choices

Active Benefits

2017 - 2018

Montana University System

Please Read

1. Closed Enrollment:

Enrollment for Plan Year 2017/18 is Closed Enrollment for spouses unless there is a qualifying event (see page 3 qualifying events). Children under age 26 may be added during this enrollment period.

2. Marriage Eligibility Change:

As of July 1, 2017, there is no longer an opportunity to add or enroll an Adult Dependent in the Montana University System Employee Health Benefits Plan (MUS Plan) as a dependent. No new Adult Dependents can be added to the MUS Plan on that date or later. Adult Dependents enrolled in the MUS Plan prior to July 1, 2017 can remain on the MUS Plan under their original qualifying status. Children of Adult Dependents who are enrolled prior to July 1, 2017 are eligible for continued coverage. An Adult Dependent is someone at least 18 yrs of age who does not meet the plan definition of spouse or dependent child. As of July 1, 2017 only legally married or common-law spouses with a certified affidavit of common-law marriage will be eligible for enrollment on the plan.

3. Tax Advantaged Accounts (TAA) funds must be expended by:

TAA contributions will no longer be provided by the MUS Plan after the July 1, 2017 TAA Wellness Incentive contribution (if earned by the plan member). This means members have two years from this time to expend any TAA funds. Any TAA balance not expended by June 30, 2019 will be forfeited (See page 29 TAA).

4. Flexible Spending Account (FSA) balance:

If an employee doesn't enroll in an FSA for Plan Year 2018 and has unused FSA funds in the amount of $50 or less that are not expended by September 30, 2017, the FSA will be closed and the remaining unused funds will be forfeited (See page 27 FSA).

CAMPUS BENEFIT CONTACTS

MSU-Bozeman	TBD, call for address	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 - 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/GSL, MUS Benefits Office	2500 Broadway, Helena, MT 59601	877-501-1722
Dawson Community College	300 College Dr., Glendive, MT 59330	406-377-9401
Flathead Valley Community College	777 Grandview Dr., Kalispell, MT 59901	406-756-3981
Miles City Community College	2715 Dickinson St., Miles City, MT 59301	406-874-6292
State Bar of MT	PO Box 577, Helena, MT 59624	406-442-7660

Table of Contents

How *Choices* Works

Mandatory (must choose) Benefits

Optional (voluntary) Benefits

Additional Benefits

How *Choices* Works

Montana Wildflowers

This workbook is your guide to ***Choices*** – 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've chosen. Please read the information in this workbook carefully. If you have any questions, contact your campus Human Resources Department (inside cover). This enrollment workbook is not a guarantee of benefits. Consult your enrollment workbook or Summary Plan Description - see pg 36 for availability.

1. Who's Eligible

A person employed by a unit of the Montana University System, Office of the Commissioner of Higher Education, or other agency or organization affiliated with the Montana University System or the Board of Regents of Higher Education is eligible to enroll in the Employee Benefits Plan if qualified under one of the following categories:

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 actually 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 actually 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 Plan.

Enrolling family members

Enrollment for plan year 2017/18 is Closed Enrollment for spouses unless there is a qualifying event (see page 3 qualifying events). Eligible children under the age of 26 may be added during this enrollment period. See next page for definition of terms.

If you're a **new employee**, you may enroll your family for benefits under ***Choices***, including Medical, Dental, Vision Hardware, life insurance and AD&D coverage.

Note: Effective July 1, 2017, there will no longer be an opportunity to add or enroll an Adult Dependent in the Montana University System Employee Health Benefits Plan (MUS Plan) as a dependent. No new Adult Dependents can be added to the MUS Plan on that date or later. See next page for Eligible family members and definition of terms.

..... Continued on next page

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. As of July 1, 2017 only legally married or common law spouses with a certified affidavit of common-law marriage will be eligible for enrollment on the plan.

- Eligible dependent children under age 26*. Children include your natural children, stepchildren, and children placed in your home for adoption before age 18 or for whom you have court-ordered custody or you are the legal guardian.

  *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 on the MUS Plan.

MSU Northern Campus

2. Waive Coverage

You can waive coverage: You have the option to waive coverage with the Montana University System Employee Benefits Plan. In order to waive coverage, you must sign a hard-copy enrollment form stating you are waiving coverage and submit the form to your campus Human Resources Department by your enrollment deadline. If you do not sign and submit an enrollment form confirming your intention to waive coverage, certain coverages will continue (existing employees) or default (new employees) as outlined below. Please note there is no continuing or default coverage for Flexible Spending Accounts (FSAs) as these accounts must be actively elected each plan year.

If you waive coverage, all of the following apply:

- You waive coverage for yourself and for all eligible dependents.
- You waive all mandatory and optional ***Choices*** coverage, including Medical, Dental, Life, Accidental Death and Dismemberment (AD&D), and Long Term Disability (LTD).
- You forfeit the monthly employer contribution toward benefit 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 spouse cannot re-enroll unless and until they have a qualifying event.

3. How to Enroll

1. Each eligible employee receives a monthly employer contribution to use toward payment of *Choices* coverage. This amount is based on the Montana State legislature's funding allocation toward the cost of benefits for state employees.

2. Within 30 days of first becoming eligible for benefits, or during annual enrollment each year, you select or make changes from among the benefit plan options. Note: Must enroll within 30 days of hire or 63 days of qualifying event (see qualifying events pg 3).

How to Enroll Cont.

3. Each benefit option in ***Choices*** has a monthly cost associated with it. These costs are shown on your enrollment form and in this Workbook.

   Mandatory (must choose):
   Medical pg 4
   Prescription Drug (included in Medical) pg 13
   Dental pg 15
   Basic Life Insurance and AD&D pg 22
   Long Term Disability pg 23

   Optional (voluntary):
   Vision Hardware pg 21
   Flexible Spending Acct. pg 27
   Tax Advantaged Acct. pg 29
   Supplemental Life Insurance pg 30
   Dependent Life Insurance pg 31
   Supplemental AD&D Insurance pg 30
   Long Term Care pg 33

4. The enrollment form will walk you through your coverage options and monthly costs. To determine the before-tax cost of your benefits, add up the total cost of the benefits you've selected and compare it to the employer contribution provided to you by the Montana University System.

If the benefits you choose cost . . .

- The same as your employer contribution, you won't see any change in your paycheck.
- More than your employer contribution, you'll pay the difference through automatic payroll deductions.

Your annual ***Choices*** elections remain in effect for the entire plan benefit period following enrollment, 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.*

Other life events may allow limited benefit changes. All questions about the enrollment process or qualifying events should be directed to your campus Human Resources Office (see contacts inside cover).

Hollow Top Lake, Tobacco Root Mountains

Makoshika State Park, Glendive MT

Medical (*must choose*) *Choices*

Choices gives you the opportunity to choose from three medical plan choices. The next two pages will help explain the medical plans and the corresponding monthly medical rates for each plan.

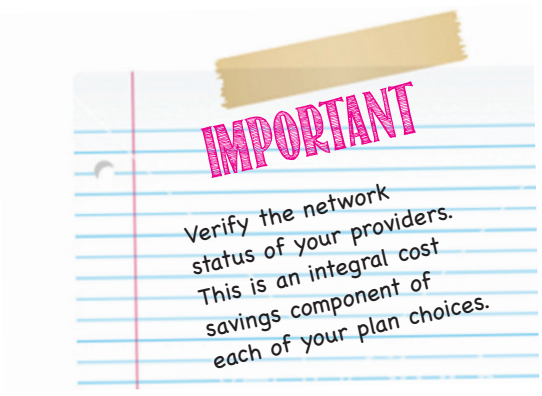
Medical Plan Choices

Allegiance, Blue Cross/Blue Shield, and PacificSource are the medical plan choices. The plans provide the same basic benefits but have differences in provider networks. Check which providers participate on the medical plan administrator's website. See back cover for website addresses.

How The Plan Works

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

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 administrator processes the claim and sends an EOB to the member showing the member's payment responsibilities (deductible, coinsurance, and any difference between the charge and the allowed amount (balance billing)).



Definition of Terms

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 $25 copayment for Primary Care Physician (PCP) visits and a $40 copayment for specialty provider visits to In-Network providers (no deductible) and 25% (after deductible) for most In-Network hospital/facility services.

Out-of-Network Providers – You pay 35% of the allowed amount (after a separate deductible) for most services received Out-of-Network. Out-of-Network providers can also balance bill you for any difference between their charge and the allowed amount.

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

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

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

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

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

Medical Plan Monthly Rates for 2017 - 2018

Monthly Premiums	Allegiance	Blue Cross Blue Shield	PacificSource
Employee Only	$798	$748	$837
Employee & Spouse	$1,169	$1075	$1225
Employee & Child(ren)	$1,045	$994	$1096
Employee & Family	$1,415	$1327	$ 1484
Survivor	$798	$748	$837
Survivor & Child(ren)	$1,045	$994	$1096

The employer contribution for 2017-2018 is $1,054 per month for eligible active employees.

Medical Plan Costs 2017 - 2018

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.	$750/Person $1,500/Family	Separate $750/Person Separate $1,750/Family
Copayment (on outpatient 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 year; includes deductibles, copay and coinsurance)	$4,000/Person $8,000/Family	Separate $6,000/Person Separate $12,000/Family

* Services from an **Out-of-Network** provider have a separate deductible and a 35% coinsurance and a separate 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 - 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.**

July 1
Beginning plan yr

→ more costs

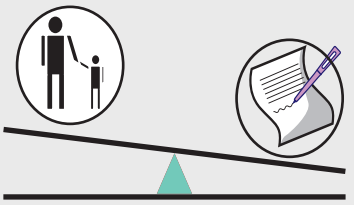
→ more costs

June 30
End of plan yr

Jack pays $25 office visit copay and 100% of allowed amount 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 $25 for the office visit and 100% of the allowed amount for covered lab charges. **For example**, Jack's doctor visit totals $1,000. The office visit is $150 and labwork is $850. The plan allows $100 for the office visit and $400 for the labwork. Jack pays $25 for the office visit and $400 for the labwork. The plan pays $75 for the office visit and $0 for the labwork. The in-network provider writes off $500.



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

Plan pays remainder of office visit and 75% of allowed amount

Jack has seen the doctor several times and reaches his $750 in-network deductible. His plan pays some of the costs of his next visit. He pays $25 for the office visit and 25% of the allowed amount for labwork and the plan pays the remainder of the office visit + 75% of the allowed amount. **For example,** Jack's doctor visit totals $1,000. The office visit is $150 and labwork is $850. The plan allows $100 for the office visit and $400 for the labwork. Jack pays $25 for the office visit and $100 for the labwork. The plan pays $75 for the office visit and $300 for the labwork. The in-network provider writes off $500.

Jack pays 0%

Plan pays 100% allowed amount

Jack reaches his $4,000 out-of-pocket maximum. Jack has seen his doctor often and paid $4,000 total (deductible + coinsurance + copays). The plan pays 100% of the allowed amount for covered 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

→ more costs

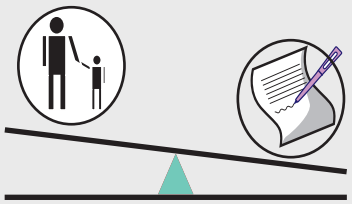
→ more costs

June 30
End of 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 allowed amounts apply to his deductible. **For example**, the provider charges $1,000. The plan allowed amount is $500. $500 applies to Jack's out-of-network deductible. Jack must pay the provider the full $1,000.



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

Plan pays 65% of allowable

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

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

Plan pays 100% of allowed amount

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

Medical Plan Services	In Network 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 auth)	25%	35%
Hospital Services (Outpatient facility charges)		
Outpatient Services	25%	35%
Outpatient Surgi-Center	25%	35%
Physician/Professional Provider Services (not listed elsewhere)		
Primary Care Physician (PCP) Visit - Includes Naturopathic visits	$25 copay/visit for office visit only - lab, x-ray & other procedures subject to deductible/coinsurance	35% **Note:** Currently there is no network for Naturopathic visits, so Out-of-Network is the same as In-Network but the member may be balance billed the difference between the allowed amount and provider charge.
Specialty Provider Visit	$40 copay/visit for office visit only - lab, x-ray & other procedures subject to deductible/coinsurance	35%
Inpatient Physician Services	25%	35%
Lab/Ancillary/Misc. Charges	25%	35%
Eye Exam (preventive & medical)	0% one/yr	35% one/yr
Second Surgical Opinion	0%/visit for office visit only - lab, x-ray & other procedures subject to deductible/coinsurance	35%
Emergency Services		
Ambulance Services for Medical Emergency	$200 copay	$200 copay
Emergency Room Facility Charges	$250 copay/visit for room charges only lab, x-ray & other procedures subject to deductible/coinsurance (waived if immediately admitted to hospital)	$250 copay/visit for room charges only lab, x-ray & other procedures subject to deductible/coinsurance (waived if immediately admitted to hospital)
Professional Charges	25%	25%
Urgent Care Services		
Facility/Professional Charges	$75 copay/visit for room charges only - lab, x-ray & other procedures subject to deductible/coinsurance	$75 copay/visit for room charges only - lab, x-ray & other procedures subject to deductible/coinsurance
Lab & Diagnostic Charges	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 charge and the allowed amount.

Schedule of Medical Benefits ..... 2017 - 2018

Medical Plan Services	In Network Copay/Coinsurance	Out-of-Network Coinsurance
Maternity Services		
Hospital Charges	25%	35%
Physician Charges (delivery & inpatient)	25% (waived if enrolled in WellBaby Program within first trimester)	35%
Prenatal Offices Visits	$25 copay/visit (waived if enrolled in WellBaby Program within first trimester)	35%
Preventive Services		
Preventive screenings/ immunizations/flu shots (adult & child Wellcare) Refer to pages 11 & 12 for listing of Preventive Services covered at 100% allowable and for age recommendations	limited to services listed on pg 11 & 12. Other preventive services subject to deductible and coinsurance	35%
Mental Health/Chemical Dependency Services		
Inpatient Services (Pre-certification is recommended)	25%	35%
Outpatient Services	First 4 visits $0 copay then $25 copay/visit **Note:** Psychiatrist is $40 copay/visit	35%
Rehabilitative Services Physical, Occupational, Cardiac, Respiratory, Pulmonary, Massage and Speech Therapy, Acupuncture and Chiropractic		
Inpatient Services (Pre-certification is recommended)	25% Max: 30 days/yr	35% Max: 30 days/yr
Outpatient Services	$25 copay/visit Max: 30 visits/yr (this is a combined max of 30 visits for all rehab services)	35% Max: 30 visits/yr (this is a combined max of 30 visits for all rehab services) **Note:** Currently there is no network for Acupuncture & Massage, so out-of-network is the same as in-network but the member will be balance billed the difference between the allowed amount and provider 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 charge and the allowed amount.

Medical Plan Services	**In Network Copay/Coinsurance**	**Out-of-Network Coinsurance**
Extended Care Services		
Home Health Care (Prior authorization is recommended)	$25 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 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 charge and the allowed amount.

Schedule of Medical Benefits …….. 2017 - 2018

Medical Plan Services	**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)	25% Must be enrolled in Take Control for non-surgical treatment	35%
TMJ (Prior authorization recommended)	25% Surgical treatment only	35%
Organ Transplants		
Transplant Services (Prior authorization required)	25%	35%
Travel		
Travel for patient only (If services are not available in local community) (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 Ed. & Support	see pg 25	
WellBaby		
Take Control Diabetes, Weight Loss, High Cholesterol, High Blood Pressure, Tobacco User	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 charge and the allowed amount.

Preventive Services

Glacier National Park, MT

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 preventive care is provided by In-Network providers, services are reimbursed at 100% of the allowed amount, without application of deductible, coinsurance, or copay.

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/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 preventive care is provided by In-Network providers, services are reimbursed at 100% of the allowed amount, without application of deductible, coinsurance, or copay.

Periodic Exams Appropriate screening tests per Bright Futures and other sources (previous page)	
Well-Child Care Infant through age 17	• Age 0 months through 4 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 - 75	• 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 Navitus Pharmacy benefit.** **For recommended immunization schedules for all ages, visit the CDC website at https://www.cdc.gov/vaccines/index.html**	

Prescription Drug Choices

(Included in Medical plan)

Navitus is your Pharmacy Plan:

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

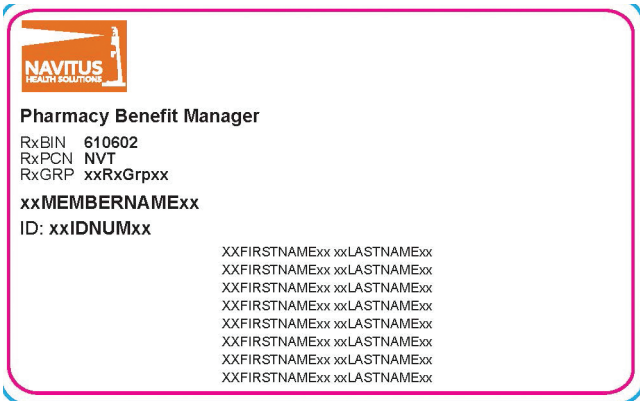
What is Navitus?
Beginning July 1, 2017, your prescription drug coverage will be managed by Navitus Health Solutions.

Starting July 1, 2017, please use your Navitus prescription ID card each time you fill your prescription. This will be explained in more detail in your pharmacy benefit booklet that will be mailed to you in June, 2017. Your new ID cards will be attached to the member benefit booklet. To determine your drug tier level and copay before going to the pharmacy, consult your Pharmacy Benefit Schedule or call Navitus Customer Care (see next page for numbers).

The Navitus Drug 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 in order to access the drug formulary (preferred drug list), drug tier level, and pharmacy directory. If you have questions regarding the drug list or pharmacy directory, please contact Navitus Customer Care.

You can also find a list of Navitus Frequently Asked Questions (FAQs) at https://www.navitus.com/members/members-faqs.aspx.

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 (up to 90-day supply). Members who use maintenance medications can experience significant savings by utilizing a mail order pharmacy.

Retail Pharmacy Network
NOTE: There is an important change to the retail pharmacy network. Starting July 1, 2017, CVS/Target pharmacies will no longer be part of the Montana University Pharmacy Plan network. Prescriptions filled at these pharmacies will be honored until June 30, 2017. Please transfer your prescriptions to another participating pharmacy on/or after July 1, 2017. If you choose to continue to use these pharmacies you will be responsible for all charges.

Mail Order
Ridgeway, Costco, and miRx Pharmacies will administer the mail order pharmacy program. For mail order prescription refills July 1, 2017 and after, you will need to update your insurance information with Costco, Ridgeway, or miRx. If you are new to mail order, you can register online (see contact details on next page).

Navitus Pharmacy Plan

Specialty Pharmacy
Starting July 1, 2017, the preferred Specialty Pharmacy will be 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. It provides 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 https://www.lumicera.com/Patients/FAQ.aspx.

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, met formin [diabetes] and omeprazole)	$0 Copay	$0 Copay
Tier 1 (low cost, high-value generics and select brands that provide high clinical value. These products are the lowest-net cost for the Plan and the lowest copayment for the member.	$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 lease value because of high cost or low clinical value, or both)	50% Coinsurance (Does not apply towards Out-of-Pocket max)	50% Coinsurance (Does not apply towards Out-of-Pocket max)
Tier 4 (Specialty) (specialty medications for certain chronic illnesses or complex diseases. $200 copay if filled at Specialty pharmacy)	50% coinsurance (Does not apply towards Out-of-Pocket max)	N/A
Out-of-Pocket max	Individual: $2,150 per year Family: $4,300 per year	

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

Secure 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.pharmacy.costco.com
Monday - Friday 5 a.m. to 7 p.m. PST

Ridgeway:
1-800-630-3214
or go to www.ridgewayrx.com
Monday -Thursday 9 a.m. to 5 p.m. MST

miRx:
1-866-894-1496
or go to www.mirxpharmacy.com
Monday - Friday 8 a.m. to 6 p.m. MST

Dental *(must choose) Choices*

Because dental coverage is an annual required benefit choice, you can choose from two options: **Basic Plan** or **Select Plan.**

Review the chart below and pay close attention to the different benefits and the different rates to help you make your selection.

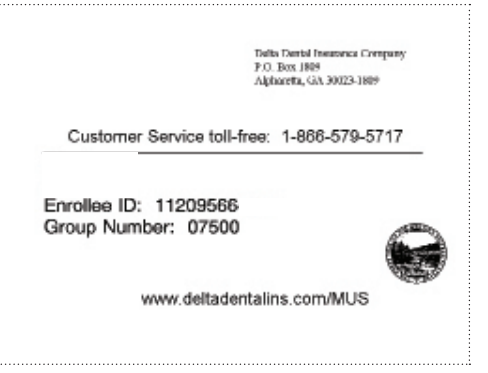
	Basic Plan - Preventive Coverage	Select Plan - Enhanced Coverage
Who May be Enrolled & Monthly Rates	• Employee Only $18 • Employee & Spouse $35 • Employee & Child(ren) $35 • Employee & Family $49	• Employee Only $42 • Employee & Spouse/Adult Dep. $80 • Employee & Child(ren) $80 • Employee & Family $113
Maximum Annual Benefit	**$750 per covered individual**	**$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	• Twice Per Benefit Year • Initial and Periodic oral exam • Cleaning Complete series of intraoral X-rays 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	• Not covered	• Amalgam filling • Endodontic treatment • Periodontic treatment • Oral surgery
Major Dental Services	• Not covered	• Crown • Root canal • Complete lower and upper denture • Dental implant • Occlusal guards
Removal of impacted teeth	• Not covered	• Covered benefit
Orthodontia	• Not covered	• Available to covered children and adults • $1,500 lifetime benefit

Select Plan Benefit Highlight Features:

Diagnostic & Preventive Maximum Waiver Benefit: The 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 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.

Sample Dental Card



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

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

Dental Codes

Dental claims are reimbursed based on a Schedule of Benefits. The following subsets of the **Select** and **Basic Plan** Schedules include the most commonly used procedure codes. Please note the Basic Plan provides coverage for a limited range of services including diagnostic and preventive.

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. Blue shaded codes are for the **Basic Plan** ONLY. All Codes (shaded and non-shaded) are for the **Select Plan**.

See Summary Plan Description (SPD) for complete listing (see pg 36 for availability).

Procedure Code	Description	Fee
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	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	$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
D0277	Vertical bitewings - 7 to 8 radiographic images	$73.00
D0320	Temporomandibular joint arthrogram, including injection	$622.00
D0330	Panoramic radiographic image	$91.00
D1110	Prophylaxis - adult	$83.00
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 (Child through age 13)	$239.00
D1515	Space maintainer - fixed - bilateral (Child through age 13)	$388.00
D1520	Space maintainer - removable - unilateral (Child through age 13)	$393.00

Dental Codes Schedule of Benefits

Procedure Code	Description	Fee
D1525	Space maintainer - removable - bilateral (Child through age 13)	$538.00
D1550	Re-cement or re-bond space maintainer	$63.00
D1555	Removal of fixed space maintainer	$63.00
D1575	Distal shoe space maintainer - fixed - unilateral	$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	$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
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 12 years and older	$375.00
D2544	Onlay - metallic - four or more surfaces 12 years and older	$440.00
D2643	Onlay - porcelain/ceramic - three surfaces 12 years and older	$375.00
D2644	Onlay - porcelain/ceramic - four or more surfaces 12 years and older	$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 – ¾ 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

Please refer to the SPD for complete listing (see pg 36 for availability).

Procedure Code	Description	Fee
D2954	Prefabricated post and core in addition to crown	$127.00
D3110	Pulp cap - direct (excluding final restoration)	$43.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$105.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$105.00
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
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	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$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
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$83.00
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

Please refer to the SPD for complete listing (see pg 36 for availability)

Dental Codes Schedule of Benefits

Procedure Code	Description	Fee
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
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
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
D6214	Pontic - titanium	$399.00
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
D6740	Retainer crown - porcelain/ceramic	$436.00
D6750	Retainer crown - porcelain fused to high noble metal	$423.00
D6752	Retainer crown - porcelain fused to noble metal	$414.00
D6790	Retainer crown - full cast high noble metal	$410.00
D6791	Retainer crown - full cast predominantly base metal	$402.00
D6794	Retainer crown - titanium	$410.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$94.00
D7210	Extraction, 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
D7870	Arthrocentesis	By Report
D7880	Occlusal orthotic device, by report	$469.00
D7899	Unspecified TMD therapy, by report	By Report
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$210.00
D7971	Excision of pericoronal gingiva	$120.00
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$69.00
D9223	Deep sedation/general anesthesia – each 15 minute increment	$107.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$90.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$67.00
D9940	Occlusal guard, by report	$245.00
D9950	Occlusion analysis - mounted case	$187.00
D9951	Occlusal adjustment - limited	$51.00
D9952	Occlusal adjustment - complete	$406.00

Vision Hardware

(voluntary)

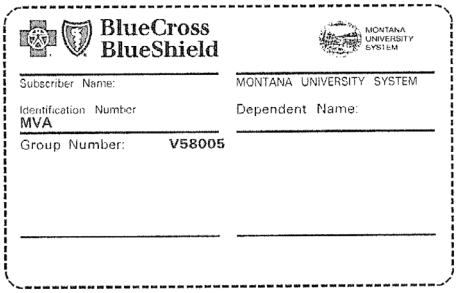
Administered by Blue Cross Blue Shield of Montana
1-800-820-1674 or 447-8747, www.bcbsmt.com
Claim submission form at: www.choices.mus.edu

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

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 of Montana for processing. The voluntary vision coverage is a hardware benefit only. Eye Exams, whether preventive or medical, are covered under the medical benefit plan. See pg. 7 Eye Exam (preventive & medical).

Monthly Vision Hardware Rates	
• Employee Only	$8.05
• Employee & Spouse.	$15.19
• Employee & Child(ren)	$15.99
• Employee & Family	$23.45

Sample Vision Hardware card



Service/Material	Coverage
Eyeglass Frames and Lenses: Once every benefit year in lieu of contact lenses	Up to $300 allowance towards purchase of a frame and prescription eyeglass lenses, including single vision, bifocal, trifocal, progressive lenses; ultraviolet treatment; tinting; scratch-resistant coating; polycarbonate; anti-reflective coating. The Plan participant may be responsible for the charges at the time of service.
Contact Lenses: Once every benefit year in lieu of eyeglass frame and lenses	Up to $150 allowance toward contact lens fitting and the purchase of Conventional, Disposable or Medically Necessary* contact lenses. The Plan participant may be responsible for the charges at the time of service.

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

Filing a claim:
When a Plan Participant purchases vision hardware, a walk-out statement should be provided by the Provider. This walk-out statement should be submitted to Blue Cross and Blue Shield of Montana for reimbursement.

Go to: www.choices.mus.edu/forms.asp and select the Vision Hardware Claim Form

Life Insurance & AD&D

(must choose)

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

Who is Eligible:
An employee may increase one level of coverage during annual benefit enrollment, if eligible and in an active work status.

Basic Life/AD&D Insurance:

Life insurance 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) coverage 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.

Basic Life/AD&D Monthly Premiums		
Basic Life/AD&D	$15,000	$ 1.49 for both
Basic Life	$30,000	$2.97 for both
Basic Life/AD&D	$48,000	$4.75 for both

If you are enrolling in ***Choices*** you must select a Basic Life Insurance.

Long Term Disability

(must choose)

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

Long Term Disability (LTD):

LTD coverage can help protect your income in the event you become disabled and unable to work. ***Choices*** includes three LTD options designed to supplement other sources of disability income that may be available to you:

- 60% of pay, following 180 days of disability
- 66-2/3% of pay, following 180 days of disability
- 66-2/3% of pay, following 120 days of disability

The three LTD options differ in terms of the amount of your pay they replace, when benefits become payable, and premium costs. Employees may increase coverage during annual enrollment. However, the increase in coverage will be subject to a pre-existing condition exclusion for disabilities occurring during the first 12 months that the increase in insurance 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 long term disability coverage. Please consult with your campus Human Resources Department.

Who May Enroll:
Employee Only

Amount of Benefit:
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.

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.

This is a brief summary provided to help you understand your coverage. Please review the group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. This information can be found on the ***Choices*** website: www.choices.mus.edu.

Long Term Disability Monthly Premiums

Option 1	60% of pay/180 days waiting period	$ 5.90
Option 2	66 2/3% of pay/180 days waiting period	$11.75
Option 3	66 2/3% of pay/120 days waiting period	$14.66

Life Services Toolkit

Montana University System employees and their beneficiaries now have access to a new tool to address important life matters via The Standard's Life Services Toolkit. The Standard has partnered with Bensinger, DuPont & Associates (BDA) to offer a lineup of additional services that can make a difference now and in the future.

As a participant, you will have access to services to help you now:

- **Estate Planning Assistance**: Online tools, found in the Legal Forms section, walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms.
- **Financial Planning**: Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness**: Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Identity Theft Prevention**: Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements**: Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

Your beneficiaries will have access to supportive services that will help them cope after a loss:

- **Grief Support**: Clinicians with master's degrees are on call to provide confidential grief sessions by phone or in person. Beneficiaries are eligible for up to six face-to-face sessions and unlimited phone contact.
- **Legal Services**: Beneficiaries can obtain legal assistance from experienced attorneys. They can:
    - Schedule an initial 30-minute office and a telephone consultation with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25 percent rate reduction from the attorney's normal hourly or fixed fee rates.
    - Obtain an estate-planning package that consists of a simple will, a living will, a health care agent form and a durable power of attorney.
- **Financial Assistance**: Beneficiaries have unlimited phone access to financial counselors who can help with issues such as budgeting strategies, and credit and debt management, including hour-long sessions on topics requiring more in-depth discussion.
- **Support Services**: During an emotional time, beneficiaries can receive help planning a funeral or memorial service. Work-life advisors can guide them to resources to help manage household repairs and chores; find child care and elder care providers; or organize a move or relocation.
- **Online Resources**: Beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements.

More details on how to access these services are on the Life Services Toolkit Flyer at https://www.standard.com/mybenefits/mus/life_toolkit.html. We encourage you to take advantage of the wealth of resources available on this site.

MUS Wellness Program

Overview
The Montana University System (MUS) Benefits Plan offers Wellness services to covered adult plan members (employees, retirees, and spouses) regardless of which medical plan you choose. For more detailed information about your Wellness Program, refer to the Wellness website: www.wellness.mus.edu.

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 over the age of 18 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.**

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 updates 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.

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

For more information call 406-660-0082 or visit the Wellness website www.wellness.mus.edu.

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

MUS Wellness Program

Wellness Incentive and Take Control Program

Incentive Program
www.muswell.limeade.com

Embark on a new expedition with the 2017 Wellness Incentive Program!
Program Kicks off April 1 - sign up anytime.

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 (406 points) up to our third level — Trailblazer (2,000 points) — to earn rewards such as a Fitbit Health Tracker and gift cards.

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 "get started" 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 2017:** 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.asp.

- Montana Meals Nutrition Challenges
- Montana Moves Fitness Challenges
- Challenges focusing on stress, sleep, and financial Wellness

If you have any questions about the MUS Wellness incentive program call 866-885-6940 or email support@limeade.com.

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
- **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 members can join Take Control as part of the WellBaby program

Services Provided:

- Monthly health coaching
- Fitness center or fitness class reimbursement
- Copay waivers for diabetic supplies
- 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:

- Up to three in-network visits with your primary health care provider (copay free)
- Certified Exercise Specialist (Personal Trainer)
- Sleep Study (deductible/coinsurance free)
  Additional Counseling Sessions (copay free)

For details or more information, call 1-800-746-2970, or visit **www.takecontrolmt.com.**

Flexible Spending Account *(voluntary)*

Flexible spending account administrative and debit card fees will again be paid by MUS

Montana Wildflowers

Administered by Allegiance Benefit Plan Management, Inc.

1-877-778-8600 - www.askallegiance.com

Account Types	Annual Amount	Qualifying Expense Examples
Medical FSAs	Minimum Contributions: $120 Maximum Contributions: $2,600	Medical expenses including deductibles, Coinsurance, copays, Rx expenses, chiropractic and naturopathic care. All dental and vision expenses that are not considered cosmetic.
Dependent Care FSAs	Minimum Contribution: $120 Maximum Contribution: $5,000	Costs for care provided to your child(ren) under age 13, or other dependents unable to care for themselves, and necessary for you to remain gainfully employed.
Adoption Assistance (Maximum listed is a lifetime maximum)	Minimum Contribution: $120 Maximum Contribution: $13,400	Adoption fees, court costs, attorney fees, medical examination costs, and related travel expenses.

Health Flex Spending Account (FSA)

During the annual enrollment period, you may elect amounts to be withheld from your earnings to pay for your out-of-pocket medical expenses. Eligible health FSA expenses include those defined by IRS Code, Section 213(d). For a list of examples, go to www.askallegiance.com

The amount you elect to set aside for Health FSA expenses is not subject to federal income, state income, or Social Security/Medicare taxes.

Your health FSA election will reimburse you for eligible expenses that you, your spouse, and your qualified dependents incur during the plan year. The entire annual amount you elect can be used at any time during the plan year.

You can request reimbursement on a mobile device, by toll-free fax, or through the mail. If the expense may be covered through your health plan coverage, please provide the Explanation of Benefits (EOB) as documentation. If your health plan coverage will not consider the expense, an itemized statement from the provider will satisfy documentation requirements.

Some expenses are considered to be "dual purpose." These expenses are for items or services that are sometimes for purposes other than to treat a medical condition. In order to be reimbursed for a "dual purpose" expense, or over the counter drugs and medicines, a diagnosis and recommendation for treatment from a medical professional is required.

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

You can access a tax savings calculator for accurate savings estimates under Tax Calculators on the Allegiance Flex Advantage website at www.askallegiance.com.

$500 Rollover from one plan year to the next.

When you enroll in the flexible spending account, you are electing to participate for the entire plan year. No changes to your election may be made during the plan year unless you experience a "qualifying event." Changes must be consistent with the change in status or qualifying event.

Be sure not to elect more than you will need to cover expenses incurred by you and/or your family members during the plan year. Under the "use-or-lose" rule, any money not used by the end of the plan year cannot be returned to you. However, the IRS permits modification of the "use-or-lose" rules for health flexible spending accounts to allow $500 to rollover from one plan year to the next. This means that up to $500 from last year's plan election can be rolled over to the new plan year that begins July 1, 2017. The $500 rollover feature does not apply to dependent care flexible spending accounts. **NOTE:** If an employee doesn't enroll in an FSA for Plan Year 2018 and has unused FSA funds in the amount of $50 or less that are not expended by September 30, 2017 for services during FY2017, the FSA will be closed and the remaining unused funds will be forfeited.

Continued on next page

Important:

- You must re-enroll each year to participate in a Flexible Spending Account (no automatic enrollment).
- All claims must be received by Allegiance by September 30, 2018 to be eligible for reimbursement.
- No exceptions can be made on late enrollment or late submissions.

Dependent Care
If both you and your spouse work or you are a single parent, you may have dependent care expenses. The Federal Child Care Tax Credit is available to taxpayers to help offset dependent care expenses. A dependent care FSA often gives employees a better tax benefit. You can complete a worksheet that compares the Federal Child Care Tax Credit to the dependent care FSA by clicking on Tax Calculators on the Allegiance Flex Advantage website.

Your dependent care FSA lets you use "before-tax" dollars to pay care expenses for children under age 13, or individuals unable to care for themselves. A dependent receiving care must live in your home at least eight (8) hours per day. The care must be necessary for you and your spouse to remain gainfully employed. Care may be provided through live-in care, baby sitters, and licensed day care centers. You cannot use "before-tax" dollars to pay your spouse or one of your children under the age of nineteen (19) for providing care. Schooling expenses at the kindergarten level and above are not reimbursable. Neither overnight camp nor nursing home care is reimbursable.

Unlike health FSAs, dependent care FSAs may only reimburse expenses up to the amount you have contributed at any time during the year.

Mid-Year Election Changes
Mid-year 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 Department or Allegiance.

Reimbursement
You may mail, fax toll-free, or scan and send claims electronically at www.askallegiance.com or via your mobile device.

Claims are normally processed within five business days of receipt. You usually have a check in your mailbox within a week after Allegiance receives your claim.

Direct Deposit: Send in the Direct Deposit form with a voided check, or sign up online at www.askallegiance.com and Allegiance will electronically deposit reimbursements directly into your checking account.

Debit Card: Your employer offers debit cards as part of the Flex Advantage Plan at a cost of $10.00 per year. That fee will be paid by MUS for the July 1, 2017-June 30, 2018 plan year. Two cards are issued per family and additional cards are available when requested. You may use the debit card to pay for medical care expenses. Documentation for the expense may be required, and should be saved for all debit card transactions.

Claims for eligible expenses that were incurred during the plan year (July 1, 2017 - June 30, 2018) must be received by Allegiance by September 30, 2018, to be eligible for reimbursement. If you terminate employment during the plan year, your participation in the plan ends, subject to COBRA limitations. However, you still may submit claims through September 30, 2018, if the claims were incurred during your period of employment, and during the plan year.

If an employee has both a medical FSA and a TAA, the two accounts will be coordinated by the plan administrator to ensure that FSA funds are expended prior to TAA funds.

Questions

Customer Service Representatives are available to answer questions each business day between 7:00 a.m. and 6:00 p.m. MST. After hours and on weekends, you can access your account information online or through the toll-free automated voice-response system.
Call toll free at 1-877-778-8600.

Tax Advantaged Account - TAA *(voluntary)*

Administered by Allegiance Benefit Plan Management, Inc.

1-877-778-8600 - www.askallegiance.com

Important:
After the July 1, 2017 TAA Wellness Incentive contribution, the MUS Plan will cease to provide TAA contributions to the accounts. Any TAA balance not expended by June 30, 2019 will be forfeited.

Tax-Advantaged Account (TAA)

The IRS permits tax-advantaged accounts to be established and funded by employers. These TAAs may only be funded with employer funds. No employee funds are permitted. MUS has a separate medical FSA account which permits employee funds to be deposited on a tax-free basis.

In Plan Year 2018 (July 1, 2017 - June 30, 2018), the employer contributions to the TAA will only consist of the following:

1. Wellness Incentive Funds ($80 and/or $250 based on achieving Scout and/or Trailblazer level requirements of the Wellness program that **ended Dec. 31, 2016**).

2. Any **remaining funds left over** from plan year 2016 and 2017.

NOTE: - TAA Wellness Incentive funds earned during the Wellness program that ended Dec. 31, 2016 will be placed in the TAA on July 1, 2017, as long as you are an active employee on July 1, 2017.

- If you are not an active employee on July 1, 2017, you will forfeit the Wellness Incentive funds earned during the Wellness program that ended Dec. 31, 2016.
- Allowable expenditures from the TAA are the same as expenditures permitted from a medical FSA. See IRS Publication 502 for details.
- Account balance is portable upon termination of employment. If an employee ceases participating in the medical plan, separates from service, or terminates employment (i.e., retires, goes to work for another employer, etc.), they can utilize the remaining balance in the TAA until June 30, 2019. Any TAA balance not expended by June 30, 2019 will be forfeited.
- The amounts in the TAAs will continue to be eligible for use by qualified active employees until June 30, 2019. Any TAA balance not expended by June 30, 2019 will be forfeited.

How to Elect and Use a Tax Advantaged Account (TAA)

In order to be eligible for the TAA, employees must have a remaining balance from plan year 2016 &/or 2017, or have earned Wellness Incentive funds while participating in the Wellness program that ended Dec. 31, 2016. Employees who waive benefits under the MUS Plan are not eligible for a TAA (this is an ACA requirement). If an employee has both a medical FSA and a TAA, the two accounts will be coordinated by the plan administrator to ensure that FSA funds are expended prior to TAA funds.

Administrative Fees and Continuation of TAA

During Plan Year 2018, the administrative fees for the TAAs will be paid by the MUS for those TAAs with remaining funds left over from Plan Year 2016 &/or 2017, or for those participants who earned a Wellness Incentive contribution during the Wellness program that ended Dec. 31, 2016.

Questions

Customer Service Representatives are available each business day between 7:00 a.m. and 6:00 p.m. MST. After hours, and on weekends, you can access your account information online or through the toll-free automated voice-response system.
Call toll free at 1-877-778-8600.

Supplemental Life Insurance *(voluntary)*

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

Optional Supplemental Life Insurance eligibility:

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

If you are not enrolling for the first time, other than new employees, you may increase one level of coverage during annual enrollment (up to $300,000) without having to submit evidence of good health - if you are eligible and are in an active work status. You may also increase coverage more than one level. However, you will need to submit evidence of good health to the insurance company for the increase above more than one level. Elections above $300,000 will always require evidence of good health.

"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 Premium (after tax) -Employee Benefit

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	$ 1.15	$ 2.30	$ 3.45	$ 4.60	$ 5.75	$ 6.90	$ 8.05	$ 9.20	$ 10.35	$ 11.50	$ 12.65	$ 13.80
30-34	$ 1.60	$ 3.20	$ 4.80	$ 6.40	$ 8.00	$ 9.60	$ 11.20	$ 12.80	$ 14.40	$ 16.00	$ 17.60	$ 19.20
35-39	$ 1.80	$ 3.60	$ 5.40	$ 7.20	$ 9.00	$ 10.80	$ 12.60	$ 14.40	$ 16.20	$ 18.00	$ 19.80	$ 21.60
40-44	$ 2.48	$ 4.95	$ 7.43	$ 9.90	$ 12.38	$ 14.85	$ 17.33	$ 19.80	$ 22.28	$ 24.75	$ 27.23	$ 29.70
45-49	$ 4.25	$ 8.50	$ 12.75	$ 17.00	$ 21.25	$ 25.50	$ 29.75	$ 34.00	$ 38.25	$ 42.50	$ 46.75	$ 51.00
50-54	$ 6.43	$ 12.85	$ 19.28	$ 25.70	$ 32.13	$ 38.55	$ 44.98	$ 51.40	$ 57.83	$ 64.25	$ 70.68	$ 77.10
55-59	$ 10.75	$ 21.50	$ 32.25	$ 43.00	$ 53.75	$ 64.50	$ 75.25	$ 86.00	$ 96.75	$ 107.50	$ 118.25	$ 129.00
60-64	$ 13.20	$ 26.40	$ 39.60	$ 52.80	$ 66.00	$ 79.20	$ 92.40	$ 105.60	$ 118.80	$ 132.00	$ 145.20	$ 158.40
65-69	$ 26.00	$ 52.00	$ 78.00	$ 104.00	$ 130.00	$ 156.00	$ 182.00	$ 208.00	$ 234.00	$ 260.00	$ 286.00	$ 312.00
over 70	$ 60.00	$ 120.00	$ 180.00	$ 240.00	$ 300.00	$ 360.00	$ 420.00	$ 480.00	$ 540.00	$ 600.00	$ 660.00	$ 720.00

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	$ 14.95	$ 16.10	$ 17.25	$ 18.40	$ 19.55	$ 20.70	$ 21.85	$ 23.00	$ 24.15	$ 25.30	$ 26.45	$ 27.60
30-34	$ 20.80	$ 22.40	$ 24.00	$ 25.60	$ 27.20	$ 28.80	$ 30.40	$ 32.00	$ 33.60	$ 35.20	$ 36.80	$ 38.40
35-39	$ 23.40	$ 25.20	$ 27.00	$ 28.80	$ 30.60	$ 32.40	$ 34.20	$ 36.00	$ 37.80	$ 39.60	$ 41.40	$ 43.20
40-44	$ 32.18	$ 34.65	$ 37.13	$ 39.60	$ 42.08	$ 44.55	$ 47.03	$ 49.50	$ 51.98	$ 54.45	$ 56.93	$ 59.40
45-49	$ 55.25	$ 59.50	$ 63.75	$ 68.00	$ 72.25	$ 76.50	$ 80.75	$ 85.00	$ 89.25	$ 93.50	$ 97.75	$ 102.00
50-54	$ 83.53	$ 89.95	$ 96.38	$ 102.80	$ 109.23	$ 115.65	$ 122.08	$ 128.50	$ 134.93	$ 141.35	$ 147.78	$ 154.20
55-59	$ 139.75	$ 150.50	$ 161.25	$ 172.00	$ 182.75	$ 193.50	$ 204.25	$ 215.00	$ 225.75	$ 236.50	$ 247.25	$ 258.00
60-64	$ 171.60	$ 184.80	$ 198.00	$ 211.20	$ 224.40	$ 237.60	$ 250.80	$ 264.00	$ 277.20	$ 290.40	$ 303.60	$ 316.80
65-69	$ 338.00	$ 364.00	$ 390.00	$ 416.00	$ 442.00	$ 468.00	$ 494.00	$ 520.00	$ 546.00	$ 572.00	$ 598.00	$ 624.00
over 70	$ 780.00	$ 840.00	$ 900.00	$ 960.00	$ 1,020.00	$ 1,080.00	$ 1,140.00	$ 1,200.00	$ 1,260.00	$ 1,320.00	$ 1,380.00	$ 1,440.00

Continued on next page.....

Optional Supplemental Dependent Life Insurance eligibility:

Your spouse and unmarried child(ren) from live birth to age 26. Optional Dependent Life Insurance 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. This benefit is paid with after-tax dollars. 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 supplemental life to be eligible for spouse or child/ren supplemental life elections.

Other than new employees, you may increase one level of coverage for child/ren without evidence of good health. Evidence of good health is always required for spouse elections over $50,000. Spouse elections cannot exceed 50% of the employee election (i.e., employee elects $100,000 for self, spouse maximum is $50,000). An employee must enroll in self coverage equal to or greater than the amount elected for child coverage.

Optional Supplemental Life Monthly Premium (after tax) -Spouse Benefit
Based on age of spouse 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	$ 1.15	$ 2.30	$ 3.45	$ 4.60	$ 5.75	$ 6.90	$ 8.05	$ 9.20	$ 10.35	$ 11.50	$ 12.65	$ 13.80
30-34	$ 1.60	$ 3.20	$ 4.80	$ 6.40	$ 8.00	$ 9.60	$ 11.20	$ 12.80	$ 14.40	$ 16.00	$ 17.60	$ 19.20
35-39	$ 1.80	$ 3.60	$ 5.40	$ 7.20	$ 9.00	$ 10.80	$ 12.60	$ 14.40	$ 16.20	$ 18.00	$ 19.80	$ 21.60
40-44	$ 2.48	$ 4.95	$ 7.43	$ 9.90	$ 12.38	$ 14.85	$ 17.33	$ 19.80	$ 22.28	$ 24.75	$ 27.23	$ 29.70
45-49	$ 4.25	$ 8.50	$ 12.75	$ 17.00	$ 21.25	$ 25.50	$ 29.75	$ 34.00	$ 38.25	$ 42.50	$ 46.75	$ 51.00
50-54	$ 6.43	$ 12.85	$ 19.28	$ 25.70	$ 32.13	$ 38.55	$ 44.98	$ 51.40	$ 57.83	$ 64.25	$ 70.68	$ 77.10
55-59	$ 10.75	$ 21.50	$ 32.25	$ 43.00	$ 53.75	$ 64.50	$ 75.25	$ 86.00	$ 96.75	$ 107.50	$ 118.25	$ 129.00
60-64	$ 13.20	$ 26.40	$ 39.60	$ 52.80	$ 66.00	$ 79.20	$ 92.40	$ 105.60	$ 118.80	$ 132.00	$ 145.20	$ 158.40
65-69	$ 26.00	$ 52.00	$ 78.00	$ 104.00	$ 130.00	$ 156.00	$ 182.00	$ 208.00	$ 234.00	$ 260.00	$ 286.00	$ 312.00
over 70	$ 60.00	$ 120.00	$ 180.00	$ 240.00	$ 300.00	$ 360.00	$ 420.00	$ 480.00	$ 540.00	$ 600.00	$ 660.00	$ 720.00

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

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
to age 26	$ 0.50	$ 1.00	$ 1.50	$ 2.00	$ 2.50	$ 3.00

Ross Pass - Bridger Mountains, MT

Supplemental AD&D Coverage *(voluntary)*

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

Optional AD&D Insurance eligibility:

This is an employee only benefit. If you enroll for Optional AD&D Insurance, your cost depends on the amount of coverage you select, as shown in the following table. Remember, this cost is paid on an after-tax basis.

You may elect any AD&D amount in increments of $25,000.

"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 Premium (after tax) -Employee Benefit

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
All Adults	$ 0.50	$ 1.00	$ 1.50	$ 2.00	$ 2.50	$ 3.00	$ 3.50	$ 4.00	$ 4.50	$ 5.00	$ 5.50	$ 6.00

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
All Adults	$ 6.50	$ 7.00	$ 7.50	$ 8.00	$ 8.50	$ 9.00	$ 9.50	$ 10.00	$ 10.50	$ 11.00	$ 11.50	$ 12.00

Optional Dependent AD&D Insurance eligibility:

Your spouse and unmarried child(ren) from live birth to age 26. Optional Dependent AD&D Insurance is designed to protect you against certain financial burdens in the event a covered dependent dies of an accidental death. You are automatically the beneficiary of any benefits that become payable. This benefit is paid with after-tax dollars. 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 AD&D in order to elect AD&D for dependents.

You may elect any amount for your spouse in $25,000 increments and any amount for your children in $5,000 increments.

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

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
All Adults	$ 0.50	$ 1.00	$ 1.50	$ 2.00	$ 2.50	$ 3.00	$ 3.50	$ 4.00	$ 4.50	$ 5.00	$ 5.50	$ 6.00

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

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
to age 26	$ 0.05	$ 0.10	$ 0.15	$ 0.20	$ 0.25	$ 0.30

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.

Great Northern Mountain, MT

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.

Additional Benefits

Dependent Hardship Waiver

The MUS Benefit Plan offers a dependent hardship waiver to allow medical coverage for children. 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 hardship, an application may be submitted to MUS Benefits requesting the Dependent Hardship Waiver. If the total household income is not more than 115% of the HMK guidelines, the dependent children will be eligible for the waiver for the plan year. The family must re-apply for HMK and the Dependent Hardship Waiver each Plan year in order to be eligible for the waiver. For more information, please contact your campus Human Resources office or call MUS Benefits at 406-444-2574, toll free at 877-501-1722.

★ Self Audit Award Program

Be sure to check all bills and EOBs from your medical providers to make sure that 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 MUS 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.

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

- Have not already been detected by the medical plan's claims administrator or reported by the provider;
- Involve charges which are allowable and covered by the MUS 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.

Hiking in Montana

Privacy Rights & Plan Documents

Eligibility and enrollment for coverage in 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 a health care plan through the Montana University System AND also 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.

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.

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), lifestyle 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 the Choices Website or by contacting Campus HR

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, 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 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. An easier way to access this information for many participants is to visit the MUS website at www.choices.mus.edu.

Summary of Benefits and Coverage (SBC)

SBC forms can be found by visiting the following website at www.choices.mus.edu/SBC.asp. These forms, required by PPAC, detail what each medical plan covers.

Bridge near Helena, MT

Montana Wildflower

Court Notice Re: Class Action Rights; Potential Monetary Recovery MT 18th Judicial District Court, Gallatin County, Cause No. DV-09-953B – Gendron vs. Allegiance Benefit Plan Management, Inc., Does and Montana University System

This case concerns members of the MUS Health Benefit Plan for the period of October 5, 2001 through December 31, 2016. For any covered claim under the Plan arising from an injury between October 5, 2001 through December 31, 2016 where MUS did not pay the medical expense(s) because the medical expense(s) were paid or able to be paid by another source, the settlement provides that MUS will pay the Plan member for this expense. Please review the Notice for more information. You will have the chance to fill out an Acknowledgment and Claims Form and send it to MUS. Those forms will be available on-line and through the mail.

MONTANA EIGHTEENTH JUDICIAL DISTRICT COURT, GALLATIN COUNTY

NOTICE OF MONTANA UNIVERSITY SYSTEM CLASS ACTION

You Or A Family Member May Be Entitled To Money Payments.
Read This Legal Notice Carefully. Your Rights May Be Affected.

Why am I receiving this Notice?	You are receiving this Notice because you are or have been a member of the Montana University System's Employee Group Benefit Plan ("Plan") between October 5, 2001 and December 31, 2016. As a potential Class Member you are entitled to this Notice.
What is the Class Action about?	The Class Action claims the Montana University System failed to pay certain medical expenses that were due under the Plan. The Montana University System has agreed to pay such medical expenses.
What determines if I am entitled to payment of money?	You or a family member are likely due money if the following two conditions exist: 1. You or a family member incurred medical expenses for injuries between October 5, 2001 and December 31, 2016; and 2. Your medical expenses were **not** paid in full by the Plan because the medical expenses were paid or able to be paid by another source, including another source of insurance.
How do I apply for additional payments?	**Please fill out the enclosed Acknowledgment and Claims Form and return it in the self-addressed envelope**. If eligible, monetary payments will be paid directly to you. If you need help, please call the class attorney—Hillary P. Carls at 406-586-1926—or visit the class website at http://choices.mus.edu/notice.asp. **The claims form must be completed and returned prior to April 13, 2018 or you may forfeit your right to payment**.

FOR MORE INFORMATION OR HELP CALL 1-844-632-5699 OR VISIT http://choices.mus.edu/notice.asp.
YOU CAN ALSO CONTACT THE ATTORNEY FOR THE CLASS AT:

Hillary P. Carls
Angel, Coil & Bartlett
125 W. Mendenhall, Suite 201
Bozeman, MT 59715
Telephone: 406-586-1926
hillary@angelcoilbartlett.com
www.angelcoilbartlett.com

If you are injured, your health insurance plan is legally required to pay your medical expenses. Even if you or the person who caused your injuries has other insurance to pay the medical expenses (such as automobile or homeowner's insurance) your health insurance must also pay your medical expenses. Only if you have been fully compensated for all damages, including payment of your attorney fees and costs, will the Montana University System have the right to be reimbursed for any payments it has made. Under Montana law, this is called your right to be "made whole."

It is your right to hire your own attorney to represent your interests in this class action.

It is your right to request that the Court exclude you from being a member of this class action, and upon receipt of a written request to exclude, the Court will exclude you from the class. To be excluded from the class you must make a written request to the Court by July 12, 2017. The written request to be excluded from the class must reference Gendron v. Montana University System, Cause No.: DV-09-953B and be submitted to:

Clerk of the District Court
Montana Eighteenth Judicial District Court, Gallatin County
W. W. Lessley Law & Justice Center
615 South 16th Ave., Rm. 302
Bozeman, MT 59715

If you do not request to exclude yourself from the class action, the Court's judgment for class members will be binding on you pursuant to Montana Rule of Civil Procedure 23(c)(3).

It is also your right to object to the award of attorney fees and costs. The Montana University System agrees that class attorneys are entitled to an award of reasonable attorneys' fees and costs, over and above the amount paid to Class Members. The parties have not yet reached agreement on the amount of the attorneys' fees and costs. If the parties do not reach an agreement on the amount of the attorneys' fees and costs, the parties will submit their written positions on the attorney fees and cost award by September 15, 2017, and the Court will decide the attorney fee and cost award at the Final Fairness Hearing.

To object to the award of attorney fees and costs you must make a written request to the Court by October 15, 2017. You have the right to inspect the parties' requests and positions regarding the attorney fees and costs award at the Clerk of the District Court office indicated below. The written request to object to the award of attorney fees and costs must reference Gendron v. Montana University System, Cause No.: DV-09-953B and be submitted to:

Clerk of the District Court
Montana Eighteenth Judicial District Court, Gallatin County
W. W. Lessley Law & Justice Center
615 South 16th Ave., Rm. 302
Bozeman, MT 59715

It is your right to attend the final Fairness Hearing in this matter. The final Fairness Hearing in this matter is scheduled for December 5, 2017 at 1:30 p.m. at the W.W. Lessley Law & Justice Center, 615 South 16th Ave., Room 201, Bozeman, Montana.

Glossary

Allowed Amount

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

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 the allowed amount and covered charges that a member is responsible for paying, after paying any applicable deductible. The medical plan pays the remaining allowed amount. For example, if Jack has met his deductible for In-Network medical costs ($750), he pays 25% of additional allowed amount up to the out-of-pocket maximum and the plan pays 75%.

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.

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 $750. Jack pays 100% of the allowed amount until his deductible has been met.

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 charge.

In-Network Providers

Providers who have a participating contract with the medical plan administrators to manage and deliver care at contracted prices. Members may self-refer to In-Network providers and specialists.

Out-of-Network Provider

Any provider who renders services to a member but does not have a participating contract with the medical plan administrators. Members may self-refer to Out-of-Network providers and specialists; however, you will pay more for Out-of-Network services.

Out-of-Pocket Maximum

The maximum amount of money you pay toward the cost of 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 plan year. Balance billing amounts (the difference between out-of-network provider charges and the allowed amount) do not apply to the out-of-pocket maximum.

Participating Provider

A provider who has a participating contract with the medical plan administrator to accept the allowed amount as payment in full.

Plan

A benefit your employer provides to you to pay for your health care services.

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.

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.

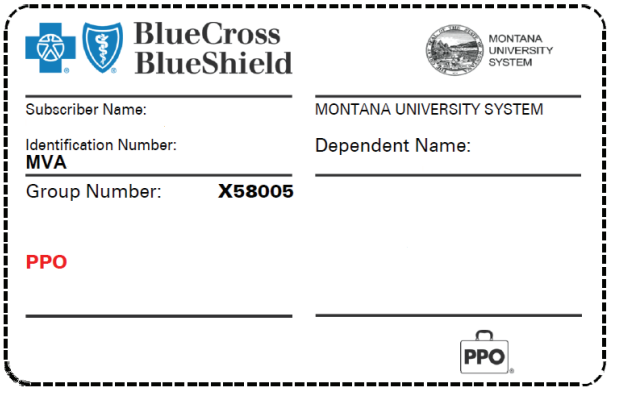
Specialist

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

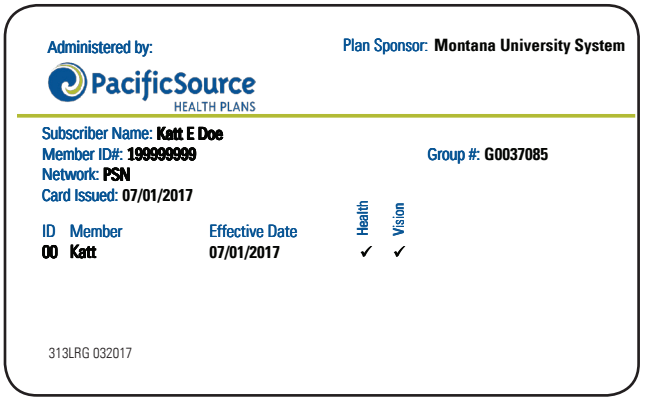
Insurance Card Examples

Allegiance Medical

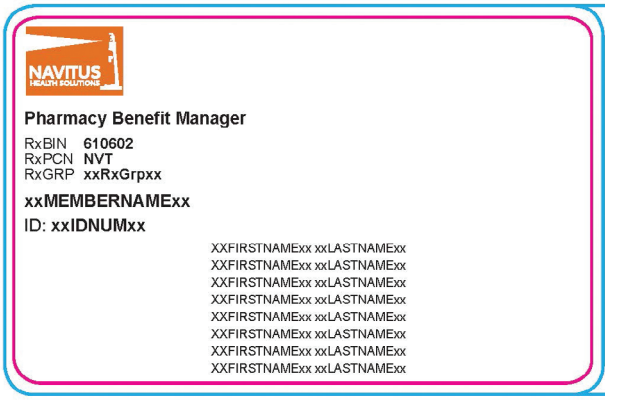
Blue Cross Blue Shield Medical



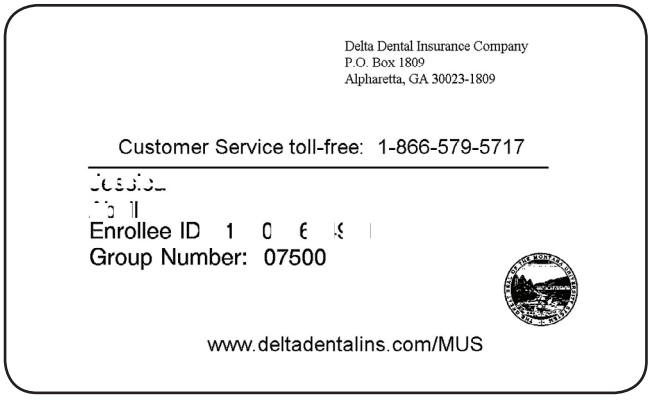
PacificSource Medical



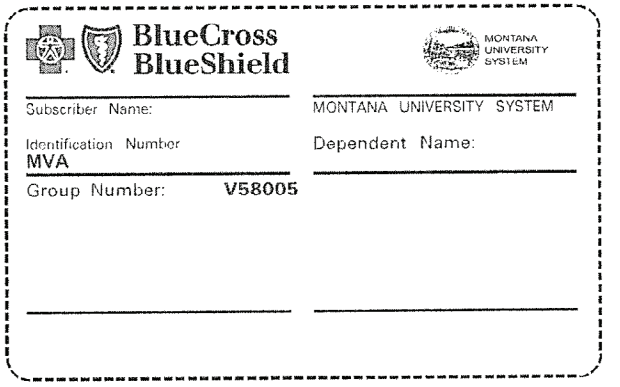
Navitus Pharmacy



Delta Dental



Blue Cross Blue Shield Vision Hardware



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
Flex Plan Administrator 1-877-778-8600
www.abpmtpa.com/mus

BLUE CROSS AND BLUE SHIELD OF MONTANA - Medical Plan
Customer Service 1-800-820-1674 or 406-447-8747
www.bcbsmt.com

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

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 406-447-8747
www.bcbsmt.com

NAVITUS – PRESCRIPTION DRUG PROGRAM

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

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

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

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

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