choices

Retiree Annual Benefits Enrollment Workbook

2015 - 2016

Montana University System Employee Benefits

Please read the following Benefit Information...

Summary of Benefits and Coverage (SBC)

SBC forms can be found by visiting the following website:
www.choices.mus.edu/SBC.asp

These forms provide the detailed coverage information
required by the Patient Protection and Affordable Care Act (PPACA). If you would like a hard copy, please call toll free 877-501-1722.

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Flathead Valley CC

Miles City CC


Dawson CC

Director's Note: Important Changes for 2015-2016

We are pleased to present the ***Choices*** Retiree Workbook for the 2015-2016 Plan Year. The Workbook contains information about Retiree options for continuing with the Montana University System (MUS) Group Benefits Plan upon retirement, or if already retired, the available options for Retirees for the next fiscal year. Plan descriptions and related explanations are provided in detail in this workbook, on our website www.mus.edu/choices, and on the Retiree enrollment form.

All Retirees should review this workbook carefully, even if enrollment updates are not needed for the next plan year. This is your opportunity during the year to make your choices regarding medical and related benefits coverage for the 2015-2016 Plan Year. The MUS MAP program will be continued as an option for Medicare-eligible Retirees. If you do not submit a new enrollment form by May 22, 2015, your current enrollment will continue as it is until June 30, 2016, with appropriate premium changes.

Closed Enrollment: The MUS is continuing closed enrollment for spouses and adult dependents. This means that you may not add a spouse or adult dependent to your plan unless you have a qualifying event. During this enrollment period you may add eligible children under age 26.

Premium Payments: An eligible Retiree may be able to apply payout of final pay toward Retiree premiums through the end of the calendar year or the benefit year, whichever comes first, on a pretax basis. Discuss this option with your campus HR office. **Note: There is NO employer contribution toward Retiree benefits.**

Other Payment Options are:

1. Automatic Deductions – when possible, the Retiree should arrange for automatic deductions from his/her monthly retirement benefit received from TRS, MPERA, or any other retirement benefit, or directly from a checking or savings account if permitted by his/her campus.
2. When automatic deductions are not possible, Retirees must arrange a schedule of timely premium payments with their former campus HR office.

Medicare Enrollment Status: Retirees and/or spouses who are or become Medicare-eligible are required to be enrolled in both MEDICARE PART A and MEDICARE PART B as of the first of the month that they become eligible. All Medicare status changes must be reported to the campus HR office to facilitate premium and reenrollment adjustments. Any person not correctly enrolled in Medicare will be given 63 days to obtain the missing coverage. After 63 days, the non-enrolled person's status will be changed to non-Medicare-enrolled and premiums will revert to non-Medicare premiums until Medicare enrollment is properly completed and the MUS Benefits Office is notified. **Enrollment in Medicare Part D (drug plan) is NOT permitted.** Responsibility for proper Medicare enrollment belongs to the Retiree or spouse; proof of Medicare enrollment may be required by MUS and/or the Retiree's former campus at any time.

Prescription Drug Coverage: All medical plans include the MUS prescription drug plan called URx, except the MUS MAP plan which has its own, traditional-style pharmacy plan. Medicare-eligible Retirees may NOT enroll in a Medicare Part D plan. More information about URx is provided later in this workbook.

Director's Note Cont.

Dental Choices: ***Choices*** offers new Retirees a one-time opportunity to enroll in Delta Select Dental Plan coverage. If you are currently enrolled for dental coverage and wish to keep that coverage, you do not have to complete an enrollment form unless you are changing other portions of your enrollment. If you are enrolled for dental coverage and wish to drop that coverage, you must complete the entire enrollment form and **submit it to your HR office by May 22, 2015**. You will not be allowed to reenroll in the Retiree dental insurance program if you cancel your enrollment! If you did not enroll previously in the Retiree dental insurance program, you may not enroll now.

New Retirees may sign up for Select Dental coverage during their initial Retiree enrollment or if experiencing a qualifying event. Information and rates for the Delta Select Dental Plan can be seen within this workbook and on the Retiree enrollment form. Remember: if you do not enroll in Retiree Dental Coverage when it's first offered or you drop your dental coverage, you are not allowed to reenroll unless a qualifying event occurs.

Vision Hardware Coverage: MUS has contracted with Blue Cross and Blue Shield of Montana to facilitate its vision hardware plan. **Please note that the optional vision plan is for vision hardware ONLY**. Eye exams are covered under the medical benefit. If you are not currently enrolled for vision hardware coverage and want to add that coverage, you must complete the entire enrollment form and **submit it to your HR office by May 22, 2015.** You may drop or add vision coverage with each annual enrollment.

Long Term Care Insurance: If a retiring Employee has UNUM Long Term Care insurance, he/she should contact his/her HR office for personal payment conversion within 30 days of retirement. Current Retirees can add Long Term Care insurance with medical underwriting any time. Medical underwriting means that UNUM can reject an application or increase rates due to existing medical conditions.

Long Term Disability Coverage: This MUS coverage ceases as of the date of retirement.

Life Insurance Coverage: Employees may be able to convert their active status policy(ies) within 30 days of retirement. The MUS does not offer any other life insurance coverage to retirees.

Dependent Coverage Options: Continuing existing Medical and Dental coverage for dependents is optional, but a Retiree must elect to continue coverage(s) with the 63-day enrollment period following his/her retirement. New dependents can be added to Medical and /or Dental coverage if the request is made within 63 days of the qualifying event (marriage, birth, adoption/guardianship, new qualifying dependent, etc.) Existing spouse/adult dependents can only be added to medical or dental coverage if they are losing eligibility for other group coverage or if there is a substantial decrease in the level of existing coverage, as determined on an individual basis and if the request is made within 63 days of termination of the other coverage. Children under the age of 26 can be added during this annual enrollment period.

Connie Welsh,
Director of Benefits
Montana University System

Notices for *Choices* Coverage

Special Enrollment Periods

If you decline retiree medical or dental coverage, you and your dependents will NOT be allowed to enroll in the future. If you are waiving coverage for your eligible dependents (including your spouse) as defined by the Montana University System (MUS) Summary Plan Description (SPD) and this Enrollment Workbook because they are currently covered by other health insurance or another health care plan, you may be able to enroll your dependents for coverage under the Plan in the future, provided that you request such coverage within sixty-three (63) days after such other coverage ends.

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

Important Note: Enrollment for plan year 2015/16 is Closed Enrollment for spouses and adult dependents unless there is a qualifying event (see SPD for qualifying events). See glossary, page 34, for definition of adult dependent.

Children under age 26 may be added during this enrollment period.

Choices Enrolling as a Retiree

To select ***Choices*** options as a Retiree you must complete and return an enrollment form:

a. within 63 days of first becoming eligible for Retiree benefits. **If you do not enroll within the 63-day period, you will permanently forfeit your eligibility for all Retiree insurance coverage.**
b. during annual benefit enrollment by the stated deadline. I**f you do not enroll, you will default to prior coverage or to the stated default coverage if your existing plan(s) is/are changing.**
c. when you have a mid-year qualifying event and want to make an allowed mid-year change in elections. **This change must be made within 63 days of the event.**

Step-by-Step Process for Completing Your Retiree *Choices* Annual Benefit Enrollment.

Step 1:

Review this workbook carefully and read the back of the form.

- Discuss this information with your spouse and/or other family members.
- Determine your benefit needs for the coming benefit year if you are enrolling during annual enrollment or for the remainder of the current benefit year if a new Retiree.
- You may want to review the Director's Note section for helpful information about your enrollment options.

Step 2:

Complete the Front Side of Your Enrollment Form.
Your Retiree enrollment form should be included with this workbook. In the event your form is missing or you need another, please contact your Campus HR/ Benefits Office. If your campus provides on-line annual benefit enrollment, you may enroll on-line at the campus' discretion.

Demographic and Dependent Coverage Sections:
Please fill in these sections completely **every** time you fill out this form.

Medical:

Medical coverage is mandatory for all MUS retirees. For Medical Coverage, you must make two elections: a plan and a coverage category. If you fail to correctly enroll, you will default as described on page 1.

- Review the medical schedule pages to compare benefits between plans.
- Review the service area lists of medical plans before choosing a medical plan. You may want to check with your doctor's office as well.
- Check the boxes corresponding to the selected plan and the coverage category you want.
- When you have selected a plan and coverage category, fill in the corresponding monthly cost in the space provided on the right-hand side of the form, by Medical Premium. Premium amounts are listed in the Workbook. If you choose to enroll in MUS MAP (Medicare Advantage Plan), you will have an additional form to complete, found in a New West envelope in your Retiree packet or supplied by your campus HR office. Be sure that you follow all directions and forward all materials to your campus.

Optional Dental:

For Dental coverage, you must be qualified to enroll (see back of form). Choose a coverage category. Retirees are offered enrollment in the Select Dental Plan only. If you do not make an election when you first retire, you will permanently forfeit your dental coverage eligibility unless a qualifying event occurs. **A spouse reaching age 65 is not a qualifying event for re-enrolling in dental.**

- Check the box corresponding to the coverage category you want.
- When you have selected a coverage category, fill in the corresponding monthly cost in the space provided on the right-hand side of the form, by Dental Premium.
- OR check the box that "opts out" of Dental coverage entirely.

Enrolling as a Retiree Cont. .....

Optional Vision Hardware:
Check the correct box if you want optional Vision Hardware coverage for the person(s) you want covered and enter the dollar amount in the space provided next to Vision Premium. At this time, you may add or delete vision hardware coverage each year. OR choose the "opt out" box.

Total Your Costs:
Add up the premium amounts and enter the total on the Total Monthly Premium line. If you have not arranged with your campus HR/Benefits Office for automatic payment of your premiums through your pension or bank account, we strongly recommend you consider doing so.

Read the Authorizing Paragraph, then Sign and Date the Form. Sign on the line that corresponds to your family situation.

Return the form by the stated deadline to your campus HR/Benefits Office. For Spring 2015, the deadline is May 22, 2015.

CAMPUS BENEFIT CONTACTS

(numbers below) or call MUS Benefits at 877-501-1722 if you have any questions.

MSU-Bozeman	920 Technology Blvd., Ste. A, Bozeman, MT 59718	406-994-3651
MSU-Billings	1500 University Dr., Billings, MT 59101	406-657-2278
MSU-Northern	300 West 11th Street, Havre, MT 59501	406-265-4147
Great Falls College	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	1115 N. Roberts, Helena MT 59601	406-447-6925
UM-Western	710 S. Atlantic St., Dillon, MT 59725	406-638-7010
MT Tech (UM)	1300 W. Park St., Butte, MT 59701	406-496-4380
OCHE/GSL, MUS Benefits Office	2500 Broadway, Helena, MT 59601	877-501-1722
Dawson Community College	300 College Dr., Glendive, MT 59330	406-377-9412
Flathead Valley Community College	777 Grandview Dr., Kalispell, MT 59901	406-756-3804
Miles City Community College	2715 Dickinson St., Miles City, MT 59301	406-874-6292
State Bar of MT, attn: Mary Ann Murray	PO Box 577, Helena, MT 59624	406-442-7660 x2214

Medical Rates for 2015-2016 (12 month rates)

Non-Medicare Retirees (generally under age 65)

Monthly Premiums	Allegiance	Blue Choice	PacificSource
Retiree Only	$660	$646	$722
Retiree + One	$1,096	$1,073	$1,199
Retiree + Two or More	$1,314	$1,286	$1,438
Retiree + Spouse *(mp)	$673	$659	$736
Retiree + Spouse *(mp) + Children	$887	$868	$970
Survivor	$660	$646	$722
Survivor + Children	$813	$795	$889

***(mp) = medicare prime**

Medicare enrolled Retirees (generally 65 and older)

Monthly Premiums	Allegiance	Blue Choice	PacificSource	MUS MAP
Retiree Only	$284	$278	$310	$196
Retiree + One	$673	$659	$736	NA
Retiree + Two or More	$887	$868	$970	NA
Retiree + Spouse *(mp)	$453	$443	$495	$392
Retiree + Spouse *(mp) + Children	$622	$608	$680	NA
Survivor	$284	$278	$310	$196
Survivor + Children	$402	$393	$440	NA

***(mp) = medicare prime**

Schedule of Medical Benefits ..... 2015 - 2016

Medical Plan Costs	**Medical Plan In-Network**	**Medical Plan Out-of-Network ***
Annual Deductible Applies to all covered services, unless otherwise noted or copayment is indicated.	$500/Person $1,000/Family	Separate $750/Person Separate $1,750/Family
Copayment (on outpatient visits)	$15 copay	N/A
Coinsurance Percentages (% of allowed charges member pays)	25%	35%
Annual out-of-pocket maximum (Maximum paid by member in a benefit year; includes deductibles, co-pay and coinsurance)	$3,500/Person $7,000/Family	Separate $6,000/Person Separate $12,000/Family

* Services from an **out-of-network** provider have a 35% coinsurance and a separate deductible and annual out-of-pocket maximum. An out-of-network provider can balance bill the difference between the allowance and the charge.

Examples of Medical costs to Plan and Member

(in-network) Jack's Plan Deductible is $500, his coinsurance is 25%, and his out-of-pocket max is $3,500.

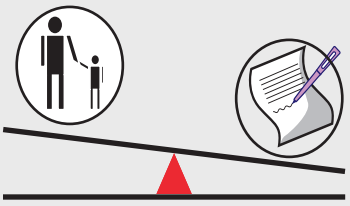
July 1
Beginning plan yr

Jack pays $15 office visit co-pay and 100% of allowable for lab charges

Plan pays remainder of office visit

Jack hasn't reached his deductible yet and he visits the doctor and has lab work. He pays $15 for the office visit and 100% of the allowable for covered lab charges. **For example**, Jack's doctor visit totals $1,000. The office visit is $150 and labwork is $850. The plan allows $100 for the office visit and $400 for the labwork. Jack pays $15 for the office visit and $400 for the labwork. The plan pays $85 for the office visit and $0 for the labwork. The in-network provider writes off $500.

→ more costs



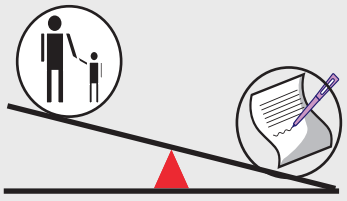
Jack pays $15 office visit co-pay and 25% of allowable for lab charges

Plan pays remainder of office visit and 75% of allowable charges

Jack has seen the doctor several times and reaches his $500 in-network deductible. His plan pays some of the costs of his next visit. He pays $15 for the office visit and 25% of the allowable cost for labwork and the plan pays the remainder of the office visit + 75% of the allowable cost. **For example,** Jack's doctor visit totals $1,000. The office visit is $150 and labwork is $850. The plan allows $100 for the office visit and $400 for the labwork. Jack pays $15 for the office visit and $100 for the labwork. The plan pays $85 for the office visit and $300 for the labwork. The in-network provider writes off $500.

→ more costs

June 30
End of plan yr



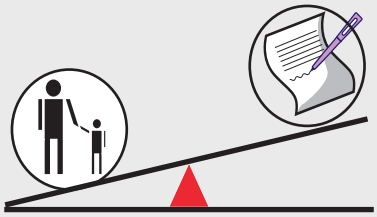
Jack pays 0%

Plan pays 100% allowable charges

Jack reaches his $3,500 out-of-pocket maximum. Jack has seen his doctor often and paid $3,500 total (deductible + coinsurance + co-pays). The plan pays 100% of the allowable for covered charges for the remainder of the benefit year. **For example**, Jack's doctor visit totals $1,000. The office visit is $150 and labwork is $850. The plan allows $100 for the office visit and $400 for the labwork. Jack pays $0 and the plan pays $500. The in-network provider writes off $500.

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

July 1
Beginning plan yr

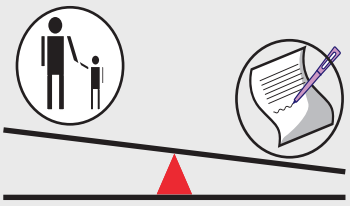


Jack pays **100%**

Plan pays **0%**

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

→ more costs



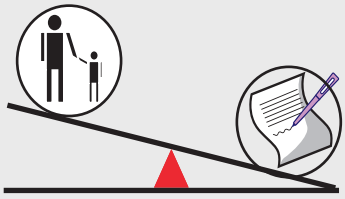
Jack pays 35% + any difference between provider charge and plan allowable.

Plan pays 65% of allowable

Jack has seen the doctor several times and reaches his $750 out-of-network deductible. His plan pays some of the costs of his next visit. He pays 35% of the allowable cost and any difference between the provider charge and the plan allowable. The plan pays 65% of the allowable cost. **For example**, the provider charges $1,000. The plan allowable is $500. Jack pays 35% of the allowable ($175) + the difference between the provider charge and the plan allowable ($500). Jack's total responsibility is $675. The plan pays 65% of the allowable ($325).

→ more costs

June 30
End of plan yr



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

Plan pays 100% of allowable

Jack reaches his $6,000 out-of-pocket maximum. Jack has seen his doctor often and paid $6,000 total (deductible + coinsurance). The plan pays 100% of the allowable for covered charges for the remainder of the benefit year. Jack pays the difference between the provider charge and the allowable. **For example**, the provider charges $1,000. The plan allowable is $500. Jack pays $500 and the plan pays $500.

Medical Plan Services	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Hospital Inpatient Services Pre-certification of non-emergency inpatient hospitalization is strongly recommended		
Room Charges	25%	35%
Ancillary Services	25%	35%
Surgical Services (See Summary Plan Description for surgeries requiring prior authorization)	25%	35%
Hospital Services (Outpatient facility charges)		
Outpatient Services	25%	35%
Outpatient Surgi-Center	25%	35%
Physician/Professional Provider Services (not listed elsewhere)		
Office visit	$15 copay/visit	35%
Inpatient Physician Services	25%	35%
Lab/Ancillary/Miscellaneous Charges	25%	35%
Eye Exam (preventive & medical)	0% one/yr	35% one/yr
Second Surgical Opinion	$15 copay/visit for office visit only - lab, x-ray & other procedures apply deductible/coinsurance	35%
Emergency Services		
Ambulance Services for Medical Emergency	$200 copay	$200 copay
Emergency Room Facility Charges	$125 copay/visit for room charges only lab, x-ray & other procedures apply deductible/coinsurance (waived if immediately admitted to hospital)	$125 copay/visit for room charges only lab, x-ray & other procedures apply deductible/co-insurance (waived if immediately admitted to hospital)
Professional Charges	25%	25%
Urgent Care Services		
Facility/Professional Charges	$50 copay/visit for room charges only - lab, x-ray & other procedures apply deductible/coinsurance	$50 copay/visit for room charges only - lab, x-ray & other procedures apply deductible/coinsurance
Lab & Diagnostic Charges	25%	25%
Maternity Services		
Hospital Charges	25%	35%
Physician Charges (delivery & inpatient)	25% (waived if enrolled in WellBaby Program within first trimester)	35%
Prenatal Offices Visits	$15 copay/visit (waived if enrolled in WellBaby Program within first trimester)	35%

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

Schedule of Medical Benefits ..... 2015 - 2016

Medical Plan Services	**In-Network Copay/Coinsurance**	**Out-of-Network Coinsurance**
Preventive Services		
Preventive screenings/ immunizations/flu shots (adult & child Wellcare) Refer to pages 15 & 16 for listing of Preventive Services covered at 100% allowable and for age recommendations	$15 copay (no deductible) limited to services listed on pg 15 & 16. Other preventive services subject to deductible and co-insurance	35%
Mental Health Services		
Inpatient Services (Pre-certification is strongly recommended)	25%	35%
Outpatient Services	First 4 visits $0 copay then $15 copay/visit	35%
Chemical Dependency		
Inpatient Services (Pre-certification is strongly recommended)	25%	35%
Outpatient Services	First 4 visits $0 copay then $15 copay/visit	35%
Rehabilitative Services Physical, Occupational, Cardiac, Respiratory, Pulmonary & Speech Therapy		
Inpatient Services (Pre-certification is strongly recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr
Outpatient Services	$15 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr

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

Medical Plan Services	In-Network Copay/Coinsurance	Out-of-Network Coinsurance
Complementary Health Care Services		
Acupuncture	$15 copay/visit Max: 30 visits/yr	**Note:** Currently there is no network for Acupuncture, Naturopathic & Massage Therapy so out-of-network is the same as in-network but the member will be balance billed the difference between allowance and provider charge.
Naturopathic	$15 copay/visit	
Medical Massage Therapy (Claim form available on MUS website)	$15 copay/visit Max: 30 visits/yr	
Chiropractic	$15 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr
Extended Care Services		
Home Health Care (Prior authorization is strongly recommended)	$15 copay/visit Max: 30 visits/yr	35% Max: 30 visits/yr
Hospice	25% Max: 6 months	35% Max: 6 months
Skilled Nursing (Prior authorization is strongly recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr
Miscellaneous Services		
Allergy Shots	$15 copay/visit Office visit only If no office visit, deductilble waived, 25% coinsurance	35%
Durable Medical Equipment, Prosthetic Appliances & Orthotics (Prior authorization is required for amounts greater than $2,500)	25% Max: $200 for foot orthotics	35% Max: $200 for foot orthotics

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

Schedule of Medical Benefits …….. 2015 - 2016

Medical Plan Service	**In-Network Copay/Coinsurance**	**Out-of-Network Coinsurance**
Miscellaneous Services cont.		
PKU Supplies (Includes treatment & medical foods)	0% (no deductible)	35%
Dietary/Nutritional Counseling (Prior authorization recommended)	0% (no deductible) Max: 8 visits/yr	35%
Obesity Management (Prior authorization recommended by all plans)	25% Must be enrolled in Take Control for non-surgical treatment	35%
TMJ (Prior authorization recommended)	25% Surgical treatment only	35%
Infertility Treatment (Prior authorization recommended for all plans providing coverage)	25% Max: 3 artificial inseminations/ lifetime	35%
Organ Transplants		
Transplant Services (Prior authorization required)	25%	35%
Travel		
Travel for patient only (If services are not available in local community)	0% up to $1,500/yr. with Prior authorization -up to $5,000/yr. in conjunction with transplants only with Prior authorization	0% up to $1,500/yr. with Prior authorization -up to $5,000/yr. in conjunction with transplants only with Prior authorization
Discover Great Health!		
Preventive Health Screenings/ Healthy Lifestyle Ed. & Support/ Emotional & Financial Wellness	see pg 29	
Take Control	see pg 30	
Tobacco Cessation, Diabetes, Weight Loss, High Cholesterol, High Blood Pressure		
WellBaby		
Infusion Therapy		

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

NEW WEST MEDICARE

2015 - 2016 Montana University System Medicare Advantage Retiree Plan (MUSMAP)

Why choose the MUSMAP Plan?

- $196 Monthly Premium per Enrollee for Medical Services, Prescription Drugs, & Vision Care
- $5,000 Out-of-Pocket Maximum for In-Network Medical Benefits
- Rich Benefits - No Deductible, Simple Co-pays
- Routine Wellness Exam
- Extensive Medicare Provider Network
- Excellent Customer Care Provided by New West Customer Service Specialists
- Worldwide Coverage for Urgent and Emergent Care
- Exercise & Healthy Aging Program

Medical Plan Highlights • Simple Co-payments

In-Network Benefits • No deductible!

$ 15 Physician/Specialist Office Visit Co-payment
$ 0 Lab/Diagnostic
$ 0 X-ray
$ 45 Urgent Care Visit Co-payment
$ 75 Emergency Room Visit Co-payment
$250 Outpatient Surgery
$200 Inpatient Hospital Co-pay Per Day (Days 1-6)

Out-of-Network Benefits • No deductible!

$ 30 Physician/Specialist Office Visit Co-payment
$ 35 Lab/Diagnostic
$ 35 X-ray
$ 45 Urgent Care Visit Co-payment
$ 75 Emergency Room Visit Co-payment
$350 Outpatient Surgery
$250 Inpatient Hospital Co-pay Per Day (Days 1-6)

Wellness Benefits

No co-payment for covered Medicare Wellness Services:

Bone Mass Measurement, Colorectal Screening, Immunizations, Screening Mammogram, Pap Smear, Prostate Screening Exam, Routine Hearing and Vision Exams

Prescription Drugs

6-Tier Closed Formulary
Medicare Part D Drug Coverage
$2,500 Out-of-Pocket Maximum
34-Day Medication Supply Co-payments:

- Low Generic - $0
- High Generic - $10
- Preferred Brand - $40
- Low Specialty/Non-Preferred Brand - $75
- High Specialty- 33%
- Vaccines - $0

90-Day Medication Supply Co-payments:

- Low Generic - $0
- High Generic - $20
- Preferred Brand - $100
- Low Specialty/Non-Preferred Brand - $225
- High Specialty - 33%

Live, Love & Age Healthy
with New West by your side.

newwestmedicare.com

Medicare Advantage Program Cont.

Commonly Asked Questions and Answers

May I go to any doctor or hospital I choose?
YES. You have the freedom to use any doctor or hospital you choose that accepts Medicare and Medicare Advantage. You may receive the best price for services and owe the least amount out-of-pocket when accessing New West Medicare Providers and Hospitals.

Will choosing to participate in the MUSMAP affect my retiree benefits?
NO. The MUSMAP through New West is offered to you as an option for your retiree medical and prescription drug plan. You may still use your TRS or PERS benefits to automatically pay your premium.

If I choose to participate in the MUSMAP this year, can I switch plans if I choose to next year?
YES. You have the opportunity to change your medical benefits during the MUSMAP annual enrollment period each year.

May I enroll (or remain enrolled) in the MUS vision and dental plans while enrolled in MUSMAP?
YES. You may enroll (if a new retiree) or remain enrolled in the separate dental (must qualify) and/or vision plans offered through your MUS retiree option.

Do I have to enroll in Medicare Parts A and B to participate?
YES. To enroll you must be eligible for Part A and enrolled in Part B, continue to pay your Part A premium (if applicable) and your Part B premium. Most people do not have a Medicare Part A premium.

Do I have coverage while traveling outside of Montana?
YES. You are covered anywhere you travel in the United States. Higher out-of-network co-pays apply for routine, elective care when accessing a non-participating provider, except for urgent and emergent services. With the MUSMAP plan, you have worldwide coverage for urgent and emergency care.

Can I still participate if I live outside of Montana during the winter months?
YES. You may participate if your permanent residence is Montana.

Who do I contact for more information regarding coverage for my specific health conditions?
Please call New West Medicare Customer Service at the number below, or if you are currently undergoing medical treatment, please contact the New West Medical Management team at 1-800-290-3657, Option 2. They will provide transition of care assistance to assure there are no interruptions in your current medical treatment.

Anything else I should know?
- Beneficiaries must use network pharmacies to access their prescription drug benefit, except in non-routine circumstances. Quantity limitations and restrictions may apply.
- This information may be available in a different format, including large print. Please call Customer Service at the number listed below if you need plan information in another format.
- You may be able to get extra help paying for your prescription drug premiums and costs. To see if you qualify:
  - Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048, 24 hours a day/7 days a week; or
  - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778; or
  - Your local Montana Medicaid office.

New West Health Services is a PPO plan with a Medicare contract. Enrollment in New West Medicare depends on contract renewal. You must continue to pay your Medicare Part B premium. Limitations, co-payments and restrictions may apply. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact Customer Service at 888-873-8049, TTY 711. Phone hours of operation 8 a.m. to 8 p.m. daily. Benefits may change on January 1 of each year.

Preventive Services

1. What Services are Preventive

All MUS health options provide 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 this preventive care is provided by in-network providers it is reimbursed at 100% of the allowed amount, without application of deductible, coinsurance, or co-pay.

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/index.html
CDC: www.cdc.gov
Bright Future: www.brightfutures.org
Secretary Advisory Committee: www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders

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 coding practices should be observed.

2. Also of importance is the difference between a "screening" test and a diagnostic, monitoring or surveillance test. A "screening" test done on an asymptomatic person is a preventive service, and is considered preventive even if the test results are positive for disease, but future tests would be diagnostic, for monitoring the disease or the risk factors for the disease. A test done because symptoms of disease are present is not a preventive screening.

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

See next page for listing of covered Preventive Services.

Covered Preventive Services

Note: When this preventive care is provided by in-network medical providers it is reimbursed at 100% of the allowed amount, without application of deductible, coinsurance, or co-pay.

Periodic Exams Appropriate screening tests per Bright Futures and other sources (previous page)	
WellChild Care Infant through age 17	• Age 0 months through 4 yrs (up to 14 visits) • Age 5 yrs through 17 yrs (1 visit per benefit plan year)
Adult Routine Exam Exams may include screening/counseling and/or risk factor reduction interventions for depression, obesity, tobacco use/abuse, drug and/or alcohol use/abuse	• Age 18 yrs through 65+ (1 visit per benefit plan year)
Preventive Screenings	
Anemia Screening	• Pregnant Women
Bacteriuria Screening	• Pregnant Women
Breast Cancer Screening (mammography)	• Women 40+ (1 per benefit plan year)
Cervical Cancer Screening (PAP)	• Women age 21 - 65 (1 per benefit plan year)
Cholesterol Screening	• Men age 35+ (age 20 - 35 if risk factors for coronary heart disease are present) • Women age 45+ (age 20 - 45 if risk factors for coronary heart disease are present)
Colorectal Cancer Screening age 50+	• Fecal occult blood testing; 1 per benefit plan year OR • Sigmoidoscopy; every 5 yrs OR • Colonoscopy; every 10 yrs
Prostate Cancer Screening (PSA) age 50+	• 1 per benefit plan year (age 40+ with risk factors)
Osteoporosis Screening	• Post menopausal women 65+, or 60+ with risk factors (1 bone density x-ray (DXA))
Abdominal Aneurysm Screening	• Men age 65 - 75 who have ever smoked (1 screening by ultrasound per plan year)
Diabetes Screening	• Adults with high blood pressure
HIV Screening	• Pregnant women and others at risk
RH Incompatibility Screening	• Pregnant women
Routine Immunizations	
Diptheria, tetanus, pertussis (DTaP) (Tdap)(TD), Haemophilus influenza (HIB), Hepatitis A & B, Human Papillomavirus (HPV), Influenza, Measles, Mumps, Rubella (MMR), Meningococcal, Pneumococcal (pneumonia), Poliovirus, Rotavirus, Varicella (smallpox), Zoster (shingles) **Influenza and Zoster (Shingles) vaccinations are reimbursed at 100% via the URx Pharmacy benefit.** **If needed, see immunization schedules on CDC website (previous page)**	

Prescription Drug Choices

(Included in Medical plan)

$$
Out-of pocket max:
Individual: $1,650/yr
Family: $3,300/yr

URx
Your Pharmacy Plan

URx is your Pharmacy Plan:

- Any member enrolled in a medical insurance plan will automatically receive URx. There is no separate premium.
- No deductible for prescription drugs.

What is URx?
URx is a prescription drug management program developed by the Montana University System. URx uses the prescription process as a mechanism to manage overall care of a member by focusing on producing better clinical outcomes by making sure members get the best drug to treat their condition.

How does URx work?
One component of the URx program is the Pharmacy & Therapeutics Committee (PTAC). Under the Montana University System's oversight, this committee is responsible for evaluating drugs for placement on the URx formulary. The PTAC committee is charged with developing the formulary (the list of preferred drugs covered by the plan) that will make the most effective drugs the least expensive to the member, regardless of the drug's actual cost.

With URx there is no deductible and tier A, B, C, S $50, and S $200 prescriptions will accumulate toward an out-of-pocket maximum of: Individual - $1,650/yr; Family - $3,300/yr.

Who is eligible?
The Prescription Drug Plan is a benefit for all benefits eligible Montana University System employees, Retirees, and COBRA members and their eligible dependents. Any member enrolled in a medical insurance plan will automatically receive URx. There is no separate premium.

Prescription Options
Prescription drugs may be obtained through the plan at either a local pharmacy (30 day supply) or a mail-order pharmacy (90 day supply). Members who use maintenance medications can experience significant savings by utilizing a mail order pharmacy.

Administrators

Under URx, the plan's administrative responsibilities are divided among four vendors:

MedImpact is the pharmacy benefit administrator. MedImpact serves as the claims processor. They have a dedicated customer service telephone line for the Montana University System to answer any questions that members may have regarding benefits or claims processing.

Specialty Pharmacy
Diplomat Specialty Pharmacy (1-877-319-6337) is the administrator of the specialty pharmacy program. Diplomat will provide assistance and resources to members who are prescribed high dollar oral, intravenous, or injectable medications.

Costco Pharmacy and **Ridgeway** will administer the mail-order drug program and will provide mail-order pharmacy services to plan members, based on URx pricing and plan design.

Questions

About the pharmacy benefit.
call MedImpact at 1-888-648-6764
or visit: www.choices.mus.edu/urx.asp

About prescriptions or alternatives call 1-888-5-Ask-Urx (527-5879) to speak with a Pharmacist and ask questions about your drug and what tier it falls under in the URx formulary.

URx Specialty Drug Program

Administered by Diplomat: 1-877-319-6337

Specialty Drugs

Specialty drugs are defined as high cost prescription drugs that may require special handling and/or administration to treat chronic, complex conditions. They require much higher levels of clinical management due to the nature of the disease they treat and their potential side effects – personalized dosing, administration and intensive monitoring.

The **URx** Specialty Drug program offers a variety of medications at $50 copay. Other specialty drugs are available through the **URx** Specialty Program with a $200 copay.

If members prefer to receive specialty drugs at retail pharmacies (if available), then the copay is 50% of the total cost of the drug.

Some drugs are limited distribution drugs and may not be available through Diplomat. For these prescriptions, Diplomat will transfer them to specialty pharmacies that are able to dispense these drugs.

Because of the complexity of the medical condition, many of these drugs will require Prior Authorization to ensure appropriate use and to maximize the effectiveness of the drug by encouraging careful adherence to treatment protocols.

Diplomat Specialty Pharmacy is the provider for specialty drug services. To enroll or for any questions regarding the specialty drug program, please contact Diplomat at: 1-877-319-6337.

Specialty Drug copays are $50 and $200.

URx Drug Classification

Call 1-888-5-Ask-URx (527-5879) to ask questions about your prescriptions or alternative drugs that may be available.

URx Drug Classification (Based on medical evidence of impact to health and overall net cost)	Drug Class	Deductible	Retail Rx (30-day supply)	Mail Rx (90-day supply)
Excellent level of value based on best medical evidence, best opportunity for improved health outcomes via disease management, and best overall net cost.	**Tier A**	**$0**	$0 Copayment †	$0 Copayment †
High level of value based on medical evidence of outcomes and lower overall net cost savings. Includes generic and brand drugs compared to higher cost brand name counterparts.	**Tier B**	**$0**	$15 Copayment †	$30 Copayment †
Good level of value based on fair medical evidence grading, but displaying higher overall net cost relative to generic counterparts and less expensive brand name drug or clinical alternatives.	**Tier C**	**$0**	$40 Copayment †	$80 Copayment †
Lower level of value based on evidence of outcomes relative to other clinical alternatives. Generally have much higher overall net costs. *[Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most drugs purchased through URx.]*	**Tier D**	**$0**	50% Coinsurance †* (You will pay half of the discounted price)	50% Coinsurance †* (You will pay half of the discounted price)
These drugs have the lowest level of value (based on clinical evidence) or the highest overall net cost in relation to generic or other brand alternatives. Tier F drugs may also include drugs that were not previously covered, allowing members to purchase them at a substantial discount. *[Coinsurance is calculated on the discounted cost of drugs. Discounts have been negotiated for most.]*	**Tier F**	**$0**	100% Coinsurance †* (You will pay 100% of the discounted price)	100% Coinsurance †* (You will pay 100% of the discounted price)
If you take a specialty drug, you are encouraged to use the URx Specialty Pharmacy program to qualify for a $50 or $200 copayment. If you fill your prescription at a retail pharmacy, you will have to pay 50% coinsurance. Specialty drugs are not covered through the mail-order program.	**Tier S**	**$0**	50% Coinsurance †* if purchased through standard retail pharmacy	Not Covered

The amounts you pay in these categories do not count toward your annual out-of-pocket prescription maximum.

† ***A copayment is a flat dollar amount you pay for Rx services. Coinsurance is a percentage of the total discounted cost you pay for Rx services.***

Interesting Facts:
Most people don't realize that just because a drug costs more does not mean that it is better. Drug manufacturers spend billions of dollars each year on advertising - so if you see six commercials for a particular drug, that drug may cost a lot of money! Currently the Montana University System Employee Benefits Plan spends more on prescription drugs than on doctor visits.

How do I determine what my drug tier is?
You can look up which tier your drug is at www.choices.mus.edu/urx.asp or by calling the Ask a Pharmacist line at 1888-527-5879. If you are unsatisfied with the tier your drug(s) makes, other therapeutically equivalent drugs that are more cost effective will be displayed that you can discuss with your physician. We encourage you to take this information to your physician to determine if you are able to use the therapeutically equivalent drug.

What does it mean that most drugs are covered?
The Montana University System's Pharmacy Benefit Administrator negotiates discounts with pharmaceutical companies. These discounts will be passed on to you regardless of the class of your drug. All drugs, including those that were formerly not covered, will have a discount. This savings will be passed on to you as a member of the Montana University System Employee Benefits Plan.

Vision hardware *(voluntary)*

Administered by Blue Cross Blue Shield:

Customer Service 1-800-820-1674 or 447-8747
www.bcbsmt.com
Claim submission form available at: www.choices.mus.edu

Who is Eligible?
Employees, spouses, adult dependents, retirees, and children are eligible if you elect to have this coverage.

Instructions
Review the premiums on the next page and complete the appropriate sections of the Enrollment Form.

Using Your Vision Hardware Benefit
Quality vision care is important to your eye wellness and overall health care. Accessing your Vision Hardware benefit is easy. Simply select your provider, purchase your hardware and submit to Blue Cross Blue Shield (BCBS) for processing.

IMPORTANT

Reminder: the voluntary vision coverage is a hardware benefit only. **Eye Exams**, whether preventive or medical, are covered under the medical benefit plan. See pg. 9

Sample Vision Hardware card

BlueCross BlueShield

MONTANA UNIVERSITY SYSTEM

Subscriber Name: MONTANA UNIVERSITY SYSTEM

Identification Number MVA

Dependent Name:

Group Number: V58005

..... Continued on next page

Vision hardware *(voluntary)* cont.

Monthly Vision Hardware Rates	
• Employee Only	$7.11
• Employee & Spouse/Adult Dep.	$13.42
• Employee & Child(ren)	$14.13
• Employee & Family	$20.73

Note: Reminder: the voluntary vision coverage is a hardware benefit only. Eye Exams, whether preventive or medical, are covered under the medical benefit plan. See pg. 9

Service/Material	Coverage
Frames: Once every two years	$175 allowance
Single Vision Bifocal Trifocal Standard Progressives Once every benefit year in lieu of contacts	$5 copay $5 copay $5 copay $25 copay
Lens Options: UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard A/R	 $5 copay $5 copay $5 copay $20 copay $25 copay
Contact Lens Materials: Conventional & Disposable *Medically Necessary Once every benefit year in lieu of eyeglass lenses	 $150 allowance $150 allowance paid in full
Contact Lens Exam Fees: Standard Contact Lens Fit & Follow-up Premium Contact Lens Fit & Follow-up Once every benefit year	 $5 copay, paid in full fit and two follow up visits $5 copay

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

Dental *(must choose) Choices*

Choices offers one Dental plan option for Retirees: **Select Plan**

Retiree enrollment in the dental plan is a one-time opportunity. See the back of the enrollment form for details. If you do not enroll in a timely manner, you will lose your right for coverage unless a qualifying event occurs.

	Select Plan - Enhanced Coverage
Who May be Enrolled & Monthly Premium	• Retiree Only $52 • Retiree & Spouse/Adult Dep. $94 • Retiree & Child(ren) $94 • Retiree & Family $156
Maximum Annual Benefit	**$1,500 per covered individual**
Preventive and Diagnostic Services	• Twice Per Benefit Year • Initial and Periodic oral exam • Cleaning • Complete series of intraoral X-rays • Topical application of fluoride **Note:** the above services do not count towards the $1,500 annual maximum and include the Diagnostic & Preventive (D&P) Maximum Waiver feature. See below
Basic Restorative Services	• Amalgam filling • Endodontic treatment • Periodontic treatment • Oral surgery
Major Dental Services	• Crown • Root canal • Complete lower and upper denture • Dental implant • Occlusal guards
Removal of impacted teeth	• Covered benefit
Orthodontia	• Available to covered children and adults • $1,500 lifetime benefit
Implants	• Included in annual benefit

Enrollment in the dental plan is a one-time opportunity for Retirees (and their dependents). However, a Retiree enrolling in the MAP plan may suspend his dental coverage (one time) and return to the dental plan in a later plan year (one time). Coverage is permanently forfeited if the Retiree fails to enroll in a timely manner, cancels dental coverage, or fails to pay premiums. NOTE: A spouse reaching age 65 is not a qualifying event for re-enrolling in dental.

Select Plan Benefit Highlight Features:

Diagnostic & Preventive Maximum Waiver Benefit

The ***Choices*** Select Plan includes the D&P Maximum waiver benefit allowing MUS plan members to obtain diagnostic & preventive services without those costs applying to the annual $1,500 maximum.

Orthodontic Benefits

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

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

MUS Dental Schedule of Benefits

Dental claims are reimbursed based on a Schedule of Benefits. The following subsets of the **Select** Schedules include the most commonly used procedure codes. The Schedule's dollar amount is the maximum reimbursement for the specified procedure code. Covered individuals are responsible for the difference (if any) between the provider's charge and the Schedule's reimbursement amount.

See Summary Plan Description (SPD) for complete listing.

Procedure Code	Description	Maximum Benefits
D0120	periodic oral evaluation - established patient	$40.00
D0140	limited oral evaluation - problem focused	$58.00
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	$40.00
D0150	comprehensive oral evaluation - new or established patient	$65.00
D0180	comprehensive periodontal evaluation - new or established patient	$72.00
D0210	intraoral - complete series of radiographic images	$110.00
D0220	intraoral - periapical first radiographic image	$26.00
D0230	intraoral - periapical each additional radiographic image	$20.00
D0240	intraoral - occlusal radiographic image	$25.00
D0250	extraoral - first radiographic image	$58.00
D0270	bitewing - single radiographic image	$22.00
D0272	bitewings - two radiographic images	$37.00
D0273	bitewings - three radiographic images	$45.00
D0274	bitewings - four radiographic images	$53.00
D0320	temporomandibular joint arthrogram, including injection	$622.00
D0330	panoramic radiographic image	$91.00
D1110	prophylaxis - adult	$83.00
D1120	prophylaxis - child	$58.00
D1206	topical application of fluoride varnish	$31.00
D1208	topical application of fluoride – excluding varnish	$28.00
D1351	sealant - per tooth	$45.00
D1510	space maintainer - fixed - unilateral	$239.00
D1515	space maintainer - fixed - bilateral	$388.00
D1520	space maintainer - removable - unilateral	$393.00
D1525	space maintainer - removable - bilateral	$538.00
D2140	amalgam - one surface, primary or permanent	$93.00
D2150	amalgam - two surfaces, primary or permanent	$118.00
D2160	amalgam - three surfaces, primary or permanent	$147.00
D2161	amalgam - four or more surfaces, primary or permanent	$176.00
D2330	resin-based composite - one surface, anterior	$98.00
D2331	resin-based composite - two surfaces, anterior	$125.00
D2332	resin-based composite - three surfaces, anterior	$156.00
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	$190.00
D2391	resin-based composite - one surface, posterior	$116.00

Procedure Code	Description	Maximum Benefits
D2392	resin-based composite - two surfaces, posterior	$148.00
D2393	resin-based composite - three surfaces, posterior	$184.00
D2394	resin-based composite - four or more surfaces, posterior	$220.00
D2543	onlay - metallic - three surfaces	$375.00
D2544	onlay - metallic - four or more surfaces	$440.00
D2643	onlay - porcelain/ceramic - three surfaces	$375.00
D2644	onlay - porcelain/ceramic - four or more surfaces	$440.00
D2740	crown - porcelain/ceramic substrate	$453.00
D2750	crown - porcelain fused to high noble metal	$423.00
D2751	crown - porcelain fused to predominantly base metal	$410.00
D2752	crown - porcelain fused to noble metal	$414.00
D2780	crown - 3/4 cast high noble metal	$406.00
D2783	crown - 3/4 porcelain/ceramic	$410.00
D2790	crown - full cast high noble metal	$410.00
D2930	prefabricated stainless steel crown - primary tooth	$148.00
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	$95.00
D2951	pin retention - per tooth, in addition to restoration	$38.00
D2954	prefabricated post and core in addition to crown	$127.00
D3110	pulp cap - direct (excluding final restoration)	$43.00
D3310	endodontic therapy, anterior tooth (excluding final restoration)	$489.00
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	$566.00
D3330	endodontic therapy, molar tooth (excluding final restoration)	$695.00
D3346	retreatment of previous root canal therapy - anterior	$592.00
D3347	retreatment of previous root canal therapy - bicuspid	$674.00
D3348	retreatment of previous root canal therapy - molar	$814.00
D3410	apicoectomy – anterior	$435.00
D3421	apicoectomy – bicuspid (first root)	$480.00
D3425	apicoectomy – molar (first root)	$520.00

 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 information.

Dental Codes Schedule of Benefits ....

Procedure Code	Description	Maximum Benefits
D3430	retrograde filling - per root	$116.00
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$358.00
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$113.00
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	$672.00
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$511.00
D4270	pedicle soft tissue graft procedure	$407.00
D4273	subepithelial connective tissue graft procedures, per tooth	$632.00
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$154.00
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$97.00
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	$59.00
D4910	periodontal maintenance	$84.00
D5110	complete denture - maxillary	$608.00
D5120	complete denture - mandibular	$608.00
D5130	immediate denture - maxillary	$666.00
D5140	immediate denture - mandibular	$666.00
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$436.00
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$436.00
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$650.00
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$650.00
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	$488.00
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	$488.00
D5510	repair broken complete denture base	$86.00
D5520	replace missing or broken teeth - complete denture (each tooth)	$76.00
D5610	repair resin denture base	$89.00
D5640	replace broken teeth - per tooth	$76.00

Please refer to the SPD for complete information.

Procedure Code	Description	Maximum Benefits
D5650	add tooth to existing partial denture	$114.00
D5751	reline complete mandibular denture (laboratory)	$274.00
D5761	reline mandibular partial denture (laboratory)	$263.00
D5820	interim partial denture (maxillary)	$216.00
D5821	interim partial denture (mandibular)	$216.00
D5850	tissue conditioning, maxillary	$51.00
D6210	pontic - cast high noble metal	$399.00
D6212	pontic - cast noble metal	$365.00
D6240	pontic - porcelain fused to high noble metal	$424.00
D6241	pontic - porcelain fused to predominantly base metal	$391.00
D6242	pontic - porcelain fused to noble metal	$408.00
D6245	pontic - porcelain/ceramic	$429.00
D6750	crown - porcelain fused to high noble metal	$423.00
D6752	crown - porcelain fused to noble metal	$414.00
D6790	crown - full cast high noble metal	$410.00
D6791	crown - full cast predominantly base metal	$402.00
D6792	crown - full cast noble metal	$406.00
D6794	crown - titanium	$410.00
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$94.00
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$160.00
D7220	removal of impacted tooth - soft tissue	$176.00
D7230	removal of impacted tooth - partially bony	$215.00
D7240	removal of impacted tooth - completely bony	$255.00
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	$305.00
D7850	surgical discectomy, with/without implant	$1,500.00
D7860	arthrotomy	$1,500.00
D7880	occlusal orthotic device, by report	$469.00
D7899	unspecified TMD therapy, by report	by Report
D7960	frenulectomy – frenectomy or frenotomy – separate procedure	$210.00
D7971	excision of pericoronal gingiva	$120.00
D9110	palliative (emergency) treatment of dental pain - minor procedure	$69.00
D9220	deep sedation/general anesthesia - first 30 minutes	$219.00
D9221	deep sedation/general anesthesia – each additional 15 minutes	$105.00
D9241	intravenous moderate (conscious) sedation/analgesia – first 30 minutes	$199.00
D9242	intravenous moderate (conscious) sedation/analgesia – each additional 15 minutes	$81.00
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$67.00
D9940	occlusal guard, by report	$245.00

Please refer to the SPD for complete information.

Delta Dental Fee examples

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

Finding a Delta Dental Dentist:

The MUS dental program utilizes schedules of benefits so you know in advance exactly how much the plan will pay for each covered service. It is important to understand that a dentist's charges may be greater than the plan benefit, resulting in balance billing to you. While you have the freedom of choice to visit any licensed dentist under the plan, you may want to consider visiting a Delta Dental dentist to reduce your out of pocket costs.

When a dentist contracts with Delta Dental, they agree to accept Delta Dental's allowed fee as full payment. This allowed fee may be greater than the MUS plan benefit in which case, the dentist may balance bill you up to the difference between the allowed fee and the MUS benefit amount.

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

The following claim examples for an adult cleaning demonstrate how lower out-of-pocket patient costs can be achieved when you visit a Delta Dental dentist (**Basic** and Select Plan coverage). The examples compare the patient's share of costs at each network level below:

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

The following claim examples for a crown demonstrate how lower out-of-pocket patient costs can be achieved when you visit a Delta Dental dentist (**Basic** and Select Plan coverage). The examples compare the patient's share of costs at each network level below:

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

Long Term Care Insurance *(voluntary)*

Provided by UNUM Life Insurance Co.

1-800-227-4165 www.unuminfo.com/mus

Options	Choices
Care Type	
Plan 1	Facility (nursing home or assisted living)
Plan 2	Facility + Professional Home Care (Provided by a licensed home health organization)
Plan 3	Facility + Professional Home Care + Total Home Care (Care provided by anyone, including family members)
Monthly Benefit	
Nursing Home	$1,000-$6,000
Assisted Living	60% of the selected nursing home amount
Home Care	50% of the selected nursing home amount
Duration	
3 years	3 years Nursing Home
6 years	6 years Nursing Home
Unlimited	Unlimited Nursing Home
Inflation Protection	
Yes	5% compounded annually
No	No protections will be provided

Unexpected events, such as accidents or illness, can catch us off guard at any age, any time. This can often lead to financial and emotional hardship. Many believe that our health plan covers long term care situations when, in most cases, it does not. We may be left thinking we should have planned better. The Long Term Care (LTC) plan is designed to pick up where our health plan leaves off. You may never need long term care. However, this year about nine million men and women will need long term care. By 2020, 12 million Americans will need long term care. Most will be cared for at home. A study by the US Department of Health and Human Services indicates that people who reach age 65 have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home stay there five years or longer. The Montana University System offers the opportunity to purchase Long Term Care Insurance from Unum Life Insurance Company of America, a subsidiary of Unum Provident.

New employees can enroll in LTC within 30 days of employment without demonstrating evidence of insurability. Continuing employees, spouses, retirees, and grandparents can enroll in our group LTC insurance with medical underwriting at any time.

Who is Eligible
Employees, retirees, spouses, parents, and parents-in-law are eligible for the Long Term Care Insurance Plan. This plan may be elected, changed, or dropped at anytime.

Enrollment
If you would like to sign up for the Long Term Care Plan, contact your campus Human Resource Department for an enrollment kit.

Discover Great Health!

Overview
The Montana University System (MUS) Benefits Plan offers Wellness services to covered adult plan members (faculty, staff, retirees, and spouses) regardless of which medical plan you choose. For more detailed information about your Wellness Program please refer to the Wellness Program book.

WELLNESS
MONTANA UNIVERSITY SYSTEM

Preventive Health Screenings

WellCheck
Every campus offers health screenings for 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 plan members are eligible for two free WellChecks per plan year. Go to **www.wellness.mus.edu/WellCheck.asp** for more information regarding WellCheck dates and times on your campus.

Online Registration
Online registration is required on all campuses for WellCheck appointments. To register go to: www.itstartswithme.com.

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

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

STAY CONNECTED

For education and Monthly Challenges visit our Blog: www.montanamovesandmeals.com

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

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

Healthy Lifestyle Education & Support

Ask an Expert
This program provides FREE telephone consultation with a registered dietitian and/or exercise specialist. See Wellness website below for an application.

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.

Emotional Wellness

Confidential Counseling
Each plan year you are eligible for four (4) FREE, confidential sessions with an In-Network counselor for any issues that may be causing stress or disruption. This can be for any issue, be it family, personal, work, or other. (Important: These sessions must be with an in-network counselor to be covered by the plan. To find an in-network counselor, contact your insurance administrator or visit their websites (Blue Cross, Allegiance, or PacificSource). See pg 10 for more information.

Financial Wellness

Solid Finances Series
Solid Finances is a series of FREE financial education webinars to provide working Montanans high quality unbiased financial education opportunities. Available to anyone. Visit **www.msuextension.org/solidfinances** for more information and to view the webinar schedule.

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

MUS MAP PLAN MEMBERS ARE NOT INCLUDED IN THE MUS WELLNESS PROGRAM

Discover Great Health!

Disease Management Programs

Infusion Therapy Program
The Infusion Therapy Program is offered in partnership with the Walgreens-OptionCare stores in Helena, Billings, Bozeman, and Butte. This program was designed for patients who need medication administered through a needle or catheter, to treat such diseases as congestive heart failure, immune deficiencies, multiple sclerosis, and rheumatoid arthritis.

Plan members receive treatment at no cost - no deductibles, no copayments, and no coinsurance. The plan reimburses 100% of the allowable charges for those enrolled in this program. The program is easy to use as well, with no prior authorization requirements. To learn more about the Infusion Program call 1-800-287-8266, or contact MUS Benefits at 1-877-501-1722.

WellBaby
WellBaby is a pregnancy benefit designed to help you achieve a healthier pregnancy. Enroll during first trimester to take advantage of all the Program benefits. For more information call 406-660-0082 or visit the Wellness website below.

Take Control Program

Eat Well. Stay Active. Reduce Your Risks.

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

Take Control Program Offerings:

- **Diabetes** -Type I, Type II, Pre-diabetes, or Gestational (Fasting GLUC > 125)
- **Overweight** - High Body Mass Index (BMI > 24.99)
- **Tobacco User** – Smoking, chewing tobacco, cigars, pipe

Take Control Program Offerings Cont.

- **High Blood Pressure** (Hypertension) (Systolic > 140 or Diastolic > 90)
- **High Cholesterol** (Hyperlipidemia) (CHOL > 240 or TRIG > 200 or LDL > 150 or HDL < 40M/50F)
- **NEW** WellBaby members can join Take Control as part of the WellBaby program

Services Provided:

- Monthly Health Coaching
- Up to three in-network visits with your primary health care provider covered at 100%
- Fitness center or fitness class reimbursement
- Reduced-cost medication waivers for qualifying health conditions
- Assistance with tobacco cessation
- Monthly Newsletter written by Take Control staff, with healthy lifestyle topics
- Website with additional health resources

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

- Weight Watchers reimbursement
- Certified Exercise Specialist (Personal Trainer)
- Sleep Study
- Additional Counseling Sessions (co-pay free)

Incentives:

- A $100 reimbursement award is available after months 6 and 12 to assist in offsetting expenses related to your life style improvement.

For details or more information, call 1-800-746-2970, visit the Take Control website **www.takecontrolmt.com**, or visit the Wellness website below.

What our participants have to say:

"I have struggled with my weight most of my life. Last month I joined Take Control and had my first phone call with a coach. I set some good goals that are obtainable and I am looking forward to making small changes to get me to those goals. Thanks for all of these great challenges and motivators!" – M.V.

"I am feeling so good with all the exercise and diet changes I have been able to make – more energy, less fatigue, I am sleeping better, I can climb stairs and am not short of breath." – J.S.

Wellness Website: www.wellness.mus.edu/DiseaseManagement.asp

MUS MAP PLAN MEMBERS ARE NOT INCLUDED IN THE MUS WELLNESS PROGRAM

Additional Benefits

Self Audit Award Program

Be sure to check all bills from your medical providers to ensure charges have not been duplicated or billed for services you did not receive. When you detect billing errors that result in a claims adjustment, the plan will share the savings with you! You may receive an award of 50 percent of the savings, up to a maximum of $1,000.00.

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

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

To receive the self-audit award, the member must:

- Notify the claims administrator of the error before it is detected by the administrator or the health care provider;
- Contact the provider to verify the error and work out the correct billing, and
- Have copies of the correct billing sent to the claims administrator for verification, claims adjustment and calculation of the self-audit award.

Privacy Rights & Plan Documents

Availability of the MUS Summary Plan Description

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, vision, dental, flex and prescription drug benefits and should always be consulted when a specific question arises about the Plan.

Participants may request a hard copy of the SPD describing the MUS medical plans by visiting, writing, or calling their campus Human Resources/Benefits Office; by writing to MUS Benefits, P.O. Box 203203, Helena, MT 59620-3203, or by calling the MUS Benefits Office at 406-444-2574, toll free 877-501-1722. Participants should know which medical plan they are enrolled in when calling or writing so that the correct information can be sent. An easier way to access this information for many participants is to visit the MUS website at: www.choices.mus.edu.

Using the FIND function on your computer will help you to locate the section you need quickly.

All participants are given or mailed a copy of the Choices Annual Benefits Enrollment Workbook or Retiree Workbook each spring during the annual enrollment period. These workbooks list the various required and optional programs available, and corresponding premiums. We encourage participants to retain this book until it is replaced the following year, as it provides most of the information needed by participants and their families to properly utilize their benefit plans. If additional information is needed after referring to Choices Annual Benefits Enrollment book or the SPD, either the Campus Human Resources/. Benefits Office or MUS Benefits should be able to help. Also, many problems can be resolved by contacting the customer service department of the appropriate claims administrator.

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

The Montana University System Employee Group Benefits 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 Plan is required by law to provide a Notice of Privacy Practices to further describe its legal obligations. The Notice can be accessed on the MUS website.

The Montana University System Employee Group Benefits 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 counseling, psychological services and pharmaceutical services, etc. These Business Associates and health care providers must also, under HIPAA, take measures to protect a plan member's personally identifiable health information from inadvertent, improper or illegal disclosure.

The Montana University System's self-insured employee group health 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, payment, wellness program (including WellChecks), disease management programs (e.g., Take Control) healthcare operations, claims processing, including review of payments or claims denied and appeals of payments or claims denied, premiums paid, liens and other reimbursements, health care fraud and abuse detection, and compliance. Information concerning these categories may be shared, without a participant's written consent, between MUS authorized benefit employees, supervisors and MUS Business Associates, participant's providers or legally authorized governmental entities.

Full HIPAA policy available on Website or by contacting Campus HR

Miscellaneous Legal Information and References

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

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

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

Coordination of Benefits: Persons covered by any health care plan through the Montana University System AND also by any other health care coverage, whether private, employer-based, governmental (including Medicare and Medicaid), or through any other type of insurance (including automobile, homeowners or premise liability insurance) 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 participant. In no case will more than 100% of a claim's allowed amount be paid by the sum of all payments from all applicable insurances.

Note to Retirees eligible for Medicare coverage: All claims are subject to coordination of benefits with Medicare whether or not the covered person is actually receiving Medicare benefits. Retirees eligible for Medicare and paying Medicare Retiree premium rates as published in the ***Choices*** Retiree Workbook are expected to be continuously enrolled in BOTH Medicare Part A and Medicare Part B. Due to MUS participation in the Medicare Retiree Drug Subsidy Program, enrollment in Medicare Part D (drug plan) is not permitted.

Glossary

Allowable Charges

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

Adult Dependent

Adult Dependent is someone at least 18 yrs of age who does not meet the plan definition of spouse or dependent child, but does meet plan eligibility requirements as defined in the Summary Plan Description.

Benefit Year/Plan Year

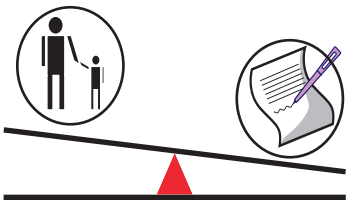
The period starting July 1 and ending June 30.

Certification/Pre-certification

A determination by the appropriate medical plan 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 administrator.

Coinsurance

A percentage of allowable and covered charges that a member is responsible for paying, after paying any applicable deductible. The medical plan pays the remaining allowable charges. For example, if Jack has met his deductible for the In-Network medical costs ($500), he pays 25% of additional allowable charges and the plan pays 75%.



Jack pays $15 office visit co-pay and 25% of allowable for lab charges

Plan pays remainder of office visit and 75% of allowable charges

Copayment

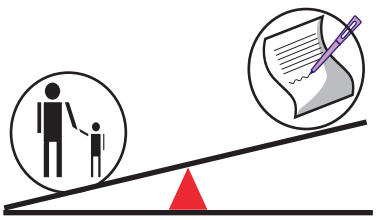
A fixed dollar amount for allowable and covered charges that a member is responsible for paying. The medical plan pays the remaining allowable charges. This type of cost-sharing method is typically used by medical plans.

Covered Charges

Charges for medical services that are determined to be medically necessary and are eligible for payment under a medical plan.

Deductible

A set dollar amount that a member and family must pay before the medical plan begins to share the costs. The deductible applies to the plan July 1 through June 30. For example, Jack's deductible is $500. Jack pays 100 percent of allowable charges until his deductible has been met.



Jack pays $15 office visit co-pay and 100% of allowable for lab charges

Plan pays remainder of office visit

In-Network Providers

Providers who have contracted with the plan to manage and deliver care at agreed upon prices. Members may self-refer to in-network providers and specialists. There are better benefits for services received **In-Network** than for services **Out-of-Network**. You pay a $15 copayment for most visits to In-Network providers (no deductible) and 25% (after deductible) for most In-Network hospital/facility services.

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Managed Care Medical Plan

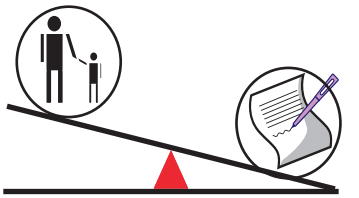
Plans that offer first dollar coverage for services such as office visits that are exempt from deductible. These plans also provide differing levels of benefits for in-network and out-of-network providers.

Out-of-Network Provider

Any provider who renders services to a member but is not a participant in the plan's network.

Out-of-pocket Maximum

The maximum amount of money you pay toward the cost of health care services. Out-of pocket expense include deductibles, copayments, and coinsurance. For example, Jack reaches his $3,500 out-of-pocket maximum. Jack has seen his doctor often and paid $3,500 total (deductible + coinsurance + co-pays). The plan pays 100% of the allowable for covered charges for the remainder of the benefit year.



Participating Provider

A provider who has a contract with the medical plan administrator to accept allowable charges as payment in 0full.

Prior Authorization

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

PPACA

The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will continue to be rolled out through 2018.

URx

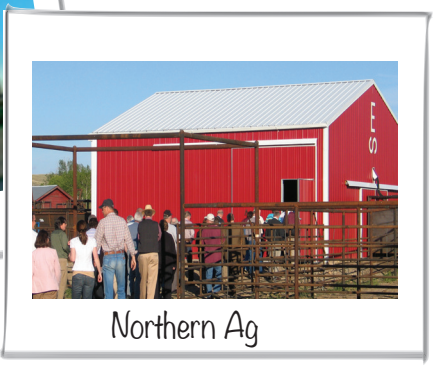
A prescription drug management program developed by the Montana University System.

Scratch Paper

Don't Forget:

Summary of Benefits and Coverage (SBC) forms can be found by visiting the following website: www.choices.mus.edu/SBC.asp These forms, required by PPACA, detail what each plan covers.


Central Ag Station


Northern Ag


Creston Ag Station

RESOURCES

Montana University System Benefits
Office of the Commissioner of Higher Education
(406) 444-2574 * Fax (406) 444-0222 * Toll Free (877) 501-1722
www.choices.mus.edu

HEALTH PLANS

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC. -Medical Plan
Customer Service 1-877-778-8600
Precertification 1-800-342-6510
www.abpmtpa.com/mus

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

PACIFICSOURCE HEALTH PLAN - Medical Plan
Customer Service 406-442-6589 or 1- 877-590-1596
Pre-Authorization: 406-442-6595 or 877-570-1563
www.PacificSource.com/MUS

NEW WEST HEALTH SERVICES - MAP
Customer Service 1-888-873-8049
www.newwestmedicare.com

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

BLUE CROSS AND BLUE SHIELD OF MONTANA - Vision Hardware Plan
Customer Service 1-800-820-1674 or 447-8747
www.bcbsmt.com

URx – PRESCRIPTION DRUG PROGRAM

www.URx.mus.edu
ASK-A-Pharmacist 1888-527-5879
Plan Exception Processing Dept. 1-888-527-5879
Plan Exception Fax:406-513-1928

MEDIMPACT
Customer Service 1-888-648-6764

MAILORDER PRESCRIPTION DRUG PROGRAM
RIDGEWAY MAIL ORDER PHARMACY – www.ridgewayrx.com
Customer Service 1-800-630-3214
Fax: 406-642-6050

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

DIPLOMAT SPECIALTY PHARMACY
Customer Service 1-877-319-6337

STANDARD LIFE INSURANCE – Life and Disability
Customer Service 1-800-759-8702
www.standard.com

UNUM LIFE INSURANCE – Long Term Care
Customer Service 1-800-822-9103
www.unuminfo.com/mus