment of Substance Use Disorder, the Plan will pay as follows:

a. **INPATIENT TREATMENT** – Services for Medically Necessary confinement as an Inpatient in a licensed Hospital, Freestanding Facility, or Substance Use Disorder Treatment Center for treatment of substance abuse, including in-Hospital/facility services of a Physician or other Licensed Health Care Provider, are Covered Medical Expenses, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

Inpatient services **must** be provided under a program in which a Physician directly supervises the staff or approves individual client treatment plans. All facilities **must** be fully licensed by the state in which the services are performed.

Medically monitored and medically managed intensive Inpatient care services and clinically managed high-intensity residential services provided at a Residential Treatment Center are benefits of this Plan.

Pre-Certification of all Inpatient Admissions and Residential Treatment Center services is strongly recommended. *(Refer to Section 6 – How to Obtain Benefits.)*

b. **OUTPATIENT TREATMENT** – Outpatient services for Substance Use Disorder treatment are Covered Medical Expenses, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, when provided by one of the following licensed Providers:
   1) Hospital
   2) Substance Use Disorder Treatment Center
   3) Physician, psychiatrist, clinical psychologist, clinical social worker, professional counselor, or certified chemical dependency/addiction counselor.

A Substance Use Disorder Treatment Center is a facility which provides a program for the treatment of substance use addiction pursuant to a written treatment plan, approved by and monitored under the direct supervision of a Physician, and the facility is:

a. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
b. Licensed, certified, or approved as a Substance Use Disorder treatment facility by the Montana Department of Public Health and Human Services (DPHHS) or by the appropriate authority within the state where services are provided. Services incurred at programs approved only by the Montana Department of Corrections will be paid as an Outpatient benefit.

36. **Treatment of Temporomandibular Joint Syndrome (TMJ)** – Surgical Treatment of TMJ that **cannot** be treated non-surgically is a Covered Medical Service. ***Prior Authorization is strongly recommended for surgical treatment of TMJ***. If determined to be Medically Necessary, standard benefits will apply to the surgery, subject to the annual Deductible and Coinsurance percentage, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

Pre-Certification of all Inpatient Admissions is strongly recommended. *(Refer to Section 6 – How to Obtain Benefits.)*

37. **Organ or Tissue Transplant Services** – ***Prior Authorization is strongly recommended.*** Expenses related to non-Experimental or non-Investigational organ or tissue transplant procedures are covered, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, subject to the following conditions:

a. A second opinion is recommended before undergoing a transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such a procedure. The Physician rendering this second opinion **must** be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and **must not** be affiliated with the Physician who will be performing the actual surgery.

b. If the donor is covered under the Medical Plan, expenses incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.

c. If the recipient is covered under the Medical Plan, expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not covered under this Medical Plan according to eligibility requirements, will be considered allowable expenses to the extent that such expenses are not payable by the donor's plan. Benefits will not be payable in an amount more than the procedure-based benefit still available to the recipient.

   If both the donor and the recipient are covered under this Medical Plan, expenses incurred by each Plan Participant will be treated separately.

   The Allowed Amount for securing an organ from a cadaver or tissue bank, including the surgeon's billed charge for removal of the organ and a Hospital's billed charge for storage or transportation of the organ will be considered a Covered Medical Expense.

Pre-Certification of all Inpatient Admissions is strongly recommended. *(Refer to Section 6 – How to Obtain Benefits.)*

38. **Transplant Travel Expenses** – If a Plan Participant's covered transplant expenses require treatment services which are not available in the area in which the Plan Participant resides, the Plan may reimburse travel expenses to an Out-of-Area In-Network Provider. The Plan will reimburse travel expenses for the Patient for meals, lodging, and transportation (commercial and personal automobile, commercial airline, train, or bus) to and from the nearest licensed medical facility that is equipped to provide the necessary treatment services. Travel expenses for covered transplant Out-of-Area treatment services are reimbursed at the State reimbursement rates and are limited to a maximum of $5,000 per transplant.

The travel benefit is for travel expenses for the <u>patient only</u>.

OUT-OF-AREA MEDICAL TRAVEL PRIOR AUTHORIZATION

Out-of-Area travel expenses <u>must</u> be Prior Authorized. If Prior Authorization is not obtained <u>prior to travel</u>, Out-of-Area travel expenses <u>will not</u> be reimbursed. *(Refer to Section 6 - How to Obtain Benefits.)*

Plan Participants **<u>must</u>** complete an Out-of-Area Medical Travel Prior Authorization Application and submit the completed application to the MUS Benefits office **<u>prior</u>** to travel. ***Prior Authorizations will not be approved retroactively and no exceptions to the Prior Authorization requirement will be considered.*** The Out-of-Area Medical Travel Prior Authorization Application is available on the MUS *Choices* website at choices.mus.edu.

Travel reimbursement requests **<u>must</u>** be received within twelve (12) months from the date the expenses were incurred.

Travel reimbursement will not be considered for payment if submitted more than twelve (12) months from the date the expenses were incurred.

On termination of the Plan, final reimbursement requests **<u>must</u>** be received within three (3) months from the date of termination, unless otherwise established by the Plan Administrator.

39. **Bariatric Surgery for Obesity Management** – Bariatric surgery for the treatment of Morbid Obesity/Clinically Severe Obesity is covered, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

Obesity Management <u>must</u> be Prior Authorized as Medically Necessary by Utilization Management at the Medical Plan Claims Administrator. If Prior Authorization is not obtained or expenses are found not to be Medically Necessary, <u>all</u> expenses related to bariatric surgery <u>will not</u> be covered.

"Morbid Obesity" means a condition of persistent and uncontrollable weight gain that is potentially life-threatening and is defined as a Body Mass Index (BMI) greater than forty (40). BBMI is calculated by dividing an individual's weight (in kilograms) by their height squared (in meters).

Expenses incurred for weight reduction, weight loss, the treatment of obesity, and the treatment of Morbid Obesity/Clinically Severe Obesity are excluded for the following:

a. Non-surgical treatment of weight gain, weight reduction or weight maintenance, including, but not limited to, prescription drugs, orthomolecular therapy, including nutrients, vitamins and food supplements, counseling, diet, and educational programs, except those services covered through the MUS Wellness Program.

b. Incurred expenses for which all conditions of the bariatric surgery benefit of the Plan have not been met.
c. Incurred expenses before a Prior Authorization has been approved by the Medical Plan Claims Administrator.
d. A redo or revision of a prior bariatric surgical procedure; and
e. A second bariatric surgical procedure, regardless of whether the first procedure was performed while covered under the Plan.

If Prior Authorized, Medical Benefits will be provided for bariatric surgery for Morbid Obesity/Clinically Severe Obesity, as defined above, and a directly related pre-surgical assessment, a directly related post-surgical follow-up care and complications due to bariatric surgery, subject to the following conditions:

Roux-en-Y gastric bypass (RYGB) or laparoscopic adjustable silicone gastric banding (LASGB or Lap-Band): The Plan considers open or laparoscopic RYGB, LASGB or Lap-Band, or vertical sleeve gastrectomy (gastric sleeve) Medically Necessary when the selection criteria listed below are met.

Selection Criteria:

1. Presence of severe obesity that has persisted for at least three (3) years for a Plan Participant who has been continuously covered under the MUS *Choices* Medical Plan for at least eighteen (18) consecutive months, is defined as meeting the following:
   a. BMI exceeding forty (40); or
   b. BMI exceeding thirty-five (35) combined with at least two (2) of these conditions:
      1) Clinically significant obstructive sleep apnea.
      2) Pickwickian syndrome.
      3) Congestive heart failure.
      4) Cardiomyopathy.
      5) Insulin dependent or oral medication dependent diabetes.
      6) Severe musculoskeletal dysfunction.
      7) Gastric Esophageal Reflux Disorder.
      8) Pulmonary edema.
      9) Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).
2. The Plan Participant completed growth (eighteen (18) years of age or documentation of completion of bone growth).
3. The Plan Participant attempted weight loss in the past without successful long-term weight reduction.
4. The Plan Participant completed pre-surgical program as required by the bariatric center; and
5. For Plan Participants who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression), are currently under the care of a psychologist/psychiatrist, or are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary to exclude Plan Participants who are unable to provide informed consent or who are unable to comply with the pre- and post-operative regimen. **NOTE:** The presence of depression due to obesity is not normally considered a contraindication to bariatric surgery.

Vertical Banded Gastroplasty (VBG): The Plan considers open or laparoscopic VBG Medically Necessary for Plan Participants who meet the selection criteria for bariatric surgery and who are at increased risk of adverse consequences of an RYGB due to the presence of the following co-morbid medical conditions:

1. Hepatic cirrhosis with elevated liver function tests or inflammatory bowel disease (Crohn's disease or ulcerative colitis).

2. Radiation enteritis or demonstrated complications from extensive adhesions involving the intestines from prior major abdominal surgery, multiple minor surgeries, or major trauma; or
3. Poorly controlled systemic disease (American Society of Anesthesiology (ASA) Class IV).

40. **Home Infusion Therapy** – Coverage is provided in lieu of hospitalization for home infusion therapy, including, but not limited to, antibiotic therapy, enteral nutrition, total parenteral nutrition, pain management and specialized disease state therapy. Services also include education for the covered Plan Participant, the covered Plan Participant's caregiver, or a family member. Home infusion therapy services include pharmacy, supplies, equipment, and skilled nursing services when billed by a licenses home infusion therapy Provider.

41. **Prescription Eyeglasses or Contact Lenses following Cataract Surgery** – Within six (6) months of cataract surgery, benefits are limited to one (1) pair of corrective eyeglass lenses and one (1) pair of eyeglass frames **or** one (1) pair of corrective contact lenses.

42. **Alternative Care** – The Plan Administrator may, at their sole discretion, authorize payments for services that are not listed as Covered Benefits. Such payments will be made only upon agreement by the Plan Participant and the Plan Administrator.

43. **Contraceptive Management** –Contraceptive Management, regardless of Medical Necessity, means Physician or Licensed Health Care Provider fees related to a prescription contraceptive device, obtaining a prescription for contraceptive drugs and U.S. Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, patient education and counseling for all women with reproductive capacity, and purchasing, fitting, injecting, implantation, or placement of a contraceptive device. Services related to follow-up and management of side effects, counseling for continued adherence, and contraceptive device removal are included.

    Self-administered prescription contraceptives are covered by the Prescription Drug Plan *(Refer to Section 9 – Prescription Drug Plan Description.)*.

44. **Breast Pump** – Breastfeeding equipment and supplies are Covered Medical Expenses, as specified below:

    Standard Breast Pump – The Plan will cover the purchase or rental (up to ten (10) months or the purchase price) of ***one*** (1) standard breast pump, either manual, battery-powered, mobile hands-free (wearable), or electric, for covered pregnant or postpartum Medical Plan Participants per delivery or adoption, up to a $300 maximum.

    Hospital Grade Electric Breast Pump – The Plan will cover the ***rental only*** (up to three (3) months) of one (1) Hospital grade breast pump for postpartum covered Medical Plan Participants, in place of the above, when deemed appropriate by the ordering Physician under the Plan Participant's Durable Medical Equipment benefit (subject to the annual Deductible, Coinsurance percentage, and Out-of-Pocket Maximum). The Plan Participant **must** have a Physician's prescription and letter of medical necessity submitted for review.

    A hospital grade breast pump may be appropriate in the following circumstances:
    1) Premature hospitalized newborn child.
        a) When the infant is premature at 24-34 weeks of gestation, and the mother is pumping breast milk, awaiting the baby's ability to nurse directly from the breast; or
        b) When the infant is premature at 35-37 weeks of gestation and continues to experience difficulty coordinating suck and swallow, and the mother is pumping breast milk, awaiting the baby's ability to nurse and transfer milk efficiently from the breast.
    2) An infant with cardiac anomalies or a medical condition that makes them unable to

sustain breast feeding due to poor coordination of suck and swallow, fatigue, neurologic disorder, or genetic abnormality (e.g., respiratory, cardiac, or genetic condition) that interferes with breast feeding.

3) An infant with a congenital anomaly that interferes with the ability to nurse directly or efficiently from the breast and achieve good milk transfer (e.g., cleft lip or palate, and/or other anomalies of the tongue, mouth, or pharynx).
4) There is an involuntary separation of an infant from its mother for more than twenty-four (24) hours due to Illness or Injury of the infant, if the mother is hospitalized and separated from the infant, or if the infant is readmitted to the Hospital within thirty (30) days after initial discharge.
5) For multiples (including twins), until breast-feeding at the breast is established consistently with good milk transfer.
6) When the mother has an anatomical breast problem, which may be resolved with the use of a Hospital grade breast pump (e.g., inverted nipple or mastitis).
7) For infants for medical reasons who are temporarily unable to nurse directly from the breast (e.g., Neonatal Intensive Care Unit (NICU) babies) or during a hospitalization of the mother or baby which will interrupt nursing.
8) When the infant has poor weight gain, in the first four (4) weeks of life, related to milk production and pumping breast milk is an intervention and the infant has a documented weight loss of seven percent (7%) or greater in the first week of life or has not regained birthweight by two (2) weeks of age.
9) When the infant has poor weight gain after four (4) weeks of age related to mother's milk production and pumping breast milk frequently throughout the day, along with baby's nursing at breast, will attempt to improve mother's supply; or
10) For women who wish to breastfeed their adopted infant or infant born through surrogacy in attempt to induce lactation. The process involves nipple stimulation with use of an electric breast pump beginning at least two (2) months before the adoptive or natural mother expects to be breast-feeding.

A Hospital grade breast pump **is not** Medically Necessary when the above criteria are not met or when it is requested solely to allow for the mother's return to work, convenience, or vacationing.

Prior Authorization of expenses for a Hospital Grade Breast Pump is strongly recommended.

The following replacement supplies are eligible for coverage, the Plan will cover the purchase of**:**

1) Tubing for breast pump.
2) Adapter for breast pump.
3) Cap for breast pump bottle.
4) Breast shield, splash protector, and flanges for use with breast pump.
5) Polycarbonate bottle for use with breast pump.
6) Locking ring for breast pump.

The following breast pump supplies are excluded from coverage:

1) Baby weight scales.
2) Batteries/battery packs, cords, power banks, and portable chargers.
3) Breast milk storage bags, ice packs, labels/labeling lids, and other similar products.
4) Breast pump cleaning expenses or supplies, including soap, sprays, wipes, steam cleaning bags, and other similar products.
5) Creams, ointments, and similar other products that relieve breast or nipple irritation or inflammation.
6) Electric power adapter for travel.
    a. Garments or other similar products that allow mobile hands-free (wearable) pump operation.
7) Nursing bras, bra pads, breast shells, nipple shield, and other similar products.

8) Travel bags and other similar travel or carrying accessories.

45. **Comprehensive Eye Exam** – A comprehensive eye exam is a complete diagnostic vision and eye health evaluation (preventive or medical) to assess a patient's visual acuity and function, ability to focus on and discern objects, and to detect or identify early signs of vision and eye health concerns, such as eye disease or systemic health issues. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for benefit guidelines.) (Refer to Section 10 – Vision Hardware Plan Description for separate Vision Hardware benefit information.)*

    A comprehensive eye exam may include the following:

    1) Eye health examination.
    2) Vision and medical history of patient and relevant family members.
    3) Dilation.
    4) Visual acuity and refraction tests.
    5) Eye chart tests.
    6) Eye muscle movement, focusing, tracking, coordination, and peripheral vision.
    7) Eye pressure tests.
    8) Optomap retinal imaging.
    9) Examination of the retina, optic nerve, cornea, and lens.
    10) Prescription for corrective eyewear (eyeglass or contact lenses).

    A comprehensive eye exam **does not** include the evaluation and management of urgent or emergency medical eye care or treatment due to a sudden onset of symptoms or an unforeseen occurrence, as these services are subject to the annual Deductible, Coinsurance percentage, and Out-of-Pocket Maximum as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, such as:

    1) Eye infection, inflammation/swelling, pain, or persistent discomfort.
    2) Foreign body, abrasions, eye trauma, blunt force injury.
    3) Ocular injuries.
    4) Chemical exposure to the eye or eyelid.
    5) Visual disturbances, sudden vision loss or changes.
    6) Retinal detachment.
    7) Mechanical globe injury.
    8) Central retinal artery occlusion (eye stroke).
    9) Monitor an ongoing eye condition, such as dry eye, diabetic eye disease, or glaucoma and implement treatment, as necessary.

46. **Hearing Exam (auditory exam)** – Hearing evaluation or screening (preventive or medical) to measure a person's ability to hear sounds at different pitches and loudness, including but not limited to, pure tone audiometry, speech discrimination tests, impedance audiometry, and auditory brainstem response (ABR). *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for benefit guidelines.) (Refer to Section 7, provision F - Specific Covered Medical Services for separate Pediatric and Adult Treatment for Hearing Loss benefit information.)*

47. **Pediatric Treatment for Hearing Loss** – Services for the diagnosis and treatment of Hearing Loss for a covered Dependent Child eighteen (18) years of age or younger, including, but not limited to:

    1) One (1) single purchase of a medically necessary hearing aid or Amplification Device (with required accessories) per ear every three (3) years or as required by a licensed audiologist for the purpose of improving or assisting hearing by directing or amplifying sound in the ear canal.
    2) Hearing aid fitting, assessment, adjustments, and auditory training.
    3) Ear molds, tinnitus masking device, and bone assisted hearing devices.

Expenses for hearing aid or Amplification Device batteries/battery packs, cords, power banks, portable chargers, microphones, storage cases, travel bags or other similar travel or carrying accessories, dehumidifiers, and related supplies are excluded.

Services are subject to the In-Network annual Deductible, Coinsurance percentage, and Out-of-Pocket Maximum, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, regardless of provider network status.

48. **Adult Treatment for Hearing Loss** – Services for the diagnosis and treatment of Hearing Loss for a covered adult Plan Participant nineteen (19) years of age or older, including, but not limited to:

    1) Up to $2,000 per ear lifetime maximum for one (1) single purchase per ear of a medically necessary hearing aid or Amplification Device (with required accessories) for the purpose of improving or assisting hearing by directing or amplifying sound in the ear canal.
    2) Hearing aid fitting, assessment, adjustments, and auditory training.
    3) Ear molds, tinnitus masking device, and bone assisted hearing devices.

    Expenses for hearing aid or Amplification Device batteries/battery packs, cords, power banks, portable chargers, microphones, storage cases, travel bags or other similar travel or carrying accessories, dehumidifiers, and related supplies are excluded.

    Deductible, Copayment, and Coinsurance **do not** apply, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, regardless of provider network status.

G. GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The Plan **does not** pay the following expenses.

1. Expenses incurred by the Plan Participant for services and supplies resulting from a work-related Illness or Injury that occurs in the course of employment for wage or profit or in the course of volunteer work when the organization for whom the Plan Participant is volunteering has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including Employees' compensation or liability laws of the U.S. (collectively referred to as "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though the Plan Participant:

    a. Receives benefits for only a portion of the services incurred under Workers' Compensation.
    b. Does not have Workers' Compensation coverage due to the organization failing to obtain such coverage.
    c. Waived their rights to such coverage or benefits.
    d. Fails to file a claim within the filing period allowed by law.
    e. Fails to comply with other provisions of the law to obtain coverage or benefits.
    f. Is permitted to elect not to be covered by Workers' Compensation but fails to make such an election; or
    g. Elects not to be covered by Workers' Compensation and has affirmatively made that election.

    This exclusion will not apply to a Plan Participant's regular household or domestic activities, employment not in the usual course of the trade, business, profession or occupation of the Plan Participant or employer, or employment of a Dependent of an Employer's family for whom the Employer under the Internal Revenue Code may claim as an exemption.

2. An expense for service or supplies which are provided or paid for by the federal government or its agencies, except for:

a. The Veterans' Administration, when services are provided to a veteran for a disability that is not service connected.
b. A military Hospital or facility, where services are provided to a Retiree (or Dependent of a Retiree) from the armed services; and
c. A group health plan established by a government for its own civilian Employees and their Dependents.

3. Expenses that are caused by or arising out of war or act of war (whether declared or undeclared), civil unrest, armed invasion, or aggression or during service in the armed forces of any country.

4. A loss or expense:

   a. That is incurred while a Plan Participant is on active duty or training in the Armed Forces, National Guard, or Reserves of any state or country; and
   b. For which a governmental body or its agencies are liable.

5. An expense in excess of the Allowed Amount.

6. Services rendered or started, or supplies furnished, prior to the Plan Participant's Effective Date of coverage under the Plan or after the Plan Participant's coverage is terminated under the Plan.

7. An expense for which a Plan Participant does not have to pay or would not be an incurred expense in the absence of the Plan.

8. An expense that is primarily for the Plan Participant's convenience or comfort or that of the Participant's family, caretaker, Physician, or other Licensed Health Care Provider.

9. Expenses for preparation of reports or itemized bills relating to Covered Medical Expenses, unless specifically requested and approved by the Plan.

10. Expenses incurred by individuals other than the covered Plan Participant receiving treatment, services, or supplies.

11. Expenses for which the Plan Participant is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

12. Expenses for services, treatment, or supplies not considered legal in the U.S.

13. Expenses for services or supplies that are not specifically listed as a Covered Medical Service of this Medical Plan.

14. Expenses for treatment, services, or supplies not actually rendered to or received and used by the Plan Participant.

15. Expenses for the following treatments, services, or supplies:

   a. Expenses related to or connected with treatments, services, or supplies that are excluded under this Medical Plan; and
   b. Treatments, services, or supplies that are the result of a medical complication resulting from a treatment, service or supply which is, or was at the time the expense was incurred, excluded from coverage under this Medical Plan.

H. MEDICAL PLAN BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Medical Benefits, in addition to the following Medical Plan Benefit Exclusions:

1. Expenses related to care or treatment of, surgery performed for, or complications from, or as the result of, a Cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a congenital anomaly for a covered Dependent Child or as specifically stated as a Covered Benefit of the Plan.**

2. Expenses for services, supplies, treatments, or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary, or are not covered under applicable Medical Policy, for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a Covered Benefit of the Plan.

3. Expenses for treatment for reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus. This exclusion will not apply to Plan Participants who are seeking services for cryopreservation who have been diagnosed with cancer, and the standard of care involves medical treatment that may directly or indirectly cause iatrogenic infertility. Coverage for this exclusion will be subject to review.

4. Expenses for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or routine physical examination, tests or treatments not connected with the actual Illness or Injury.

5. Expenses for Physicians' fees for treatment not provided by a Physician.

6. Special duty nursing services:

    a. If provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or
    b. When a private duty nurse is employed solely for the convenience of the patient or the patient's family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication, or acting as a companion, sitter, or when otherwise deemed not Medically Necessary as requiring Skilled Nursing Care.

7. Expenses related to the purchase or fitting of eyeglasses, contact lenses, or related supplies.

8. Expenses for hearing aid or Amplifications Device batteries/battery packs, cords, power banks, portable chargers, storage cases, travel bags or other similar travel or carrying accessories, dehumidifiers, and related supplies, or exceeding the hearing aid benefit maximum.

9. Expenses for Dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue, or alveolar processes. However, benefits will be payable for treatment required due to accidental bodily Injury to sound natural teeth, diseased teeth, or supporting bone or tissue. Such expenses **must** be incurred within twelve (12) months of the date of accident or diagnosis of disease. This exception will not include expenses for treatment for the repair or replacement of a denture.

10. Expenses related to or in connection with treatment of infertility, including, but not limited to, (a) artificial insemination, in-vitro fertilization, Gamete Intrafallopian Transfer (G.I.F.T.), Zygote Intrafallopian Transfer (Z.I.F.T.), Artificial Response Technology (A.R.T.), or other ovum transplant procedures; (b) gene manipulation therapy; (c) procedures to restore or enhance fertility; (d)assisted reproductive techniques or surgical procedures; (e) expenses related to donor sperm and donor ova (collection, preparation, storage); and (f) surrogate services.

11. Expenses for couples or family counseling without the patient(s) present, recreational counseling, or milieu therapy.

12. Expenses resulting from or related to the reversal of a sterilization procedure.

13. An expense which results from appetite control or treatment of obesity, except surgical treatment for morbid obesity. Coverage for surgical treatment of morbid obesity will only be provided as specifically stated in the Bariatric Surgery for Obesity Management provision of Covered Medical Services.

14. An expense for orthopedic shoes or other supportive device for the feet, except as provided under the Orthotic Devices provision.

15. Hair transplant procedures, wigs, and artificial hairpieces or drugs which are prescribed to promote hair growth or remove hair. This exclusion will not apply to the purchase of one (1) wig or artificial hairpiece per lifetime if purchased for alopecia or within three (3) months of cancer treatment. Coverage for a replacement wig or artificial hairpiece will be subject to review and may be allowed if normal wear and tear has made the prosthetic ineffective or if the patient's size changes (i.e., a child grows, and the prosthetic no longer fits).

16. Expenses for surgical, medical or Hospital services and/or supplies rendered relating to radial keratotomy, LASIK or other procedure designed to correct farsightedness, nearsightedness, or astigmatism.

17. Expenses related to Custodial Care or sanitarium care.

18. Expenses for artificial organ implant or nonhuman organ transplant procedures.

19. Complications that directly result from acting against medical advice, non-compliance with specific Physician's orders, or leaving an Inpatient facility against medical advice.

20. Equipment, including, but not limited to, motorized wheelchairs or beds, which exceeds the patient's needs for everyday living activities as defined by the Americans with Disabilities Act (ADA), as amended from time to time, unless Medically Necessary by independent review, and not primarily for personal convenience.

21. Specialized computer equipment, including, but not limited to, Braille keyboards and voice recognition software, unless determined to be Medically Necessary, and not primarily for personal convenience.

22. An expense that is primarily for the Plan Participant's education, training, or development of skills needed to cope with an Injury or Illness, except as provided under the rehabilitative care provision and the Disease Management Education Programs.

23. Expenses for smoking cessation products, unless provided through the Prescription Drug Plan and based on the limitation of two (2) 90-day quit attempts per year (one-hundred eighty (180) days total).

24. Expenses for homeopathic services, products, and botanical preparations.

25. Nutrition-based therapy for Substance Use Disorder.

26. Health care services to treat substance use co-dependency.

27. Expenses for the following (known as a "Never Event") when the condition is due to patient confinement or surgery:

a. Removal of an object left in the body during surgery.
b. Catheter-associated urinary tract infection.
c. Pressure ulcers.
d. Vascular catheter-associated infection.
e. Infection inside the chest after coronary artery bypass graft surgery.
f. Hospital acquired Injuries such as fractures, dislocations, intracranial injuries, crushing Injuries and burns; and
g. Amputation or removal of the wrong body part or organ.

28. Chelation therapy expenses, except for acute arsenic, gold, mercury, or lead poisoning.

29. Expenses for non-surgical treatment of TMJ syndrome. Surgical treatment of TMJ is covered, if Medically Necessary. ***Prior Authorization is strongly recommended for surgical treatment of TMJ*** *(Refer to Section 6 – How to Obtain Benefits).*

30. Expenses for genetic counseling, except for genetic counseling for routine BRCA testing *(Refer to Section 7 – Medical Plan Description, provision 30 (c) (3)).*

31. Ambulance services or expenses resulting from or related to non-emergent, non-Medically Necessary transport or transport for the patient's or family's convenience or comfort.

32. Expenses for electrical stimulation treatment are considered Experimental, Investigational, and/or unproven. Providers who commonly use this type of treatment in their practice include, but are not limited to: Physical Therapists, Chiropractors, and Acupuncturists. The types of electrical stimulation treatment that are excluded include, but are not limited to:

    a. H-Wave electrical stimulation
    b. Threshold Electrical Stimulation (TES)
    c. Microcurrent stimulation
    d. Galvanic stimulation
    e. Electroceutical therapy- identified by other names including, but not limited to, non-invasive neuron blockade, electroceutical neuron blockade, bioelectric treatment systems.
    f. Cranial Electrotherapy Stimulation (CES)
    g. Auricular electrostimulation
    h. Transcutaneous electrical stimulation (TENS)
    i. Interferential Current Stimulation (IFCS)
    j. Electric stimulation
    k. Sympathetic therapy; and
    l. Functional Neuromuscular Stimulation (FNS)

33. Services or expenses for half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities.

34. Charges associated with health clubs, health spas, weight loss clubs or clinics, personal trainers, or exercise programs.

35. Charges for services, treatments, or supplies that may be useful in the absence of Illness or Injury such as, but not limited to, air conditioners or purifiers, humidifiers, dehumidifiers, exercise equipment, health club memberships, whether prescribed or recommended by a Physician.

36. Charges for incidental supplies or common first-aid supplies such as, but not limited to, adhesive tape, bandages, antiseptics, and analgesics.

37. Any service or procedure which is determined to be an inclusive service or procedure.

38. Services, supplies, drugs, or devices relating to any of the following treatments or related procedures:

    a. Acupressure
    b. Hypnotherapy
    c. Rolf Structural Integration therapy (Rolfing)
    d. Holistic medicine
    e. Religious counseling
    f. Recreational counseling
    g. Mileu therapy
    h. Homeopathy
    i. Stress management
    j. Self-help programs
    k. Reiki therapy

39. Charges for services of a doula, direct-entry midwife or lay midwife, or the practice of direct-entry midwifery. A direct-entry midwife is one practicing midwifery and licensed pursuant to the state in which services are being performed pursuant to § 37-27-101 et seq, MCA. "Direct-entry midwife" means a person who advises, attends, or assists a woman during Pregnancy, labor, natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.

40. Charges for expenses for examinations and treatment conducted for the purpose of medical research.

Section 8
DENTAL PLAN DESCRIPTION

This Section describes the Dental Plan benefits for Plan Participants. *(Refer to Section 6 – How to Obtain Benefits. Refer to provision C.- Dental Benefit Maximum of this Section. Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for Dental Plan contact information.)*

Employees may change their Dental Plan option **only** during the annual benefits enrollment period. Dental Plan options **may not** be changed during a Special Enrollment period.

A. DENTAL PLAN OPTIONS

There are two (2) Dental Plan options:

1. **Basic Plan** (available to Eligible Employees and their covered Dependents)
   The Basic Plan covers **only** Diagnostic and Preventive services (e.g., oral exam, cleaning, x-rays) listed in provision F. – *Basic Plan Dental Fee Schedule* of this Section.

2. **Select Plan** (available to Eligible Employees, Retirees, and their covered Dependents)
   The Select Plan covers Diagnostic and Preventive, Basic Restorative (e.g., oral surgery, fillings, periodontic treatment), and Major Dental (e.g., dentures, bridges, crowns) services listed in provision G. – *Select Plan Dental Fee Schedule* of this Section.

   The **Select Plan** also covers:
   a. Implant procedures performed by a Dentist for endosseous, transosseus, subperiosteal and endodontic implants, implant connecting bars, and implant repairs. Implants are defined as prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support Dental prosthesis.
   b. Orthodontia procedures performed by a Dentist involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth

and/or jaws which significantly interferes with their functions. Orthodontia procedures are subject to a lifetime maximum amount for each covered Plan Participant, as specified in provision C – *Dental Benefit Maximum* of this Section.

B. DENTAL PLAN COVERAGE

The Dental Plan will pay only for the Covered Services as indicated in the Basic and Select Plan Dental Fee Schedules, not to exceed the maximum reimbursement amount for the specified procedure code or the Plan limitations specified in provisions F. – *Basic Plan Dental Fee Schedule*, G. – *Select Plan Dental Fee Schedule*, and H. – *Dental Plan Benefit Limitations* of this Section.

Covered Dental expenses are those services within the Plan Dental Fee Schedule, specified in provision E. – *Dental Fee Schedule,* for covered Dental services listed in provisions F. – *Basic Plan Dental Fee Schedule*, G – *Select Plan Dental Fee Schedule*, and not excluded in provisions H. – *Dental Plan Benefit Limitations.*, or I. – *Dental Plan Exclusions and Limitations* of this Section, when performed by a licensed Physician, Dentist, or licensed denturist operating within the scope of their license.

The Dental Plan Claims Administrator may require the submission of clinical reports, charts, and x-rays to complete the adjudication of a claim.

Where a more expensive course of treatment is performed than is Medically Necessary or where the treatment is more extensive than is customary, the Plan will pay an amount for the least expensive medically adequate course of treatment in accordance with the Dental Plan Fee Schedule. The Plan Participant will be responsible for the difference between the higher cost of the service and the lower cost of the customary service or standard practice.

For a Dental appliance, or modification of a Dental appliance, an expense is considered incurred at the time the impression is made. For a crown, bridge, or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened. All other expenses are considered incurred at the time a service is rendered or a supply furnished.

NOTE: The Plan has a "closed enrollment", which means that a legal spouse may not be enrolled in the Dental Plan after the thirty (30) day initial benefits enrollment period, unless there is a Qualifying Event or Qualifying Life Event.

C. DENTAL BENEFIT MAXIMUM

	Basic Plan	***Select Plan***
Annual Benefit Maximum (per covered member)	$750	$2,000
Orthodontia Lifetime Maximum (per covered member)	N/A	$1,500

D. COORDINATION OF BENEFITS

If a Plan Participant receives Dental services that are covered under both the Plan and another Dental plan, coverage and benefits are governed by COB rules. These rules determine which plan pays benefits first and which plan pays second. Depending on the situation, the Plan may be the primary or secondary Dental Plan. The primary plan pays benefits without regard to the secondary plan. When the Plan is the secondary plan, the Plan will coordinate with the primary insurance carrier and pay for Plan-covered services according to Plan provisions and limitations.

When acting as a secondary carrier, the Plan payment will not exceed the billed charge or the maximum reimbursement amount that would have been paid as the primary carrier.

Follow the guidelines set forth in Section 13 – *Coordination of Benefits* to determine if the Plan may be the primary or secondary Dental Plan.

If it is determined the Plan is the primary Dental Plan, Dental claims should be submitted to the Plan first. If the other plan is the primary Dental Plan, that plan's claims processing rules should be followed and then submit the remaining liability to the Plan. When submitting a claim when the Plan is the secondary plan, include a copy of the primary carrier's Dental EOB.

E. DENTAL FEE SCHEDULE

Dental claims are reimbursed based on a fixed dental fee schedule dollar amount. The fee schedule's fixed dollar amount is the maximum reimbursement paid by the Plan for the specified covered procedure code listed in provisions F. – *Basic Plan Dental Fee Schedule* and G. – *Select Plan Dental Fee Schedule* of this Section, regardless of provider network. Covered Dental Plan participants are responsible for the difference (if any) between the provider's billed charge and the fee schedule's maximum reimbursement amount.

Dental Plan participants have the freedom of choice to seek covered services with any licensed dentist, however, Out-of-Pocket costs may be reduced if utilizing a Delta Dental PPO or Premier network dentist.

The maximum reimbursement amount for Covered Services provided:

a. by a Preferred Provider Organization (PPO) Dentist is the lesser of the Dentist's submitted fee, the amount shown on the Dental Fee Schedule, or the PPO Dentist's fee agreement.
b. by a Premier Dentist is the lesser of the Dentist's submitted fee, the amount shown on the Dental Fee Schedule or the Premier Dentist's fee agreement.
c. by a non-Participating Dentist is the lesser of the Dentist's submitted fee or the amount shown on the Dental Fee Schedule.

The shaded dental procedure codes below are applicable to the **Basic Plan** only. All of the dental procedure codes below (shaded and non-shaded) are applicable to the **Select Plan**.

Procedure Code	Description	Fee Schedule
D0120	Periodic oral evaluation – established patient	$56
D0140	Limited oral evaluation – problem focused	$81
D0145	Oral evaluation for a patient under three (3) years of age	$77
D0150	Comprehensive oral evaluation – new or established patient	$73
D0160	Detailed and extensive oral evaluation – problem focused, by report	$153
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	$57
D0180	Comprehensive periodontal evaluation – new or established patient	$122
D0190	Screening of a patient	$31
D0191	Assessment of a patient	$31
D0210	Intraoral – complete series of radiographic images (including bitewings)	$137
D0220	Intraoral – periapical first radiographic image	$29
D0230	Intraoral – periapical each additional radiographic image	$22
D0240	Intraoral – occlusal radiographic image	$37
D0250	Extraoral – 2D projection radiographic image created using stationary radiation source, and detector	$64
D0270	Bitewing – single radiographic image	$25
D0272	Bitewings – two radiographic images	$55
D0273	Bitewings – three radiographic images	$54
D0274	Bitewings – four radiographic images	$72
D0277	Vertical bitewings – 7 to 8 radiographic images	$135
D0310	Sialography	$453
D0320	Temporomandibular joint (TMJ) arthrogram, including injection	$685

Procedure Code	Description	Fee Schedule
D0321	Other temporomandibular joint (TMJ) radiographic images, by report	$247
D0322	Tomographic survey	$391
D0330	Panoramic radiographic image	$133
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	$99
D0350	2D oral/facial photographic image obtained intraorally or extraorally	$41
D0364	Cone beam CT capture/interpretation, limited field of view – less than whole jaw	$175
D0365	Cone beam CT capture/interpretation, field of view of one dental arch – mandible	$297
D0366	Cone beam CT capture/interpretation, field of view of one dental arch – maxilla	$297
D0367	Cone beam CT capture/interpretation, field of view of both jaws	$178
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	$98
D0419	Assessment of salivary flow by measurement	$4
D0460	Pulp vitality tests	$34
D0461	Testing for cracked tooth	$34
D0470	Diagnostic casts	$105
D0472	Tissue accession – gross examination	$88
D0473	Tissue accession – gross and microscopic examination	$182
D0474	Tissue accession – gross and microscopic examination, including assessment of surgical margins for presence of disease	$225
D0601	Caries risk assessment and documentation, with a finding of low risk	$17
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$17
D0603	Caries risk assessment and documentation, with a finding of high risk	$17
D1110	Prophylaxis (cleaning) – adult	$115
D1120	Prophylaxis (cleaning) – child *(through age 13)*	$77
D1206	Topical application of fluoride varnish *(child through age 18)*	$34
D1208	Topical application of fluoride – excluding varnish *(child through age 18)*	$31
D1351	Sealant – per tooth *(child through age 15)*	$64
D1354	Application of caries arresting medicament – per tooth	$39
D1510	Space maintainer – fixed – unilateral – per quadrant	$313
D1516	Space maintainer – fixed – bilateral, maxillary	$439
D1517	Space maintainer – fixed – bilateral, mandibular	$484
D1520	Space maintainer – removable, unilateral – per quadrant	$480
D1526	Space maintainer – removable bilateral, maxillary	$592
D1527	Space maintainer – removable – bilateral, mandibular	$592
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	$69
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$69
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$69
D1556	Removal of fixed unilateral space maintainer – per quadrant	$69
D1557	Removal of fixed bilateral space maintainer – maxillary	$69
D1558	Removal of fixed bilateral space maintainer – mandibular	$69
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant	$263
D2140	Amalgam – one surface, primary or permanent tooth	$93
D2150	Amalgam – two surfaces, primary or permanent tooth	$118
D2160	Amalgam – three surfaces, primary or permanent tooth	$147
D2161	Amalgam – four or more surfaces, primary or permanent tooth	$176
D2330	Resin-based composite – one surface, anterior tooth	$112
D2331	Resin-based composite – two surfaces, anterior tooth	$143
D2332	Resin-based composite – three surfaces, anterior tooth	$174
D2335	Resin-based composite – four or more surfaces or involving incisal angle, anterior tooth	$214
D2391	Resin-based composite – one surface, posterior tooth	$127
D2392	Resin-based composite – two surfaces, posterior tooth	$162
D2393	Resin-based composite – three surfaces, posterior tooth	$207

Procedure Code	Description	Fee Schedule
D2394	Resin-based composite – four or more surfaces, posterior tooth	$241
D2510	Inlay – metallic – one surface	$292
D2520	Inlay – metallic – two surfaces	$344
D2530	Inlay – metallic – three or more surfaces	$494
D2542	Onlay – metallic – two surfaces	$419
D2543	Onlay – metallic – three surfaces	$375
D2544	Onlay – metallic-four or more surfaces	$545
D2610	Inlay – porcelain/ceramic – one surface	$292
D2620	Inlay – porcelain/ceramic – two surfaces	$335
D2630	Inlay – porcelain/ceramic – three or more surfaces	$380
D2642	Onlay – porcelain/ceramic – two surfaces	$453
D2643	Onlay – porcelain/ceramic – three surfaces	$580
D2644	Onlay – porcelain/ceramic – four or more surfaces	$553
D2650	Inlay – resin-based composite – one surface	$292
D2651	Inlay – resin-based composite – two surfaces	$335
D2652	Inlay – resin-based composite – three or more surfaces	$380
D2662	Onlay – resin-based composite – two surfaces	$371
D2663	Onlay – resin-based composite – three surfaces	$375
D2664	Onlay – resin-based composite – four or more surfaces	$440
D2710	Crown – resin-based composite (indirect)	$284
D2712	Crown - ¾ resin-based composite (indirect)	$698
D2720	Crown – resin with high noble metal	$500
D2721	Crown – resin with predominantly base metal	$369
D2722	Crown – resin with noble metal	$343
D2740	Crown – porcelain/ceramic substrate	$497
D2750	Crown – porcelain fused to high noble metal	$463
D2751	Crown – porcelain fused to predominantly base metal	$420
D2752	Crown – porcelain fused to noble metal	$461
D2753	Crown – porcelain fused to titanium and titanium alloys	$459
D2780	Crown – ¾ cast high noble metal	$516
D2781	Crown – ¾ cast predominantly base metal	$363
D2782	Crown – ¾ cast noble metal	$463
D2783	Crown – ¾ porcelain/ceramic	$488
D2790	Crown – full cast high noble metal	$520
D2791	Crown – full cast predominantly base metal	$402
D2792	Crown – full cast noble metal	$545
D2794	Crown – titanium and titanium alloys	$474
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	$81
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$65
D2920	Re-cement or re-bond crown	$63
D2921	Reattachment of tooth fragment, incisal edge, or cusp	$143
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$222
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$252
D2930	Prefabricated stainless-steel crown – primary tooth	$186
D2931	Prefabricated stainless-steel crown – permanent tooth	$222
D2932	Prefabricated resin crown	$221
D2933	Prefabricated stainless-steel crown with resin window	$222
D2934	Prefabricated esthetic coated stainless-steel crown – primary tooth	$222
D2940	Placement of interim direct restoration	$70
D2950	Core buildup, including pins when required	$151
D2951	Pin retention – per tooth, in addition to restoration	$38
D2952	Post and core in addition to crown, indirectly fabricated	$263
D2954	Prefabricated post and core in addition to crown	$189

Procedure Code	Description	Fee Schedule
D2960	Labial veneer (resin laminate) – direct	$622
D2961	Labial veneer (resin laminate) – indirect	$754
D2962	Labial veneer (porcelain laminate) – indirect	$934
D2971	Customize a crown to fit under an existing partial denture framework	By Report
D2976	Band stabilization – per tooth	$147
D2980	Crown repair necessitated by restorative material failure	$94
D2981	Inlay repair necessitated by restorative material failure	$81
D2982	Onlay repair necessitated by restorative material failure	$162
D2983	Veneer repair necessitated by restorative material failure	$112
D3110	Pulp cap – direct (excluding final restoration)	$49
D3220	Therapeutic pulpotomy (excluding final restoration)	$121
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	$183
D3310	Endodontic therapy (root canal) anterior tooth (excluding final restoration)	$553
D3320	Endodontic therapy (root canal) premolar tooth (excluding final restoration)	$667
D3330	Endodontic therapy (root canal) molar tooth (excluding final restoration)	$873
D3346	Retreatment of previous root canal therapy – anterior	$763
D3347	Retreatment of previous root canal therapy – premolar	$850
D3348	Retreatment of previous root canal therapy – molar	$1,036
D3351	Apexification/recalcification – initial visit	$520
D3352	Apexification/recalcification – interim medication replacement	$240
D3353	Apexification/recalcification – final (includes completed root canal therapy	$376
D3410	Apicoectomy – anterior	$776
D3421	Apicoectomy – premolar (first root)	$903
D3425	Apicoectomy – molar (first root)	$801
D3426	Apicoectomy (each additional root)	$280
D3430	Retrograde filling – per root	$154
D3450	Root amputation – per root	$720
D3471	Surgical repair of root resorption – anterior	$359
D3472	Surgical repair of root resorption – premolar	$359
D3473	Surgical repair of root resorption – molar	$359
D3501	Surgical exposure of root surface without apicoectomy or repair – anterior	$359
D3502	Surgical exposure of root surface without apicoectomy or repair – premolar	$359
D3503	Surgical exposure of root surface without apicoectomy or repair – molar	$359
D3920	Hemisection (including any root removal), not including root canal therapy	$240
D3921	Decoronation or submergence of an erupted tooth	$115
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth per quadrant	$371
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth per quadrant	$136
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$113
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth per quadrant	$400
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth per quadrant	$310
D4245	Apically positioned flap	$320
D4249	Clinical crown lengthening – hard tissue	$455

Procedure Code	Description	Fee Schedule
D4260	Osseous surgery – four or more contiguous teeth per quadrant	$1,000
D4261	Osseous surgery – one to three contiguous teeth per quadrant	$657
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$391
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$213
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$219
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site	$160
D4268	Surgical revision procedure, per tooth	$237
D4270	Pedicle soft tissue graft procedure *(limited to two sites per quadrant)*	$620
D4273	Autogenous connective tissue graft procedure – first tooth, implant, or edentulous position	$703
D4274	D or proximal wedge procedure, single tooth (not performed with surgery in the same area)	$386
D4275	Non-autogenous connective tissue graft – first tooth, implant, or edentulous position	$916
D4276	Combined connective tissue and pedicle graft, per tooth	$826
D4277	Free soft tissue graft – first tooth, implant, or edentulous position	$814
D4278	Free soft tissue graft – each additional contiguous tooth, implant or edentulous position	$474
D4283	Autogenous connective tissue graft procedure– each additional contiguous tooth, implant, or edentulous position	$379
D4285	Non-autogenous connective tissue graft procedure – each additional contiguous tooth, implant, or edentulous position	$480
D4286	Removal of non-resorbable barrier	$32
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$173
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$117
D4346	Scaling with generalized moderate or severe gingival inflammation – full mouth	$96
D4355	Full mouth debridement to enable complete periodontal evaluation and diagnosis on a subsequent visit	$104
D4910	Periodontal maintenance	$99
D5110	Complete denture – maxillary (upper)	$675
D5120	Complete denture – mandibular (lower)	$662
D5130	Immediate denture – maxillary	$783
D5140	Immediate denture – mandibular	$793
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$464
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$556
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including conventional clasps, rests, and teeth)	$718
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including conventional clasps, rests, and teeth)	$715
D5221	Immediate maxillary partial denture – resin base (including conventional clasps, rests, and teeth)	$523
D5222	Immediate mandibular partial denture – resin base (including conventional clasps, rests, and teeth)	$706
D5223	Immediate maxillary partial denture – cast metal framework with resin denture base (including conventional clasps, rests, and teeth)	$780
D5224	Immediate mandibular partial denture – cast metal framework with resin denture base (including conventional clasps, rests, and teeth)	$780
D5225	Maxillary partial denture – flexible base (including clasps, rests, and teeth)	$488
D5226	Mandibular partial denture – flexible base (including clasps, rests, and teeth)	$643
D5227	Immediate maxillary partial denture – flexible base (including clasps, rests, and teeth)	$577

Procedure Code	Description	Fee Schedule
D5228	Immediate mandibular partial denture – flexible base (including clasps, rests, and teeth)	$814
D5282	Removable unilateral partial denture – one-piece cast metal (including clasps and teeth), maxillary	$445
D5283	Removable unilateral partial denture – one-piece cast metal (including clasps and teeth), mandibular	$445
D5284	Removable unilateral partial denture – one-piece flexible base (including clasps and teeth) – per quadrant	$401
D5286	Removable unilateral partial denture – one-piece resin (including clasps and teeth) – per quadrant	$401
D5410	Adjust complete denture – maxillary	$32
D5411	Adjust complete denture – mandibular	$32
D5421	Adjust partial denture – maxillary	$46
D5422	Adjust partial denture – mandibular	$33
D5511	Repair broken complete denture base, mandibular	$86
D5512	Repair broken complete denture base, maxillary	$86
D5520	Replace missing or broken teeth – complete denture (per tooth)	$84
D5611	Repair resin partial denture base, mandibular	$89
D5612	Repair resin partial denture base, maxillary	$89
D5621	Repair cast partial framework, mandibular	$160
D5622	Repair cast partial framework, maxillary	$160
D5630	Repair or replace broken retentive clasping materials – per tooth	$160
D5640	Replace missing or broken teeth – partial denture (per tooth)	$102
D5650	Add tooth to existing partial denture	$117
D5660	Add clasp to existing partial denture – per tooth	$160
D5710	Rebase complete maxillary denture	$320
D5711	Rebase complete mandibular denture	$320
D5720	Rebase maxillary partial denture	$314
D5721	Rebase mandibular partial denture	$360
D5725	Rebase hybrid prosthesis	$314
D5730	Reline complete maxillary denture (direct)	$200
D5731	Reline complete mandibular denture (direct)	$200
D5740	Reline maxillary partial denture (direct)	$200
D5741	Reline mandibular partial denture (direct)	$200
D5750	Reline complete maxillary denture (indirect)	$283
D5751	Reline complete mandibular denture (indirect)	$274
D5760	Reline maxillary partial denture (indirect)	$263
D5761	Reline mandibular partial denture (indirect)	$276
D5765	Soft liner for complete or partial removable denture – indirect	$263
D5820	Interim partial denture (including retentive clasping materials, rest, and teeth), maxillary	$216
D5821	Interim partial denture (including retentive clasping materials, rest, and teeth), mandibular	$233
D5850	Tissue conditioning, maxillary	$51
D5851	Tissue conditioning, mandibular	$51
D5863	Overdenture – complete maxillary (natural tooth bone)	$930
D5864	Overdenture – partial maxillary (natural tooth bone)	$788
D5865	Overdenture – complete mandibular (natural tooth bone)	$861
D5866	Overdenture – partial mandibular (natural tooth bone)	$725
D6010	Surgical placement of implant body: endosteal implant	$860
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$850
D6013	Surgical placement of mini implant	$463
D6040	Surgical placement of eposteal implant	$1,500

Procedure Code	Description	Fee Schedule
D6049	Scaling and debridement of a single implant where there is mucositis – no flap	$106
D6050	Surgical placement of transosteal implant	$1,500
D6055	Connecting bar – implant/abutment supported	$1,014
D6056	Prefabricated abutment – includes modification and placement	$248
D6057	Custom fabricated abutment – includes placement	$344
D6058	Abutment supported porcelain/ceramic crown	$543
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$565
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$954
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$604
D6062	Abutment supported cast metal crown (high noble metal)	$588
D6063	Abutment supported cast metal crown (predominantly base metal)	$513
D6064	Abutment supported cast metal crown (noble metal)	$494
D6065	Implant supported porcelain/ceramic crown	$627
D6066	Implant supported crown – porcelain fused to high noble metal alloys	$649
D6067	Implant supported crown – high noble alloys	$599
D6068	Abutment supported retainer for porcelain/ceramic FPD	$550
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$541
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$502
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$529
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$670
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$518
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$532
D6075	Implant supported retainer for ceramic FPD	$800
D6076	Implant supported retainer for FPD – porcelain fused to high noble alloys	$1,072
D6077	Implant supported retainer for metal FPD – high noble alloys	$699
D6080	Implant maintenance procedures when a full arch fixed denture is removed and reinserted	$79
D6081	Scaling and debridement of a single implant, where there is inflammation – no flap	$106
D6082	Implant supported crown – porcelain fused to predominantly base alloys	$954
D6083	Implant supported crown – porcelain fused to noble alloys	$523
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	By Report
D6086	Implant supported crown – predominantly base alloys	$513
D6087	Implant supported crown – noble alloys	$494
D6088	Implant supported crown – titanium and titanium alloys	By Report
D6090	Repair of implant/abutment supported prosthesis	$253
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	By Report
D6092	Re-cement or re-bond implant/abutment supported crown	$42
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$62
D6094	Abutment supported crown – titanium and titanium alloys	By Report
D6097	Abutment supported crown – porcelain fuse to titanium and titanium alloys	By Report
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	$502
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	$529
D6100	Surgical removal of implant body	$250
D6101	Debridement of a peri-implant defect(s) surrounding implant and surface cleaning of the exposed implant surfaces	$348
D6102	Debridement and osseous contouring of a peri-implant defect(s) surrounding implant and includes surface cleaning of the exposed implant surfaces	$511
D6105	Removal of implant body not requiring bone removal or flap evaluation	$119
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$1,070
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	$1,340

Procedure Code	Description	Fee Schedule
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$948
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$999
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	$1,500
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	$1,500
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$1,500
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$1,500
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	$518
D6121	Implant supported retainer for metal FPD – predominantly base alloys	$518
D6122	Implant supported retainer for metal FPD – noble alloys	$532
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	By Report
D6180	Implant maintenance when a full arch fixed hybrid denture is not removed	$79
D6190	Radiographic/surgical implant index, by report	$115
D6193	Replacement of an implant screw	$42
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys	By Report
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys	$538
D6197	Replace a filling access hole of an implant supported prosthesis, per implant	$112
D6199	Unspecified implant procedure, by report	$50
D6205	Pontic – indirect resin-based composite	$363
D6210	Pontic – cast high noble metal	$622
D6211	Pontic – cast predominantly base metal	$383
D6212	Pontic – cast noble metal	$365
D6214	Pontic – titanium and titanium alloys	$528
D6240	Pontic – porcelain fused to high noble metal	$499
D6241	Pontic – porcelain fused to predominantly base metal	$425
D6242	Pontic – porcelain fused to noble metal	$463
D6243	Pontic – porcelain fused to titanium and titanium alloys	$463
D6245	Pontic – porcelain/ceramic	$489
D6250	Pontic – resin with high noble metal	$525
D6251	Pontic – resin with predominantly base metal	$351
D6252	Pontic – resin with noble metal	$427
D6280	Implant maintenance when a full arch removable denture is removed and reinserted	$79
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$350
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$257
D6549	Retainer – for resin bonded fixed prosthesis	$186
D6600	Retainer inlay – porcelain/ceramic, two surfaces	$375
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces	$394
D6602	Retainer inlay – cast high noble metal, two surfaces	$500
D6603	Retainer inlay – cast high noble metal, three or more surfaces	$383
D6604	Retainer inlay – cast predominantly base metal, two surfaces	$350
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	$353
D6606	Retainer inlay – cast noble metal, two surfaces	$358
D6607	Retainer inlay – cast noble metal, three or more surfaces	$365
D6608	Retainer onlay – porcelain/ceramic, two surfaces	$390
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	$596
D6610	Retainer onlay – cast high noble metal, two surfaces	$423
D6611	Retainer onlay – cast high noble metal, three or more surfaces	$486
D6612	Retainer onlay – cast predominantly base metal, two surfaces	$365
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	$375
D6614	Retainer onlay – cast noble metal, two surfaces	$381
D6615	Retainer onlay – cast noble metal, three or more surfaces	$395
D6624	Retainer inlay – titanium	$383

Procedure Code	Description	Fee Schedule
D6634	Retainer onlay – titanium	$425
D6710	Retainer crown – indirect resin-based composite	By Report
D6720	Retainer crown – resin with high noble metal	$432
D6721	Retainer crown – resin with predominantly base metal	$353
D6722	Retainer crown – resin with noble metal	$442
D6740	Retainer crown – porcelain/ceramic	$497
D6750	Retainer crown – porcelain fused to high noble metal	$507
D6751	Retainer crown – porcelain fused to predominantly base metal	$420
D6752	Retainer crown – porcelain fused to noble metal	$490
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$456
D6780	Retainer crown – ¾ cast high noble metal	$452
D6781	Retainer crown – ¾ cast predominantly based metal	$363
D6782	Retainer crown – ¾ cast noble metal	$365
D6783	Retainer crown – ¾ porcelain/ceramic	$473
D6784	Retainer crown – ¾ titanium and titanium alloys	$498
D6790	Retainer crown – full cast high noble metal	$498
D6791	Retainer crown – full cast predominantly base metal	$402
D6792	Retainer crown – full cast noble metal	$475
D6794	Retainer crown – titanium and titanium alloys	$548
D6930	Re-cement or re-bond fixed partial denture	$54
D6940	Stress breaker	$122
D6980	Fixed partial denture repair necessitated by restorative material failure	$131
D7111	Extraction, coronal remnants – primary teeth	$68
D7140	Extraction, erupted tooth, or exposed root (elevation and/or forceps removal)	$119
D7210	Surgical removal, erupted tooth – flap elevation, removal of bone and/or section	$204
D7220	Removal of impacted tooth – soft tissue	$239
D7230	Removal of impacted tooth – partially bony	$283
D7240	Removal of impacted tooth – completely bony	$327
D7241	Removal of impacted tooth – completely bony, unusual surgical complications	$473
D7250	Surgical removal of residual tooth roots (cutting procedure)	$202
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	$458
D7252	Partial extraction for immediate implant placement	$255
D7260	Oroantral fistula closure	$960
D7261	Primary closure of a sinus perforation	$428
D7280	Surgical access of an unerupted tooth	$319
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$214
D7284	Excisional biopsy of minor salivary glands	$209
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	$541
D7286	Incisional biopsy of oral tissue – soft	$209
D7290	Surgical repositioning of teeth	$269
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$36
D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant	$400
D7297	Corticotomy – four or more teeth or tooth spaces, per quadrant	$400
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$187
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$176
D7320	Alveoloplasty (no extractions) – four or more teeth or tooth spaces, per quadrant	$375
D7321	Alveoloplasty (no extractions) – one to three teeth or tooth spaces, per quadrant	$225
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$800

Procedure Code	Description	Fee Schedule
D7350	Vestibuloplasty – ridge extension (soft tissue graft and attachment	$1,500
D7410	Excision of benign lesion up to 1.25 cm	$280
D7411	Excision of benign lesion greater than 1.25 cm	$360
D7412	Excision of benign lesion, complicated	$494
D7413	Excision of malignant lesion up to 1.25 cm	$560
D7414	Excision of malignant lesion greater than 1.25 cm	$616
D7415	Excision of malignant lesion, complicated	$712
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$480
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$627
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$403
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$621
D7460	Removal of benign non-odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$380
D7461	Removal of benign non-odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$582
D7465	Destruction of lesion(s) by physical or chemical method, by report	$320
D7471	Removal of lateral exostosis (maxilla or mandible)	$529
D7472	Removal of torus palatinus	$529
D7473	Removal of torus mandibularis	$580
D7485	Surgical reduction of osseous tuberosity	$346
D7509	Marsupialization of odontogenic cyst	$621
D7510	Incision and drainage of abscess – intraoral soft tissue	$172
D7520	Incision and drainage of abscess – extraoral soft tissue	$282
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$206
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$360
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$400
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$1,024
D7610	Maxilla – open reduction (teeth immobilized, if present)	By Report
D7620	Maxilla – closed reduction (teeth immobilized, if present)	By Report
D7630	Mandible – open reduction (teeth immobilized, if present)	By Report
D7640	Mandible – closed reduction (teeth immobilized, if present)	By Report
D7650	Malar and/or zygomatic arch – open reduction	By Report
D7660	Malar and/or zygomatic arch – closed reduction	By Report
D7670	Alveolus – closed reduction, may include stabilization of teeth	By Report
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	By Report
D7830	Manipulation under anesthesia	By Report
D7840	Condylectomy	$1,500
D7850	Surgical discectomy, with/without implant	$1,500
D7860	Arthrotomy	$1,500
D7865	Arthroplasty	By Report
D7870	Arthrocentesis	By Report
D7880	Occlusal orthotic device, by report	$469
D7899	Unspecified TMD therapy	By Report
D7910	Suture of recent small wounds up to 5 cm	$192
D7911	Complicated suture – up to 5 cm	$360
D7912	Complicated suture – greater than 5 cm	$580
D7920	Skin graft (identify defect covered, location and type of graft)	$213
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$1,360
D7952	Sinus augmentation via a vertical approach	$400
D7953	Bone replacement graft for ridge preservation – per site	$264

Procedure Code	Description	Fee Schedule
D7955	Repair of maxillofacial soft and/or hard tissue defect	$304
D7961	Buccal/labial frenectomy (frenulectomy)	$217
D7962	Lingual frenectomy (frenulectomy)	$217
D7970	Excision of hyperplastic tissue – per arch	$287
D7971	Excision of pericoronal gingiva	$120
D7972	Surgical reduction of fibrous tuberosity	$217
D7979	Non-surgical sialolithotomy	$373
D8010	Limited orthodontic treatment of the primary dentition	By Report
D8020	Limited orthodontic treatment of the transitional dentition	By Report
D8030	Limited orthodontic treatment of the adolescent dentition	By Report
D8040	Limited orthodontic treatment of the adult dentition	By Report
D8070	Comprehensive orthodontic treatment of the transitional dentition	By Report
D8080	Comprehensive orthodontic treatment of the adolescent dentition	By Report
D8090	Comprehensive orthodontic treatment of the adult dentition	By Report
D8210	Removable appliance therapy	By Report
D8220	Fixed appliance therapy	By Report
D8660	Pre-orthodontic treatment examination to monitor growth and development	By Report
D8670	Periodic orthodontic treatment visit	By Report
D8680	Orthodontic retention (removal of appliances, construction, and placement of retainer(s)	By Report
D8681	Removable orthodontic retainer adjustment	By Report
D8999	Unspecified orthodontic procedure	By Report
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$73
D9120	Fixed partial denture sectioning	$86
D9222	Deep sedation/general anesthesia – first 15 minute increment or any portion	$280
D9223	Deep sedation/general anesthesia – each subsequent 15-minute increment or portion	$135
D9224	General anesthesia with advanced airway – first 15 minutes increment or portion	$280
D9225	General anesthesia with advanced airway – each subsequent 15-minute increment or portion	$135
D9239	Moderate sedation, intravenous – first 15 minute increment or any portion	$252
D9243	Moderate sedation, intravenous– each subsequent 15-minute increment or portion	$111
D9310	Consultation – provided by dentist other than requesting dentist	$67
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	$92
D9942	Repair and/or reline of occlusal guard	$40
D9944	Occlusal guard – hard appliance, full arch	$283
D9945	Occlusal guard – soft appliance, full arch	$151
D9946	Occlusal guard – hard appliance, partial arch	$320
D9947	Custom sleep apnea appliance fabrication and placement	$273
D9949	Repair of a custom sleep apnea appliance	$40
D9950	Occlusion analysis – mounted case	$187
D9951	Occlusal adjustment – limited	$51
D9952	Occlusal adjustment – complete	$406
D9953	Reline custom sleep apnea appliance (indirect)	$40

NOTE: The CDT codes and nomenclature are copyright of the American Dental Association. *Notes in italic type have been added for clarification.* The procedures described, and the Dental Fee Schedule Maximum Benefit indicated on this table, are subject to the terms of the contract and processing policies. These Fee Schedule amounts may be further reduced due to maximums, limitations, and exclusions.

Procedure Code	Description	Fee Schedule
	By Report – The Dental Plan will determine the Maximum Benefit allowed based on a narrative report submitted by the dentist and subject to the Plan's Fee Schedule Maximum Benefit and annual and lifetime maximum.	

F. DENTAL PLAN BENEFIT LIMITATIONS

Diagnostic & Preventive Benefits *(Basic and Select Plans)*

1. Reimbursement for Diagnostic and Preventive services **do not** apply to the Select Plan $2,000 annual benefit maximum.
2. Routine oral examinations and cleanings are limited to two (2) per Benefit Plan Year, including periodontal cleanings. **NOTE*:*** Periodontal cleanings are covered as a Basic Restorative Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit.
3. Full mouth x-rays or panoramic x-rays are limited to one (1) x-ray every five (5) years.
4. Bitewing x-rays are limited to two (2) per Benefit Plan Year for a Plan Participant under age eighteen (18) and one (1) per Benefit Plan Year for a Plan Participant aged eighteen (18) and older.
5. Space maintainers are limited to once per lifetime for a Plan Participant under age fourteen (14).
6. Topical application of fluoride is limited to two (2) in a twelve (12) month period for a Plan Participant under age nineteen (19).
7. Sealants are limited as follows:
    a. Available only to a Plan Participant through age fifteen (15).
    b. Limited to application to permanent molars with no caries (decay), without restorations and with the occlusal surface intact.
    c. Does not include the repair or replacement of a sealant on a tooth within two (2) years of its application.
8. The Plan allows anesthesia coverage for pediatric dental work for a Dependent through age eighteen (18), as necessary and upon review, based on age, disability, or the amount of work that **must** be done at one time. Expenses for these Covered Services will be subject to the Medical Plan annual Deductible, Coinsurance, and Out-of-Pocket Maximum.

Basic Restorative Benefits *(Select Plan)*

1. The Dental Plan will not pay to replace an amalgam, synthetic porcelain or plastic fillings, or prefabricated stainless-steel restorations within twenty-four (24) months of treatment if the service is provided by the same Dentist.
2. Periodontal scaling and root planning in the same quadrant are limited to once within a twenty-four (24) month period.

Major Restorative Benefits *(Select Plan)*

1. The Dental Plan will not pay to replace crowns, inlays/onlays or cast restorations that the Plan Participant received in the previous five (5) years.
2. The Dental Plan limits payment for stainless-steel crowns to services on baby teeth; however, after consultant's review, the Dental Plan may allow stainless-steel crowns on permanent teeth.
3. The Dental Plan will not pay to replace a bridge or denture the Plan Participant received in the previous five (5) years. An exception is made if the bridge or denture **cannot** be made satisfactory due to a change in supporting tissues or due to too many teeth having been lost.
4. The Dental Plan limits payment for dentures to a standard partial or denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
5. The initial installation of a fixed bridge or partial denture is not a benefit unless the bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Plan Participant was eligible under the Dental Plan.
6. Implant Benefits are subject to all limitations, exclusions and other terms and conditions in this Dental Plan.

7. The Dental Plan will not pay to replace an implant the Plan Participant received in the previous five (5) years. Benefits are not payable for the removal of an implants.
8. The initial installation of an implant is not a Benefit unless the implant is made necessary by natural, permanent teeth extraction occurring during a time the Plan Participant was eligible under the Dental Plan.

Orthodontia Benefits *(Select Plan)*

1. All payments will be monthly. The obligation of the Dental Plan to make periodic payments for an Orthodontic treatment plan begun prior to the date the Plan Participant becomes covered will commence with the first payment due following the date the Plan Participant's coverage is effective.
2. The obligation of the Dental Plan to make periodic payments for Orthodontic treatment will terminate on the next payment due date following the date the Plan Participant loses coverage, or upon termination of the Plan, whichever will occur first.
3. Orthodontia services are payable at 50% of the Dental Fee Schedule for authorized services, subject to a $1,500 lifetime maximum, per covered Plan Participant.
4. The Dental Plan will not make payment for repair or replacement of an Orthodontic appliance furnished, in whole or in part, under this Dental Plan.
5. X-rays or extractions are not subject to the Orthodontic maximum.
6. Surgical procedures are not subject to the Orthodontic maximum.

G. DENTAL PLAN EXCLUSIONS AND LIMITATIONS

The Dental Plan **does not** cover expenses for the following:

1. Dental services not listed on the Dental Fee Schedule in provisions F. – *Basic Plan Dental Fee Schedule* or G – *Select Plan Dental Fee Schedule,* or for Dental services that exceed the limitations in provision H. – *Dental Plan Benefit Limitations* of this Section.

2. Supplies furnished and services rendered or started before the Effective Date of coverage under the Plan or after coverage is terminated under the Plan, except as specifically provided in provision B. – *Dental Plan Coverage* of this Section.

3. Expenses incurred after termination, except for prosthetic devices, bridges, and crowns, which were fitted and ordered prior to termination, and were delivered within thirty (30) days of the date of termination.

4. Treatment for Cosmetic purposes.

5. Prosthetic services and devices, including bridges and crowns, started before the Plan Participant became covered by the Plan.

6. After initial placement of a denture and required adjustment rebase and/or reline of the dentures, rebase and/or reline of a denture is not allowed more than once in every two (2) year period.

7. Replacement of lost or stolen prosthetics.

8. Expenses for which a Plan Participant covered by this Dental Plan is not required to pay.

9. An expense which is primarily for the education or training of a Plan Participant covered by this Dental Plan.

10. Treatment of Injuries or Illness covered under workers' compensation or employers' liability laws; services received without cost from a federal, state, or local agency, unless this exclusion is prohibited by law.

11. Services for congenital (hereditary) or developmental (following birth) malformations, including, but not limited to, cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth), except those services provided to a newborn child for cleft lip or cleft palate.

12. Treatment to restore tooth structure lost from wear, erosion, or abrasion, to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion, or to stabilize the teeth. Examples include, but are not limited to, equilibration, periodontal splinting, or occlusal adjustment.

13. A single procedure started before the date the covered Plan Participant became covered for such services under this Dental Plan.

14. Prescribed drugs, medication, pain killers or Experimental procedures.

15. Expenses by a Hospital or other surgical or treatment facility and any additional fees billed by the Dentist for treatment in a facility.

16. Expenses for anesthesia, other than by a licensed Dentist for administering general anesthesia related to covered oral surgery services.

17. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

18. Treatment performed by an individual other than a Dentist or an individual who by law may work under a Dentist's direct supervision.

19. Expenses incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening, or missed appointments.

20. Treatment rendered by an individual who ordinarily resides in your household or who is related to you (or to your legal spouse) by blood, marriage, or legal adoption.

21. The initial placement of a denture or fixed bridge, unless such placement is needed to replace one or more natural, permanent teeth extracted while the covered Plan Participant is covered under the Dental Plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. A denture or fixed bridge **must** include the replacement of the extracted tooth or teeth.

H. FILING DENTAL CLAIMS

Claims are processed in the order in which they are received by the Dental Plan Claims Administrator and **must** be received within twelve (12) months from the date of service(s) or treatment(s) is received or completed. Benefits will be applied to the first claim received and will not be changed if additional claims are received during the Benefit Plan Year.

A claim will not be considered for payment of benefits if initially submitted to the Plan Claims Administrator more than twelve (12) months from the date that services were incurred.

On termination of the Plan, final claims **must** be received by the Plan Claims Administrator within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL RECEIVED BY THE PLAN CLAIMS ADMINISTRATOR.

Section 9
PRESCRIPTION DRUG PLAN DESCRIPTION

Plan Participants enrolled in the Medical Plan will be automatically enrolled in the Prescription Drug Plan (PDP). There is no separate monthly premium cost for the PDP.

A. PRESCRIPTION DRUG PLAN BENEFITS

Plan Participants will receive a prescription drug ID card from the PDP's Pharmacy Benefit Manager (PBM). Plan Participants can present their prescription drug card, along with a prescription from a Physician or Licensed Health Care Provider, at a participating In-Network retail pharmacy, for a thirty-four (34) day supply or ninety (90) day supply of medication. The PBM provides a participating In-Network of pharmacies throughout the U.S. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.)*

The PBM offers a preferred Specialty Pharmacy who can assist Plan Participants who take medications that require special handling and/or administration to treat certain chronic Illnesses or complex conditions. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.)*

The PDP has five (5) benefit tier levels:

Tier $0 – Preventive medications (ACA, certain statins, metformin, omeprazole).
Tier 1 – Low cost, high value generic and select brand name medications that provide high clinical value.
Tier 2 – Preferred brand name and select generic medications that are less cost effective.
Tier 3 – Non-preferred brand name and generic medications that provide the least value due to high cost or low clinical value, or both.
Tier 4 – Specialty medications for certain chronic Illnesses or complex diseases.

Plan Participants are responsible for a Copayment or Coinsurance percentage when the prescription is purchased. The Coinsurance amount paid for Specialty medications purchased at an In-Network retail pharmacy or an Out-of-Network (non-preferred) specialty pharmacy does not apply to the pharmacy Out-of-Pocket Maximum, nor does the Tier 3 Coinsurance amounts. *(Refer to the current MUS Choices Enrollment Workbook Prescription Drug Plan Schedule of Benefits for Copayment amounts, Coinsurance percentage, and annual Out-of-Pocket Maximums.)*

Plan Participants are NOT permitted to be enrolled in more than one Medicare Part D drug plan.

B. OUT-OF-NETWORK BENEFITS

Plan Participants may choose to purchase a prescription from a pharmacy that does not participate in the Pharmacy Network. To be reimbursed, Plan Participants **must** follow these procedures:

1. Out-of-Network pharmacies may submit the claim electronically, if available.
2. If an Out-of-Network pharmacy is unable to submit the claim electronically, Plan Participants **must** pay the full cost to the Out-of-Network pharmacy at the time the prescription is received.
3. Plan Participants **must** obtain a Direct Member Reimbursement form from the PBM's website and send the completed form and proof of drug purchase to the PBM. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.)* The PBM will process the claim for reimbursement for the amount allowed under the Plan.
4. Reimbursement **cannot** exceed the cost for the same drug purchased at a participating In-Network pharmacy.

Pharmacies that are excluded from the participating retail pharmacy Network are excluded from the Out-of-Network reimbursement process. Prescriptions filled at an excluded pharmacy will not be covered and the patient will be responsible for all billed charges (applicable to Commercial Plan enrollees only).

C. ACCESS GUIDANCE SERVICES PROGRAM

The MUS PDP offers a copay assistance program, Access Guidance Services, to offer copay assistance on the Plan Participant's behalf for certain eligible medications. This copay assistance program will manage expenses for eligible medications that have manufacturer-funded copay assistance programs available, while lowering the Plan's overall cost. If a Plan Participant's medication is eligible for the copay assistance program, the Plan Participant **will be required** to enroll in the manufacturer copay assistance program. If the Plan Participant **does not** enroll in the manufacturer copay assistance program, they will be responsible for the full cost of the medication.

Under the Access Guidance Services Program, the amount the Plan Participant pays for eligible medications may be set to the maximum of the current MUS Formulary benefit tier levels, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, Plan Participants will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including copay assistance. Amounts paid by manufacturers on the Plan Participant's behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward the annual Out-of-Pocket Maximum. Instead, only those payments made directly by the Plan Participant will count toward the Out-of-Pocket Maximum. Once manufacturer-funded copay assistance is exhausted, the amount the Plan Participant pays will be no more than the MUS Formulary benefit tier levels. If a specialty medication does not qualify or is removed from the copay assistance program, the copay will default to the medications current MUS Formulary benefit tier levels.

MedicareRx (Part D) Plan Participants are NOT eligible for the Access Guidance Services Program.

D. MAIL ORDER PHARMACY PROGRAM

Plan Participants who take prescription drugs on a maintenance schedule may purchase up to a ninety (90) day supply of medications through the PBM. Certain medications are allowed for purchase at a retail pharmacy only (e.g., narcotics). Plan Participants are encouraged to use a local In-Network retail pharmacy if a prescription is needed immediately, or if it is a first-time medication. To purchase a prescription through a mail order program, Plan Participants should submit a prescription written for a ninety (90) day supply plus refills, a completed Patient Profile/Mail Order Form, and the appropriate Copayment/Coinsurance amount to the mail order pharmacy program of choice.

Information for the mail order program can be accessed through the contracted vendor's website or by contacting the pharmacy mail order program vendor directly. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.)* With the mail order program, Plan Participants can save money on prescriptions for ongoing maintenance medications and the medication will be mailed directly to the Plan Participant.

Certain compound prescription drugs are available from the mail order pharmacy program. These prescriptions will take longer to dispense, so allow more time.

E. COVERED PRESCRIPTION DRUG EXPENSES

Expenses for prescription drugs that are Medically Necessary for the treatment of an Injury or Illness, and which require a legal prescription authorized by a Physician or Licensed Health Care Provider, and expenses for other pharmaceutical services listed below are covered under both the retail and mail order pharmacy programs. Expenses for these same prescription drugs purchased outside the retail or mail order pharmacy programs are covered up to the PDP's Allowed Amount for the drug. Covered pharmaceutical services include:

1. Federal legend prescription drugs.

2. Drugs requiring a prescription under applicable state law; and
3. Diabetic supplies: injectable insulin, test strips, syringes, needles, lancets, and alcohol swabs.

Contraceptive Management, injectable contraceptives, and contraceptive devices are covered under the Medical Plan.

F. EXCLUSIONS

The PDP **does not** cover the following:

1. Expenses that fall under, or are related to, the General Exclusions and Limitations in the Medical Plan's SPD.

2. Durable Medical Equipment (DME), except for diabetic supplies.

3. Expenses for all pharmaceuticals, drugs and medical supplies that may be purchased over the counter without a written prescription.

4. An expense for a prescription drug that is not Medically Necessary, or not considered appropriate for the treatment of an Injury or Illness or is Experimental/Investigational.

5. Drugs or supplies prescribed for Cosmetic purposes; (e.g., Rogaine for hair loss or Retin-A (age twenty-six (26) and older)).

6. Growth hormones unless Prior Authorized by the PBM.

7. A prescription drug expense that has been paid by another health insurance plan, workers' compensation program, or has been paid under the Medical Plan.

8. Hearing aids, Amplifications Devices, ear molds, batteries/battery packs, cords, chargers, power banks, storage cases, bags or other similar travel or carrying accessories, and related supplies.

9. An expense for which a Plan Participant does not have to pay, or which would not be a Covered Expense in the absence of the Plan.

10. An expense incurred prior to the Plan Participant's Effective Date or after the Plan Participant's coverage terminates.

11. Investigational or Experimental Services or drugs, including compounded medications, for a use not approved by the FDA.

12. Non-prescription vitamins, nutritional supplements, or fluoride supplements.

13. Anorexiants (prescription drugs used for weight loss).

14. Infertility drugs (prescription drugs used for infertility).

G. APPEAL OF PRESCRIPTION DRUG BENEFITS DENIED IN WHOLE OR PART

An appeal of an Adverse Benefit Determination may be filed under these procedures.

An appeal of an Adverse Benefit Determination **must** be made in writing (or orally by the attending Physician or Licensed Health Care Provider in the case of an Adverse Benefit Determination rendered on an urgent care claim) and submitted to the PBM. Appeal of an Adverse Benefit Determination **must** be made in writing within one-hundred eighty (180) days from receipt of the Adverse Benefit Determination. The Claimant **must** state why the Plan Participant does not agree with the Adverse Benefit Determination. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.)*

An appeal should include the name of the Plan Participant, the PBM ID card number, Plan Participant's date of birth, a written statement of the issue, the name of the prescription drug being appealed, and documents, records or other pertinent or supporting information related to the claim.

Providers may submit urgent appeal requests to the PBM. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.)* The PBM will review the appeal of an Adverse Benefit Determination. The claim should include at least the following information: the identity of the Plan Participant, a specific medical condition or symptom, the name of the prescription drug for which approval or payment is requested, and reasons why the appeal should be processed on an expedited basis.

The PBM will decide the appeal of an urgent care claim as soon as possible but no later than seventy-two (72) hours after receipt of the appeal.

H. TIMEFRAMES FOR DECIDING AN APPEAL OF AN ADVERSE BENEFIT DETERMINATION

The timeline for the PBM to decide an appeal of an Adverse Benefit Determination and to notify the Plan Participant of the final internal Adverse Benefit Determination depends upon the type of claim on appeal.

1. **Urgent Care Claim** – No later than seventy-two (72) hours from the date the PBM received the Plan Participant's appeal.
2. **Pre-Service Claim** – No later than thirty (30) days from the date the PBM received the Plan Participant's appeal.
3. **Post-Service Claim** – No later than sixty (60) days from the date the PBM received the Claimant's appeal.
4. **Rescission of Coverage Claim** – No later than sixty (60) days from the date the Plan Administrator received the Plan Participant's appeal.

These rules require the Plan Participant to initiate the appeal within the timeframe applicable to the claim at issue. Failure to submit a written appeal or request for review within the relevant time may cause the Plan Participant to forfeit their right to further review of an Adverse Benefit Determination under these procedures or in court and will render the determination final. An untimely appeal will not be considered.

Appeals or requests for review of Adverse Benefit Determinations **must** be submitted to the PBM in writing, along with supporting materials.

I. FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

The PBM's determination will be communicated in writing to the Plan Participant. If the PBM renders an Adverse Benefit Determination on appeal, the PBM will provide written notification which will include:

1. The specific reason(s) for the final internal Adverse Benefit Determination. If the final internal Adverse Benefit Determination upholds a Rescission, the notice will include the factual basis for the finding of fraud or intentional misrepresentation of a material fact.
2. Specific reference to pertinent Plan provisions or rules, on which the final internal Adverse Benefit Determination is based.
3. The standard the Plan Administrator relied on to deny the claim (such as a medical necessity standard).
4. If applicable, a statement describing the Plan Participant's right to request an external review and the time limits for requesting an external review.

5. An offer to provide (upon request and at no cost) reasonable access to and copies of all documents, records and other information or materials relevant to the final internal Adverse Benefit Determination.
6. If applicable, an offer to provide (upon request and at no cost) any internal rule, guideline, protocol or other similar criterion, Medical Policy, or other medical information was used to make the final internal Adverse Benefit Determination.
7. If applicable, an offer to provide (upon request and at no cost) an explanation for a final internal Adverse Benefit Determination is based on a medical necessity standard or an Experimental treatment or similar exclusion or limitation.
8. If applicable, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Plan Participant's medical circumstances or an offer to provide such a statement (upon request and at no cost).
9. If applicable, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the Plan Participant's medical circumstances or an offer to provide such a statement (upon request and at no cost).

The Plan Administrator will review the claim and any additional information submitted by the Plan Participant. If necessary, the Plan Administrator may confer with the Plan Participant/appellant and with the PBM to clarify the issues presented in the appeal. The Plan Administrator will conduct a full and fair review of the claim. The Plan Administrator is neither the original decisionmaker nor the decisionmaker's subordinate. The Plan Administrator will give no deference to the initial benefit determination. The Plan Administrator may consult with relevant pharmacists and/or health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental Treatment, the Plan Administrator will consult with a pharmacist and/or health care professional with appropriate training. Neither the pharmacist, health care professional, nor their subordinate will be the medical professional consulted in the initial determination.

After a full and fair review of the Plan Participant's appeal, the Plan will provide written or electronic notice to the PBM of the final benefit determination, within a reasonable time, but no later than thirty (30) days for a Pre-Service Claim or sixty (60) days for a Post-Service Claim from the date the second level appeal is received by the PBM. The PBM will provide this notice to the Plan Participant within the relevant time frame specified above. Such notice will contain the same information as notices for the initial determination.

All claims are based upon the terms contained in the SPD on file with the Plan Administrator and the PBM. The Plan Participant may also request (at no cost) more detailed information, names of medical professionals consulted, and copies of relevant documents, as defined in and required by law, which were used by the PBM to adjudicate the claim.

Right to Request External Review:

Standard External Review

A Plan Participant (or an individual authorized to act on the Plan Participant's behalf) may request external review of an Adverse Benefit Determination by filing a request for external review within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination. The request for external review **must** be submitted in writing to the PBM. Within five (5) business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether:

1. the Plan Participant is (or was) covered under the Plan at the time the health care item or service was requested, or, in the case of a retrospective review, the Plan Participant was covered under the Plan at the time the health care item or service was provided.
2. the Adverse Benefit Determination is not due to the Plan Participant was not eligible for coverage under the Plan.

3. the Plan Participant has exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); and
4. the Plan Participant has provided all the information and forms required to process an external review.

The Plan Participant will be notified of the results of the preliminary review within one (1) business day after completion of the preliminary review. If the request is incomplete, the notice **must** describe the information or documentation needed to complete the request. The notice **must** set forth the time limit for the Plan Participant to provide the additional information needed (either the four-month period within which to request an external review or forty-eight (48) hours after the receipt of this notice, whichever comes later).

If the claim is eligible for external review, an Independent Review Organization (IRO) will be assigned to conduct the external review.

Expedited External Review

Expedited external review may be requested when:

1. an Adverse Benefit Determination involves a medical condition where the timeframe completing an expedited internal appeal would seriously jeopardize the Plan Participant's life, health, or ability to regain maximum function, and a request for an internal appeal has been filed; or
2. a final internal Adverse Benefit Determination involves: (1) a medical condition where the timeframe for completing an expedited internal appeal would seriously jeopardize the Plan Participant's life, health, or ability to regain maximum function; or (2) an admission, availability of care, continued stay, or health care item or service for which the Plan Participant received emergency services, but has not been discharged from a facility.

The request for an expedited external review **must** be made in writing to the PBM. Immediately upon receipt of the request for an expedited review, a determination will be made as to whether the request meets the requirements (as described above) for a standard external review, the Plan Participant will be notified of the determination, and an IRO will be assigned (as described above) for a standard external review.

External Review by IRO

The PBM will timely (in the case of an expedited external review, expeditiously) provide to the IRO documents and information considered in making the Adverse Benefit Determination. The Plan Participant may submit additional information in writing to the IRO within ten (10) business days of the IRO's notification it has been assigned the request for external review. The IRO will review all information and documents timely received. In making its decision, the IRO is not bound by the Plan's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

1. The Plan Participant's medical records.
2. The attending health care professional's recommendation.
3. Reports from appropriate health care professionals and other documents submitted by the Plan, the Plan Participant, or the Participant's treating health care provider.
4. The terms of the Participant's SPD.
5. Evidence-based practice guidelines.
6. Applicable clinical review criteria developed and used by the Plan; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

Notice of Final External Review Decision

The IRO will provide written notice of the final external review decision to the Plan Participant and the PBM within forty-five (45) days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and evidence-based

standards that were relied on in making its decision. To the extent the final external review decision reverses the Plan's decision (as was reflected in the notice of adverse benefit determination), the Plan will follow the final external review decision of the IRO.

In the case of an expedited external review, the IRO will provide the notice of the final external review decision as expeditiously as the Participant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO **must** provide written confirmation of the decision within forty-eight (48) hours.

Compliance with IRO Decision
If the IRO reverses the Plan's Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will immediately provide coverage or issue payment according to the terms of the Plan.

Section 10
VISION HARDWARE PLAN DESCRIPTION

This Section describes the Vison Hardware Plan benefits for Plan Participants. The Vision Hardware Plan is for vision hardware **only**. Eye exams are covered under the Medical Plan. The Vision Hardware Plan is designed to cover visual needs rather than cosmetic materials. *(Refer to Section 6 – How to Obtain Benefits. Refer to provision A.- Vision Hardware Plan Coverage of this Section. Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for Vision Hardware Plan contact information.)*

Employees and their Eligible Dependents may enroll in the Vision Hardware Plan **only** during their initial benefits enrollment period or during the annual benefits enrollment period. An Employee **may** disenroll from the Vision Hardware Plan during the annual benefits enrollment period. An Employee **may not** enroll in or disenroll from the Vision Hardware Plan during a Special Enrollment period.

A. VISION HARDWARE PLAN COVERAGE

Eyeglass Frames and Prescription Lenses – The Plan will pay up to a $300.00 allowance per Benefit Plan Year, in lieu of prescription contact lenses, toward the purchase of **one** the following:

1. One (1) pair of eyeglass frames and prescription plastic or glass lenses, including single vision, bifocal, trifocal, progressive, polycarbonate, photochromatic, and oversize lenses; **or**

2. One (1) single purchase of eye glass frames and prescription plastic or glass lenses, including single vision, bifocal, trifocal, progressive, polycarbonate, photochromatic, and oversize lenses.

   Prescription eyeglass lens enhancements, including ultraviolet, scratch-resistant, and anti-reflective coatings, and tinting are included in the benefit maximum allowance.

Prescription Contact Lenses – The Plan will pay up to a $200.00 allowance, per Benefit Plan Year, in lieu of eyeglass frames and prescription eyeglass lenses, toward the purchase of **one** of the following:

1. One (1) pair of prescription conventional, disposable, or medically necessary* contact lenses; **or**

2. One (1) single purchase of a supply of prescription conventional, disposable, or medically necessary* contact lenses.

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

B. VISION HARDWARE PLAN EXCLUSIONS

The Vision Hardware Plan **does not** cover expenses for the following:

1. Non-prescription or cosmetic eyeglass lenses or contact lenses.
2. Eyeglass lens polarization or mirror coating.
3. Eyeglass or contact lens cases.
4. Dispensing fees.
5. Magnification or low vision aids.
6. An eye examination, medical or surgical treatment of the eyes.
7. Safety glasses or lenses required for employment.
8. An eye examination, or corrective eyewear, required by employer as a condition of employment.
9. Expenses incurred over the benefit allowance.
10. Orthoptic or vision training and associated supplemental testing.
11. More than one (1) frame and one (1) pair of prescription eyeglass lenses per Benefit Plan Year, in lieu of prescription contact lenses.
12. More than one (1) pair of prescription contact lenses or single purchase of a supply of prescription contact lenses per Benefit Plan Year, in lieu of a frame and prescription eyeglass lenses.
13. Replacement of prescription eyeglass lenses, frames, or contact lenses which are lost, stolen, or broken except at the normal interval when services are otherwise available.
14. Experimental or non-conventional procedure, corrective vision treatment, lens, or device.
15. Prescription medication or supplies of any type.

C. FILING VISION HARDWARE CLAIMS

When a Plan Participant purchases Vision Hardware from an In-Network Provider, the Provider should submit the claim on behalf of the Plan Participant to the Vision Hardware Plan Claims Administrator for reimbursement. If a Provider does not bill for Vision Hardware purchases, a walk-out statement should be provided to the Plan Participant by the Provider for submission to the Vision Hardware Plan Claims Administrator for reimbursement. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for Vision Hardware Plan contact information.)*

Claims are processed in the order in which they are received by the Vision Hardware Plan Claims Administrator and **must** be received within twelve (12) months from the date of purchase. Benefits will be applied to the first claim received and will not be changed if additional purchases are made during the Benefit Plan Year.

A claim will not be considered for payment of benefits if initially submitted to the Plan Claims Administrator more than twelve (12) months from the date of purchase.

On termination of the Plan, final claims **must** be received by the Plan Claims Administrator within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL RECEIVED BY THE PLAN CLAIMS ADMINISTRATOR.

The Plan Participant may be responsible for the billed charges at the time of service.

Section 11
FLEXIBLE SPENDING ACCOUNTS

A. ELIGIBILITY

An Employee who:

1. Meets the eligibility requirements of the Plan in Section 1 – *Eligibility* and is entitled to make benefit elections under the terms of Section 2 – *Enrollment, Changes in Enrollment, Effective Dates of Coverage* & Section 3 – *Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options* and may elect Flexible Spending Account (FSA) benefits.
2. Enrolls in the Plan; and
3. Does not opt out of IRS Section 125 pre-tax premium payment *(Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage, provision A. – New Employee Benefits Enrollment).*

B. OPERATION

At the time of initial enrollment in the Plan and during each annual benefits enrollment period, an Eligible Employee may elect amounts to be withheld from their earnings (pre-tax) to be contributed monthly to a Health Care (General Purpose) or Limited Purpose Flexible Spending Account (HCFSA or LPFSA) and/or Dependent Care (day care) Flexible Spending Account (DCFSA). These accounts are used to pay for qualified Eligible Expenses of the Employee and their eligible family members. Family members do not have to be covered under the Employee's Plan to have expenses paid out of these accounts.

The portion of the Employee's earnings which they elect to have contributed monthly into an FSA is not subject to federal or state income taxes or Social Security taxes, resulting in payroll tax savings. As the Employee and eligible family members incur qualifying expenses, the FSA participant may submit claims to be reimbursed for those expenses using tax-free dollars. Expenses reimbursed from an FSA **cannot** be claimed as a federal or state income tax credit or deduction on tax returns.

If an Eligible Employee enrolls in an FSA during their initial enrollment, the account(s) becomes effective the first day of the month following their date of hire or date of benefits eligibility. If the Eligible Employee enrolls in an FSA during the annual benefits enrollment period, the account(s) becomes effective July 1st. FSA funds may only be used for expenses incurred on or after the FSA effective date and can be used at any time during the Benefit Plan Year.

When an Eligible Employee enrolls in an FSA, they are electing to participate for the entire Benefit Plan Year (July 1st – June 30th or if enrolling mid-year as a new benefits Eligible Employee, for the remainder of a Benefit Plan Year. No changes to FSA elections may be made during the Benefit Plan Year, unless the Plan Participant experiences a Qualifying Event, subject to Plan restrictions. FSA changes **must** be consistent with the change in status or Qualifying Event.

NO AUTOMATIC ENROLLMENT! No exceptions will be made for late enrollment.

C. EMPLOYEE CONTRIBUTION

The portion of the Eligible Employee's earnings they choose to contribute to an FSA for a Benefit Plan Year (or if enrolling mid-year, for the remainder of a Benefit Plan Year) will be deducted from their earnings each pay period in equal installments over the course of the Benefit Plan Year (or remaining part of the Benefit Plan Year).

D. HEALTH CARE FLEXIBLE SPENDING ACCOUNT

An HCFSA (General Purpose FSA) allows an Eligible Employee to set aside pre-tax contributions to pay for qualified Out-of-Pocket Medical, Prescription, Dental, and Vision expenses that are not covered under the group health care plan. During initial enrollment and during each annual benefits enrollment period, an Employee **must** decide whether they wish to participate in an HCFSA for the upcoming Benefit Plan Year. At that time, the Employee **must** also elect the amount to be contributed monthly from their earnings over the course of the Benefit Plan Year into the account. The minimum and maximum amount that may be elected is specified in the current MUS *Choices* Enrollment Workbook. An HCFSA **may not** be newly elected or terminated mid-year due to a Special Enrollment period. The current HCFSA election amount may be increased or decreased mid-year due to a Special Enrollment period, subject to Plan restrictions. **If an Employee does not complete a new HCFSA election during the annual benefits enrollment period, the Employee will not be enrolled in an HCFSA for the upcoming Benefit Plan Year.**

ELIGIBLE HCFSA EXPENSES: Expenses that are eligible for reimbursement include, but are not limited to: annual Deductibles, Coinsurance, Copayments, amounts remaining after the Medical Plan has paid Benefit Maximums, Dental and orthodontia expenses, prescription drug costs, over-the-counter drugs/medications eligible without a practitioner's prescription, Vision expenses, menstrual care products, hearing aids and exams, and other Covered Medical Expenses.

Eligible Expenses must be *incurred* during the Benefit Plan Year. A Plan Participant may submit a claim and request reimbursement from the HCFSA at any time during the Benefit Plan Year for up to the full annual elected amount. Requests for reimbursement **must** be for amounts of $10.00 or more. **No exceptions will be made for late claim submissions.**

INELIGIBLE HCFSA EXPENSES: Ineligible Expenses which are not eligible for reimbursement include, but are not limited to: Cosmetic procedures, health care insurance premiums, missed appointment fees, vitamins, supplements, cosmetics, toiletries, hygiene products, prescriptions obtained from other countries, and safety glasses.

E. LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

An LPFSA (or Health Savings Account (HSA)-Compatible FSA) is a health care spending account that an Eligible Employee who is, or whose legal spouse is, enrolled in a High-Deductible Health Plan (HDHP) with an HSA under a different employer may enroll in that can **only** be used for eligible **Dental and Vision expenses**. During initial enrollment and during each annual benefits enrollment period, an Eligible Employee **must** decide whether they wish to participate in an LPFSA for the upcoming Benefit Plan Year. At that time, the Employee **must** also elect the amount to be contributed monthly from their earnings over the course of the Benefit Plan Year into the account. The minimum and maximum amount that may be elected is specified in the current MUS *Choices* Enrollment Workbook. Plan Participants enrolling in an LPFSA **may not** enroll in an HCFSA. An LPFSA **may not** be newly elected or terminated mid-year due to a Special Enrollment period. The current LPFSA election amount may be increased or decreased mid-year due to a Special Enrollment period, subject to Plan restrictions. **If an Employee does not complete a new LPFSA election during the annual benefits enrollment period, the Employee will not be enrolled in an LPFSA for the upcoming Benefit Plan Year.**

ELIGIBLE LPFSA EXPENSES: Expenses which are eligible for reimbursement include, but are not limited to: contact lens materials, eyeglass cleaners, reading glasses, eye exams, Dental exams and

treatment, eyeglass frames and lenses, contacts, denture adhesives, and toothache pain relievers (prescribed by a medical practitioner).

Eligible Expenses must be *incurred* during the Benefit Plan Year. A Plan Participant may submit a claim and request reimbursement from the LPFSA at any time during the Benefit Plan year for up to the full annual elected amount. Requests for reimbursement **must** be for amounts of $10.00 or more. **No exceptions will be made for late claim submissions.**

INELIGIBLE LPFSA EXPENSES: Ineligible Expenses which are not eligible for reimbursement include, but are not limited to: expenses related to medical treatment and care, health care insurance premiums, Cosmetic Dental surgery, teeth bleaching/whitening, Dental hygiene products, and over-the-counter sunglasses.

F. DEPENDENT CARE (DAY CARE) FLEXIBLE SPENDING ACCOUNT

A DCFSA allows an Eligible Employee to set aside pre-tax contributions to pay for qualified Dependent Care (day care) for children under age fourteen (14) and older Dependents (including parents) if they are mentally or physically incapable of taking care of themselves. The purpose of the Dependent Care (day care) expenses **must** be to allow the Employee and/or legal spouse to work. Dependent Care (day care) expenses paid through the Plan's DCFSA **may not** exceed the Employee's or legal spouse's taxable income.

During initial enrollment and during each annual benefits enrollment period, an Employee **must** decide whether they wish to participate in a DCFSA for the upcoming Benefit Plan Year. At that time, the Employee **must** also elect the amount to be contributed monthly from their earnings over the course of the Benefit Plan Year into the account. The minimum and maximum amount that may be elected is specified in the current MUS *Choices* Enrollment Workbook. A DCFSA **may** be newly elected or the current DCFSA election amount may be increased or decreased mid-year due to a Special Enrollment period or due to a change in day care needs. A DCFSA election **may** be terminated mid-year due to a Special Enrollment period or due to a change in day care needs, subject to Plan restrictions. **If an Employee does not complete a new DCFSA (day care) election during the annual benefits enrollment period, the Employee will not be enrolled in a DCFSA for the upcoming Benefit Plan Year.**

NOTE: The Dependent Care (day care) FSA is **not** used for reimbursement of health care expenses.

ELIGIBLE DCFSA (DAY CARE) EXPENSES: Expenses which are eligible for reimbursement include, but are not limited to: live-in care, babysitters, non-educational, non-medical day care expenses, elder care, day camps, after school care, nanny, and preschool.

Eligible Expenses must be *incurred* during the Benefit Plan Year. Reimbursement of claims for Eligible Expenses can only be up to the amount in the account at the time the claim is submitted. The remaining portion of a partially paid claim will be paid when additional contributions are made. **No exceptions can be made for late claim submissions.**

INELIGIBLE DCFSA (DAY CARE) EXPENSES: Ineligible Expenses which are not eligible for reimbursement include, but are not limited to: meals, overnight camps, diapers, educational expenses (kindergarten level and above), activity fees, field trips, entertainment, nursing homes, and transportation.

G. IRS RULES FOR FSAS

Expenses eligible for FSA reimbursement **must** be incurred in the Benefit Plan Year.

Reimbursements from an FSA may only be for expenses allowed for that account. Only eligible health care expenses can be reimbursed from an HCFSA, only eligible Dental or Vision expenses can be

reimbursed from an LPFSA, and only Dependent Care (day care) expenses can be reimbursed from a DCFSA using pre-tax premium contributions.

If a HCFSA or LPFSA expense is covered by your health insurance coverage, you **must** provide the Explanation of Benefits (EOB) as documentation to support your reimbursement request (except for prescriptions (receipts and/or bag tags are required), copays, and over the counter items), even if the expense is denied for exhausting a benefit maximum. If the expense is not covered by your health insurance, an itemized statement from the provider may satisfy documentation requirements.

Documentation to substantiate the expense **will be required** for most FSA debit card expenses, so keep all health care receipts/statements, EOBs, and other supporting documentation when you use your debit card to submit to substantiate the expense incurred on your debit card.

Expenses reimbursed from the FSA **cannot** be claimed as a federal or state income tax credit deduction on the Employee's tax return. Please consult a tax advisor if this is a concern.

Participating in an HCFSA, LPFSA, and/or DCFSA (day care) using pre-tax premium contributions results in Social Security tax reduction. This could affect an Employee's future Social Security benefits. Please consult a tax advisor if this is a concern.

MID-YEAR ELECTION CHANGES: Generally, FSA elections, like other benefit elections whose costs are paid pre-tax, **may not** be changed after the beginning of the Benefit Plan Year. However, there are certain limited situations when employees are permitted to change elections when a qualifying change in status (other than a health insurance cost or coverage change) occurs, subject to Plan restrictions and Plan Administrator review. FSA changes due to a mid-year change will become effective the first day of the month following the date the change is initiated. *(Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage.)* **Changes must be consistent with the Plan Participant's change in status.**

USE IT OR LOSE IT RULE: If eligible HCFSA or LPFSA expenses incurred in the Benefit Plan Year are less than the amount contributed to the HCFSA or LPFSA for the Benefit Plan Year, the remaining account balance over the carryover amount, as specified in the current MUS *Choices* Enrollment Workbook, will be forfeited. Unused DCFSA (day care) account balances will be forfeited. The Plan allows a run out period for submitting claims after the Benefit Plan Year ends, but the expense(s) **must** have been incurred in the Benefit Plan Year. All claims **must** be received by the FSA Administrator by September 30th following the end of the Benefit Plan Year to be eligible for reimbursement. If an Employee **does not** enroll in an HCFSA or LPFSA for the next Benefit Plan Year and has unused FSA funds that are not expended by June 30th of the prior Benefit Plan Year, the FSA will be closed, and the remaining unused funds will be forfeited.

FSA CARRYOVER: Remaining account balances in an HCFSA or LPFSA, up to and including the carryover amount specified in the current MUS *Choices* Enrollment Workbook, will carryover to the next Benefit Plan Year **only** if an Employee enrolls in an HCFSA or LPFSA for the next Benefit Plan Year. If an HCFSA or LPFSA is not elected for the next Benefit Plan Year, the FSA will be closed, and the remaining unused funds will be forfeited. DCFSA (day care) balances **cannot** be carried over to the next Benefit Plan Year.

H. LEAVE, TERMINATION, AND REHIRE

LEAVE: FSA benefits during a leave of absence may be continued like other Plan benefits through the remainder of the Benefit Plan Year. *(Refer to Section 3 – Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options.)* After applicable sick, vacation, or compensatory time pay is exhausted, contributions **must** be made on a post-tax basis. If benefits lapse, re-enrollment upon return to work will be as follows:

If an Eligible Employee returns to work in the same Benefit Plan Year, prior FSA elections are reinstated and:

1. Coverage is resumed at the original annual amount, and missing contributions are made up by increasing the remaining monthly contributions; or

2 Coverage is resumed at an annual amount reduced by the amount of the missing contributions.

No expenses incurred during the lapsed period of coverage are eligible for reimbursement. The FSA election(s) may only be changed if one (1) of the changes in status *(Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage)* has occurred.

If an Eligible Employee returns to work in a new Benefit Plan Year, the Employee must make new FSA elections.

TERMINATION: An Employee no longer participating in an FSA due to termination of employment, death, termination of the Plan, or other loss of eligibility for benefits may request reimbursement from the remaining balance for qualifying HCFSA or LPFSA expenses incurred through the last day of the month in which termination occurs.

An Employee who terminates employment or otherwise loses eligibility for benefits may continue an HCFSA or LPFSA through COBRA FSA for the remainder of the Benefit Plan Year by paying the total remaining monthly contributions to the HCFSA or LPFSA out of their final paycheck.

An Employee who terminates employment or otherwise loses eligibility for benefits **may not** continue a DCFSA but may request reimbursement from the remaining balance for qualifying Dependent Care (day care) expenses incurred through the last day of the month in which termination occurs.

REHIRE: If a benefits Eligible Employee is rehired within thirteen (13) weeks from their last day of coverage, prior FSA elections are reinstated. The annual FSA election(s) may be reduced by the amount of missing contributions or the amount of missing contributions may be applied to future payroll deductions. Expenses incurred during the lapsed period of coverage are **not** eligible for reimbursement.

FSA election(s) may only be changed if one of the changes in status *(Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage)* has occurred.

If a benefits Eligible Employee is rehired after thirteen (13) weeks from their last day of coverage, the Employee may make new FSA elections, up to the annual maximum election amount as specified in the current MUS *Choices* Enrollment Workbook. Only expenses incurred after re-enrollment are eligible for reimbursement.

I. HIGHLY COMPENSATED AND KEY EMPLOYEES

If an Employee meets the IRS Section 125 definition of a highly compensated or key Employee, the amount of monthly contributions and benefits available may be limited so the Plan does not unfairly favor those who are highly paid, their legal spouses, or their Dependents. Employees who meet this definition will be notified by the Plan Administrator of these limitations if affected.

A copy of the FSA Plan Document (PD) is available on the MUS *Choices* website at choices.mus.edu.

J. ONLINE RESOURCES

FSA related materials are available from the FSA Administrator *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for FSA contact information.)*. These forms and documents include:

1. HCFSA/LPFSA and DCFSA (day care) claim forms.
2. Examples of eligible expenses that qualify for reimbursement under an HCFSA, LPFSA, and DCFSA.
3. Examples of expenses that do not qualify for reimbursement under an HCFSA, LPFSA, and DCFSA.
4. Worksheets to help estimate annual HCFSA/LPFSA and DCFSA (day care) expenses.
5. Answers to frequently asked questions.
6. Instructions for completing and submitting reimbursement claim forms.

K. CLAIMS PROCESSING GUIDELINES

1. Notify your campus HR/Benefits Representative of a change of address.

2. Obtain a claim form from the FSA Administrator.

3. Provide information regarding the expenses for which you wish to be reimbursed on the claim form including date of service, Provider, individual for whom the expenses were incurred, and the amount of Out-of-Pocket expenses. Attach documentation to support the data on the claim form, such as a copy of an EOB from the Claims Administrator.

4. Make a copy of the claim form and all associated documentation for your records.

5. Submit claims to the FSA Administrator *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for FSA contact information.)*

6. Review account balances on the FSA Administrator website. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for FSA contact information.)*

7. The date of service for which reimbursement is being claimed **must** be within the Benefit Plan Year (July 1st – June 30th).

9. All claims **must** be received by the FSA Administrator by September 30th following the end of the Benefit Plan Year to be eligible for reimbursement.

Section 12
GENERAL PROVISIONS

A. RIGHT TO TERMINATE OR CHANGE PLAN PROVISIONS

The MUS in its sole discretion and through authorized agents may, within the limits of contract provisions and requirements for adequate public notice, terminate, amend, rescind, suspend, delay, or otherwise modify some or all benefits or provisions described in the SPD. The discretion includes, but is not limited to, the following:

1. To terminate some or all Medical, Dental, Vision Hardware, Life, AD&D, or LTD Insurance benefits for some or all covered Plan Participants, including Employees, Retirees, COBRA, and/or Eligible Dependents.
2. To alter or postpone the amounts, schedules, or methods of calculation for payment of benefits.
3. To amend or rescind benefit provisions of the Plan.
4. To increase or otherwise change the contributions, fees, or monthly premiums required from units of the MUS and/or the Plan Participant.

B. COMPLIANCE WITH LAW AND REGULATIONS

Any provision of the SPD, which on its Effective Date conflicts with the statutes of Montana or laws and regulations of the U.S., is hereby amended to conform to the minimum requirements of such statutes, regulations, or laws.

C. RIGHT TO MEDICAL RECORDS

The Plan Administrator, Medical Plan Claims Administrator, and Utilization Management at the Medical Plan Claims Administrator will have full access to all medical or other records relating to the diagnosis, treatment, or services provided to the Plan Participant or to other information that is needed to administer provisions of the Plan. Release of such information or records by the Plan Participant will be a condition of receipt of benefits from the Plan. Medical records will be held as confidential by the above parties and, under penalty of law, will not be released or disclosed to unauthorized individuals, except as provided by law.

D. RIGHT TO CONDUCT MEDICAL EXAMINATIONS

The Medical Plan Claims Administrator will, at the Plan's expense, have the right and opportunity to examine through its own medical examiner a Plan Participant whenever Illness or Injury is the basis of a claim. The Medical Plan Claims Administrator may exercise this right as often as may be reasonably required during the time a claim is pending.

E. RIGHT TO MAKE PAYMENTS

The Plan Claims Administrator(s) may make payment to (1) the Plan Participant; (2) the Provider; or (3) the Plan Participant and Provider jointly (lien). A payment made by the Plan Claims Administrator(s) in good faith pursuant to this provision will fully discharge the liability of the Plan to the extent of such payment.

F. RIGHT TO RECOVER PAYMENTS

Whenever payments have been made in error or more than the amount necessary to satisfy the liability of the Plan, the Plan Claims Administrator(s) will have the right to recover some or all excess payments from a Plan Participant to whom such payments have been made.

The Plan can deduct the amount paid from the Plan Participant's future benefits, or from the benefits for a covered Dependent, even if the erroneous payment was not made on that Dependent's behalf.

G. NO OBLIGATION TO PROVIDE BENEFITS IF MEDICAL CARE IS NOT AVAILABLE

The MUS is not obligated to provide benefits or to arrange for the delivery of medical services if Hospital facilities are not available or if medical services are not available due to an epidemic, disaster, or for other reasons beyond the control of the Plan.

H. THE MUS IS NOT LIABLE FOR ACTS, ERRORS, OR OMISSIONS BY HEALTH CARE PROVIDERS

The MUS is not liable for acts of error or omission by a Hospital or health care Provider.

I. COVERAGE EXTENDS TO SERVICES OUTSIDE THE U. S.

The expenses for Covered Services provided outside the U.S. are covered in the same manner as expenses for services provided within the U.S. *(Refer to Section 6 – How to Obtain Benefits.)*

J. BENEFITS WILL BE PROVIDED ON A NON-DISCRIMINATORY BASIS

Plan provisions will be administered without regard to the race, color, religion, creed, sex, national origin, age, handicap, marital status, or political belief of a Plan Participant, except when such factors are reasonably applicable and necessary for medical reasons to be considered when Plan provisions are administered. Plan Participants and/or Providers will be protected from retaliation for reporting or appraising an unlawful discriminating practice.

K. RIGHT TO TERMINATE COVERAGE FOR FALSE CLAIMS

A Plan Participant or Provider who submits bad faith or false claims, misrepresents facts, or attempts to perpetuate a fraud upon the Plan may be subject to criminal charges or a civil action brought by the Plan Administrator or its designee, as permitted under state and federal laws. Additionally, if a Plan Participant has been found to have committed such acts after an informal hearing with the Plan Administrator or its designee, they will immediately become ineligible to remain on the Plan and coverage will be terminated. *(Refer to Section 1 – Eligibility, provision D. – Rescission of Coverage.)*

L. RIGHT TO TERMINATE COVERAGE FOR A PATTERN OF FRIVOLOUS CLAIM APPEALS

A Plan Participant, who evidences a pattern of appealing baseless, frivolous claims that were initially denied, may become terminated from coverage on the Plan. The Plan Administrator or its designee will issue a fifteen (15) day notice to the Plan Participant to cease and desist and abide by the Plan terms or terminated from the Plan. If the Plan Participant continues to insist on appealing matters that are deemed frivolous, the Plan Administrator or its designee may issue a thirty (30) day notice of termination of coverage from the Plan following an informal hearing with the Plan Administrator or its designee. *(Refer to Section 1 – Eligibility, provision D. – Rescission of Coverage.)*

Section 13
COORDINATION OF BENEFITS

A. COORDINATION OF BENEFITS (COB)

The COB provision sets out rules for the order of payment of Covered Expenses when a Plan Participant is covered by two (2) or more plans, including Medicare, so payments from all Plans do not exceed the Allowed Amount. COB limits the benefits that may be received by a Plan Participant covered by more than one (1) plan to no more than the total health care expenses Allowed Amount and divides responsibility for those expenses between the plans. Only the amount paid by the Plan will be applied to the Plan benefit maximums.

Standard COB
The plan that pays first, the primary plan, according to COB rules will apply benefits and pay without taking the existence of another plan or coverage into consideration. The secondary and subsequent plans will pay the balance up to the total Allowed Amount, less any Copayments, Deductibles, Coinsurance, and/or benefit maximums. A secondary plan has benefits determined after those of the primary plan. The exception to this statement is if:

1. The other plan has rules coordinating its benefits with the Plan; and
2. those rules and the Plan's rules require the Plan's benefits be determined before those of the other plan or coverage.

The COB provision applies even if a claim is not filed under the other plan or plans. If needed, authorization is provided to the Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

Plan, for purposes of COB, means the Plan or any of the following plans:

1. Group and individual health insurance plans.
2. Group and individual health insurance coverage through closed panel plans, licensed Health Maintenance Organizations (HMO), or other prepaid plans.
3. The medical care components of long-term health care contracts, such as Skilled Nursing Care. This does not include long-term care coverage for non-medical services, such as respite care, personal care, or Custodial Care.
4. Coverage for students which is sponsored by or provided through a school or other educational institution. This does not include school accident-type coverages that cover students for accidents only (such as athletic Injuries); or
5. Medicare or other governmental benefits, and other coverage required or provided by a statute.

The term "Plan" is construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

COB RULES

1. If a Plan Participant is covered by another plan as defined above, the benefits will be coordinated. One (1) plan will be determined as the primary plan and will pay benefits first. The other plan(s) will be determined as the secondary plan(s).

2. If the claim, as applied to the primary plan, is subject to a contracted or negotiated rate, the Allowed Amount is equal to that contracted or negotiated amount.

3. If the claim, as applied to the primary plan, is not subject to a contracted or negotiated rate, but the claim as applied to the secondary plan is subject to a contracted or negotiated rate, the Allowed Amount is equal to that contracted or negotiated amount of the secondary plan.

4. The secondary plan(s) will limit benefits, so the sum of all benefits paid by the primary plan and by the secondary plan(s) do not exceed 100% of the total contracted or negotiated rate (Allowed Amount), or total billed charge(s) for non-contracted providers.

ORDER OF BENEFIT DETERMINATION

Rules 1 through 5 below apply when there are multiple health insurance plan coverages, with obligations to cover health care expenses for a Plan Participant, regardless of that Plan Participant's coverage status as an Employee, Retiree, or Dependent.

1. **Non-Dependent/Dependent**
   The plan that covers the Plan Participant other than as a Dependent (e.g., as an Employee or Retiree), is primary and the plan that covers the Plan Participant as a Dependent is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.

2. **Dependent Child Covered Under More Than One (1) Plan**

   a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      1) The parents are married.
      2) The parents are not separated (even if they have never been married); or
      3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

b. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

c. If the specific terms of a court decree state that one (1) of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph will not apply with respect to a claim determination period or Benefit Plan Year during which benefits are paid or provided before the entity has actual knowledge.

d. If the parents are not married or are separated (even if they have never been married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parent's spouses' is:
   1) The plan of the custodial parent.
   2) The plan of the spouse of the custodial parent.
   3) The plan of the non-custodial parent.
   4) The plan of the spouse of the non-custodial parent.

e. For a dependent child covered under more than one (1) plan of individuals who are not the parents of the child, the order of benefits shall be determined under subparagraph a or b as if those individuals were parents of the child.

f. For a married dependent child who has coverage under either or both parent's plans, and coverage as a dependent under their spouse's plan, the length of coverage rule in paragraph 3 applies.

g. If a married dependent child's coverage under their spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in paragraph 2.

3. **Longer or Shorter Length of Coverage**
   If the proceeding rules do not determine the order of benefits, the plan that has covered the Plan Participant longer is primary.

   a. To determine the length of time a Plan Participant has been covered under a plan, two (2) plans will be treated as one (1) if the covered Plan Participant was eligible under the second plan within twenty-four (24) hours after the first ended.

   b. The start of a new plan does not include:
      1) A change in the amount or scope of a plan's benefits.
      2) A change in the entity that pays, provides, or administers the plan's benefits; or
      3) A change from one (1) type of plan to another (such as from a single employer plan to that of a multiple-employer plan).

   c. A Plan Participant's length of time covered under a plan is measured from the Plan Participant's first date of coverage under that plan. If that date is not readily available for a group plan, the date the Plan Participant first became a member of the group will be used as the date from which to determine the length of time the Plan Participant's coverage under the present plan has been in force.

4. **No Rules Apply**
   If none of these preceding rules determines the primary plan, the Allowed Amount will be determined equally between the plans.

B. COORDINATION WITH MEDICARE:

Medicare Part A and Medicare Part B will be considered a plan for the purposes of COB. The Plan will coordinate benefits with Medicare even if the Plan Participant is not actually receiving Medicare Benefits.

WORKING AGED: A covered Employee who is eligible for Medicare Part A and Medicare Part B due to age may be covered under the Plan and under Medicare, in which case the Plan will be primary. A covered Employee, eligible for Medicare Part A and Medicare Part B due to age, may choose to waive all MUS Plan coverages.

A covered Dependent, eligible for Medicare Part A and Medicare Part B due to age may also be covered under the Plan and under Medicare, in which case the Plan will be primary. A covered Dependent, eligible for Medicare Part A and Medicare Part B due to age, may elect not to be covered under the Plan. If such an election is made, coverage under the Plan will terminate.

RETIREE: Medicare is primary, and the Plan will be secondary, for the covered Retiree Plan Participant who is eligible for Medicare Part A and Medicare Part B due to age or disability.

Medicare is primary, and the Plan will be secondary, for the covered Retiree's covered Dependent who is eligible for Medicare Part A and Medicare Part B due to age or disability.

Retirees and/or their covered Dependents who are or become Medicare-eligible at retirement or after **must** be enrolled in **BOTH** Medicare Part A and Medicare Part B to remain covered on the Medical and Prescription Drug Plans. *(Refer to Section 3 – Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options, provision I. – Retiree Coverage.)*

MUS Retirees who have Medicare as primary coverage **cannot** cover or continue medical coverage for their legal spouse or Adult Dependent if the legal spouse or Adult Dependent is also a MUS Retiree who has Medicare as primary coverage. Medicare rules prohibit enrollment in more than one (1) Medicare Part D drug plan (dual coverage). MUS Retirees who have Medicare as primary coverage will need to choose to remain on their own MUS Medicare Retiree plan or choose to enroll on their legal spouse's or Adult Dependent's MUS Medicare Retiree plan as a Dependent.

DISABLED PLAN PARTICIPANT: The Plan will be primary, and Medicare will be secondary, for a covered Employee or Employee's covered Dependent who is eligible for Medicare due to disability and for whom Medicare requires the employer plan to be primary.

The Plan will be secondary, and Medicare will be primary, for a covered Retiree or Retiree's covered Dependent who is eligible for Medicare due to disability.

END-STAGE RENAL DISEASE: The Plan will be primary only during the first thirty (30) months of Medicare coverage for Plan Participants for whom Medicare requires the employer plan to be primary if Medicare eligibility is due solely to End-Stage Renal Disease (ESRD). Thereafter, the Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period (as described above):

1. The Plan Participant has no dialysis for a period of twelve (12) consecutive months and then resumes dialysis, at which time the Plan will again become primary for a period of thirty (30) months; or

2. The Plan Participant undergoes a kidney transplant; at which time the Plan will again become primary for a period of thirty (30) months.

If a Plan Participant is covered by Medicare due to disability, and Medicare is primary for that reason on the date the Plan Participant becomes eligible for Medicare due to ESRD, Medicare will continue to be primary, and the Plan will be secondary.

C. COORDINATION WITH MEDICAID

If a Plan Participant is covered by Medicaid, the Plan will be primary, and Medicaid will be secondary.

D. COORDINATION WITH TRICARE/CHAMPVA

If a Plan Participant is entitled to and covered under TRICARE/Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), the Plan will be primary and TRICARE/CHAMPVA will be secondary. TRICARE coverage will include programs established under its authority.

E. COORDINATION WITH VETERANS AFFAIRS BENEFITS

If the Plan Participant is eligible for Medicare and entitled to veterans benefits through the Department of Veterans Affairs (VA), the Plan will be primary, and the VA will be secondary, for non-military service-related medical claims. For these claims, the Plan will make payment to the VA as though the Plan was making payment secondary to Medicare.

Section 14
DEFINITIONS

The Medical Plan definitions in this Section apply to the Plan.

1. **Acupuncture** – Professional services performed by a licensed acupuncturist to treat Illnesses using the insertion of needles at specified sites of the body.

2. **Allowed Amount** – The maximum amount considered for payment for covered treatments, services, or supplies, subject to all Plan Maximum Benefit limitations.

3. **Amplification Device** – A hearing device, hearing aid, or a wearable, non-disposable, non-experimental device, designed to aid or compensate for impaired hearing and any required parts, attachments, or accessories for the instrument or device, including ear molds. **Expenses for hearing aid or Amplification Device batteries/battery packs, cords, power banks, portable chargers, storage cases, travel bags or other similar travel or carrying cases, dehumidifiers, and related supplies are excluded.**

4. **Benefit Plan Year** – The period beginning July 1st and ending June 30th of each year.

5. **Case Management and Case Manager** – Services of a professional Case Manager that involve working with Plan Participants of the Medical Plan, their families, their Physicians, and other Providers to identify the most appropriate, effective, and cost-efficient treatment possible for catastrophic Illnesses and accidents.

   The use of Case Management services is voluntary, offered at no cost to the Plan Participant, and advantageous in several ways. Case management: (1) permits treatment options not normally available under the Plan through Plan exceptions; (2) provides another opinion on the most effective treatment options for a specific diagnosis; and (3) saves both the Plan and Plan Participant money by providing a third party to help identify the lower cost suppliers of medical goods and services, help coordinate services, and facilitate cost reductions.

The Plan strongly recommends all Inpatient care be Pre-Certified by Utilization Management at the Medical Plan Claims Administrator who identifies cases that may benefit from Case Management. *(Refer to Section 6 – How to Obtain Benefits.)*

6. **Chiropractic Services** – Professional services for spinal treatment performed by a licensed chiropractor. Spinal treatment means detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the body for removing nerve interference or its effects where such interferences are the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

7. **Claimant** – The Plan Participant for whom the claim is filed.

8. **Claims Administrator** – An entity employed by the Plan to administer its Medical Plan, Dental Plan, or Vision Hardware Plan, including consulting services to the Plan regarding the operation of the Medical, Dental, or Vision Hardware Plan and other functions, including the processing and payment of claims. The Claims Administrator provides ministerial duties only, exercises no discretion over Plan assets, and will not be considered a fiduciary as defined by any applicable state or federal law or regulation.

9. **Coinsurance** – The percentage of the Allowed Amount for Covered Medical Expenses, which are not specifically exempted from Coinsurance, the Plan Participant is responsible for paying after the Deductible has been met. For the PDP, it is the percentage of Covered Prescription Drug Expenses, which are not specifically exempted from Coinsurance the Plan Participant is responsible to pay.

10. **Copayment** – A fixed dollar amount of Covered Medical Expenses or Covered Prescription Drug Expenses the Plan Participant is responsible for paying.

11. **Cosmetic** – Surgery, procedures, treatment, or other services performed solely to change, enhance, or improve appearance rather than for the restoration of bodily function, including, but not limited to, those surgeries, procedures, treatments, and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological, or mental health conditions.

12. **Covered Prescription Drug Expense** – An expense for drugs and medicines that are Medically Necessary for the treatment of an Injury or Illness, and which require a legal prescription authorized by a Physician or Licensed Health Care Provider, and expenses for other pharmaceutical services specifically listed as covered in Section 9 – *Prescription Drug Plan Description* and not excluded in Section 9 – *Prescription Drug Plan Description*. Expenses for these same drugs and medicines purchased outside the prescription drug card or mail order programs are covered up to the PDP's allowance for the drug or medicine.

13. **Covered Services** – Services for visits, treatments, procedures, or supplies that are:
    a. listed in Section 7 – *Medical Plan Description* or in the current MUS *Choices* Enrollment Workbook Schedule of Benefits and not specified as exclusions in this Section or in the Enrollment Workbook.
    b. Medically Necessary for the diagnosis or treatment of Injury, Illness, maternity, or specified as covered preventive services.
    c. provided to a Plan Participant by a covered Licensed Health Care Provider practicing within the scope of their license; and
    d. provided and coded in accordance with applicable standard medical and insurance practice.

14. **Creditable Coverage** – Health insurance coverage prior to the date of enrollment in the Plan under any of the following:
    a. A group or individual health insurance plan coverage.
    b. Medicare Part A, Part B, or Part C.
    c. Medicaid.
    d. TRICARE/CHAMPVA.

e. A medical care program of the Indian Health Service or a tribal organization.
f. Federal Employee Health Benefits Program.
g. A public health plan, including a plan established by a state, U. S. government, foreign country, or political subdivision of the foregoing.
h. A health benefit plan under the Peace Corps Act.
i. State Children's Health Insurance Program.

15. **Deductible** – A specified dollar amount of Covered Medical Expenses the Plan Participant is responsible to pay, or a covered Dependent is responsible to pay, in a Benefit Plan Year before the Plan will pay for Covered Medical Services during each Benefit Plan Year that are not specifically exempt from Deductible. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for annual Deductible amounts.)*

16. **Dependent or Eligible Dependent** – An individual who meets one (1) or more of the definitions of Eligible Dependent in Section 1 – *Eligibility*, except when the context clearly refers to a Dependent on another health insurance plan as in the COB Section or to Dependents eligible for benefits under an HCFSA, LPFSA, or DCFSA with their own eligibility requirements.

17. **Dependent Child or Eligible Dependent Child** – An individual who meets one (1) or more of the definitions of Eligible Dependent Child in Section 1 – *Eligibility* or who meets the definition of a disabled Dependent Child in Section 1– *Eligibility*, except when the context clearly refers to a Dependent on another health insurance plan as in the COB Section or to Dependents eligible for benefits under an HCFSA, LPFSA, or DCFSA with their own eligibility requirements.

18. **Durable Medical Equipment (DME)** – Durable Medical Equipment that:
    a. Is designed for prolonged use over a period of years.
    b. Serves a specific therapeutic purpose in the treatment of an Injury or Illness.
    c. Is primarily and customarily used to serve a medical purpose.
    d. Is suitable for use at home; and
    e. Is not useful to an individual in the absence of Illness or Injury.

19. **Effective Date** – The date on which a Plan Participant's coverage begins.

20. **Eligible Expense** – An expense that is incurred by a Plan Participant:
    a. for a Covered Service, treatment, or supply.
    b. is within the Allowed Amount for the Covered Service; and
    c. is within benefit maximums and limitations specified for the Covered Service in the SPD or the Schedule of Benefits and meets other requirements of the SPD.

    An Eligible Expense that may be considered for payment by the Plan includes a portion of the Allowed Amount for billed charges that may be applied to the annual Deductible, Coinsurance, Copayment, or used to satisfy the Out-of-Pocket Maximum. However, an Eligible Expense which is not payable by another primary plan due to the Plan Participant's failure to comply with cost containment requirements (e.g., second surgical opinions, preadmission testing, preadmission review of Hospital confinement) will not be considered an Eligible Expense of the Plan as a secondary payer.

21. **Employee or Eligible Employee** – An individual who meets the definition of an Eligible Employee in Section 1 – *Eligibility*, except when the context clearly refers to an Employee or Eligible Employee on another health insurance plan as in the COB Section or an Employee of an organization involved in administering the Plan.

22. **Experimental/Investigational Services** – A drug, device, medical treatment, or procedure that meets any of the following:

a. That **cannot** be lawfully marketed without the approval of the FDA. Further, approval for marketing the drug or device has not been provided at the time the drug or device is furnished.

b. The patient's informed consent document utilized was reviewed and approved by:
   1) The treating facility's Institutional Review Board.
   2) Other body serving a similar function; or
   3) Federal law requires such review or approval.

c. That is under study, prior to or in the absence of a clinical trial to determine its:
   1) Maximum tolerated dose
   2) Toxicity
   3) Safety
   4) Efficacy; or
   5) Efficacy as compared with medically accepted means of treatment or diagnosis.

d. Based upon Reliable Evidence is the subject of an ongoing Phase I or Phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not Experimental or Investigational). The routine patient care costs (conventional care) will be provided by the patient's health plan.

   1) "Routine" patient care costs are items or services that are covered benefits under the patient's health plan whether part of the clinical trial and, in the case of cancer treatment, are listed on the National Comprehensive Cancer Network web site as appropriate for treatment of the condition.
   2) The Health Care Provider managing the clinical trial will provide to the health plan, in advance of incurring expenses, copies of the trial protocol, informed consent and other documents necessary to ascertain routine patient care costs versus costs incurred for patient care generated specifically by the clinical trial. The sponsor of the clinical trial will provide its assessment of what it would deem routine care for review for coverage by the health plan.
   3) The Plan will provide coverage for routine patient care costs incurred for drugs and devices provided to the patient during the clinical trial provided that those drugs or devices have been approved for treatment of the patient's condition by the FDA and to the extent those drugs or devices are not provided or paid for by the sponsor of the clinical trial, or the manufacturer, distributor, or Provider of that drug or device.

e. Based upon Reliable Evidence, the prevailing opinion among experts is that further studies or clinical trials are necessary to determine its:
   1) Maximum tolerated dose
   2) Toxicity
   3) Safety
   4) Efficacy; or
   5) Efficacy as compared with medically accepted means of treatment or diagnosis.

f. Used in a manner outside the scope of use for which it was approved by the FDA, or other applicable regulatory authority. Such authorities include:
   1) U.S. Department of Health and Human Services (HHS)
   2) The Centers for Medicare and Medicaid Services (CMS)
   3) American Dental Association
   4) American Medical Association

"Reliable Evidence" means reports and/or articles published in authoritative medical and scientific literature. This includes:

1. The written protocol or protocols used by a treating facility or the protocol(s) of another facility studying the same drug, device, medical treatment, or procedure.
2. The informed consent document used by the treating facility or by another facility studying the same drug, device, medical treatment, or procedure.

23. **Experimental/Investigational Treatment** – Treatment that would otherwise be considered Experimental/Investigational will be covered if the proposed Experimental/Investigational treatment has been proposed by a Physician, has been reviewed by four (4) unrelated, independent board-certified Physicians actively practicing within the same specialty as the treating Physician, with unanimous agreement amongst the four (4) reviewing Physicians that:

    a. Due to the rarity of the disease or condition, there is no U.S. FDA-approved regimen of treatment.

    b. All U.S. FDA-approved regimens of treatment have been attempted within the twelve (12) month period immediately prior to the date the proposed Experimental treatment is to begin without significant clinical improvement in the patient's disease or condition.

    c. The proposed course of treatment is medically indicated and is considered the standard of care in the U.S. for the disease or condition being treated, based upon published reports and articles in authoritative medical and scientific literature, including, but not limited to, the following:
    1) The written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, treatment, device, or procedure, and
    2) The informed consent documents used by the treating facility or of another facility studying substantially the same drug, treatment, supply, device, or procedure.

    d. To a reasonable degree of medical certainty, there is a likelihood the proposed treatment will clinically improve the disease or condition being treated.

    e. The patient is not considered to be terminal regardless of the treatment proposed or attempted.

    f. The treatment has been recognized by the National Comprehensive Cancer Network (NCCN) as the only available treatment that has demonstrated efficacy for the disease or condition in question.

24. **Fee Schedule** – A Fee Schedule is a listing of fees used by the Plan to reimburse Providers and suppliers for providing select covered health care services. The comprehensive listing of fee maximums is used to reimburse a Provider on a fee-for-service or flat-fee basis.

25. **Flexible Spending Account (FSA)** – A personal reimbursement account into which an Employee enrolled in the Plan may allocate earnings on a pre-tax basis for use in reimbursing eligible Benefit Plan Year expenses. An HCFSA may be used to reimburse eligible health care expenses, an LPFSA or HSA-Compatible FSA may be used to reimburse eligible Dental and Vision expenses, and a DCFSA may be used to reimburse Eligible Expenses for Dependent day care (e.g., day care, preschool, day camps, babysitter). *(Refer to Section 11 – Flexible Spending Accounts.)*

26. **Formulary** – A list of drugs deemed to be appropriate and effective in treating an Illness in a cost-effective manner. The decision to place or remove a drug from the Formulary is made by Physicians and professional pharmacists under contract with the Pharmacy Benefit Manager. As new drugs become available on the market, they are evaluated and often added to the Formulary as other drugs are replaced. A new drug may be non-Formulary when first filled and Formulary at the next refill. Formulary drugs may be removed as generic equivalents become available.

27. **Freestanding Inpatient Facility** – A facility that:
    a. Is licensed or approved as such by the DPHHS or by the appropriate licensing authority in the state where the service is provided.
    b. Has rooms for resident patients.
    c. Is equipped to treat Mental Health or Substance Use Disorders.
    d. Has an RN always on duty.
    e. Has a resident Physician or psychiatrist on duty or on call.

28. **Hearing Loss** – A disruption in the normal hearing process that may occur in the outer, middle, or inner ear, where sound waves are not converted to electrical signals and nerve impulses are not transmitted to the brain to be interpreted. Types of Hearing Loss are conductive, sensorineural, and mixed. Hearing Loss may be mild, moderate, severe, or profound.

29. **Hospital** – An institution which meets the following conditions:
    a. It is engaged primarily in providing medical care and treatment to individuals suffering Illness or Injury on an emergency, Outpatient, or Inpatient basis.
    b. It is licensed as a Hospital or a critical access Hospital, under the laws of the jurisdiction in which the facility is located.
    c. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an Illness or an Injury or provides for the facilities through arrangement or agreement with another Hospital.
    d. It provides treatment by or under the supervision of a Physician with nursing services by RNs as required under the laws of the jurisdiction in which the facility is licensed.
    e. It is a Provider of services under Medicare. This condition is waived for otherwise Covered Medical Expenses incurred outside of the U.S.
    f. It is not, other than incidentally, a place for rest, a place for the aged, a place for substance use addictions, or a nursing home.

30. **Identification Card** – A card issued by the Claims Administrator for each MUS offered benefit plan (Medical Plan, Dental Plan, Vision Hardware Plan, and Prescription Drug Plan) to Plan Participants who have enrolled in that plan. ID Cards contain such information as a unique Subscriber Identification Number, Dependent coverage, and other information required for claims administration.

31. **Illness** – A bodily disorder, disease, physical sickness, Mental Health, Substance Use, or functional nervous disorder.

32. **Injury** – Physical damage to the body, which is not caused by disease or bodily infirmity.

33. **Inpatient or Inpatient Admission** – A Medically Necessary stay (or admission for a stay) of twenty-four (24) consecutive hours or more in a single or multiple departments or parts of a Hospital, Psychiatric Hospital, Freestanding Inpatient Facility, Mental Health Treatment Center, Substance Use Disorder Treatment Center, Skilled Nursing Care Facility, or other facility licensed in the state where the service is provided to provide skilled twenty-four (24) hour medical care. A stay that meets these requirements is Inpatient even if the facility does not bill for daily room and board.

34. **Medical Massage Therapy** – Professional Medical Massage Therapy services performed by a licensed massage therapist. Medical Massage Therapy is the manual manipulation of soft body tissues (muscle, connective tissue, tendons, and ligaments) to enhance a Plan Participant's health and well-being.

35. **Maximum Benefit** – The maximum Medical, Dental, Vision Hardware, and Pharmacy benefit amount payable under the Plan for covered treatment, service, or supply. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for the Maximum Benefit.)*

36. **Medicaid** – The program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.

37. **Medical Emergency** – A severe condition which (in the opinion of the Medical Plan Claims Administrator and/or an independent medical review panel):
    a. Results in symptoms which occur suddenly and unexpectedly; and
    b. Requires the immediate care of a Physician or surgeon to prevent death or serious impairment of the health of the Plan Participant.

38. **Medical Policy** – A policy adopted by the Plan which is created and updated by Physicians and other medical Providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:
    a. Final approval from the appropriate governmental regulatory agencies.
    b. Scientific studies showing conclusive evidence of improved net health outcome; and
    c. In accordance with established standards of good medical practice.

39. **Medically Necessary** – Treatment, tests, services, or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under the Plan, and which **must** meet the following criteria:
    a. For treatment or diagnosis of an Illness or Injury.
    b. Ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury.
    c. Not primarily for the convenience of the Plan Participant, Physician, or other Licensed Health Care Provider.
    d. Uses the standard or level of services most appropriate for good medical practice that can be safely provided to the Plan Participant.
    e. Not of an Experimental/Investigational or solely educational nature.
    f. In accordance with the Plan's Medical Policy.
    g. Not provided primarily for medical or other research.
    h. Does not involve excessive, unnecessary, or repeated tests.
    i. Commonly and customarily recognized by the medical profession as appropriate and generally accepted as the common medical management used in the U.S. for the treatment or diagnosis of the diagnosed condition.
    j. Are approved procedures based upon the medical treatment circumstances or meet required guidelines or protocols of the FDA or CMS.

    The fact that services were recommended or performed by a Physician or other Licensed Heath Care Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary will be made only after a claim for benefits is submitted. The Claims Administrator may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary. The Plan recommends that Plan Participants who have questions concerning proposed, non-emergent Medical and Dental services follow the procedure for Prior Authorization. *(Refer to Section 6 – How to Obtain Benefits.)*

40. **Medicare** – The programs established under the "Health Insurance for the Aged Act", Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended. "Medicare" is used to pay for various Covered Medical Expenses for qualified individuals.

41. **Medicare Benefits** – Benefits for services and supplies which the Plan Participant receives or is eligible for under Medicare, regardless of whether the Plan Participant has applied for or is enrolled in Medicare.

42. **Mental Health Disorder** – A clinically significant behavioral or psychological syndrome or pattern (which is a manifestation of a behavioral, psychological, or biological dysfunction in an individual) that is associated with:
    a. Present distress or a painful symptom.
    b. A disability or impairment in one or more areas of functioning; or
    c. A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

    Mental Health Disorder does not include:
    a. Developmental disorders.
    b. Speech disorders.
    c. Psychoactive Substance Use Disorders.

d. Substance Use Disorder or other addictive behavior.
e. Eating disorders (except for bulimia and anorexia nervosa).

43. **Naturopathic** – Professional services performed by a licensed naturopath to treat disease that employs no surgery or synthetic drugs to assist the natural healing process by using special diets, herbs, and vitamins.

44. **Network (of Providers), Preferred or In-Network** – A group of Covered Providers who have entered into a contract with the Medical Plan or other benefit plan, such as a Vision Hardware Plan (or with an In-Network administrator who has a contract with the Medical or other benefit plan) to provide services to Plan Participants according to contract terms.

45. **Nurse or Registered Nurse** – An individual who is duly licensed as a RN unless specifically identified as a LPN or a Nurse with other licensure.

46. **Occupational Therapy** – The use of purposeful activity with a Plan Participant who is limited by physical Injury or Illness, psychosocial dysfunction, developmental or learning disability, or the aging process to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation provided by a licensed occupational therapist. OT services **must** be ordered by a Physician and may be provided individually, in groups, or through social systems subject to medical review. Specific OT services include, but are not limited to:
    a. Teaching daily living skills.
    b. Developing perceptual motor skills and sensory integrative functioning.
    c. Designing, fabricating, or applying splints or selective adaptive equipment, and training in the use of upper-extremity prosthetics or upper-extremity orthotic devices.
    d. Using specifically designed crafts and exercises to enhance functional performance.
    e. Administering and interpreting tests such as manual muscle and range of motion.

47. **Out-of-Pocket Maximum** – The Out-of-Pocket Maximum is the total amount of Deductible, applicable Coinsurance, and/or Copayments a Plan Participant and/or family **must** pay for Covered Medical Expenses incurred during the Benefit Plan Year. Once the Plan Participant and/or family has satisfied the Out-of-Pocket Maximum, the Plan pays the remaining Covered Medical Expenses of that Benefit Plan Year. Review the current MUS Choices Enrollment Workbook Schedule of Benefits for specific In-Network and Out-of-Network Out-of-Pocket Maximums.

48. **Outpatient** – Medical services provided, or procedures performed in an Outpatient setting without an overnight stay.

49. **Participating Providers** – Covered Providers who have agreed to accept the Plan's Allowed Amount as full compensation and not bill Plan Participants for amounts above the Allowed Amount. Plan Participants of the Plan will still be responsible for applicable Deductible, Coinsurance and Copayment amounts, but not for amounts above the Allowed Amount. Providers may agree to be Participating Providers of the Plan but not In-Network Providers of the same plan due to being part of the Network may involve additional contractual obligations.

50. **Pharmacy Benefit Administrator** – The company retained by the Plan to manage its Prescription Drug Plan.

51. **Physical Therapy** – The treatment of physical dysfunction or injury by physical methods such as the application of modalities, therapeutic exercise, and patient education and training rather than by drugs or surgery provided by a licensed physical therapist. The aim is for preservation, enhancement, or restoration of movement, mobility, and physical function and to return the Plan Participant to the highest level of motor functioning possible.

52. **Physician** – An individual who is:

a. Licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO).
b. Providing services which are Covered Medical Services of the Plan; and
c. Practicing within the scope of their license.

53. **Plan** – The MUS Group Benefits Plan, including all the provisions contained in the SPD, Plan Descriptions of other benefits such as life insurance, and associated contracts with Claims Administrators, Insurance Companies, Utilization Management at the Medical Plan Claims Administrator, the Pharmacy Benefit Administrator and other companies and organizations retained to provide, administer or assist in the administration of the Plan, except when the context is clearly used to refer to another or generic health insurance plan (such as when describing COB) or to a health or other insurance plan. Exceptions are un-capitalized unless designating a specific plan.

54. **Plan Administrator** – The Office of the Commissioner of Higher Education is the Plan Administrator.

55. **Plan Description Amendment** – An amendment to the SPD.

56. **Plan Participant** – An enrolled Employee, Retiree, or individual who has continued coverage under COBRA or other provisions of the Plan and covered Eligible Dependents of these individuals for which Plan coverage has commenced and not terminated.

57. **Pre-Certification** – A process *(Refer to Section 6 – How to Obtain Benefits.)* for contacting Utilization Management at the Medical Plan Claims Administrator for the Plan prior to an Inpatient Admission for a non-emergency Illness or Injury for a preadmission certification review. Pre-Certification and post-admission notifications of an emergency admission are designed to:
    a. Optimize efficient resource utilization.
    b. Ensure that patients have equitable access to care.
    c. Foster collaboration and communication among all members of the healthcare team to enhance Medically Necessary care in a cost-effective manner.
    d. Assist in identifying possible ways to reduce Out-of-Pocket expenses.
    e. Help avoid reductions in benefits which may occur if the services are not Medically Necessary, or the setting is not appropriate; and
    f. If appropriate, refer a Case Manager to provide Case Management services.

58. **Prior Authorize (Prior Authorization)** – A process *(Refer to Section 6 – How to Obtain Benefits)* for contacting Utilization Management at the Medical Plan Claims Administrator to determine whether a planned procedure or service meets criteria for benefits under the Plan. Prior Authorization is recommended for many Covered Medical Services and required to receive benefits for services *(Refer to Section 6 – How to Obtain Benefits.)* and in the descriptions of the applicable services.

59. **Provider or Licensed Health Care Provider** – An individual who is:
    a. Duly licensed or certified by an applicable government regulatory authority and practicing in the area in which services are rendered.
    b. Providing services which are Covered Medical Services of the Plan; and
    c. Practicing within the scope of their license.

60. **Psychiatric Hospital** – A licensed Hospital which, for compensation from or on behalf of its patients, provides therapeutic facilities for medical/psychiatric diagnosis, treatment and care of individuals with psychiatric disorders or Mental Illness by or under the supervision of a staff of duly licensed Physicians/psychiatrists that continually provides nursing services for twenty-four (24) hours per day by or under the supervision of registered graduate Nurses and which is not primarily a nursing home or place of rest for the aged, or for the treatment of pulmonary tuberculosis.

61. **Qualified Beneficiary** – An Employee, former Employee, or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA, Section 609(a) of Employee Retirement Income Security Act (ERISA) in relation

to QMCSO's, and Section 4 – *Continuation of Coverage Rights Under COBRA* of the SPD. A Qualified Beneficiary also includes a child born to, adopted (prior to age 18) by, or placed for adoption (prior to age 18) with, an Employee or former Employee during the Employee's or former Employee's COBRA Continuation of Coverage.

62. **Qualified Medical Child Support Order** (QMCSO) – A state or court judgment, decree, or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under state law and which has the same force and effect of law under applicable state law and:
    a. Provides child medical support for a child of an Employee or covered legal spouse under the Plan.
    b. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under the Plan; and
    c. Is made pursuant to a law relating to medical child support as described in Section 1908 of the Social Security Act.

63. **Rescission** – A cancellation or discontinuance of coverage that has a retroactive effect.

64. **Residential Treatment Center** – A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with twenty-four (24) hour medical availability and on-site nursing care and supervision for at least one (1) shift a day with on-call available for other shifts for patients with Mental Illness and/or Substance Use Disorder. The MUS Plan requires that any Mental Health and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located and/or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

65. **Retiree and Eligible Retiree** – A Retiree is a former Employee who is retiring or has retired from the MUS. An Eligible Retiree is a Retiree who meets the requirements *(Refer to Section 3 – Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options)* to continue certain Plan benefits provided by the MUS for Eligible Retirees.

66. **Skilled Nursing Care** – Confinement in a Skilled Nursing Care Facility:
    a. Upon the specific recommendation and under the general supervision of a legally qualified Physician or surgeon; and
    b. To receive medical care necessary for convalescence from the condition(s) causing or contributing to a precedent Hospital confinement.

67. **Skilled Nursing Care Facility (Extended Care Facility/Unit or Transitional Care Unit)** – An institution, or distinct part thereof, which meets the following conditions:
    a. Is licensed as a long-term care facility or Skilled Nursing Facility in the state in which the facility is located.
    b. Is not, other than incidentally, a place for rest, the aged, substance use addictions, individuals with intellectual disabilities, Custodial or educational Care, or care of Mental Health disorders; and
    c. Is certified by Medicare. This condition is waived for otherwise Covered Medical Expenses incurred outside of the U.S.

68. **Speech Therapy** – Training to help a Plan Participant with speech and language problems to speak more clearly. Treatment includes assessment of communication problems, speech disorders, voice, language, communication, and swallowing provided by a licensed speech therapist. Treatment may include physical exercises to strengthen the muscles used in speech (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

69. **Subscriber** – A Plan Participant whose eligibility for Plan coverage is based on their direct relationship to the MUS (Employee or Retiree) rather than on Dependent status, or a Plan Participant who was covered as a Dependent but continues coverage in their own name under surviving legal spouse or Adult Dependent, surviving Dependent or COBRA provisions of the Plan. The Subscriber is the Plan Participant whose name administrative records are kept and who is named as the ID Card holder.

70. **Substance Use Disorder** – Substance Use Disorder (SUD) is a mental health disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances, such as legal or illegal drugs, alcohol, tobacco, or medications, to the point the person's ability to function in day-to-day life becomes impaired. Symptoms can range from moderate to severe, with addiction being the most severe form of SUD.

71. **Utilization Management** – A program designed to assure that Plan Participants receive the most effective and appropriate medical services and to reduce waste. The program involves Pre-Certification (defined above) of planned Inpatient Admissions be obtained prior to Admission, post-review of emergency or other Inpatient Admissions be obtained after the fact, continued stay review and Case Management (defined above). All Utilization Management services are described in Section 6 – *How to Obtain Benefits* and, except for Case Management, are provided by Utilization Management at the Medical Plan Claims Administrator defined below.

72. **Utilization Management Administrator** – The company retained by the Plan to administer its Utilization Management program for the Plan.