

choices



Active Benefits

2021 - 2022
Montana University System

MUS Annual Enrollment – April 26, 2021 - May 14, 2021

Please Read

- Visit the MUS **Choices** website home page at www.choices.mus.edu and click on the **Benefits Enrollment** button to make your 2021-2022 benefit elections in the Benefitsolver online enrollment system.
- If you do not complete the online annual enrollment process between **April 26, 2021 – May 14, 2021**, you and your dependents will automatically be re-enrolled in your current benefit plan(s) and coverage levels.
- To add an eligible dependent child not currently on your plan during annual enrollment you **must** make an active election.
- You **must** complete the online annual enrollment process if you wish to re-elect:
 - Healthcare Flexible Spending Account
 - Dependent Care Flexible Spending Account

Questions?

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

Employee Annual Benefits Presentation

Live, interactive webcast: Thursday, April 22, 2021, at 10:00 a.m.

Access from the MUS **Choices** website home page at www.choices.mus.edu

On-Demand Benefits Presentation

Available on April 28, 2021 at www.choices.mus.edu

Montana University System Benefit Plan

www.choices.mus.edu

1-877-501-1722

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

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Ruby River, MT



Rounding Cattle foothills, MT

Choices Enrollment for an Employee

This workbook is your guide to **Choices** – The Montana University System’s employee benefits program that lets you match your benefits to your individual and family situation. To get the most out of this opportunity to design your own benefits package, you need to consider your benefit needs, compare them to the options available under **Choices**, and enroll for the benefits you have chosen. Please read the information in this workbook carefully. If you have any questions, contact your campus Human Resources/Benefits Office (inside cover). This enrollment workbook is not a guarantee of benefits. Consult your enrollment workbook or Summary Plan Description (see page 34 for availability).



Glacier National Park, MT

Who’s Eligible

1. Permanent faculty or professional staff members regularly scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of more than six months in a 12-month period.
2. Temporary faculty or professional staff members scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of more than six months in a 12-month period, or who do so regardless of schedule.
3. Seasonal faculty or professional staff members regularly scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of more than six months in a 12-month period, or who do so regardless of schedule.
4. Academic or professional employees with an individual contract under the authority of the Board of Regents which provides for eligibility under one of the above requirements.

Note: Student employees who occupy positions designated as student positions by a campus are not eligible to join the MUS Group Benefits Plan.

Waiver of Coverage:

You have the option to waive benefits coverage with the Montana University System Group Benefits Plan. To waive coverage, you must actively elect to waive coverage in the online enrollment system by your enrollment deadline, verifying you are waiving coverage. If you do not actively elect to waive coverage, coverages will continue (existing employees) or you will be defaulted into coverage (new employees) as outlined below. The cost of default coverage will be within the employer contribution amount. Please note, there is no continuing or default coverage for Flexible Spending Accounts (FSAs), as these accounts must be actively elected each benefit plan year.

Waiver of Coverage:

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

- You waive coverage for yourself and for all eligible dependents.
- You waive all mandatory and optional **Choices** coverages, including Medical, Dental, Vision Hardware, Life/Accidental Death and Dismemberment (AD&D), Long Term Disability (LTD), and Flexible Spending Accounts.
- You forfeit the monthly employer contribution toward benefits coverage.
- You and your eligible children cannot re-enroll unless and until you have a qualifying event or until the next annual enrollment period.
- Your legal spouse cannot be added to the Plan unless and until they have a qualifying event.

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

- Employee Only – Medical Plan
- Employee Only – Basic Dental Plan
- Basic Life/AD&D – Option 1 (\$15,000)
- Long Term Disability – Option 1 (60% of pay/180-day waiting period)

Enrolling family members

Enrollment for FY2022 is Closed Enrollment for legal spouses unless there is a qualifying event (see page 3 for qualifying events). Eligible children under the age of 26 may be added during the annual enrollment period or if there is a qualifying event.

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

Eligible family members include your:

- **Legal spouse:** Legally married or certified common-law married spouses, as defined under Montana law, will be eligible for enrollment as a dependent on the MUS Plan. Only legally married or common-law spouses with a certified affidavit of common-law marriage will be eligible for enrollment on the Plan during the employee's initial enrollment period or within 63 days of a qualifying event.
- **Eligible dependent children under age 26*:** Children include your natural children, step-children, and children placed in your home for adoption before age 18 or for whom you have court-ordered custody or legal guardianship.

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

How to Enroll

1. New benefits eligible employees have the option of enrolling themselves and any eligible dependents, or waiving all coverages, during a 30-day initial enrollment period, that begins the day following the date of hire or the date of benefits eligibility under the Plan.
2. Employees may make benefit changes from among the benefit plan options during annual enrollment each benefit plan year or within 63 days of a qualifying event (see page 3 for qualifying events) based on Plan rules.

How to Enroll Cont.

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

Mandatory (must choose):

- Medical Plan pg 6
- Prescription Drug Plan (included in Medical) pg 15
- Dental Plan pg 17
- Basic Life and AD&D Insurance pg 23
- Long Term Disability pg 23

Optional (voluntary):

- Vision Hardware Plan pg 24
- Flexible Spending Accounts pg 28
- Optional Supplemental Life Insurance pg 30-31
- Optional Supplemental AD&D Insurance pg 32-33

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

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

If the benefits you choose cost . . .

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

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

Qualifying Events

- Marriage
- Birth of a child
- Adoption of a child

Loss of eligibility for other health insurance coverage - **voluntarily canceling other health insurance does not constitute loss of eligibility.**

Documentation to support the change will be required.

Qualifying events may allow limited benefit changes.

Questions? If you have questions about the enrollment process or enrolling in the Benefitsolver online benefits enrollment system, please contact your campus Human Resources/Benefits Office directly (page 39).

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



Complete your Montana University System benefits enrollment today!

LOG IN

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

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

GET STARTED

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

MAKE YOUR ELECTIONS

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

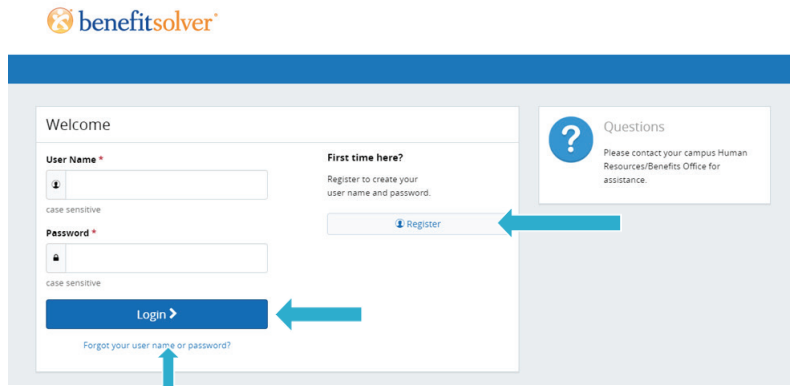
Select plan(s) and what dependent(s) you would like to cover.

Track your benefit elections and costs on each page.

REVIEW AND CONFIRM

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

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



Need to reset your User Name or Password?

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

1. About You ▾ 2. Election Information ▾ 3. Review

Total Employee Cost
\$0.00/Bi-Weekly (24 deductions)
\$153.00 Credit Remaining

Review Your Election

Enrolled in Medical?	Yes	Edit
Covered Members		Edit
Members		Covered
Effective Date:	02/13/2021	Yes
Plan Selected		Edit
Plan Selected	Blue Cross Blue Shield	
Employee Cost		\$374.00
		Bi-Weekly (24 deductions)
Your Cost		
Total Premium		\$374.00
Total cost of all plan premiums		Bi-Weekly (24 deductions)
Credit Used		-\$374.00
Credit Remaining: \$153.00		Bi-Weekly (24 deductions)
Total Cost		\$0.00
		Bi-Weekly (24 deductions)

*Total employee cost represents the total approved cost of benefits included on the summary. Other benefits not displayed are not included.

The information submitted may be subject to further review and/or approval. The deduction amounts are based on rates and calculations stored in the Benefitsolver system at the time of elections. To verify actual elections and/or deduction amounts, please contact your benefits administrator.

Employer remains responsible for any and all loss or damages, and in no event shall Businessolver be liable for any amount, including, but not limited to, insurance premiums, stop-loss deductibles, reinsurance fees, health plan or other claims, cancellation or reinstatement fees, or penalties, for a failure to pay a carrier/vendor or for failure to provide appropriate billing information in a timely manner, unless such delay is caused by the negligent acts of Businessolver.

Every effort has been made to report information accurately, but the possibility of error exists. In case of any conflict between your benefits election confirmation and an official plan document, the plan document will be the final authority. Please note, some insurance coverage elections only become effective upon approval of your evidence of insurability (EOI) by the carrier.

Confirmation **Back** **Approve**

Thank you for completing your new hire enrollment!

After you click "I Agree" please do not forget to upload any necessary documentation required for verifying your dependents, and if you made any life insurance election that require evidence of insurability, please do not forget to click on the link to Standard Life Insurance in the following screens.

Please note: By selecting "Agree" you have confirmed your benefit elections for the current plan year of July 1st through June 30th. This is an irrevocable election and you will not be able to make any benefit changes until Annual Enrollment or you experience a Qualifying Life Event.

By selecting "I Disagree" your changes will not be submitted.

*Total employee cost represents the total approved cost of benefits included on the summary. Other benefits not displayed are not included.

The information submitted may be subject to further review and/or approval. The deduction amounts are based on rates and calculations stored in the Benefitsolver system at the time of elections. To verify actual elections and/or deduction amounts, please contact your benefits administrator.

I Disagree Total Employee Cost: **\$0.00** **I Agree**

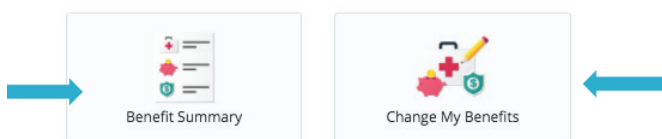
FINALIZE

When your enrollment is complete, you will receive a confirmation number and you can also [Print Benefit Summary](#).

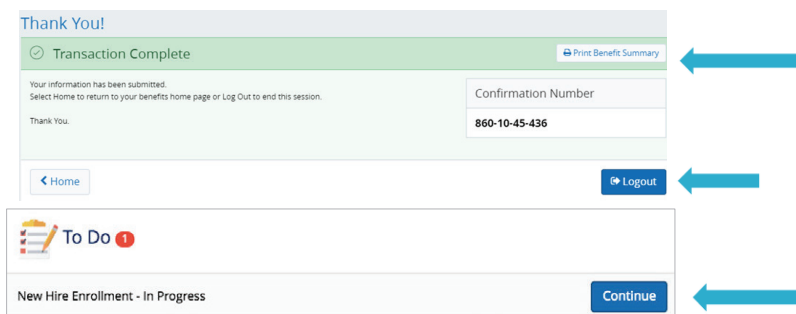
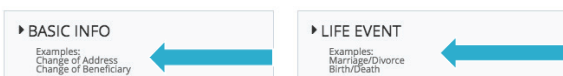
Your **To Do** list will notify you if you have any additional actions needed to complete your enrollment.

REVIEW YOUR BENEFITS

You have 24/7 access to your benefit summary that shows your benefit elections. Click [Benefit Summary](#) on the Home page to review your current benefits at any time.



Select the reason for change that applies and enter the date of the event.



CHANGE YOUR BENEFITS

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

1. Click on [Change My Benefits](#).
2. Select [Life Event](#) and the event type.
3. Review your options and follow the election steps previously outlined to complete your changes.

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

FIND BENEFIT INFORMATION

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

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

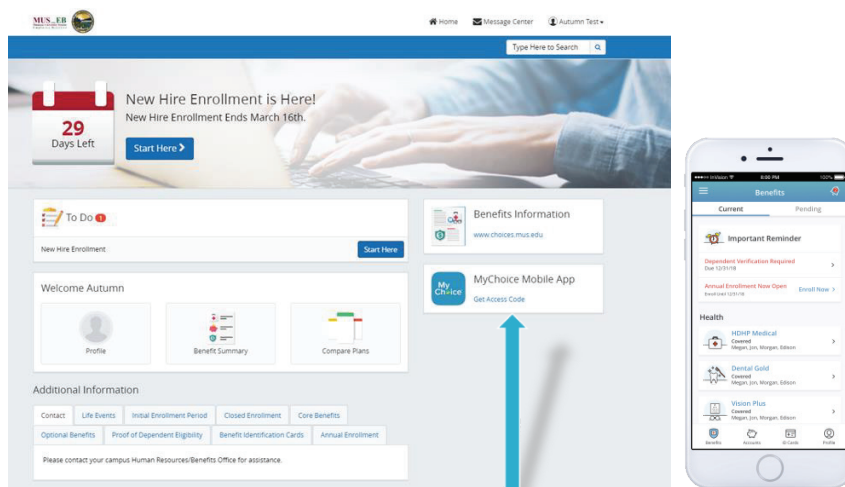
CHANGE YOUR BENEFICIARY(IES)

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

1. Click on [Change My Benefits](#)
2. Select [Basic Info](#) and [Change of Beneficiary](#).
3. Follow the prompts to complete your change.

Download the MyChoiceSM Mobile App

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



How the *Choices* Medical Plan Works

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

If the provider is **Out-of-Network**, the member must verify if the provider will submit the claim or if the member must submit the claim. The Medical Plan claim's administrator processes the claim and sends an EOB to the member showing the member's payment responsibilities (deductible, coinsurance, and any difference between the billed charge and the allowed amount (balance billing)).

Definition of Terms

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

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

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

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

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

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

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

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



IMPORTANT

Verify the network status of your providers. This is an integral cost savings component of each of your plan choices.

Medical Plan (*mandatory*)

FY2022



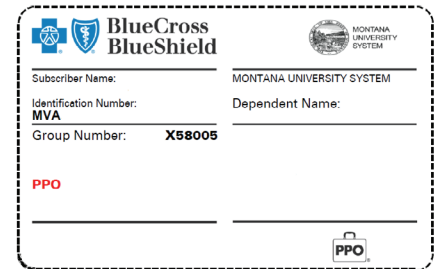
An Independent Licensee of the Blue Cross and Blue Shield Association

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

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

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

Sample Medical card



The employer contribution for FY2022 is \$1,054 per month for eligible active employees (applies to pre-tax benefits only).

Medical Plan Costs

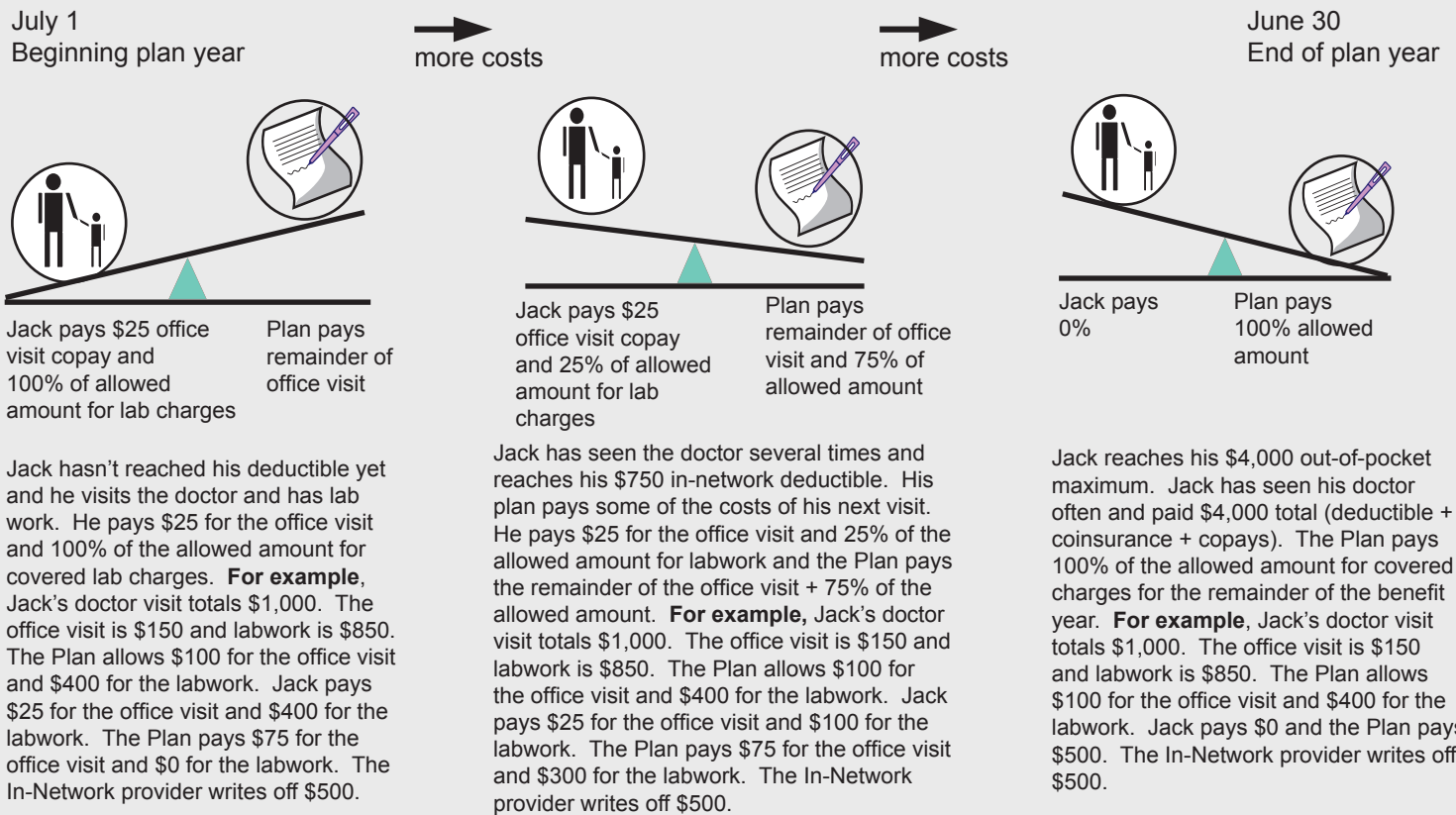
FY2022

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

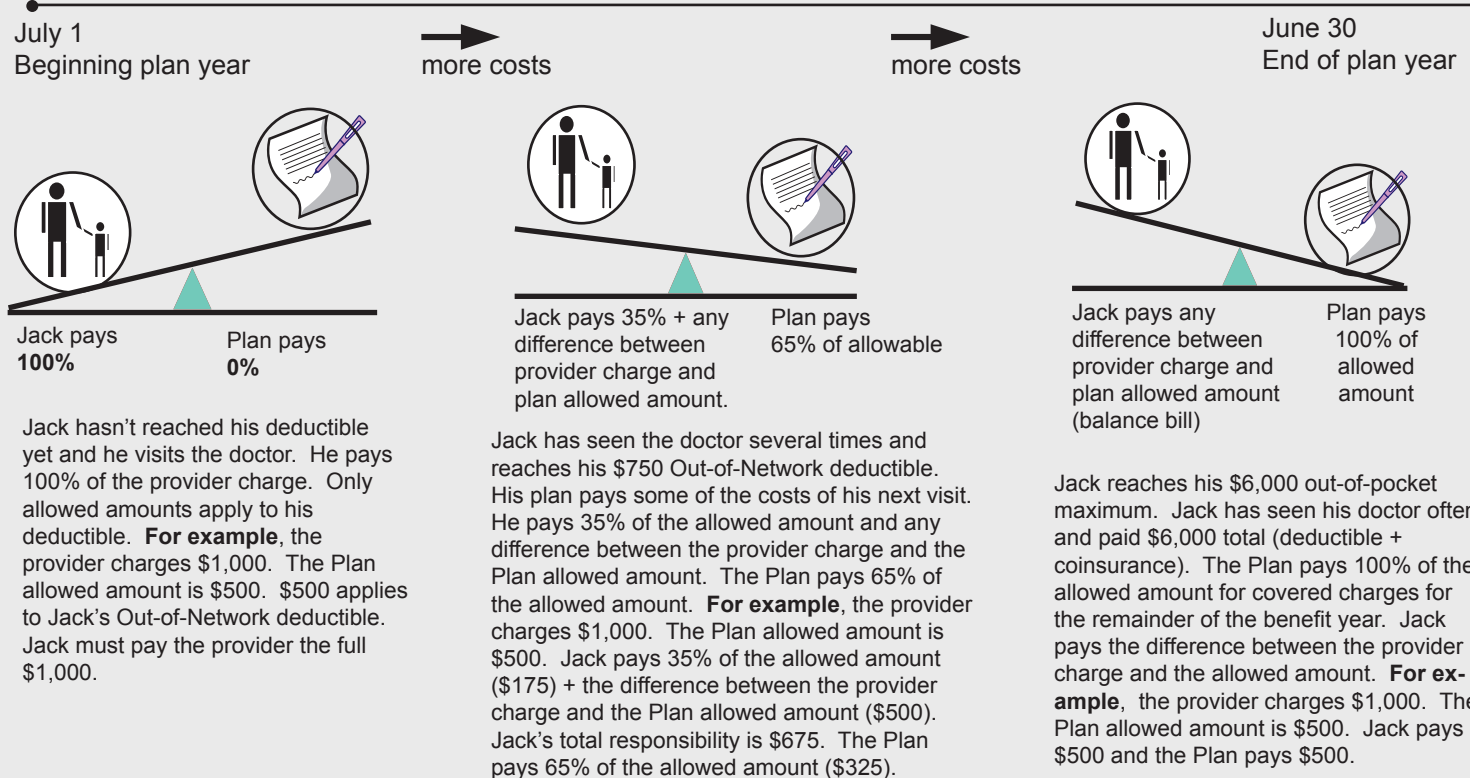
* Services from an Out-of-Network provider have separate deductibles, % coinsurance, and Out-of-Pocket maximums. An Out-of-Network provider can balance bill the difference between the allowed amount and the billed charge.

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

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



(Out-of-Network) Jack's Plan deductible is \$750, his coinsurance is 35%, and his out-of-pocket max is \$6,000.



<i>Medical Plan Services</i>	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Hospital Inpatient Services Pre-Certification of non-emergency inpatient hospitalization is strongly recommended		
Room and Board Charges	25%	35%
Ancillary Services	25%	35%
Surgical Services (See Summary Plan Description for surgeries requiring prior authorization)	25%	35%
Hospital Outpatient Services		
Outpatient Services	25%	35%
Outpatient Surgi-Center Services	25%	35%
Physician/Professional Provider Services (not listed elsewhere)		
Primary Care Physician (PCP) Office Visit - Includes Telemedicine and Naturopathic visits	\$25 copay/visit for office visit only - lab, x-ray & other procedures are subject to deductible/coinsurance	35% Note: There is no network for Naturopaths, so they are treated as In-Network, however, the member may be balance billed the difference between the allowed amount and the provider billed charge.
Specialty Provider Office Visit - Includes Telemedicine visits	\$40 copay/visit for office visit only - lab, x-ray & other procedures are subject to deductible/coinsurance	35%
Inpatient/Outpatient Physician Services	25%	35%
Lab/Ancillary/Misc. Charges	25%	35%
Eye Exam (preventive or medical)	0% one/yr	35% one/yr
Second Surgical Opinion	0%/visit for office visit only - lab, x-ray & other procedures are subject to deductible/coinsurance	35%
Emergency Services		
Ambulance Services for Medical Emergency	\$200 copay/transport	\$200 copay/transport
Emergency Room Charges	\$250 copay/visit for room charges only - lab, x-ray & other procedures are subject to deductible/coinsurance (waived if immediately admitted to hospital)	\$250 copay/visit for room charges only - lab, x-ray & other procedures are subject to deductible/coinsurance (waived if immediately admitted to hospital)
Professional Provider Services	25%	25%
Urgent Care Services		
Facility/Professional Services	\$75 copay/visit for room charges only - lab, x-ray & other procedures are subject to deductible/coinsurance	\$75 copay/visit for room charges only - lab, x-ray & other procedures are subject to deductible/coinsurance
Lab & Diagnostic Services	25%	25%

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

Schedule of Medical Benefits

FY2022

<i>Medical Plan Services</i>	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Maternity Services		
Hospital Services	25%	35%
Physician Services (delivery & inpatient)	25% (waived if enrolled in WellBaby Program within first trimester)	35%
Prenatal Office Visit	\$25 copay/visit (waived if enrolled in WellBaby Program within first trimester)	35%
Preventive Services		
Preventive screenings/immunizations (adult & Well-Child care) Refer to pgs 13 & 14 for listing of Preventive Services covered at 100% of the allowed amount and for age recommendations	0% (limited to services listed on pgs 13 & 14. Other preventive services subject to deductible and coinsurance)	35%
Mental Health/Chemical Dependency Services		
Inpatient Services (Pre-Certification is recommended)	25%	35%
Outpatient Visit (this is a combined max of 4 visits at \$0 copay for mental health and chemical dependency services) -Includes Telemedicine Visits	First 4 visits \$0 copay, then \$25 copay/visit	35%
Psychiatrist Visit -Includes Telemedicine visits	\$40 copay/visit	35%
Rehabilitative Services Physical, Occupational, Speech, Cardiac, Respiratory, Pulmonary, and Massage Therapy, Acupuncture and Chiropractic		
Inpatient Services (Pre-Certification is recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr
Outpatient Services (this is a combined max of 60 visits for all outpatient rehabilitative services) - Includes Telemedicine visits	\$25 copay/visit Max: 60 visits/yr	35% Max: 60 visits/yr Note: There is no network for Acupuncture & Massage Therapy, so they are treated as In-Network, however, the member may be balance billed the difference between the allowed amount and the provider billed charge.

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

<i>Medical Plan Services</i>	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Extended Care Services		
Home Health Care Visit (Prior Authorization is recommended)	\$25 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr
Hospice Services	25% Max: 6 months	35% Max: 6 months
Skilled Nursing Facility Services (Prior Authorization is recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr
Miscellaneous Services		
Allergy Shots	\$40 copay/visit Office visit only. If no office visit, deductible & coinsurance waived	35%
Durable Medical Equipment, Prosthetic Appliances & Orthotics (Prior Authorization is required for amounts greater than \$2,500)	25% Max: \$200 for foot orthotics	35% Max: \$200 for foot orthotics

Reminder:

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

Schedule of Medical Benefits FY2022

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

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

Preventive Services



1. What Services are Preventive

The MUS Medical Plan provides preventive care coverage that complies with the federal health care reform law, the Patient Protection and Affordable Care Act (PPACA). Services designated as preventive care include:

- periodic wellness visits,
- certain designated screenings for symptom free or disease-free individuals, and
- designated routine immunizations.

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

The PPACA has used specific resources to identify the preventive services that require coverage: U.S. Preventive Services Task Force (USPSTF) A and B recommendations and the Advisory Committee on Immunization Practices (ACIP) recommendations adopted by the Center for Disease Control (CDC). Guidelines for preventive care for infants, children, and adolescents, supported by the Health Resources and Services Administration (HRSA), come from two sources: Bright Futures Recommendations for Pediatric Health Care and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

U.S. Preventive Services Task Force: www.uspreventiveservicestaskforce.org
Advisory Committee on Immunization Practices (ACIP): www.cdc.gov/vaccines/acip/
CDC: www.cdc.gov
Bright Futures: www.brightfutures.org
Secretary Advisory Committee: www.hrsa.gov/about/organization/committees.html

2. Important Tips

1. Accurate coding for preventive services by your health care provider is the key to accurate reimbursement by your health care plan. All standard correct medical coding practices should be observed.

2. Also of importance is the difference between a “screening” test and a diagnostic, monitoring, or surveillance test. A “screening” test done on an asymptomatic person **is** a preventive service and is considered preventive even if the test results are positive for disease, but future tests would be considered diagnostic, for monitoring the disease or the risk factors for the disease. A test done because

symptoms of disease are present **is not** a preventive screening and is considered diagnostic.

3. Ancillary services directly associated with a “screening” colonoscopy are also considered preventive services. Therefore, the evaluation office visit with the doctor performing the colonoscopy, the colonoscopy procedure, the ambulatory facility fee, anesthesiology (if necessary), and pathology will be reimbursed as preventive, provided they are submitted with accurate preventive coding.

See next page for listing of covered Preventive Services.

Covered Preventive Services

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

Covered Preventive Services	
Periodic Exams Appropriate screening tests per Bright Futures and other sources (previous page)	
Well-Child Care Infant through age 17	<ul style="list-style-type: none"> Age 0 months through 4 yrs (up to 14 visits) Age 5 yrs through 17 yrs (1 visit per benefit plan year)
Adult Routine Exam Exams may include screening/counseling and/or risk factor reduction interventions for depression, obesity, tobacco use/abuse, drug and/or alcohol use/abuse	<ul style="list-style-type: none"> Age 18 yrs through 65+ (1 visit per benefit plan year)
Preventive Screenings	
Anemia Screening	<ul style="list-style-type: none"> Pregnant Women
Bacteriuria Screening	<ul style="list-style-type: none"> Pregnant Women
Breast Cancer Screening (mammography)	<ul style="list-style-type: none"> Women age 40+ (1 per benefit plan year)
Cervical Cancer Screening (PAP)	<ul style="list-style-type: none"> Women age 21 - 65 (1 per benefit plan year)
Cholesterol Screening	<ul style="list-style-type: none"> Men age 35+ (age 20 - 35 if risk factors for coronary heart disease are present) Women age 45+ (age 20 - 45 if risk factors for coronary heart disease are present)
Colorectal Cancer Screening age 50 - 75	<ul style="list-style-type: none"> Fecal occult blood testing; 1 per benefit plan year OR Sigmoidoscopy; every 5 yrs OR Colonoscopy; every 10 yrs
Prostate Cancer Screening (PSA) age 50+	<ul style="list-style-type: none"> 1 per benefit plan year (age 40+ with risk factors)
Osteoporosis Screening	<ul style="list-style-type: none"> Post-menopausal women age 65+, or age 60+ with risk factors (1 bone density x-ray (DXA))
Abdominal Aneurysm Screening	<ul style="list-style-type: none"> Men age 65 - 75 who have ever smoked (1 screening by ultrasound per benefit plan year)
Diabetes Screening	<ul style="list-style-type: none"> Adults with high blood pressure
HIV Screening	<ul style="list-style-type: none"> Pregnant women and others at risk
RH Incompatibility Screening	<ul style="list-style-type: none"> Pregnant women
Routine Immunizations	
Diphtheria, tetanus, pertussis (DTaP) (Tdap)(TD), Haemophilus influenza (HIB), Hepatitis A & B, Human Papillomavirus (HPV), Influenza, Measles, Mumps, Rubella (MMR), Meningococcal, Pneumococcal (pneumonia), Poliovirus, Rotavirus, Varicella (smallpox), Zoster (shingles)	
Influenza and Zoster (Shingles) vaccinations are reimbursed at 100% via the Navitus Pharmacy benefit.	
For recommended immunization schedules for all ages, visit the CDC website at www.cdc.gov/vaccines/index.html	

Prescription Drug Plan

(Included in Medical Plan)



Your prescription drug coverage is managed by Navitus Health Solutions.

Who is eligible?

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

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

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

Sample Pharmacy Card



How do I fill my prescriptions?

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

Retail Pharmacy Network

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

Mail Order Pharmacies

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

Specialty Pharmacy

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

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



Prescription Drug Plan

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

Questions?

Navitus Customer Care

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

Secure Member Portal

member Portal: www.navitus.com

Specialty Pharmacy

Lumicera Health Services

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

Costco

1-800-607-6861
or go to www.costco.com/Pharmacy/home-delivery
Monday - Friday 5 a.m. to 7 p.m. PST

Ridgeway:

1-800-630-3214
or go to
www.ridgewayretailpharmacy.com/
Monday -Thursday 9 a.m. to 5 p.m.
MST

miRx:

1-866-894-1496
or go to www.mirxpharmacy.com

Dental Plan (mandatory)



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

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

Dental Plan Coverage		
	Basic Plan - Preventive Coverage	Select Plan - Enhanced Coverage
Monthly Dental Plan Rates	<ul style="list-style-type: none"> Employee/Survivor Only \$18 Employee & Spouse \$34 Employee/Survivor & Child(ren) \$34 Employee & Family \$49 	<ul style="list-style-type: none"> Employee/Survivor Only \$43 Employee & Spouse \$82 Employee/Survivor & Child(ren) \$82 Employee & Family \$116
Maximum Annual Benefit	\$750 per covered individual	\$2,000 per covered individual
Diagnostic & Preventive Services	Twice per benefit plan year: <ul style="list-style-type: none"> Initial and periodic oral exam Cleaning Complete series of intraoral X-rays 	Twice per benefit plan year: <ul style="list-style-type: none"> Initial and periodic oral exam Cleaning Complete series of intraoral X-rays <p>Note: The above services <u>do not</u> count towards the \$2,000 annual maximum (see below).</p>
Basic Restorative Services	<ul style="list-style-type: none"> Not covered 	<ul style="list-style-type: none"> Amalgam filling Endodontic treatment Periodontic treatment Oral surgery Removal of impacted teeth
Major Dental Services	<ul style="list-style-type: none"> Not covered 	<ul style="list-style-type: none"> Crown Root canal Complete lower and upper denture Dental implant Occlusal guards
Orthodontia Services	<ul style="list-style-type: none"> Not covered 	<ul style="list-style-type: none"> Available to all Select Plan covered members. \$1,500 lifetime benefit/individual

Select Plan Benefit Highlights:

Diagnostic & Preventive Services

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

Orthodontic Benefits: The **Choices Select Plan** allows a \$1,500 lifetime orthodontic benefit per covered individual. Benefits are paid at 50% of the allowed amount for authorized services. Treatment plans usually include an initial down payment and ongoing monthly fees. If an initial down payment is required, **Choices** will pay up to 50% of the initial payment, up to 1/3 of the total treatment charge. In addition, Delta Dental (the Dental Plan claims administrator) will establish a monthly reimbursement based on your provider's monthly fee and your prescribed treatment plan.

Sample Dental Card



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

Dental Fee Schedule

Dental claims are reimbursed based on a dental fee schedule. The following subsets of the **Select Plan** and **Basic Plan** fee schedules include the most common used procedure codes. Please note the **Basic Plan** provides coverage for a limited range of services, including diagnostic and preventive treatment.

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

The CDT codes and nomenclature are copyright of the American Dental Association. The procedures described and maximum allowances indicated on this table are subject to the terms of the MUS-Delta Dental contract and Delta Dental processing policies. These allowances may be further reduced due to maximums, limitations, and exclusions. Please refer to the SPD for complete benefit and fee schedule information (see pg. 34 for availability).

Procedure Code	Description	Fee Schedule
D0120	Periodic oral evaluation – established patient	\$44.00
D0140	Limited oral evaluation – problem focused	\$59.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$47.00
D0150	Comprehensive oral evaluation – new or established patient	\$65.00
D0160	Detailed and extensive oral evaluation – problem focused, by report	\$139.00
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	\$52.00
D0180	Comprehensive periodontal evaluation – new or established patient	\$72.00
D0190	Screening of a patient	\$28.00
D0191	Assessment of a patient	\$28.00
D0210	Intraoral – complete series of radiographic images	\$122.00
D0220	Intraoral – periapical first radiographic image	\$26.00
D0230	Intraoral – periapical each additional radiographic image	\$20.00
D0240	Intraoral – occlusal radiographic image	\$25.00
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	\$58.00
D0270	Bitewing – single radiographic image	\$23.00
D0272	Bitewings – two radiographic images	\$41.00
D0273	Bitewings – three radiographic images	\$49.00
D0274	Bitewings – four radiographic images	\$54.00
D0277	Vertical bitewings – 7 to 8 radiographic images	\$75.00
D0310	Sialography	\$411.00
D0320	Temporomandibular joint arthrogram, including injection	\$622.00
D0321	Other temporomandibular joint radiographic images, by report	\$224.00
D0322	Tomographic survey	\$355.00
D0330	Panoramic radiographic image	\$97.00
D1110	Prophylaxis – adult	\$87.00
D1120	Prophylaxis – child (through age 13)	\$58.00
D1206	Topical application of fluoride varnish (Child through age 18)	\$31.00
D1208	Topical application of fluoride – excluding varnish (Child through age 18)	\$28.00
D1351	Sealant – per tooth (Child through age 15)	\$45.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (Child through age 15)	\$54.00
D1510	Space maintainer – fixed, unilateral – per quadrant (Child through age 13)	\$280.00
D1516	Space maintainer – fixed – bilateral, maxillary (Child through age 13)	\$388.00
D1517	Space maintainer – fixed – bilateral, mandibular (Child through age 13)	\$388.00
D1520	Space maintainer – removable, unilateral – per quadrant (Child through age 13)	\$393.00
D1526	Space maintainer – removable – bilateral, maxillary (Child through age 13)	\$538.00

..... **Dental Fee Schedule**

Procedure Code	Description	Fee Schedule
D1527	Space maintainer – removable – bilateral, mandibular (Child through age 13)	\$538.00
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	\$63.00
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	\$63.00
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	\$63.00
D1556	Removal of fixed unilateral space maintainer – per quadrant	\$63.00
D1557	Removal of fixed bilateral space maintainer – maxillary	\$63.00
D1558	Removal of fixed bilateral space maintainer – mandibular	\$63.00
D1575	Distal shoe space maintainer - fixed, unilateral – per quadrant	\$239.00
D2140	Amalgam – one surface, primary or permanent	\$93.00
D2150	Amalgam – two surfaces, primary or permanent	\$118.00
D2160	Amalgam – three surfaces, primary or permanent	\$147.00
D2161	Amalgam – four or more surfaces, primary or permanent	\$176.00
D2330	Resin-based composite – one surface, anterior	\$109.00
D2331	Resin-based composite – two surfaces, anterior	\$141.00
D2332	Resin-based composite – three surfaces, anterior	\$170.00
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$209.00
D2391	Resin-based composite – one surface, posterior	\$124.00
D2392	Resin-based composite – two surfaces, posterior	\$159.00
D2393	Resin-based composite – three surfaces, posterior	\$203.00
D2394	Resin-based composite – four or more surfaces, posterior	\$238.00
D2510	Inlay – metallic – one surface	\$292.00
D2520	Inlay – metallic – two surfaces	\$344.00
D2542	Onlay – metallic – two surfaces (12 years and older)	\$419.00
D2610	Inlay – porcelain/ceramic – one surface	\$292.00
D2620	Inlay – porcelain/ceramic – two surfaces	\$335.00
D2642	Onlay – porcelain/ceramic – two surfaces (12 years and older)	\$453.00
D2650	Inlay – resin-based composite – one surface	\$292.00
D2651	Inlay – resin-based composite – two surfaces	\$335.00
D2662	Onlay – resin-based composite – two surfaces (12 years and older)	\$371.00
D2740	Crown – porcelain/ceramic substrate	\$492.00
D2750	Crown – porcelain fused to high noble metal	\$463.00
D2751	Crown – porcelain fused to predominantly base metal	\$410.00
D2780	Crown – ¾ cast high noble metal	\$516.00
D2783	Crown – ¾ porcelain/ceramic	\$488.00
D2790	Crown – full cast high noble metal	\$515.00
D2930	Prefabricated stainless steel crown – primary tooth	\$186.00
D2931	Prefabricated stainless steel crown – permanent tooth	\$222.00
D2932	Prefabricated resin crown	\$221.00
D2933	Prefabricated stainless steel crown with resin window	\$222.00
D2940	Protective restoration	\$70.00
D2950	Core buildup, including any pins when required	\$151.00
D3110	Pulp cap – direct (excluding final restoration)	\$49.00

..... **Dental Fee Schedule**

Procedure Code	Description	Fee Schedule
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	\$121.00
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$858.00
D3346	Retreatment of previous root canal therapy – anterior	\$759.00
D3347	Retreatment of previous root canal therapy – premolar	\$828.00
D3410	Apicoectomy – anterior	\$762.00
D3425	Apicoectomy – molar (first root)	\$765.00
D3430	Retrograde filling – per root	\$153.00
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	\$364.00
D4249	Clinical crown lengthening – hard tissue	\$455.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	\$1,000.00
D4270	Pedicle soft tissue graft procedure	\$620.00
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	\$170.00
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	\$112.00
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	\$95.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	\$104.00
D4910	Periodontal maintenance	\$96.00
D5110	Complete denture – maxillary	\$658.00
D5120	Complete denture – mandibular	\$662.00
D5130	Immediate denture – maxillary	\$764.00
D5140	Immediate denture – mandibular	\$777.00
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	\$442.00
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	\$535.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$703.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$695.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	\$488.00
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	\$617.00
D5411	Adjust complete denture – mandibular	\$32.00
D5611	Repair resin partial denture base, mandibular	\$89.00
D5612	Repair resin partial denture base, maxillary	\$89.00
D5640	Replace broken teeth – per tooth	\$99.00
D5650	Add tooth to existing partial denture	\$114.00
D5660	Add clasp to existing partial denture – per tooth	\$160.00
D5710	Rebase complete maxillary denture	\$320.00
D5711	Rebase complete mandibular denture	\$320.00
D5720	Rebase maxillary partial denture	\$314.00
D5721	Rebase mandibular partial denture	\$360.00

Dental Fee Schedule

Procedure Code	Description	Fee Schedule
D5820	Interim partial denture (maxillary)	\$216.00
D5821	Interim partial denture (mandibular)	\$233.00
D5850	Tissue conditioning, maxillary	\$51.00
D5851	Tissue conditioning, mandibular	\$51.00
D5863	Overdenture – complete maxillary	\$930.00
D6010	Surgical placement of implant body: endosteal implant	\$855.00
D6210	Pontic – cast high noble metal	\$622.00
D6212	Pontic – cast noble metal	\$365.00
D6214	Pontic – titanium and titanium alloys	\$528.00
D6240	Pontic – porcelain fused to high noble metal	\$491.00
D6241	Pontic – porcelain fused to predominantly base metal	\$425.00
D6242	Pontic – porcelain fused to noble metal	\$463.00
D6740	Retainer crown – porcelain/ceramic	\$492.00
D6750	Retainer crown – porcelain fused to high noble metal	\$499.00
D6752	Retainer crown – porcelain fused to noble metal	\$490.00
D6790	Retainer crown – full cast high noble metal	\$498.00
D6791	Retainer crown – full cast predominantly base metal	\$402.00
D6794	Retainer crown – titanium and titanium alloys	\$548.00
D7111	Extraction, coronal remnants – primary tooth	\$68.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$115.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$199.00
D7220	Removal of impacted tooth – soft tissue	\$237.00
D7230	Removal of impacted tooth – partially bony	\$283.00
D7240	Removal of impacted tooth – completely bony	\$326.00
D7850	Surgical discectomy, with/without implant	\$1,500.00
D7860	Arthrotomy	\$1,500.00
D7971	Excision of pericoronal gingiva	\$120.00
D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$70.00
D9120	Fixed partial denture sectioning	\$86.00
D9222	Deep sedation/general anesthesia – first 15 minutes	\$280.00
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	\$134.00
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	\$252.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	\$111.00
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	\$67.00
D9942	Repair and/or relines of occlusal guard	\$40.00
D9944	Occlusal guard – hard appliance, full arch	\$273.00
D9945	Occlusal guard – soft appliance, full arch	\$146.00
D9946	Occlusal guard – hard appliance, partial arch	\$320.00
D9950	Occlusion analysis – mounted case	\$187.00
D9951	Occlusal adjustment – limited	\$51.00
D9952	Occlusal adjustment – complete	\$406.00

Delta Dental Fee examples

How to select a Delta Dental network dentist that will best suit your needs and your pocket book! Understand the difference between a PPO and Premier network dentist.

Finding a Delta Dental Network Dentist

The MUS Dental Plan utilizes a fee schedule so you know in advance exactly how much the Plan will pay for each covered service. It is important to understand that a dentist's billed charges may be greater than the Plan benefit fee schedule amount, resulting in balance billing. When a dentist contracts with Delta Dental, they agree to accept Delta Dental's allowed fee as full payment. This allowed fee may be greater than the MUS Plan benefit fee schedule amount in which case, the dentist may balance bill you up to the difference between the allowed fee and the MUS Plan benefit fee schedule amount.

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

Montana University System plan members will usually save when they visit a Delta Dental network dentist. Delta Dental Preferred Provider Organization (PPO) network dentists agree to lower levels of allowed fees and therefore offer the most savings. Delta Dental Premier network dentists also agree to a set level of allowed fees, but not as low as with a PPO network dentist. Therefore, when visiting a Premier network dentist, MUS members usually see some savings, just not as much as with a PPO network dentist. The best way to understand the difference in fees is to view the examples below. Go to: www.deltadentalins.com/mus and use the *Find a Dentist* search to help you select a network dentist that is best for you!

The following claim example for an adult cleaning demonstrates how lower Out-of-Pocket patient costs can be achieved when you visit a Delta Dental network dentist (**Select Plan** coverage). The example compares the patient's share of costs at each network level below:

Adult Cleaning	PPO Network Dentist	Premier Network Dentist	Out-of-Network Dentist
What the dentist bills	\$87	\$87	\$87
Dentists allowed fee with Delta Dental	\$57	\$71	No fee agreement with Delta Dental
MUS Plan benefit allowed amount	\$83	\$83	\$83
What you pay	\$0	\$0	\$4

The following claim example for a crown demonstrates how lower Out-of-Pocket patient costs can be achieved when you visit a Delta Dental network dentist (**Select Plan** coverage). The example compares the patient's share of costs at each network level below:

Crown	PPO Network Dentist	Premier Network Dentist	Out-of-Network Dentist
What the dentist bills	\$1,000	\$1,000	\$1,000
Dentists allowed fee with Delta Dental	\$694	\$822	No fee agreement with Delta Dental
MUS Plan benefit allowed amount	\$423	\$423	\$423
What you pay	\$271	\$399	\$577

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

Basic Life/AD&D Insurance:

This is an Employee only benefit.

Basic life insurance coverage under **Choices** pays benefits to your beneficiary or beneficiaries if you die from most causes while coverage is in effect. Accidental Death & Dismemberment (AD&D) insurance coverage under **Choices** adds low-cost accidental death protection by paying benefits in the event your death is due to accidental causes. Full or partial AD&D benefits are also payable to you following certain serious accidental injuries. **No evidence of insurability is required.**

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



Basic Life/AD&D Options & Monthly Rates		
Option 1	\$15,000	\$1.28 for both
Option 2	\$30,000	\$2.56 for both
Option 3	\$48,000	\$4.08 for both

Long Term Disability:

This is an Employee only benefit.

Long Term Disability (LTD) coverage can help protect your income in the event you become disabled and unable to work. **Choices** includes three LTD plan options designed to supplement other sources of disability income that may be available to you. The three LTD plan options differ in the amount of your pay they replace, when benefits become payable, and monthly premium costs.

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

Benefit Options:

Option 1: 60% of pre-disability earnings, to a maximum benefit of \$9,200 per month. The minimum monthly benefit is the greater of \$100 or 10% of your LTD benefit before reduction by deductible income.

Option 2: 66-2/3% of pre-disability earnings, to a maximum benefit of \$9,200 per month. The minimum monthly benefit is \$100 or 10% of your LTD benefit before reduction by deductible income.

Option 3: 66-2/3% of pre-disability earnings, to a maximum benefit of \$9,200 per month. The minimum monthly benefit is \$100 or 10% of your LTD benefit before reduction by deductible income.

Employees increasing coverage one level during annual enrollment or due to a qualifying event will be subject to a pre-existing condition exclusion for disabilities occurring during the first 12 months that the increase in coverage is effective. Any coverage existing for at least 12 months prior to the increase will not be subject to the pre-existing condition exclusion.

Employees on a leave status may not be eligible for LTD coverage. Please consult with your campus Human Resources/Benefits Office.

Do you have other Disability Income?

The level of LTD coverage you select ensures that you will continue to receive a percentage of your base pay each month if you become totally disabled.

Some of the money you receive may come from other sources, such as Social Security, Workers' Compensation, or other group disability benefits. Your **Choices** LTD benefit will be offset by any amounts you receive from these sources. The total combined income will equal the benefit level you selected.

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

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

Vision Hardware Plan (optional)



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

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

Using Your Vision Hardware Benefit

Quality vision care is important to your eye wellness and overall health care. Accessing your Vision Hardware Plan benefit is easy. Simply select your provider, purchase your hardware, and submit your claim form to BlueCross BlueShield of Montana for processing. **The optional vision coverage is a hardware benefit only. Eye Exams, whether preventive or medical, are covered under the Medical Plan (see pg. 9 Eye Exam (preventive & medical)).** Please refer to the Summary Plan Description (SPD) for complete Vision Hardware Plan benefits and plan exclusions (see pg. 34 for availability).

Monthly Vision Hardware Rates

- Employee/Survivor Only \$10.70
- Employee & Spouse. \$20.20
- Employee/Survivor & Child(ren) \$21.26
- Employee & Family \$31.18

Sample Vision Hardware card

Subscriber Name:	MONTANA UNIVERSITY SYSTEM		
Identification Number:	Dependent Name:		
MVA			
Group Number:	V58005		

Service/Material	Coverage
Eyeglass Frame and Lenses: Frame: One eyeglass frame per benefit plan year, in lieu of contact lenses Lenses: One pair of prescription lenses per benefit plan year, in lieu of contact lenses	Up to \$300 allowance toward the purchase of one eyeglass frame and one pair of prescription lenses, including single vision, bifocal, trifocal, progressive lenses; ultraviolet treatment; tinting; scratch-resistant coating; polycarbonate; anti-reflective coating. The Plan member may be responsible for charges at the time of purchase.
Contact Lenses: One purchase per plan year, in lieu of eyeglass frame and prescription lenses	Up to \$200 allowance toward contact lens fitting and the purchase of conventional, disposable or medically necessary* contact lenses. The Plan participant may be responsible for charges at the time of purchase.

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

Filing a claim:

When a Plan member purchases vision hardware, a walk-out statement should be provided by the Provider. This walk-out statement should be submitted to BlueCross BlueShield of Montana for reimbursement, along with a Vision Hardware Claim Form, which can be found at www.choices.mus.edu/forms.html.

MUS Wellness Program (optional)

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



Preventive Health Screenings

WellCheck

Each campus offers preventive health screenings for adult Medical Plan members called WellChecks. A free basic blood panel and biometric screening are provided at WellCheck, with optional additional tests available at discounted prices. Representatives from MUS Wellness are also present at most WellChecks to answer wellness related questions. Adult Medical Plan members over the age of 18 are eligible for two free WellChecks per benefit plan year (July 1 - June 30). Go to www.wellness.mus.edu/WellCheck.html for more information regarding WellCheck dates and times in your area.

Online Registration

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

Lab Tests -

Log on to your **It Starts With Me** account for a complete listing of tests available at WellCheck.

Flu Shots

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

Healthy Lifestyle Education & Support

Quick Help Program

If you have a quick question regarding health, fitness, or nutrition related topics, send us an email at: wellness@montana.edu. We'll do our best to provide the information you need, or point you in the right direction if we don't have an answer ourselves!

The information given through the Quick Help Program does not provide medical advice, is intended for general educational purposes only, and does not always address individual circumstances.

WellBaby Program

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



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

Stay Connected



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



Follow us on Twitter: [@montanamoves](https://twitter.com/montanamoves)
[@montanameals](https://twitter.com/montanameals)

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

MUS Wellness Program (optional)



Incentive Program
www.muswell.limeade.com

Discover your own path to wellness with the 2021 Wellness Incentive Program!

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

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

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

- 1. Login at www.muswell.limeade.com**
Haven't registered? Click "Activate Account" on www.muswell.limeade.com and follow the detailed instructions..
- 2. Take the Well-Being Assessment:** Your assessment helps you understand the many dimensions of your well-being. Plan on spending approximately 15 minutes to complete.
- 3. Complete a WellCheck Health Screening (blood draw and biometric screening) in 2021:** Completing a WellCheck health screening will give you an accurate measure of your health so you can maintain your health and prevent disease. For the Wellcheck schedule go to: www.wellness.mus.edu/WellCheck.html.

For more information about the MUS Wellness incentive program, please contact the MUS Wellness office at 406-994-6111. For Limeade technical help or problems registering, please contact Limeade Support at 866-885-6940 or email support@limeade.com.

Take Control Lifestyle Management Program



Take Control is a health coaching program that believes living well is within everyone's reach. Take Control offers comprehensive and confidential education and support for the medical conditions listed below. Their unique and convenient telephonic delivery method allows Plan members to participate from work or home and receive individual attention specific to each Plan member's needs. Members with any of the following conditions may enroll:

Take Control Program Offerings:

- **Diabetes** -Type I, Type II, Pre-diabetes, or Gestational (Fasting GLUC > 125)
- **Weight Loss** - High Body Mass Index (BMI > 24.99)
- **Tobacco User** – Smoking, chewing tobacco, cigars, pipe
- **High Blood Pressure** (Hypertension) (Systolic > 140 or Diastolic > 90)
- **High Cholesterol** (Hyperlipidemia) (CHOL > 240 or TRIG > 200 or LDL > 150 or HDL < 40M/50F)
- **WellBaby** participants can join Take Control as part of the WellBaby program

Services provided include monthly health coaching, copay waivers for diabetic supplies, monthly blog written by Take Control staff with healthy lifestyle topics and website with additional health resources.

Additional Benefits That Can Be Pre-Authorized by your Health Coach:

Visit with your In-Network primary health care provider (with \$0 copay), sleep study (deductible/coinsurance waived), additional counseling visits (with \$0 copay).

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

Employee Assistance Program (EAP) (optional)

An Overview for Employees



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

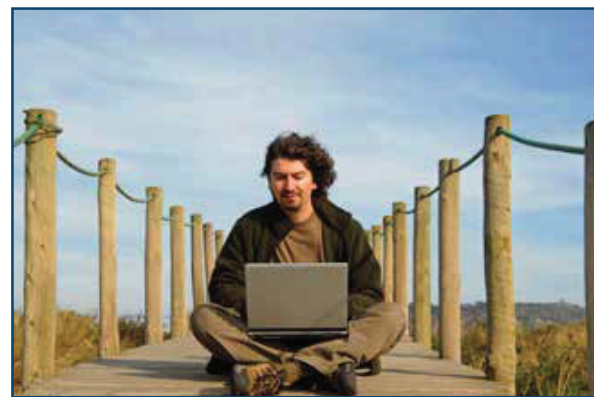
The EAP Can Help with Almost Any Issue

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



EAP Services for Employees and Families

- ▶ 24-hour Crisis Help: toll-free access for you or a family member experiencing a crisis.
- ▶ In-person Counseling: up to 6 face-to-face counseling sessions for relationship and family issues, stress, anxiety, and other common challenges.
- ▶ RBH eAccess: convenient access to online consultations with licensed counselors.



Online Resources at ibhsolutions.com

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

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

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

Access Counseling and Benefit Information

CALL 866-750-1327

WEBSITE ibhsolutions.com

- Select Members from the top right corner
- Click on the RBH logo
- Enter your Access Code: MUS
- Click the My Benefits button



Flexible Spending Accounts (optional)

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

Temporary Changes – The Consolidated Appropriations Act, 2021 allows the MUS to **temporarily** amend the HCFSA, LPFSA, and DCFSA to provide enhanced benefits for a limited time. This means that unused funds from HCFSA, LPFSA, and DCFSA from FY2020 (July 1, 2019 – June 30, 2020) from Allegiance Flex Advantage and from FY2021 (July 1, 2020 - June 30, 2021) from WageWorks will be rolled over to the new benefit plan year that begins July 1, 2021 (FY2022). The rollover for FY2022 is only applicable for active MUS benefits eligible members and **does not** include employees who have terminated employment with MUS.

Rollover Funds: Be sure not to elect more than you will need to cover expenses incurred by you and/or your family members during the benefit plan year. Under the “use it – or – lose it” rule, any money not used by the end of the benefit plan year will be forfeited. The IRS permits health FSAs to allow rollover from one benefit plan year to the next.

Important Reminders: If an employee does not enroll in an FSA for FY2022 and has unused FSA funds in the amount of \$50 or less that are not expended by June 30, 2022, the FSA will be closed and the remaining unused funds will be forfeited. Claims **must** be received by WageWorks by September 30, 2022 for reimbursement.

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

Flexible spending account administrative fees will be paid by MUS.

FSA Account Types	FSA Annual Contribution Amount	FSA Qualifying Expense Examples
Health Care FSA	Minimum Contribution: \$120 Maximum Contribution: \$2,750	Medical and Rx expenses, including but not limited to, deductibles, coinsurance, copays, and dental and vision expenses.
Limited Purpose FSA	Minimum Contribution: \$120 Maximum Contribution: \$2,750	Dental and Vision expenses only, including but not limited to, dental exams, dentures, contacts, eyeglass frames and lenses.
Dependent Care FSA	Minimum Contribution: \$120 Maximum Contribution: \$5,000	Costs for day care provided to your dependent child(ren) under age 14, or other dependents unable to care for themselves, and is necessary for you to remain employed.

Health Care Flexible Spending Account (HCFSA)

During the annual enrollment period, you may elect amounts to be withheld from your earnings to pay for your Out-of-Pocket medical, dental, and/or vision expenses.

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

If you or your legal spouse contribute to a Health Savings Account (HSA), you are not eligible to participate in a general purpose HCFSA.

However, you may enroll in a Limited Purpose Flexible Spending Account (LPFSA).

Limited Purpose Flexible Spending Account (LPFSA)

The LPFSA guidelines are the same as the HCFSA, with the exception of eligible expenses. The LPFSA eligible expenses **only** include dental and vision expenses. For a comprehensive list of eligible LPFSA expenses, visit www.wageworks.com/employees/support-center/support-and-faq/forms-eligible-expenses/.

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

Your FSA will reimburse you for eligible expenses that you, your legal spouse, and your qualified dependents incur during the benefit plan year. The annual amount you elect will be available on July 1st and can be used at any time during the benefit plan year.

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

Dependent Care Flexible Spending Account (DCFSA)

If both you and your legal spouse work or you are a single parent, you may have dependent day care expenses. The Federal Child Care Tax Credit is available to taxpayers to help offset dependent day care expenses.

A DCFSA often gives employees a better tax benefit. You should consult your tax preparer to determine which option works best for you.

Your DCFSA lets you use “before-tax” dollars to pay day care expenses for children under age 14, or individuals unable to care for themselves. A dependent receiving day care must live in your home at least eight (8) hours per day. The day care must be necessary for you and your legal spouse to remain gainfully employed. Day care may be provided through live-in care, babysitters, licensed day care/preschool centers, and after school care. You cannot use “before-tax” dollars to pay your legal spouse or one of your children under the age of nineteen (19) for providing day care. Schooling expenses at the kindergarten level and above, overnight camps, and nursing home care are not reimbursable.

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

Reimbursement Options:

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

Pay Me Back or Pay My Provider:

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

Direct Deposit:

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

Healthcare Debit Card:

WageWorks sends debit cards as part of the HCFSA and LPFSA. You may request a Healthcare Debit Card(s), at no cost, by calling WageWorks or requesting online. You may use the Healthcare Debit Card to pay for eligible medical, dental or vision care expenses. Documentation for the expense may be re-

quired so it's a good rule of thumb to keep all receipts, Explanation of Benefits (EOB), and other supporting documentation when you use your Healthcare Debit Card.

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

To be eligible for reimbursement:

All claims must be received by WageWorks by September 30, 2022.

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

All claims for eligible expenses that were incurred during FY2020 (July 1, 2019 – June 30, 2020) and FY2021 (July 1, 2020 - June 30, 2021) benefit plan years **must be received by WageWorks by September 30, 2022, to be eligible for reimbursement.** If you terminate employment during the benefit plan year, your participation in the plan ends, subject to COBRA limitations. However, you still may submit claims through September 30, 2022, if the claims were incurred during your period of employment, and during the benefit plan year. No exceptions can be made on late claims submissions.

Mid-Year Election Changes

Mid-year FSA election changes must be made within 63 days of a qualifying event. Changes are limited and differ for each pre-tax option. Changes must be consistent with the change in status or qualifying event. For more information about mid-year election changes, please contact your campus Human Resources/Benefits Office.

FSA Questions?

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

Supplemental Life Insurance (optional)

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



Optional Supplemental Life Insurance:

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

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

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

Optional Supplemental Life Monthly Rates (after-tax) -Employee Benefit (based on age of Employee as of July 1)

Age	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000	\$225,000	\$250,000	\$275,000	\$300,000
under 30	\$ 1.50	\$ 3.00	\$ 4.50	\$ 6.00	\$ 7.50	\$ 9.00	\$ 10.50	\$ 12.00	\$ 13.50	\$ 15.00	\$ 16.50	\$ 18.00
30-34	\$ 2.00	\$ 4.00	\$ 6.00	\$ 8.00	\$ 10.00	\$ 12.00	\$ 14.00	\$ 16.00	\$ 18.00	\$ 20.00	\$ 22.00	\$ 24.00
35-39	\$ 2.25	\$ 4.50	\$ 6.75	\$ 9.00	\$ 11.25	\$ 13.50	\$ 15.75	\$ 18.00	\$ 20.25	\$ 22.50	\$ 24.75	\$ 27.00
40-44	\$ 2.50	\$ 5.00	\$ 7.50	\$ 10.00	\$ 12.50	\$ 15.00	\$ 17.50	\$ 20.00	\$ 22.50	\$ 25.00	\$ 27.50	\$ 30.00
45-49	\$ 4.50	\$ 9.00	\$ 13.50	\$ 18.00	\$ 22.50	\$ 27.00	\$ 31.50	\$ 36.00	\$ 40.50	\$ 45.00	\$ 49.50	\$ 54.00
50-54	\$ 6.75	\$ 13.50	\$ 20.25	\$ 27.00	\$ 33.75	\$ 40.50	\$ 47.25	\$ 54.00	\$ 60.75	\$ 67.50	\$ 74.25	\$ 81.00
55-59	\$ 11.00	\$ 22.00	\$ 33.00	\$ 44.00	\$ 55.00	\$ 66.00	\$ 77.00	\$ 88.00	\$ 99.00	\$ 110.00	\$ 121.00	\$ 132.00
60-64	\$ 16.50	\$ 33.00	\$ 49.50	\$ 66.00	\$ 82.50	\$ 99.00	\$ 115.50	\$ 132.00	\$ 148.50	\$ 165.00	\$ 181.50	\$ 198.00
65-69	\$ 31.75	\$ 63.50	\$ 95.25	\$ 127.00	\$ 158.75	\$ 190.50	\$ 222.25	\$ 254.00	\$ 285.75	\$ 317.50	\$ 349.25	\$ 381.00
70 & over	\$ 67.25	\$ 134.50	\$ 201.75	\$ 269.00	\$ 336.25	\$ 403.50	\$ 470.75	\$ 538.00	\$ 605.25	\$ 672.50	\$ 739.75	\$ 807.00

Age	\$325,000	\$350,000	\$375,000	\$400,000	\$425,000	\$450,000	\$475,000	\$500,000	\$525,000	\$550,000	\$575,000	\$600,000
under 30	\$ 19.50	\$ 21.00	\$ 22.50	\$ 24.00	\$ 25.50	\$ 27.00	\$ 28.50	\$ 30.00	\$ 31.50	\$ 33.00	\$ 34.50	\$ 36.00
30-34	\$ 26.00	\$ 28.00	\$ 30.00	\$ 32.00	\$ 34.00	\$ 36.00	\$ 38.00	\$ 40.00	\$ 42.00	\$ 44.00	\$ 46.00	\$ 48.00
35-39	\$ 29.25	\$ 31.50	\$ 33.75	\$ 36.00	\$ 38.25	\$ 40.50	\$ 42.75	\$ 45.00	\$ 47.25	\$ 49.50	\$ 51.75	\$ 54.00
40-44	\$ 32.50	\$ 35.00	\$ 37.50	\$ 40.00	\$ 42.50	\$ 45.00	\$ 47.50	\$ 50.00	\$ 52.50	\$ 55.00	\$ 57.50	\$ 60.00
45-49	\$ 58.50	\$ 63.00	\$ 67.50	\$ 72.00	\$ 76.50	\$ 81.00	\$ 85.50	\$ 90.00	\$ 94.50	\$ 99.00	\$ 103.50	\$ 108.00
50-54	\$ 87.75	\$ 94.50	\$ 101.25	\$ 108.00	\$ 114.75	\$ 121.50	\$ 128.25	\$ 135.00	\$ 141.75	\$ 148.50	\$ 155.25	\$ 162.00
55-59	\$ 143.00	\$ 154.00	\$ 165.00	\$ 176.00	\$ 187.00	\$ 198.00	\$ 209.00	\$ 220.00	\$ 231.00	\$ 242.00	\$ 253.00	\$ 264.00
60-64	\$ 214.50	\$ 231.00	\$ 247.50	\$ 264.00	\$ 280.50	\$ 297.00	\$ 313.50	\$ 330.00	\$ 346.50	\$ 363.00	\$ 379.50	\$ 396.00
65-69	\$ 412.75	\$ 444.50	\$ 476.25	\$ 508.00	\$ 539.75	\$ 571.50	\$ 603.25	\$ 635.00	\$ 666.75	\$ 698.50	\$ 730.25	\$ 762.00
70 & over	\$ 874.25	\$ 941.50	\$ 1,008.75	\$ 1,076.00	\$ 1,143.25	\$ 1,210.50	\$ 1,277.75	\$ 1,345.00	\$ 1,412.25	\$ 1,479.50	\$ 1,546.75	\$ 1,614.00

Continued on next page.....

Optional Supplemental Dependent Life Insurance eligibility:

Optional Supplemental Dependent Life Insurance for your legal spouse and unmarried dependent child(ren) from live birth to age 26 is designed to protect you against certain financial burdens (such as funeral expenses) in the event a covered dependent dies. You are automatically the beneficiary of any benefits that become payable. The cost of this benefit is paid on after-tax dollars. Employees **MAY NOT** cover other MUS employed family members. In addition, dependent children **MAY NOT** be insured by more than one MUS employed member. You must enroll in employee optional supplemental life coverage to be eligible for your legal spouse or dependent child(ren) to enroll in supplemental life coverage elections.

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

Optional Supplemental Life Monthly Rates (after-tax) -Spousal Benefit (based on age of Legal Spouse as of July 1st)

Age	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000	\$225,000	\$250,000	\$275,000	\$300,000
under 30	\$ 1.50	\$ 3.00	\$ 4.50	\$ 6.00	\$ 7.50	\$ 9.00	\$ 10.50	\$ 12.00	\$ 13.50	\$ 15.00	\$ 16.50	\$ 18.00
30-34	\$ 2.00	\$ 4.00	\$ 6.00	\$ 8.00	\$ 10.00	\$ 12.00	\$ 14.00	\$ 16.00	\$ 18.00	\$ 20.00	\$ 22.00	\$ 24.00
35-39	\$ 2.25	\$ 4.50	\$ 6.75	\$ 9.00	\$ 11.25	\$ 13.50	\$ 15.75	\$ 18.00	\$ 20.25	\$ 22.50	\$ 24.75	\$ 27.00
40-44	\$ 2.50	\$ 5.00	\$ 7.50	\$ 10.00	\$ 12.50	\$ 15.00	\$ 17.50	\$ 20.00	\$ 22.50	\$ 25.00	\$ 27.50	\$ 30.00
45-49	\$ 4.50	\$ 9.00	\$ 13.50	\$ 18.00	\$ 22.50	\$ 27.00	\$ 31.50	\$ 36.00	\$ 40.50	\$ 45.00	\$ 49.50	\$ 54.00
50-54	\$ 6.75	\$ 13.50	\$ 20.25	\$ 27.00	\$ 33.75	\$ 40.50	\$ 47.25	\$ 54.00	\$ 60.75	\$ 67.50	\$ 74.25	\$ 81.00
55-59	\$ 11.00	\$ 22.00	\$ 33.00	\$ 44.00	\$ 55.00	\$ 66.00	\$ 77.00	\$ 88.00	\$ 99.00	\$ 110.00	\$ 121.00	\$ 132.00
60-64	\$ 16.50	\$ 33.00	\$ 49.50	\$ 66.00	\$ 82.50	\$ 99.00	\$ 115.50	\$ 132.00	\$ 148.50	\$ 165.00	\$ 181.50	\$ 198.00
65-69	\$ 31.75	\$ 63.50	\$ 95.25	\$ 127.00	\$ 158.75	\$ 190.50	\$ 222.25	\$ 254.00	\$ 285.75	\$ 317.50	\$ 349.25	\$ 381.00
70 & over	\$ 67.25	\$ 134.50	\$ 201.75	\$ 269.00	\$ 336.25	\$ 403.50	\$ 470.75	\$ 538.00	\$ 605.25	\$ 672.50	\$ 739.75	\$ 807.00

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

- New employees may elect up to \$30,000 in dependent child coverage during initial enrollment.
- If you are enrolling for the first time and did not elect dependent child coverage during initial enrollment, you can add dependent child coverage of \$5,000 at annual enrollment.
- Employees may increase or decrease their dependent child coverage one level or drop completely due to a qualifying event, as long as the change is consistent with the event (such as dependent child is disenrolled, coverage may be decreased one level or dropped completely).
- Employees may increase their dependent child coverage one level or decrease their coverage to any level or drop completely during annual enrollment.

Disabled dependent children over the age of 26 who are covered on the Plan **MAY NOT** be covered on optional supplemental life coverage.

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

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

Supplemental AD&D Coverage (optional)



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

Optional Supplemental AD&D Insurance eligibility:

This is an Employee only benefit. If you enroll for Optional Supplemental Accidental Death & Dismemberment (AD&D) Insurance, your cost depends on the amount of coverage you select, as shown in the following table. No evidence of insurability is required for optional supplemental AD&D coverage at any level. The cost of this benefit is paid on an after-tax basis.

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

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

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

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

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



Bob Marshall, MT

Optional Supplemental Dependent AD&D Insurance eligibility:

Optional Supplemental Dependent AD&D Insurance for your legal spouse and unmarried dependent child(ren) from live birth to age 26 is designed to protect you against certain financial burdens in the event a covered dependent dies due to an accidental death. You are automatically the beneficiary of any benefits that become payable. The cost of this benefit is paid on an after-tax basis. Employees **MAY NOT** cover other MUS employed family members. In addition, dependent children **MAY NOT** be insured by more than one member. You must enroll in employee optional supplemental AD&D coverage to be eligible for your legal spouse or dependent child(ren) to enroll in supplemental AD&D coverage elections.

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

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

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

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

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

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

Disabled dependent children over the age of 26 who are covered on the Plan **MAY NOT** be covered on optional supplemental AD&D coverage.

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

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

Additional Benefit Plan Information

Dependent Hardship Waiver

The MUS Benefit Plan offers a Dependent Premium Hardship Waiver to assist with the cost of medical health care coverage for children covered on the MUS Medical Plan. The family must first apply for Healthy Montana Kids (HMK) coverage for all children under the age of 19. If HMK denies coverage and the family has a financial hardship, an application may be submitted to the MUS Benefits Office requesting the Dependent Premium Hardship Waiver. If the total household income is not more than 120% of the HMK guidelines, covered dependent children will be eligible for the waiver for the benefit plan year (July 1 – June 30). The family **must** re-apply for HMK and the Dependent Premium Hardship Waiver each benefit plan year to be eligible for the waiver. For more information, please contact your campus Human Resources/Benefits Office or call MUS Benefits Office at 1-877-501-1722.

★ Self-Audit Award Program



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

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

- Have not already been detected by the Medical Plan’s claims administrator or reported by the health care provider,
- Involve medical services which are allowable and covered by the MUS Medical Plan, and
- Total \$50 or more in errant charges.

To receive the Self-Audit Award, the member must:

- Notify the Medical Plan claims administrator of the error before it is detected by the claims administrator or the health care provider,
- Contact the provider to verify the error and work out the correct billing, and
- Have copies of the correct billing sent to the Medical Plan claims administrator for verification, claims adjustment and calculation of the Self-Audit Award.

Summary Plan Description (SPD)

All Montana University System (MUS) Plan participants have the right to obtain a current copy of the Summary Plan Description (SPD). Despite the use of “summary” in the title, this document contains the full legal description of the Plan’s medical, dental, vision hardware, and prescription drug benefits and should always be consulted when a specific question arises about the Plan.

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

Summary of Benefits and Coverage (SBC)

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

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

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

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

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

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

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

The Montana University System Group Benefit Plan has a duty to safeguard and protect the privacy of all plan members' personally identifiable health information that is created, maintained, sent, or received by the Plan.

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

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

The Montana University System's self-insured Group Benefit Plan, in administering Plan benefits, shares and receives personally identifiable medical information concerning Plan members as required by law and for routine transactions concerning eligibility, treatment, payments, wellness programs (including WellChecks), lifestyle management programs (e.g., Take Control) healthcare operations, claims processing (including review of claims payments or denials, appeals, health care fraud and abuse detection, and compliance). Information concerning these categories may be shared, without a Plan participant's written consent, between authorized MUS Benefits Division employees and MUS Business Associates, the participant's providers, or legally authorized governmental entities.

Benefits Worksheet

Monthly Out-of-Pocket Benefit Premium Costs

MANDATORY (must choose) BENEFITS (unless you waive all benefits)

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

OPTIONAL (voluntary) BENEFITS (Pre-Tax)

VISION HARDWARE PLAN	(f)
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PRE-TAX PREMIUM TOTALS

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

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

TOTAL MONTHLY OUT-OF-POCKET COST (Pre-Tax)	Subtract line (j) from line (i)	(k)
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If line (k) is a negative amount, this is the left-over employer contribution amount. If line (k) is positive, this

FLEXIBLE SPENDING ACCOUNT ELECTIONS

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

Flexible Spending Account (FSA): Employees have the option to elect an FSA using Pre-Tax employee salary

OPTIONAL (voluntary) BENEFITS (Post-Tax)

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

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

Allowed Amount

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

Balance Billing

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

Benefit Plan Year

The period starting July 1 and ending June 30.

Certification/Pre-Certification

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

Coinsurance

A percentage of the allowed amount for covered health care services that a member is responsible for paying, after paying any applicable deductible. For example, if Jack has met his deductible for In-Network medical costs (\$750), he pays 25% of the allowed amount up to the Out-of-Pocket Maximum and the Plan pays 75%.

Copayment

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

Covered Charges

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

Deductible

A set dollar amount that a member must pay for covered health care services before the Medical Plan pays. The deductible applies to the benefit plan year (July 1 through June 30). For example, Jack's deductible is \$750. Jack pays 100% of the allowed amount until his deductible has been met.

Diagnostic

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

Emergency Services

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

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Fee Schedule

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

In-Network Provider

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

Out-of-Network Provider

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

Out-of-Pocket Maximum

The maximum amount of money a member pays toward the cost of covered health care services. Out-of-Pocket expenses include deductibles, copayments, and coinsurance. For example, Jack reaches his \$4,000 Out-of-Pocket Maximum. Jack has seen his doctor often and paid \$4,000 total (deductible + coinsurance + copays). The Plan pays 100% of the allowed amount for covered charges for the remainder of the benefit plan year. Balance billing amounts (the difference between Out-of-Network provider billed charges and the allowed amount) do not apply to the Out-of-Pocket Maximum.

Plan

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

Preventive Services

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

Prior Authorization

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

PPACA

The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a list of health-related provisions that took effect in 2010.

Primary Care Physician

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

Screening

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

Specialist

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

RESOURCES

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

MEDICAL PLAN & VISION HARDWARE PLAN

BLUECROSS BLUESHIELD OF MONTANA
Customer Service 1-800-820-1674 or 406-447-8747
www.bcbsmt.com

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

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

Navitus – PRESCRIPTION DRUG PLAN

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

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

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

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

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

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