

MONTANA UNIVERSITY SYSTEM

SUMMARY PLAN DESCRIPTION

EFFECTIVE JULY 1, 2016

THE MONTANA UNIVERSITY SYSTEM

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To: Plan Participants

The Montana University System (MUS) offers a comprehensive Employee Group Benefits Plan called “*Choices*” or “Plan.” The Plan offers three Medical Plans, a Prescription Drug Plan, a Basic (preventive) Dental Plan option, a Select Dental Plan option, a Basic Life and Accidental Death & Dismemberment (AD&D) Insurance Plan, and a Long-Term Disability Insurance Plan. The Plan also offers a number of optional benefits including a Vision Hardware, Supplemental Life Insurance, Dependent Life Insurance, additional AD&D Insurance, Long Term Care Insurance, and Health Care and Dependent Care Reimbursement Accounts.

This is the Summary Plan Description for the Medical Plans. There are also separate Life Insurance, Accidental Death and Dismemberment, and Long-Term Disability Plan Descriptions.

This Summary Plan Description (SPD) explains the benefits participants may receive as a member of the MUS Employee Group Benefits Plan (known as the Plan or *Choices* throughout the rest of this document). The Plan provides coverage for participating employees, retirees and eligible dependents.

This SPD will help you, the participant, understand and use your benefits. You and your covered dependents should review this SPD. It is a primary Plan Document under the Plan and it will help each member to understand the coverage provided to the members, steps to follow to access Plan benefits, specific exclusions or limitations under the Plan, how the Plan is funded, and your rights & responsibilities as a member.

Federal Health Care Reform

The federal Patient Protection and Affordable Care Act (the “Affordable Care Act” or “ACA”) has and will continue to affect the way health care coverage is provided by employers. Many of the primary health care reform provisions, such as elimination of lifetime limits on essential health benefits, dependent coverage for children under age 26, preventive health services, and other patient protections have already been implemented by the MUS Employee Group Benefits Plan. New requirements continue to be placed by ACA on employers and their group health plans. The “employer mandate,” also referred to as the “employer shared responsibility” or “pay or play” rules requires employers to pay significant new taxes if (1) they do not offer health care coverage to substantially all of their full-time employees or (2) the coverage they do offer is not affordable or does not provide a certain minimum level of benefits.

Beginning in 2015, in order to avoid a new set of taxes, the employer mandate effectively requires the MUS to offer coverage to any employee who works an average of 30 or more hours per week (or an average of 130 hours per month). For some employment categories, such as adjunct faculty, student employees, coaches, and certain other seasonal or temporary employees, the MUS needs to track hours actually worked or create a reasonable method for crediting hours worked. The MUS will credit an adjunct faculty member with 3 hours of service per week for every credit hour taught per week.

It is important to know that the definitions provided in the MUS SPD that defines plan and eligibility requirements are still the rules the MUS will follow every day.

Final IRS regulations under ACA allow employers to identify full-time employees by calculating employees’ hours during a specified period of months (a measurement period) and then locking in that

status (full-time or not) for a separate specified period (a stability period). Following this regulation will allow the MUS to comply with the employer mandate. The IRS 'safe harbors' regulations uses the following defined terms:

A "measurement period" is the look-back period over which hours are calculated to determine whether an employee has averaged at least 30 hours per week. There are two types of measurement periods: standard measurement periods and initial measurement periods.

The "standard measurement period" is used for ongoing employees.

The "initial measurement period" is used for new employees.

The "stability period" is the look-forward period for which an employee's status (determined during the measurement period as full-time or not) is generally locked in, regardless of the employee's actual hours during this period (provided that the employee continues to be an employee during the stability period). The stability period begins at the end of the measurement period and any administrative period.

The "administrative period" is a period after the end of a measurement period – and before the beginning of the next stability period – during which an employer can perform administrative tasks, such as calculating the hours for the measurement period and determining eligibility for offer of coverage.

An "ongoing employee" is an employee who has been employed for at least one complete standard measurement period.

An employee is a "variable-hour employee" if it cannot be determined on the employee's start date that the employee is reasonably expected to work an average of at least 30 hours per week during the initial measurement period (based on the facts and circumstances on the employee's start date).

An "hour of service" means (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and (2) each hour for which an employee is paid, or entitled to payment, by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Hours of Service for all employees are credited using actual Hours of Service from records of hours worked and hours for which payment is made or due. Three (3) Hours of Service will be applied for each credit taught by Adjunct Faculty. For example, 6 credits taught will equate to 18 Hours of Service.

The Plan elects to use the look-back measurement method with respect to all employees for purposes of identifying those employees who are full-time employees, which also identifies those employees who are eligible employees.

The Plan elects to define the MUS standard measurement period as a 12-month period beginning June 1 each year and ending the following May 31. Notwithstanding the foregoing, the first MUS standard measurement period or initial measurement period will be the period beginning July 1, 2014 and ending on May 31, 2015.

The Plan elects to define the stability period as a 12-month period of time that an employee has health care coverage based on the requirements of ACA as long as actively employed.

The Plan elects to define the administrative period as the 30-day period beginning on June 1 each year and ending June 30 each year.

Beginning in 2016 (for reporting on the calendar year 2015) and annually thereafter, the MUS, in its role as an employer sponsoring group health plan coverage, will be required to file annual information returns with the Internal Revenue Service (IRS) and furnish annual statements to employees on health plan coverage information. Compliance with employer reporting requirements is mandatory.

Plan Funding

All medical plans, the Prescription Drug Plan, the Vision Hardware Plan, and the Dental Plan(s) are self-insured. Premium contributions go directly into a fund, which is used to pay the cost of benefits for Plan

Participants who experience Illness or Injury. In order to keep the Plan financially sound and affordable, it is important that all Plan Participants use their benefits responsibly. Plan Participants are expected to pay a portion of their medical costs in the form of annual Deductibles, percentage Coinsurance and/or dollar Copayments. These cost-containment features are part of the Plan design so Plan dollars will be available should a high-cost Medical Emergency or a catastrophic Illness strike a Plan Participant.

Medical coverage is very important. Medical costs are rising faster than the prices of other goods and services, and this inflationary trend shows no sign of abating. The cost of a serious Illness or Injury is so expensive today that the savings of even an affluent individual can be quickly exhausted. Medical benefits provide essential protection that few of us could afford on our own.

As a Plan Participant, you should consider the following ways to personally help save yourself and your Plan dollars:

- 1. Make sure that planned (non-emergency) services are covered.** Look over this Plan Description to see what services are covered, what services have benefit limits (defined in the current *Choices* Enrollment Workbook Schedule of Benefits), and which ones require a call to the Claims Administrator for Prior Authorization. It is important to Prior Authorize any services that are new and could be considered experimental, or services that may be considered cosmetic. You should Pre-certify any planned admission to a Hospital or facility, and call in an emergency admission by the end of the next working day. Since you are responsible for non-covered charges, you should make sure your stay meets your Plan's criteria for coverage.

You may also review benefits online at www.choices.mus.edu or call your medical Claims Administrator.

- 2. Use your medical plan's Participating or Network Providers and any facilities designated as "Preferred."** Participating Providers accept Allowable Fees for services as their full reimbursement, saving you charges above the Allowable Fee. Preferred facilities also accept Allowable Fees and you pay a smaller portion of these fees. Using Network Providers provides the best benefit (covered services, smallest Copayment or Coinsurance).

If you choose to use a non-Participating or out-of-Network Provider, you may wish to ask your Provider **IN ADVANCE** if he or she would accept the Allowable Fee as payment in full.

- 3. Ask your Hospital and/or Physician to use Participating or Network Providers for ancillary services.** This includes services of a referral Physician, an anesthesiologist, radiologist, or independent laboratory. Be assertive – this is your right.
- 4. Consider using public health services for immunizations you need.**
- 5. Find a good book that describes common medical symptoms.** Use it as a reference to help decide what symptoms or combinations of symptoms require the immediate attention of a Physician. Only use a Physician when necessary!
- 6. Consult with a Physician by phone when you are uncertain that a particular symptom is serious enough to justify a visit.** Please note, however, that not all plans will cover telephone consultations - if there is a charge.
- 7. Use emergency rooms only for Medical Emergencies.** On weekends or evenings when your Physician's office is closed, use a freestanding clinic or urgent care center, where available, for urgent care.

8. **Discuss with your Physician the risks, alternatives, and fees before treatment or drugs are prescribed.** You should ask enough questions to assure yourself: (1) that the treatment is necessary and appropriate for your condition, (2) does not involve unacceptable risks, and (3) that no better option exists or no equally effective but less costly option exists. Let your Physician know that the cost of any prescribed medical treatment is a concern to you.
9. **Seek a second opinion for non-emergency surgical procedures.** It is your health that is at stake. You should know if another qualified medical specialist would not advise surgery or the same kind of surgery as your doctor recommends.
10. **Request generic drug prescriptions when possible.** Generic drugs are usually less expensive than comparable name brands.
11. **Read your medical bills.** Make sure you were only billed for services that you actually received. If you do not think you were billed correctly, call your Physician's office or the Hospital and bring the matter to their attention.
12. **Finally, the most important thing you can do is guard your health.** Eat right, exercise, stop smoking, limit alcohol consumption, and participate in the MUS Wellness Programs. A healthy lifestyle can prevent or mitigate many common illnesses. Only you can make the *choices* that will improve your lifestyle and your health.

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Section 1 ELIGIBILITY

A. ELIGIBLE EMPLOYEE

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 under the provisions of Section 2, if qualified under one of the following categories:

1. **Permanent faculty or staff members** regularly scheduled to work at least twenty (20) hours per week or forty (40) hours over two (2) weeks for a continuous period of six (6) months or more in a twelve (12) month period.
2. **Temporary faculty or staff members** regularly scheduled to work at least twenty (20) hours per week or forty (40) hours over two (2) weeks for a continuous period of six (6) months or more, or who actually do so regardless of schedule.
3. **Seasonal faculty or staff members** regularly scheduled to work at least twenty (20) hours per week or forty (40) hours over two (2) weeks for six (6) months or more per year, or who actually do so regardless of schedule.
4. **Academic or Employees with an individual contract under the authority of the Board of Regents** which provides for eligibility under one of the above requirements.

Student employees who occupy positions designated as student positions by a campus are not eligible to join the Plan.

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

B. ELIGIBLE DEPENDENTS

Note: The Plan has “closed enrollment” which means that a legal spouse or Adult Dependent may not be added to the Plan unless there is a Qualifying Change in Status, also known as a Qualifying Event or Qualifying Life Event.

An Eligible Employee, defined above, who enrolls in the Plan as a Subscriber may enroll the following Dependents according to the terms of Section 2, and continue the coverage of some or all of these Dependents along with continuation of the Employee’s coverage under Retiree or COBRA provisions of Sections 3 or 4.

1. **Legal Spouse** – The Subscriber’s legal spouse as defined by Montana law.
2. **Adult Dependent** – One Adult Dependent of the Subscriber where the Subscriber and Adult Dependent meets the following criteria:
 - a. Are both over the age of eighteen (18), of legal age to contract;
 - b. Have shared a common household with proof of joint ownership or joint tenancy for at least the most recent six (6) consecutive months;
 - c. Does not meet the legal definition of spouse or the Plan’s definition of Dependent Child;
 - d. The Adult Dependent is ineligible for any other comparable group insurance coverage;
 - e. The Adult Dependent does not have a parental relationship with the Subscriber and is not otherwise related to the Subscriber by blood or marriage;
 - f. Are mutually responsible for each other’s welfare and share financial obligations as evidenced by at least **two (2)** of the following conditions:
 - 1) Joint ownership or lease of a residence.

- 2) At least two (2) of the following:
 - i. Joint bank account;
 - ii. Joint billing statements (residential utilities or phone);
 - iii. Joint credit card accounts;
 - iv. Joint loan agreements;
 - v. Joint car ownership; or
 - vi. Other titles or deeds that are jointly owned.
- 3) Mutually-granted powers of attorney or mutually-granted health care powers of attorney;
- 4) Designation of each other as primary beneficiary in wills, life insurance policies, or retirement annuities; and
- 5) Are not in a federally or state recognized marriage either by law or common law, or legally separated.

A Subscriber claiming an Adult Dependent must submit a **Declaration of Adult Dependent** form to the Campus Benefit Representative/Human Resource Office for approval.

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

2. **Child(ren)** – A Subscriber’s child will be an eligible dependent until reaching the limiting age of twenty-six (26) without regard to student status, marital status, financial dependency or residency status with the Subscriber or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child’s birthday month.

A Subscriber’s child will be an eligible dependent if the child meets all of the following criteria:

Is a natural child of, a legally adopted child of, or a child placed for adoption with the Subscriber; the Subscriber’s spouse or the Subscriber’s Adult Dependent or a child who has one of the following parent-child relationships with the Subscriber:

- 1) Court-ordered custody of the child by the Subscriber, or the Subscriber’s spouse or Adult Dependent.
- 2) Legal guardianship of the child by the Subscriber, or the Subscriber’s spouse, or Adult Dependent.
- 3) Stepchild of the Subscriber’s spouse or Adult Dependent.
- 4) Child for whom the Subscriber or the Subscriber’s spouse is responsible for medical insurance under a Qualified Medical Child Support Order.

Proof of the above relationships must be provided upon request of the Plan Administrator.

C. **DISABLED DEPENDENT CHILD**

An unmarried Dependent Child who is mentally or physically handicapped may continue coverage after age twenty-six (26), provided the child is incapable of self-supporting employment and is chiefly dependent upon the Subscriber for support and maintenance. Satisfactory proof of incapacity must be submitted within thirty- one (31) days of the child’s 26th birthday. The Plan Administrator may request additional proof of continued incapacity from time to time. The **Proof of Incapacitated Child** form is available at the campus Human Resource/Benefits Office.

D. **RESCISSION OF COVERAGE**

Group health plans, including the MUS Plan, are prohibited from rescinding coverage for individuals who are covered under the plan, except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the Plan and with advance notice. The term “rescission” means a cancellation or discontinuance of coverage that has a retroactive effect. Retroactive cancellation of coverage may occur with enrollment of a Dependent who is not eligible for coverage under the Plan’s terms. Enrolling an ineligible Dependent or otherwise failing to comply with

the Plan's requirements will constitute fraud or an intentional misrepresentation of a material fact that will trigger rescission. It is the responsibility of the Subscriber to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also the Subscriber's responsibility to update previously provided information and statements. The consequences of covering ineligible individuals include liability for benefits already paid that may be asserted against the Subscriber. All claims for health care benefits incurred on or after the rescission date will be rejected. The rescission of coverage constitutes an Adverse Benefit Determination, and the Subscriber may file a claim under the Plan's internal claim and appeal procedures to challenge the rescission.

E. IMPORTANT NOTICE – ENROLLMENT AND RESPONSIBILITY FOR REMOVING INELIGIBLE DEPENDENTS

1. When you enroll a Dependent in the Plan, you represent the following:
 - a. The individual is eligible under the terms of the Plan; and
 - b. You will provide evidence of eligibility on request.
2. Further, you understand that:
 - a. The Plan is relying on your representation of eligibility in accepting the enrollment of your Dependent;
 - b. Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
 - c. Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual became ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan's provisions on rescissions of coverage.
3. It is the responsibility of the Subscriber to contact his or her campus Human Resources/Benefits Office to remove from coverage any Dependent who ceases to be eligible, as defined in Sections B. and C. above, within thirty (30) days of the loss of eligibility. Failure to notify the campus Human Resources/Benefits Office or the Claims Administrator of the Dependent's loss of Dependent status within sixty (60) days results in the Dependent's loss of COBRA rights as described in Section 4. COBRA Subscribers should contact their health plan's Claims Administrator directly to report a Dependent's loss of Dependent status (*see Section 4 for COBRA rights of an individual who ceases to qualify as a Dependent*). **After the month in which a Dependent's eligibility ends, the Subscriber will be held responsible for repayment of any claims dollars paid for an ineligible Dependent's claims for services.**

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

Section 2

ENROLLMENT, CHANGES IN ENROLLMENT, EFFECTIVE DATES OF COVERAGE

A. NEW EMPLOYEE ENROLLMENT

ENROLLMENT OPTIONS: Newly Eligible Employees have the option of enrolling themselves and any Eligible Dependents as Plan Participants or waiving all coverage during a thirty-one (31) day initial enrollment period that begins on the enrollment date, which is the date of hire if eligible on that date, or the first date of eligibility under the Plan. If the Employee chooses to enroll, he or she must select a medical plan, a dental plan, a Long Term Disability Insurance option, and a Basic Life Insurance option. Eligible Dependents may be enrolled in the selected medical plan and/or selected dental plan. During this initial enrollment period, the Employee may also elect (and, if applicable, enroll Eligible Dependents in) optional benefits according to the provisions of those benefit plans.

A full range of life insurance options is only available without showing evidence of insurability (proof of good health) during the initial thirty-one (31) day enrollment period (*see the current Choices Enrollment Booklet or separate Life, Accidental Death and Dismemberment and Long Term Disability Plan descriptions*).

PREMIUM PAYMENT: The MUS makes an employer contribution toward benefits for Eligible Enrolled Employees. Enrollment in benefits with premium costs exceeding the employer contribution authorizes the MUS to deduct the extra premium from the Employee's pay. Payroll deductions for medical, dental, basic life/Accidental Death and Dismemberment (AD&D) and long term disability insurance and for optional Vision Hardware coverage are pre-tax under IRS Section 125, unless the Employee opts out of pre-tax premium payment. Opting out precludes participation in a Reimbursement Account described in Section 11.

EFFECTIVE DATE: For an Employee and any Eligible Dependents enrolled within the thirty-one (31) day initial enrollment period, medical, prescription drug, dental, and optional vision hardware coverage **shall be effective on the enrollment date**, which is the hire date if the Employee is eligible on the hire date, or on the first day of eligibility. *See separate Plan Descriptions for the Effective Dates of Life, Accidental Death and Dismemberment and Long Term Disability insurance.*

IF THE EMPLOYEE CHOOSES TO WAIVE ALL COVERAGE: If the Employee waives coverage in writing, he or she may not enroll in the Plan until the next annual enrollment period or until he or she has a Special Enrollment event described below. **If the Employee waives coverage, he or she waives all coverages including medical, dental, basic life/AD&D, and long term disability and forfeits employer contribution toward benefits until any later enrollment. In making the decision to waive all coverage, it is recommended that the Employee discuss implications of waiving all coverage with his or her campus Human Resources/Benefits Office so as to better understand the benefits of the employer contribution.**

DEFAULT COVERAGE: If a newly Eligible Employee neither enrolls nor waives coverage within the thirty- one (31) day initial enrollment period, he or she will default to Employee only coverage defined in the current *Choices Enrollment Workbook*. The cost of default coverage will be within the employer contribution. This coverage will consist of:

1. Employee Only Blue Cross Blue Shield Plan.
2. Employee Only Basic Dental.
3. Basic Life/AD&D \$15,000.
4. Long Term Disability Option 1 (60% of pay/180 day waiting period).

B. ANNUAL BENEFITS ENROLLMENT

Each spring, the MUS and various campuses will designate an enrollment period. During enrollment, any Subscriber may change his or her benefit elections, subject to any Plan restrictions. All enrollments and benefit changes are effective for the new Benefit Year beginning July 1. *See the current Choices Enrollment Workbook for plan options and premium costs.*

PREMIUM PAYMENT: Enrolling in benefits commits the Subscriber to paying any required out-of-pocket premium for elections. For active Employees, it authorizes MUS to deduct premium costs that exceed employer contribution from the Employee's pay as described in provision A. of this Section.

C. SPECIAL ENROLLMENT

An eligible person may be enrolled in the Plan during a sixty-three (63) day Special Enrollment period as provided by the Health Insurance Portability and Accountability Act (HIPAA) when one of the Special Enrollment events listed below occurs. The sixty-three (63) day Special Enrollment period begins on the date of the Special Enrollment event. A request for Special Enrollment must be made to the appropriate campus Human Resource/Benefits Office during this sixty-three (63) day period, and required enrollment forms must be submitted within two (2) weeks of the request.

- 1. Marriage** - An Employee who marries and is eligible but not enrolled in the Plan may enroll self, the new legal spouse, and any other Eligible Dependents. A Subscriber who marries may enroll the new legal spouse and any other Eligible Dependents and change benefit elections, subject to any Plan restrictions. **Coverage will be effective on the first day of the first calendar month following the Plan's receipt of a mid-year election change form. The form must be received within the sixty-three (63) day special enrollment time period.** *See separate Plan Descriptions for the Effective Dates of Life, Accidental Death and Dismemberment and Long Term Disability insurance.*
- 2. Meeting Criteria to Cover an Adult Dependent** - An individual who meets the Adult Dependency criteria in Section 1 and who is declared as an Adult Dependent by an Eligible Employee within sixty-three (63) days of first meeting the criteria may be enrolled in the Plan, provided the Eligible Employee also enrolls or is already enrolled. An individual who meets the Adult Dependency criteria and who is declared as an Adult Dependent by a Retiree or COBRA Subscriber within sixty-three (63) days of first meeting the criteria may also be enrolled in the Plan. Other Eligible Dependents may be enrolled with the Adult Dependent, and the Subscriber may change benefit elections. **Coverage will be effective on the first day of the first calendar month following the Plan's receipt of a mid-year election change form and a qualifying Declaration of Adult Dependency form. The forms must be received within the sixty-three (63) day special enrollment period.** *See separate Plan Descriptions for the Effective Dates of Life, Accidental Death and Dismemberment and Long Term Disability insurance.*
- 3. Birth** - The birth of a child of an Employee who is eligible but not enrolled in the Plan allows the Employee to enroll self, the newborn, and any other Eligible Dependents. The birth of a child of a Subscriber allows the Subscriber to enroll the newborn and any other Eligible Dependents (spouse or children) and change benefit elections, subject to any Plan restrictions. Coverage of a child born to a Subscriber, covered legal spouse, or covered Adult Dependent automatically begins at birth and continues for a thirty-one (31) day period. To add the child beyond the first thirty-one (31) days, the Subscriber must affirmatively enroll the newborn child and pay any required Employee contribution toward premium paid for coverage to continue beyond thirty-one (31) days. **A mid-year election change form must be received by the Plan within the sixty-three (63) day special enrollment period. Special Enrollment coverage is effective on the date of birth.** *See separate Plan Descriptions for the Effective Dates of Life, Accidental Death and Dismemberment, and Long Term Disability insurance.*

4. **Adoption or Placement for Adoption** – The adoption of a child by, or placement for adoption of a child with, an Employee who is eligible but not enrolled in the Plan allows the Employee to enroll self, the child and any other Eligible Dependents. The adoption of a child by or placement for adoption of a child with, a Subscriber allows the Subscriber to enroll the child and any other Eligible Dependents and change benefit elections, subject to any Plan restrictions. This provision applies to children under the age of eighteen (18). **A mid-year election change form must be received by the Plan within the sixty-three (63) day special enrollment period. Coverage is effective on the date of the qualifying adoption or placement for adoption.** *See separate Plan Descriptions for the Effective Dates of Life, Accidental Death and Dismemberment, and Long Term Disability insurance.*
5. **Loss of Eligibility for other Health Insurance Coverage**– Loss of other health insurance coverage due to one of the following causes by an Employee who is eligible for this Plan but not enrolled in the Plan allows the Eligible Employee to enroll self and any Eligible Dependents. Loss of other health insurance coverage by an Eligible Dependent of a Subscriber due to one of the following causes allows the Subscriber to enroll the Eligible Dependent and to change benefit elections, subject to any Plan restrictions:
- a. The Employee or Dependent loses eligibility for other group health insurance (including Medicaid, Medicare benefits) due to:
 - employment events such as termination of employment or reduction in hours;
 - a change in status resulting in loss of eligibility under the other insurance plan (such as divorce, a Dependent Child reaching a limiting age, etc.); or
 - loss of eligibility for another group (or individual) health plan due to no longer residing, living or working in the plan’s service area.
 - b. The Employee or Dependent loses other COBRA coverage because the COBRA continuation period under the other plan is exhausted.
 - c. The Employee or Dependent loses other employer coverage because the plan is terminated by the employer or the employer ceases employer contributions towards it.

Loss of eligibility for other coverage does not occur if coverage was terminated due to a failure of the Employee or Dependent to pay premiums on a timely basis or coverage was terminated for cause. Voluntary cancellation of other coverage does not constitute a qualifying event. **A mid-year election change form must be received by the Plan within the sixty-three (63) day special enrollment period.**

6. **Coverage will be effective on the first day of the first calendar month following the Plan’s receipt of the mid-year election change form. The mid-year election change form must be received by the Plan within the sixty-three (63) day special enrollment period.** Individuals may enroll and become covered when coverage under Medicaid or any state children’s insurance program recognized under the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA/Healthy Montana Kids (HMK)) is terminated due to loss of eligibility, subject to the following:
- a. A request for enrollment must be made in writing within sixty-three (63) days after this special enrollment event, and written application for such coverage must be made within sixty-three (63) days after such event.
 - b. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
 - c. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

- d. If an eligible Dependent of a Retiree loses coverage, the eligible Dependent who lost coverage may enroll and become covered.

Coverage will be effective on the date coverage under CHIPRA/HMK is lost. A mid-year election change form must be received by the Plan within the sixty-three (63) day special enrollment period.

7. Individuals who are eligible for coverage under this Plan may enroll and become covered on the date they become entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement shall be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (HMK or Medicaid). A request for enrollment, either verbal or in writing, must be made within sixty-three (63) days after this special enrollment event, and written application for such coverage must be made in writing within sixty-three (63) days after such event.

PREMIUM PAYMENT: Enrolling in benefits commits the Subscriber to paying any required out-of-pocket premium for elections. For active Employees, it authorizes the MUS to deduct premium costs that exceed employer contribution from the Employee's pay as described in provision A. of this Section.

D. OTHER MID-BENEFIT YEAR ENROLLMENT

Court Ordered Custody or legal guardianship of a child– A court order awarding custody or legal guardianship of a child to a Subscriber or a Subscriber's spouse or declared Adult Dependent allows the Subscriber to enroll the child, provided the child is an Eligible Dependent as defined in Section 1. **Coverage may be made effective on the date of the court order** provided the child is enrolled within sixty-three (63) days of the date of the court order, a copy of the court order is presented to the campus Human Resources/Benefits Office and any required premium is paid.

Qualified Medical Child Support Order – A Qualified Medical Child Support Order requiring a Subscriber or a Subscriber's legal spouse or declared Adult Dependent to provide medical insurance for the child allows the Subscriber to enroll the child within sixty-three (63) days of the Order, provided the child is an Eligible Dependent as defined in Section 1. **Coverage may be made effective on the date of the Order** provided the child is enrolled within sixty-three (63) days of the Order, a copy of the Order is presented to the campus Human Resources/Benefits Office, and any required premium is paid. Enrollments will be made after the sixty-three (63) day enrollment period for a Qualified Medical Child Support Order presented to an appropriate campus Human Resources/Benefits Office after that time, and **coverage will be effective on the date the Order is received.**

PREMIUM PAYMENT: Enrolling in benefits commits the Subscriber to paying any required out-of-pocket premium for elections. For active Employees, it authorizes the MUS to deduct premium costs that exceed employer contribution from the Employee's pay as described in provision A. of this Section.

E. ALLOWED AND REQUIRED MID-BENEFIT YEAR ELECTION CHANGES

Employees (Subscribers) in the MUS Cafeteria Plan (who make Employee contributions on a pre-tax basis for eligible benefits whose costs exceed the Employer contribution) may revoke and enter into new elections Mid-Benefit Year if:

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

Employees who are eligible but not enrolled and who qualify for Special Enrollment may also make new elections mid-Benefit Year. Changes in elected medical plan are only allowed as part of Special Enrollment described in provision C. of this Section, or when a Subscriber moves outside the elected health plan's service area described below, or when the elected medical plan ceases to be available or suffers substantial adverse changes in benefits or costs.

EFFECTIVE DATES AND RETROACTIVE PREMIUM ADJUSTMENT: Regardless of when the Plan is notified or learns of a Dependent's loss of eligibility, coverage terminates effective the first of the month following the month of loss of eligibility, as described in Section 3. *See Section 1, provision D., "RESCISSION OF COVERAGE" for triggering events and consequences.* Election changes for Special Enrollment and mid-year enrollment described in provisions C. and D. are effective on the dates indicated. Premium paid pre-tax may not be retroactively adjusted to provide a refund back more than thirty (30) days or beyond the start of the calendar year whichever comes first.

QUALIFYING CHANGES IN STATUS AND PERMITTED ELECTION CHANGES: The following are qualifying changes in status and permitted changes in elections:

1. **Marriage or Declaration of an Adult Dependent.** Elections may be changed for Special Enrollment described above. Elections may be changed to reduce coverage if individuals currently on the Plan become eligible for and move to the new legal spouse's/Adult Dependent's health plan.
2. **Birth, Adoption, Placement for Adoption, a court order granting custody or guardianship, a Qualified Medical Child Support Order or any other event making a Dependent eligible for Plan coverage.** Elections may be changed for Special Enrollment and Mid-Benefit Year Enrollment described above.
3. **Divorce, legal separation, marriage annulment, cancellation of an Adult Dependent Declaration or failure of the Adult Dependent to meet criteria, death of a legal spouse or death of an Adult Dependent.** Elections may be changed to Special Enroll Dependent Children who lose eligibility under a former legal spouse's or Adult Dependent's plan as provided above. Elections may be changed to drop coverage on deceased Dependents and on Dependents who are no longer eligible under this Plan.

An ex-spouse, legally separated spouse or Adult Dependent who no longer meets Adult Dependent criteria must be removed from coverage within thirty (30) days of the date of the event, i.e., date of divorce decree or date of legal separation decree. The Subscriber must notify the Plan within thirty (30) days of the date of the event so as to enable the Plan to remove the ex-spouse, legally separated spouse or Adult Dependent from coverage. Termination of coverage is effective thirty (30) days from the date of the event. *See Section 1, provision D., "RESCISSION OF COVERAGE" for triggering events and consequences.* A deceased Dependent should be removed from coverage within thirty (30) days to avoid paying premium that cannot be reimbursed. *See "EFFECTIVE DATES AND RETROACTIVE PREMIUM ADJUSTMENT" above. See Section 4 for COBRA continuation rights of Dependents who lose eligibility. See separate life insurance Plan Descriptions for life insurance claim procedures.*

4. **A Dependent Child dies or ceases to meet the Plan's criteria as an Eligible Dependent.** Elections must be changed within thirty (30) days to remove an ineligible Dependent Child. A deceased Dependent Child should be removed from coverage within thirty (30) days to avoid paying premium that cannot be reimbursed. *See above paragraph. See Section 4 for COBRA continuation rights of Dependents who lose eligibility. See separate life insurance Plan Descriptions for life insurance claim procedures.*
5. **Employee has a change in status triggering eligibility under this Plan.** Elections may be changed to enroll the Employee and Eligible Dependents as provided in provision A. of this Section on initial enrollment or Section 3, provision F., on re-enrollment.
6. **A Dependent becomes eligible for other coverage.** Elections may be changed to decrease coverage if the Dependent leaves this Plan.

7. **A Dependent loses eligibility for other coverage.** Elections may be changed for Special Enrollment or mid-year enrollment described earlier in this Section.
8. **A Dependent's other coverage suffers a major adverse change.** Elections may be changed for mid-year enrollment described earlier in this Section.
9. **Employee moves out of an elected health plan's service area and no longer lives or works in the service area.** The health plan election may be changed.
10. **Employee becomes eligible for Medicare.** The employee may cancel or reduce his or her coverage under the health plan.

PREMIUM PAYMENT: Enrolling in benefits commits the Subscriber to paying any required out-of-pocket premium for elections. For active Employees, it authorizes the MUS to deduct premium costs that exceed employer contribution from the Employee's pay as described in provision A. of this Section.

F. CREDITABLE COVERAGE PROCEDURES

This provision advises Plan Participants of their Creditable Coverage rights under the federal Health Insurance Portability and Accountability Act (HIPAA). Certificates of Creditable Coverage will no longer be required for proof of pre-existing conditions on or after December 31, 2014.

CREDITABLE COVERAGE/Medicare Part D/COB: An Eligible Employee or Dependent under this Plan may submit to the Plan, Certification of Creditable Coverage from any prior health insurance or health care plan under which the Employee or Dependent had coverage, for the purpose of providing an end date to previous insurance or health care coverage. End dates are important to establish for Medicare Part D or Coordination of Benefits issues.

Section 3

LEAVE, LAYOFF, COVERAGE TERMINATION, RE-ENROLLMENT, SURVIVING SPOUSE AND RETIREMENT OPTIONS

A. SICK, FMLA AND WORKERS' COMPENSATION LEAVE

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

The Employee may change enrollment elections (as provided in Section 2, provision E.) to drop some or all optional and/or Dependent coverage within sixty-three (63) days of the date leave begins or of the date any applicable benefits (sick leave, vacation, MUS compensatory pay, FMLA employer contribution to benefits, or Workers' Compensation pay) cease.

See provision F. of this Section for re-enrollment into dropped or lapsed coverage upon return to benefits-eligible employment. See Section 4 for COBRA continuation rights when rights to continue coverage under this provision end.

B. FAMILY AND MEDICAL LEAVE

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

For these FMLA provisions only, the following definitions apply:

1. "Member of the Armed Forces" includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation, or therapy.
2. "Next of Kin" means the nearest blood relative to the service member.
3. "Parent" means Employee's biological parent or someone who has acted as Employee's parent in place of Employee's biological parent when Employee was a son or daughter.
4. "Serious health condition" means an illness, injury impairment, or physical or mental condition that involves:
 - A. Inpatient care in a hospital, hospice, or residential medical facility; or
 - B. Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services).

5. "Serious injury or illness" means an injury or illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform his or her military duties.
6. "Son or daughter" means Employee's biological child, adopted child, stepchild, foster child, a child placed in Employee's legal custody, or a child for which Employee is acting as the parent in place of the child's natural blood related parent. The child must be:
 - A. Under the age of eighteen (18); or,
 - B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.
7. "Spouse" means Employee's husband or wife as defined or recognized under State law in the State where the Employee resides.

In general, FMLA applies to any employer engaged in interstate commerce or in any industry or activity affecting interstate commerce who employs 50 or more Employees for each working day during each of 20 or more calendar work weeks in the current or preceding Calendar Year. FMLA also applies to those persons described in Section 3(d) of the Fair Labor Standards Act, 29 U.S.C. 203(d). The FMLA applies to government entities, including branches of the United States government, state governments and political subdivisions thereof.

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

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

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

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

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

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

C. EXTENDED LEAVE OF ABSENCE

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

Life and Long-Term Disability may not be continued beyond one year (12 months) unless the leave is provided under a collective bargaining agreement, in which case, they may be continued for up to two years (24 months). *Please see the Life and Long Term Disability Plan Booklets.* After applicable vacation or MUS compensatory pay is exhausted, the Employee will be responsible for paying the entire monthly premium.

The Employee may change enrollment elections (as provided in Section 2, provision E.) to drop optional and/or Dependent coverage within sixty-three (63) days of the date leave begins. *See provision F. of this Section for re-enrollment in lapsed or cancelled benefits upon return to benefits-eligible employment. See Section 4 for COBRA continuation rights when rights to continue coverage under this provision end.*

D. STATE AND FEDERAL COVERED MILITARY LEAVE

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA):

When an Employee enrolled in the Plan is absent from employment with the MUS due to service in the uniformed services and such absence or leave is subject to Federal USERRA requirements, the Employee may elect to continue medical and dental coverage under this Plan for himself or herself and any covered Dependents. The maximum period of coverage is the period of service and subsequent time USERRA provides for reporting back to work, not to exceed a twenty-four (24) month period beginning on the date the Employee's absence begins.

PREMIUM PAYMENT: An Employee who elects to continue coverage shall not be required to pay more than 102% of the full premium associated with the same coverage for the Employer's other Employees. After any accumulated vacation or MUS compensatory pay, which the Employee chooses to have applied to premiums, the Employee will be responsible for paying the entire monthly premium, except that an Employee who is called to service for less than thirty-one (31) days will only be responsible for the Employee contribution made prior to such service. *See provision F. below for re-enrollment rights if coverage is allowed to lapse.*

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

“**A timely manner**” means the following:

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

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

PREMIUM PAYMENT: An Employee who elects to continue Plan coverage may not be required to pay more than one hundred two percent (102%) of the full Plan premium associated with such coverage for the Employer’s other Employees, except that if an Employee performs State Active Duty for less than one hundred eighty-one (181) days, such Employee may not be required to pay more than the regular Employee share, if any.

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

See provision F. of this Section for re-enrollment into dropped or lapsed benefits upon return to benefits-eligible employment. See Section 4 for COBRA continuation rights when rights to continue coverage under this provision end.

E. TEMPORARY LAYOFF

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

The Employee may change enrollment elections (as provided in Section 2, provision E.) to drop optional and/or Dependent coverage within sixty-three (63) days of the date layoff begins or of the date any applicable vacation or compensatory pay ceases. *See provision F. for re-enrollment into dropped or lapsed benefits upon return to benefits-eligible employment. See Section 4 for COBRA continuation rights when rights to continue coverage under this provision end.*

F. COVERAGE TERMINATION

Coverage ends for a Subscriber at 12:01 a.m. on the day any one of the following events occurs (unless coverage is continued under COBRA provisions described in Section 4):

1. The first day of the month following the month in which an Employee Subscriber terminates employment.
2. The first day of the month following the month for which required premiums **have not** been paid.
3. The day an Employee Subscriber enters active duty (defined as more than thirty (30) days of full time service) with the Armed Forces of any country. *See State and Federal Covered Military Leave rights described in provision C. of this Section.*
4. The day the Plan is terminated by the Montana Board of Regents and a Plan of Benefits is no longer offered.

5. The first day of the month following the month in which the Subscriber ceases to be eligible for coverage.
6. The date the Subscriber dies.

Coverage also ends for an enrolled Dependent (unless coverage is continued under Surviving Dependent provisions below or under COBRA provisions described in Section 4) at 12:01 a.m. on the day any one of the following occurs:

1. On the first day of the month following the month in which the Dependent ceases to be an Eligible Dependent as defined by the Plan;
2. On the first day of the month in which the Subscriber's coverage terminates under the Plan;
3. The date the Subscriber fails to make any required contribution for Dependent coverage;
4. The day the Plan is terminated by the Board of Regents and a Plan of Benefits is no longer offered;
5. The date the Employer terminates the Dependent's coverage;
6. On the first day of the month following the month in which the Subscriber dies; or
7. The date the Dependent enters active duty (defined as more than thirty (30) days of full time service) with the Armed Forces of any country.

The Subscriber is responsible for notifying the Plan of a Dependent's loss of eligibility as described in Section 1, provision E.

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

FOLLOWING APPROVED LEAVE OR TEMPORARY LAYOFF:

Employees who cancel or let their medical and/or dental coverage lapse, or who cancel coverage on their Dependents during one of the above approved leaves or during a temporary layoff of no more than six (6) months, may re-enroll themselves and any formerly covered Dependents upon return to benefit-eligible employment. If re-enrollment is within the same Benefit Year, coverage must be reinstated to the same coverage as before the leave or layoff. If re-enrollment is in a subsequent Benefit Year, new elections of available plan and coverage options must be made.

FOLLOWING TERMINATION OF EMPLOYMENT:

Eligible Employees rehired within sixty-three (63) days of the last day worked and within the same Benefit Year may re-enroll in the Plan and will have prior benefit elections. Dependents can only be added if there has been a Special Enrollment or Mid-Year Enrollment event described in Section 2 during the approved leave or temporary layoff. *See separate Plan Descriptions for Life, Accidental Death and Dismemberment, and Long Term Disability insurance re-enrollment requirements and restrictions.*

Eligible Employees rehired after sixty-three (63) days or in a new Benefit Year may enroll the same as a new Employee and make new elections. *See separate Plan Descriptions for Life, Accidental Death and Dismemberment, and Long Term Disability insurance re-enrollment requirements and restrictions.*

H. SURVIVING DEPENDENT CONTINUATION OF COVERAGE

A covered surviving legal spouse or Adult Dependent of a deceased Employee or Retiree may continue medical coverage on self and any Dependents covered by the Plan at the time of the Employee's or Retiree's death provided enrollment as a surviving legal spouse or Adult Dependent occurs within sixty-three (63) days of the death. A child born to the surviving legal spouse that was conceived before or a child for whom adoption proceedings were initiated before the Employee's death may also be enrolled in the Plan, provided the newborn is enrolled within sixty-three (63) days of birth.

A surviving legal spouse or Adult Dependent's medical plan options are the same as the Retiree options listed below. A surviving legal spouse or Adult Dependent may continue coverage for as long as he or she makes required premium payments or until he or she becomes eligible to participate in another group plan with equivalent benefits and costs.

Surviving Dependent Child(ren) covered by the Plan at the time of the Employee's or Retiree's death may independently continue medical coverage through self-payment of premium until they cease to meet Dependent Child eligibility criteria described in Section 1, provision B., or become eligible to participate in another group plan with equivalent benefits.

Surviving Dependent coverage becomes effective on the first of the month following the Employee's or Retiree's death provided required premium is paid.

COBRA ALTERNATIVE: Alternatively, a surviving legal spouse could elect to continue current coverage for self and covered Dependents (or a Dependent Child could independently elect to continue coverage on self) under COBRA as described in Section 4. The surviving legal spouse's COBRA rights are waived if the surviving legal spouse elects surviving Dependent coverage. Similarly, a Dependent Child's COBRA rights are waived if the Dependent Child independently elects to continue surviving Dependent coverage on self. However, the surviving legal spouse can continue Dental coverage for self and covered Dependents (and the Dependent Child can continue Dental coverage on self) under COBRA while electing surviving Dependent medical coverage.

I. RETIREE COVERAGE

ELIGIBILITY: A person retiring from a unit of the MUS or any agency or organization affiliated with the MUS or the Montana Board of Regents of Higher Education may continue certain group insurance benefits as described below. To be eligible as a Retiree, the individual must be eligible to receive benefits from the public retirement plans as specified below at the time he or she leaves employment with the MUS. Retirees who are in the Montana University System Retirement Plan (MUS-RP) (formerly the Optional Retirement Plan (ORP)) (with investment options through TIAA), the Public Employees' Retirement System (PERS), the Teachers' Retirement System (TRS) or any other defined contribution plan sponsored by the MUS or the State of Montana must, in order to continue certain group insurance benefits at the time he or she leaves employment with the MUS, meet the following criteria for their specific retirement plan:

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

PERS Defined Benefit Plan:

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

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

TRS:

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

CONTINUATION OF COVERAGE: An eligible Retiree must make arrangements with his or her campus Human Resources/Benefits Office to continue coverage as a Retiree on a self-pay basis within sixty-three (63) days of retirement. Continuation of coverage as a retiree requires enrollment in the medical plan with an option to enroll in the dental plan and the vision hardware plan as well as spouse and/or children. *There is no Employer contribution toward Retiree benefits.* The right to continue coverage under the Plan is a one-time opportunity. **RETIRES WHO FAIL TO CONTINUE COVERAGE WITHIN SIXTY-THREE (63) DAYS OR WHO ALLOW COVERAGE TO LAPSE DUE TO NONPAYMENT OF PREMIUM MAY NOT LATER REJOIN THE PLAN --** with one exception:

EXCEPTION: A Retiree with the right to continue coverage under the MUS Plan, who chooses to continue coverage under spousal coverage in either the MUS Plan or the State of Montana Employee Benefit Health Plan, may be reinstated to the MUS Plan with Retiree coverage upon the retirement, death, divorce, or any other event which causes ineligibility for spousal coverage. This exception applies only to a Retiree who has maintained continuous coverage as a dependent under either the MUS Plan or the State of Montana Employee Benefit Health Plan. If a MUS Retiree at any time becomes an active State of Montana employee under the State of Montana Employee Benefit Health Plan, such Retiree forfeits forever the right to return to the MUS Plan.

PREMIUM PAYMENT: An Eligible Retiree may be able to apply payout of final pay toward Retiree premiums through the end of the calendar year or the Benefit Year, whichever comes first, on a pre-tax basis. Discuss this option with your campus Human Resources/ Benefits office. Other payment options are:

1. Automatic Deductions – When possible, the Retiree should arrange automatic deductions from the retirement annuity received from the Teachers Retirement System, Public Employees Retirement System, Optional Retirement Plan, or other retirement benefit, or directly from a checking or savings account.
2. Timely Schedule of Payments – When automatic deductions are not possible, Retirees must arrange a schedule of timely premium payments with the campus Human Resources/Benefits office.

Premium rates vary depending on number of persons covered, the plans selected (as described below), and whether the Retiree and/or legal spouse are Medicare enrolled. Retiree coverage may be canceled by the MUS for nonpayment of premium on the first day of the month following the month for which the premium was due. *Cancelled or lapsed coverage cannot be restored.*

MEDICARE ENROLLMENT STATUS: Retirees and/or legal spouses who are or become Medicare-eligible and who expect to pay Medicare Primary premiums are required to be enrolled in BOTH MEDICARE PART A AND MEDICARE PART B. All Medicare status changes must be reported to the campus Human Resources/Benefits Office to facilitate premium and enrollment adjustments. Any person not correctly enrolled with Medicare will be given sixty-three (63) days to obtain the missing coverage. After sixty-three (63) days, the non-enrolled person's status will be changed to non-Medicare-enrolled and premiums will revert to the non-Medicare premiums until Medicare enrollment is completed and the MUS Benefits Office is notified.

Enrollment in Medicare Part D (drug plan) is NOT permitted.

COVERAGE OPTIONS: Non-Medicare Retirees may continue medical coverage under a medical plan as outlined in the *Choices Retiree Workbook*. All plans include the Prescription Drug Plan. Retirees have the option to add the Select Dental Plan. **This is a one-time opportunity for continuing Retirees.** If a Retiree is currently covered by COBRA dental, she or he can drop the COBRA now and add regular Select Dental coverage or wait until the COBRA dental coverage expires and add Select Dental at that time. If a Retiree does not make an election when he/she first retires or when COBRA dental coverage expires or during the Annual Enrollment, he or she will permanently forfeit eligibility for dental coverage. *See any updates to the options available to Retirees in the current Retiree Enrollment Workbook.*

PLAN BENEFITS COORDINATED WITH MEDICARE BENEFITS:

See Section 13 on Coordination of Benefits.

COBRA ALTERNATIVE: Alternatively, a Retiree could choose to continue current coverage for self and covered Dependents under COBRA as described in Section 4. The Retiree's COBRA rights are waived if the Retiree elects Retiree Medical coverage.

Section 4 CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

A. CONTINUATION RIGHTS – COBRA

Under the Public Health Service Act, as amended, covered Employees and their covered Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. **Only covered Employees, their covered spouses and covered Dependent Children and the covered spouses and Dependent Children of covered Retirees are qualified beneficiaries.**

The Plan Administrator is the Office of the Commissioner of Higher Education, 2500 Broadway, Helena, MT 59601; 406-444-2574. COBRA continuation coverage for the Dental Plan and the Vision Hardware Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, 406-721-2222. Blue Cross and Blue Shield of Montana continues to process vision hardware claims. Delta Dental continues to process dental claims. COBRA continuation coverage for Medical Plans is administered by the Claims Administrators for those plans.

COBRA continuation coverage is available to any qualified beneficiary whose coverage would otherwise terminate due to any qualifying event. COBRA continuation coverage under this provision will begin on the first day immediately following the date coverage terminates.

Qualifying events for Employees, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:

1. The termination (other than by reason of gross misconduct) of the Employee's employment (including retirement).
2. The reduction in hours of the Employee's employment.

Qualifying events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:

1. Death of the Employee or Retiree.
2. Termination of the Employee's employment (other than by reason of gross misconduct).
3. Reduction in hours of the Employee's employment.
4. Divorce or legal separation of the legal spouse from the Employee or Retiree.
5. A covered Dependent Child ceases to be eligible as a Dependent

NOTIFICATION RESPONSIBILITIES: A Plan Participant must notify his or her employer of a qualifying event within sixty (60) days after the date of the qualifying event. The Plan Participant must make notice on the *Choices* Enrollment Form, available from each campus Human Resources/Benefits Office or on the website, www.abpmpa.com/mus, and return the completed *Choices* Enrollment Form to the campus Human Resources/ Benefits Office within **sixty (60) days** of the date of the qualifying event.

The campus Human Resources/ Benefits Office must notify the COBRA Administrator on behalf of the Plan of any of the following events it receives notice of:

1. Death of the Retiree.
2. The divorce or legal separation of the Employee or Retiree from his/her legal spouse.
3. A covered Dependent Child's loss of eligibility as a Dependent under the Plan.

Notice to the COBRA Administrator must occur within thirty (30) days after the applicable event or within thirty (30) days after the MUS/employer receives notice of the applicable event, whichever occurs later.

ELECTION OF COVERAGE: When the COBRA Administrator is notified of a qualifying event, the COBRA Administrator will notify the qualified beneficiary of the right to elect continuation of coverage. The qualified beneficiary may continue current medical/dental/vision hardware coverage. New benefit elections may be made during the annual enrollment period. Notice of the right to COBRA continuation

of coverage will be sent by the COBRA Administrator on behalf of the Plan no later than fourteen (14) days after the COBRA Administrator is notified of the qualifying event.

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

MONTHLY PREMIUM PAYMENTS: A qualified beneficiary is responsible for the full cost of continuation. Monthly premium for continuation of coverage must be paid in advance to the COBRA Administrator, on behalf of the Plan Administrator. The premium required under the provisions of COBRA is as follows:

1. **For a qualified beneficiary**, the premium is the same as applicable to any other similarly situated non-COBRA Subscriber plus an additional administrative expense of up to a maximum of two percent (2%).
2. **For a qualified beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration** within sixty (60) days after becoming covered under COBRA, the premium may be up to a maximum of one hundred fifty percent (150%) of the premium applicable to any other similarly situated non-COBRA Subscriber.
3. **For a qualified beneficiary with a qualifying Social Security Disability who experiences a second qualifying event:**
 - a. If another qualifying event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce, legal separation, or Medicare entitlement, the monthly fee for a qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.
 - b. If the second qualifying event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a qualified beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under COBRA continuation coverage will be contingent upon the receipt by the MUS of the applicable monthly premium for such coverage. The monthly premium for continuation coverage under this provision is due the first of the month for each month of coverage. A grace period of **thirty (30) days** from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the MUS.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE: If a qualified beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the COBRA Administrator (on behalf of the Plan Administrator) is notified in a timely fashion, the qualified beneficiary covered under the Plan can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The COBRA Administrator (on behalf of the Plan Administrator) must be provided with a copy of the Social Security Administration's disability determination letter within **sixty (60) days** after the date of the determination and before the end of the original 18-month period of COBRA continuation coverage. If this notice is sent to a campus Human Resources/Benefits Office or to the Plan Administrator, it should be sent to the appropriate COBRA Administrator.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE: If another qualifying event occurs while receiving COBRA continuation coverage, the spouse and Dependent Children of the former Employee can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and Dependent Children if the former Employee dies or becomes divorced or legally separated from the spouse. The extension is also available to a Dependent Child when that Child ceases eligibility under the Plan as a Dependent Child. In all of these cases, the COBRA Administrator (on behalf of the Plan Administrator) must be notified of the second qualifying event within **sixty (60) days** of the second qualifying event. **Failure to make notice within the sixty (60) days will result in loss of eligibility for**

an extension of COBRA Continuation Coverage.

WHEN COBRA CONTINUATION COVERAGE ENDS: COBRA continuation coverage and any coverage under the Plan that has been elected with respect to any qualified beneficiary will cease on the earliest of the following:

1. On the date the qualified beneficiary becomes covered under another group health plan or health insurance.
2. On the date after the date of election for COBRA continuation coverage, that the qualified beneficiary becomes enrolled in Medicare (either Part A or B).
3. On the first date that timely payment of any premium required under the Plan with respect to COBRA continuation coverage for a qualified beneficiary is not made to the Plan Administrator.
4. On the date the MUS ceases to provide any group health plan coverage to any Employee.
5. On the date of receipt of written notice that the qualified beneficiary wishes to terminate COBRA continuation coverage.
6. On the date that the maximum coverage period for COBRA continuation coverage ends, as follows:
 - a. Eighteen (18) months for a former Employee who is a qualified beneficiary as a result of termination (or reduction of hours) of employment;
 - b. Eighteen (18) months for a Dependent who is a qualified beneficiary unless a second qualifying event occurs within that eighteen month period entitling that Dependent to an additional eighteen (18) months;
 - c. On the first day of the month beginning thirty (30) days after a qualified beneficiary is determined to be no longer disabled by the Social Security Administration if the qualified beneficiary was found to be disabled on or within the first sixty (60) days of the date of the qualifying event and has received at least eighteen (18) months of COBRA continuation coverage. COBRA continuation coverage will also terminate on such date for all Dependents who are qualified beneficiaries as a result of the qualifying event unless that Dependent is entitled to a longer period of COBRA continuation coverage without regard to disability;
 - d. Twenty-nine (29) months for any qualified beneficiary if a disability extension period of COBRA continuation coverage has been granted for that qualified beneficiary; or
 - e. Thirty-six (36) months for all other qualified beneficiaries.
7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Subscriber.

QUESTIONS: Any questions about COBRA Continuation Coverage should be directed to Allegiance COBRA Services, Inc., P.O. Box 2097, Missoula, MT 59806 or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES: In order to protect the Employee's or Retiree's family's rights, the Employee, Retiree or Dependent should keep the Plan Administrator informed of any changes in the addresses of family members. The Employee or Retiree should also keep a copy, for his/her records, of any notices sent to the Plan Administrator or campus Human Resources/Benefits Office.

Section 5

HIPAA PRIVACY AND SECURITY

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

A. COMPLIANCE WITH HIPAA PRIVACY AND RECOVERY STANDARDS

Certain Authorized Individuals of the MUS workforce perform services in connection with administration of the Plan. To perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the “Privacy Standards”), these employees are permitted to have such access subject to the following:

General. The Plan shall not disclose Protected Health Information to any Authorized Individual of the MUS workforce unless each of the conditions set out in this HIPAA Privacy and Security Section is met. “Protected Health Information” or “PHI” shall have the same definition as set out in the Privacy Standards (45 CFR Part 164) and generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment. PHI does not include employment records held by MUS in its role as an employer.

Permitted Uses and Disclosures. Protected Health Information disclosed to Authorized Individuals of the MUS workforce shall be used or disclosed by them only for the purposes of Plan administrative functions. The Plan’s administrative functions shall include all Plan payment and health care operations. The term “payment” and “health care operations” shall have the same definitions as set out in the Privacy Standards. Generally, “payment” is defined as any activity undertaken by the Plan to collect money due to it or to determine or fulfill its responsibility for payment of benefits under the Plan. “Health care operations” include activities related to payment and plan administration. Plan administration functions do not include employment-related functions or functions in connection with other benefit plans.

Authorized Employees. The Plan shall disclose Protected Health Information only to Authorized Individuals of the MUS workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform Plan administrative functions. For purposes of this HIPAA Privacy and Security Section, “Authorized Individuals of the MUS workforce” include the following:

- The Director of Benefits
- The Associate Director of Benefits
- Employees working in the Employee Benefits Division
- Human Resources Representatives
- Employees in the Information Technology Department who support the Employee Benefits Division.

Updates Required. The Plan Sponsor shall amend the Plan promptly with respect to any changes in the Authorized Individuals of the MUS workforce who are authorized to receive Protected Health Information.

Use and Disclosure Restricted. An Authorized Individual of the MUS workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan’s administrative functions.

Resolution of Issues of Noncompliance In the event that any Authorized Individual of the MUS workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including

- Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment; Mitigating any harm caused by the breach, to the extent practicable; and

Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

Summary Health Information means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the zip code; dates related to the individual (e.g., birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or Subscriber numbers; vehicle identifiers; and any photo or biometric identifier.

B. CERTIFICATION

The MUS hereby certifies to the Plan that it agrees to:

1. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law. Such uses or disclosures may be for the purposes of Plan administration, including but not limited to, the following:
 - a. Operational activities such as quality assurance or assessment and Utilization Management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews; legal services or auditing functions; business planning, management and general administrative activities or customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage. Genetic information will not be used or disclosed for underwriting purposes.
 - b. Payment activities such as determining eligibility or coverage; coordination of benefits; determination of cost-sharing amounts; adjudicating or subrogating claims; claims management and collection activities; obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for Medical Necessity, coverage or appropriateness of care, justification of charges, or utilization review activities.
 - c. For purposes of this certification, Plan administration does not include disclosing Summary Health Information to help the MUS obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the MUS as to whether the individual is a participant in, is an enrollee of or has disenrolled from the group Plan or any medical plan offered by the Plan.
2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the MUS with respect to such information;
3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the MUS;
4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
5. Make available Protected Health Information to individual covered Plan Participants in accordance with Article 164.524 of the Privacy Standards;
6. Make available Protected Health Information for amendment by individual covered Plan Participants and incorporate any amendments to Protected Health Information in accordance with Article 164.526 of the Privacy Standards;
7. Make available the Protected Health Information required to provide any accounting of disclosures to individual covered Plan Participants in accordance with Article 164.528 of the Privacy Standards;
8. Make available the Protected Health Information required to provide any accounting of disclosures

to individual covered Plan Participants in accordance with Article 164.528 of the Privacy Standards;

9. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance with the Privacy Standards;

If feasible, return or destroy all Protected Health Information received from the Plan that the MUS still retains in any form, and return no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction of the information is unfeasible; and ensure the adequate separation between the Plan (including Authorized Individuals of the MUS workforce) and the MUS, as required by Article 164.504(f)(2)(iii) of the Privacy Standards.

10. To fulfill this requirement, MUS will restrict access to nonpublic personal information to the Plan Administrator designated in this Summary Plan Description or Employees designated by the Plan Administrator who need to know that information to perform Plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. MUS will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator and any Employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies MUS establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Plan Participant's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

C. SECURITY CERTIFICATION

The MUS hereby certifies to the Plan that it agrees to comply with the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards") by incorporation of the following provisions:

1. Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the MUS creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but shall generally mean Protected Health Information that is transmitted by or maintained in an electronic media.
2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that Electronic Protected Health Information is used and disclosed only as stated in the Privacy Certification section above.
3. Ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to the same restrictions and conditions that apply to the MUS with respect to Electronic Protected Health Information including, but not limited to, direct liability for breach involving unsecured Electronic Protected Health Information.
4. Report to the Plan Administrator of the Plan any attempted breach, or breach of security measures described in this certification and any disclosure or attempted disclosure of Electronic Protected Health Information of which the MUS becomes aware.

Section 6 HOW TO OBTAIN BENEFITS

This Section describes how to obtain medical benefits for Plan Participants enrolled in a (medical indemnity) Plan. This Section also describes the claims appeal process for all Plan Participants on the Dental Plan.

Payment of benefits will be made on the basis of submission of required information to the Medical Plan Claims Administrator (Allegiance, Blue Cross Blue Shield of Montana or PacificSource) or Dental Plan Claims Administrator, Delta Dental.

A. STEPS TO TAKE IN ADVANCE OF, OR WHEN, RECEIVING SERVICES

1. **OBTAIN AN IDENTIFICATION CARD.** Make sure you have a current Identification Card that contains the correct Identification Number, Subscriber name, Dependent coverage information, and Effective Date. Plan Participants will receive a single card for medical benefits and a separate card for dental benefits.
2. If a new Subscriber needs services before he or she receives an Identification Card or the Card is lost, the Provider's office may be willing to call the Medical Plan Claims Administrator or the campus Human Resources/Benefits Office to verify coverage. Replacement cards may be ordered by calling the Medical or Dental Plan Claims Administrators.
3. **CHOOSE A PARTICIPATING PROVIDER AND PREFERRED FACILITY FOR MEDICAL CARE WHEN POSSIBLE.** Providers who are Participating Providers with the Medical Plan Claims Administrator will accept the Allowable Fee and not balance bill Plan Participants for charges in excess of the Allowable Fee. For most Covered Medical Services (services without a specified benefit maximum), a Plan Participant who uses a Participating Provider will only be responsible for his or her portion of Allowable Fees (Deductible, Coinsurance, and Copayments), not for charges over the Allowable Fee. A Plan Participant who uses a Preferred Facility may pay a lower percentage Coinsurance. *See the current Choices Enrollment Workbook Schedule of Benefits.*
4. **DETERMINE IF A PLANNED NON-EMERGENCY SERVICE REQUIRES PRIOR AUTHORIZATION OR SHOULD BE PRIOR AUTHORIZED. ADVERSE PRIOR AUTHORIZATION DETERMINATIONS CANNOT BE APPEALED.**
Prior Authorization is required to receive benefits for:
 - a. Bariatric Surgery benefits
 - b. Commercial or Private Automobile Transportation

IF PRIOR AUTHORIZATION IS NOT OBTAINED FOR THE SERVICES LISTED ABOVE, CHARGES IN CONNECTION WITH, OR RELATED TO, THESE SERVICES WILL BE DENIED.

Prior Authorization is strongly recommended for the following services so Plan Participants will know whether a planned procedure or service meets criteria for benefits under the Medical Plan:

- a. Surgery that could be considered cosmetic under some circumstances.
- b. Any procedure or service that could possibly be considered Experimental or Investigational.
- c. Surgical treatment of TMJ.
- d. Durable Medical Equipment that costs more than \$2,500.
- e. Home Health Care services.
- f. Organ or Tissue Transplant.

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

- a. A written request from the Provider explaining the proposed service and/or the functional aspects of a surgery and why it is being done;
- b. A complete diagnosis and all medical records regarding the condition for which the requested procedure(s) or treatment(s) will be utilized, including, but not limited to informed consent form(s), all lab and/or x-rays, or diagnostic studies;

- c. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding CPT or HCPCS codes;
- d. The attending Physician's prescription, if applicable;
- e. A Physician's referral letter, if applicable;
- f. A letter of Medical Necessity;
- g. A written treatment plan;
- h. For commercial or private automobile transportation, why the transportation is necessary; and
- i. Any other information deemed necessary to evaluate the Prior Authorization request.

Be sure to include your name, address, and the Subscriber's Identification Number when mailing the above to your selected Medical Plan Claims Administrator.

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

If you choose not to request Prior Authorization for recommended services, the charge could be denied if the service, treatment, or supply is not found to be Medically Necessary when the claim is submitted. Bariatric surgery or commercial/private automobile transportation benefits are not covered without Prior Authorization.

5. PRE-CERTIFY NON-EMERGENCY ADMISSIONS AND NOTIFY THE MEDICAL PLAN CLAIMS ADMINISTRATOR OF EMERGENCY ADMISSIONS.

The Plan recommends that prior to Inpatient Admission for any non-emergency Illness or Injury, and within seventy-two (72) hours after admission for any Medical Emergency, a Plan Participant or the Participant's attending Physician call the designated Utilization Management Administrator for Pre-certification review of a planned Inpatient stay.

Pre-certification and notification are designed to do the following:

- a. Optimize efficient resource utilization;
- b. Ensure that patients have equitable access to care;
- c. Foster collaboration and communication among all members of the health care team in an effort to enhance Medically Necessary care in a cost effective manner;
- d. Assist in identifying possible ways to reduce out-of-pocket expenses;
- e. Help avoid reductions in benefits which may occur if the services are not Medically Necessary or the setting is not appropriate; and
- f. If appropriate, refer a Case Manager to work with the Plan Participant and Providers as described in step 5, below.

To Pre-certify or provide notice of an emergency admission, call the Utilization Management Department at your selected medical plan.

Most certifications occur over the phone. Once a final decision is made, a notice of the number of Pre-certified days, if any, will be sent to the Physician, to the Plan Participant, to the Medical Plan Claims Administrator and to the facility. Pre-certification is not required and therefore cannot be appealed. However, a pre-service claim can be filed for Prior Authorization as described in provision C. (Claims and Eligibility Procedures) described later in this Section.

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

recommended to obtain coverage information prior to incurring the charges or additional charges.

NOTE: Pre-certification of benefits is not a guarantee of payment of the claim(s). Eligibility for claim payments is determined at the time claims are adjudicated since the amount of benefit coverage, if any, is subject to all applicable Plan provisions including, but not limited to, Medical Necessity, patient eligibility, Deductibles, Copayments, Coinsurance and any limitations or maximums in effect when the services are provided. Providers and covered Plan Participants are informed at the time claims are Pre-certified that Pre-certification of a course of treatment by the Plan does not guarantee payment of claims for the same.

CONTINUED STAY CERTIFICATION: At the time of Initial Pre-certification, the Utilization Management Department at your selected medical plan will certify a number of days of Inpatient stay. If the stay exceeds the number of days certified, certification for additional days should be obtained in the same manner as the pre-admission certification.

Charges for Inpatient days in a Hospital or other facility in excess of any days previously certified by the Utilization Management Department are subject to all terms, conditions, and exclusions of the Medical Plan.

6. TAKE ADVANTAGE OF CASE MANAGEMENT AND MATERNITY CASE MANAGEMENT SERVICES

Case Management services are provided by the Plan to Medical Plan Participants with major or long term Illness or Injuries who can benefit from the services. Appropriate candidates are primarily identified through the Pre-certification process or through review of large claims. Candidates are contacted by the Case Manager. Case Management is designed to:

- a. Interface with the attending Physician and the patient so that a care plan can be coordinated with all parties;
- b. Educate patients about their condition, treatment options, and benefit plan;
- c. Assist the Physician with monitoring compliance and patient progression along the recovery continuum; and
- d. Assisting with arrangements for home health services, Durable Medical Equipment, or therapies as needed by individual patients.

Maternity Case Management services are services designed to monitor the expectant mother's progress, respond to questions, and help assure a healthy full-term delivery. These services are available to all pregnant MUS Plan Participants who notify the WellBaby Program Manager at 1-406-660-0082. Notification should occur when pregnancy is diagnosed or as soon after as possible. **In order to receive the full benefits of this program, notification is required within the first trimester.**

7. FOCUSED CASE MANAGEMENT, DISEASE MANAGEMENT, AND HEALTH COACHING

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

- a. a catastrophic illness or injury;
- b. significant medical risks;
- c. chronic health care needs, which can be reduced through prevention or disease management;

or

- d. needs for wellness promotion and/or health coaching.

Plan Participants will be identified through analysis of information, such as medical/pharmaceutical claims data, and/or wellness screening results to determine who is most likely to benefit from these services. You or an adult family member enrolled in a MUS health plan offering will be individually contacted by a care professional if you (or the enrolled family member) qualify. Program provisions require that the care professional which provides these services keep all claims data and other medical information strictly confidential. When offered focused case management, disease management, or health coaching services, Plan Participants are encouraged to give them careful consideration, but are free to reject some or all proposals or advice. Use of these services is voluntary, free of charge to the MUS Plan Participants and helpful in several ways:

- a. It can permit treatment options not normally available under the MUS Plan through Plan exceptions. The MUS Plan may, at its sole discretion, make payment for medical or dental services that are not listed as covered services or benefits of this SPD in order to provide quality care at a lesser cost. Such payments shall be made only upon mutual agreement by the Plan Participant and the MUS plan; and
- b. It saves both the MUS Plan and its Plan Participants money by providing a third party to help identify the more efficient/lower cost suppliers of medical goods and services, coordinate services, work out cost reductions, and make arrangements for special treatment plans.

B. FILING A CLAIM

Claims must be submitted to the selected Medical Claims Administrator within twelve (12) months after the date services or treatment are received or completed. A Plan Participant or Subscriber becomes a Claimant when he or she makes a request for a Plan benefit or benefits in accordance with these claims procedures. Non-electronic claims may be submitted on any approved claim form, available from the Provider. The claim must be completed in full with all the requested information. A complete claim must include the following information:

1. Date of service;
2. Name and Identification Number of the covered Subscriber;
3. Name and date of birth of the patient receiving the treatment or service and his/her relationship to the Covered Subscriber;
4. Diagnosis [code] of the condition being treated;
5. Treatment or service [code] performed;
6. Amount charged by the Provider for the treatment or service; and
7. Sufficient documentation, in the sole determination of the selected Medical Claims Administrator, to support the Medical Necessity of the treatment or service being provided and sufficient to enable the selected Medical Claims Administrator to adjudicate the claim pursuant to applicable terms and conditions of the Plan.

When completed, the claim must be sent to the selected Medical Claims Administrator.

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

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

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

The Plan will have the right, in its sole discretion and at its own expense, to require a Claimant to undergo a medical examination, when and as often as may be reasonable, and to require the Claimant to submit, or cause to be submitted, any and all medical and other relevant records it deems necessary to properly adjudicate the claim.

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

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

"Authorized Representative" means a representative authorized by the Claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize the Authorized Representative when the Plan receives the written authorization. **INFORMATION REGARDING URGENT CARE CLAIMS IS PROVIDED TO YOU UNDER THE DISCLOSURE REQUIREMENTS OF APPLICABLE LAW: THE PLAN DOES NOT MAKE TREATMENT DECISIONS. ANY DECISION TO RECEIVE TREATMENT MUST BE MADE BETWEEN THE PATIENT AND HIS OR HER HEALTHCARE PROVIDER; HOWEVER, THE PLAN WILL ONLY PAY BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS, AND EXCLUSIONS OF THIS SPD.**

Types of Claims

Claims are classified by type of claim and the timeline in which a decision must be decided. The notice to be provided depends on the type of claim involved. The initial benefit determination notice will be included in the Plan Participant's Explanation of Benefits (EOB) or in a letter from the Plan, whether adverse or not. There are five types of claims:

1. **Pre-Service Claim** – A pre-service claim is any claim that must be submitted to the selected Medical Claims Administrator before the Plan Participant receives medical treatment or service. A Pre-Service Claim under this Plan requires a Prior Authorization determination before a Plan Participant obtains medical care or treatment.
2. **Urgent Care Claim** – An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously

jeopardize the Claimant's life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

3. **Post-Service Claim** – A post-service claim is any claim for a medical benefit under the Plan that is not a pre-service claim, an urgent care claim, or a concurrent care claim.
4. **Rescission Claim** – A rescission of coverage is considered a special type of claim. A rescission is defined as any cancellation or discontinuation of coverage that has a retroactive effect based upon a Claimant's fraud or intentional misrepresentation of a material fact. A cancellation or discontinuance of coverage that has a retroactive effect is not a rescission if and to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.
5. **Concurrent Care Claim** – A concurrent care decision represents a decision of the selected Medical Claims Administrator approving an ongoing course of medical treatment for the Claimant to be provided over a period of time or for a specific number of treatments. A concurrent care claim is any claim that relates to the ongoing course of medical treatment (and the basis of the approved concurrent care decision), such as a request by the Claimant for an extension of the number of treatments or the termination by the Plan of the previously approved time period for medical treatment.

Initial Claim Determination By Type of Claim and Notice

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

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

Urgent Care Claim Determination and Notice

a. Designation of Claim

Upon receipt of a pre-service claim, the selected Medical Claims Administrator will make a determination if the claim involves urgent care. If a physician with knowledge of the Claimant's medical condition determines the claim involves urgent care, the selected Medical Claims Administrator will treat the claim as an urgent care claim.

b. Notice of Determination

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

c. Notice of Incomplete or Improperly Submitted Claim

If an urgent care claim is incomplete or was not properly submitted, the selected Medical Claims Administrator will notify the Claimant about the incomplete or improper submission no later than 24 hours from the selected Medical Claims Administrator's receipt of the claim. The Claimant will have at least 48 hours to provide the necessary information. The selected Medical Claims Administrator will notify the Claimant of the initial claim determination no later than 48 hours after the earlier of the date the selected Medical Claims Administrator receives the specific information requested or the due date for the requested information.

Post-Service Claim Determination and Notice

a. Notice of Determination

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

b. Notice of Extension

1. For reasons beyond the control of the selected Medical Claims Administrator

The selected Medical Claims Administrator may extend the thirty (30) day timeframe for an additional fifteen (15) day period for reasons beyond the selected Medical Claims Administrator's control. The selected Medical Claims Administrator will notify the Claimant in writing of the circumstances requiring an extension and the date by which the selected Medical Claims Administrator expects to render a decision in such case.

2. For receipt of information from the Claimant to decide the claim

If the extension is necessary due to the Claimant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed. The Claimant will be given forty-five (45) days from receipt of the notice to provide the information. The selected Medical Claims Administrator will notify the Claimant of the initial claim determination no later than fifteen (15) days after the earlier of the date the selected Medical Claims Administrator receives the specific information requested, or the due date for the information.

Concurrent Care Determination and Time Frame for Decision and Notice

a. Request for Extension of Previously Approved Time Period or Number of Treatments

1. In response to the Claimant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Claimant's claim involves urgent care, the selected Medical Claims Administrator will review the claim and notify the Claimant of its determination no later than 24 hours from the date the selected Medical Claims Administrator received the Claimant's claim, provided the Claimant's claim was filed at least 24 hours prior to the end of the approved time period or number of treatments.

2. If the Claimant's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Claimant's claim will be treated as and decided within the timeframes for an urgent care claim as described in the section entitled "Initial Claim Determination By Type of Claim and Notice."

3. If the Claimant's claim did not involve urgent care, the time periods for deciding pre-service claims and post-service claims, as applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

Other than through a Plan amendment or termination, the selected Medical Claims Administrator may not subsequently reduce or terminate an ongoing course of treatment for which the Claimant has received prior approval unless the selected Medical Claims Administrator provides the Claimant with written notice of the reduction or termination and the scheduled date of its occurrence sufficiently in advance to allow the Claimant to appeal the determination and obtain a decision before the reduction or termination occurs.

Rescission of Coverage Determination and Notice of Intent to Rescind

If the Plan makes a decision to rescind the Claimant's coverage due to a fraud or an intentional misrepresentation of a material fact, the Plan will provide the Claimant with a Notice of Intent to Rescind at least thirty (30) days prior to rescinding coverage. The Notice of Intent to Rescind will include the following information:

- a. The specific reason(s) for the rescission that show the fraud or intentional misrepresentation of a material fact;
- b. A statement that the Claimant will have the right to appeal any final decision of the Plan to rescind coverage after the thirty (30) day period;
- c. A reference to the Plan provision(s) on which rescission is based;
- d. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents and records and other information relevant to the rescission.

D. NOTICE OF AN ADVERSE BENEFIT DETERMINATION: A decision on a claim is "adverse" if it is a rescission or a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Plan benefit. If a claim is denied in whole or in part, the Claimant will receive written notice of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the selected Medical Claims Administrator showing:

1. The reason the claim was denied. If the adverse benefit determination is a rescission, the notice will include the basis for the fraud and/or intentional misrepresentation of a material fact;
2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based;
3. If applicable, a description of any additional material or information needed to perfect the claim and why such information is necessary;
4. A description of the Plan internal and external review procedures (and for urgent care claims only, a description of the expedited review process applicable to such claims) and time limits for appeal of the decision, and, if applicable, a statement of the Plan Participant's right to file a civil action;
5. If applicable, a statement that any internal rule, guidelines, protocol or similar criterion, Medical Policy or other medical information relied upon in making the Adverse Benefit Determination will be provided, free of charge upon request;
6. If applicable, a statement that an explanation for any Adverse Benefit Determination that is based on an experimental or investigational treatment or similar exclusion or limitation or a medical necessity standard will be provided, upon request and free of charge;
7. If the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances; or a statement that such explanation will be provided, upon request and free of charge; and
8. A statement that reasonable access to and copies of all documents and records and other information or materials relevant to the Adverse Benefit Determination will be provided, upon request and free of charge.

If a Claimant does not understand the reason for any Adverse Benefit Determination, he or she should contact the selected Medical Claims Administrator at the address shown on the EOB form.

E. APPEALING AN ADVERSE BENEFIT DETERMINATION

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

Important Appeal Deadline

If a Claimant disagrees with an Adverse Benefit Determination (including a rescission), the Claimant may appeal the determination within 180 days from receipt of the Adverse Benefit Determination. With

the exception of urgent care claims, the Claimant's appeal must be made in writing, should list the reasons why the Claimant does not agree with the Adverse Benefit Determination, and must be sent to the address shown for claims denial in the selected Medical Claims Administrator's EOB.

How The Appeal Will Be Decided

The appeal of an Adverse Benefit Determination will be reviewed and decided by the Montana University System, as named fiduciary under the Plan. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit determination and will not be a subordinate of the person who made the initial benefit determination. The review on appeal will not give deference to the initial Adverse Benefit Determination and will be made anew. The Plan will not make any decision regarding hiring, compensation, termination, promotion or other similar matters with respect to the individual selected to conduct the review on appeal based upon how the individual will decide the appeal.

Consideration of Comments

The review of the claim on appeal will take into account all evidence, testimony, new and additional records, documents, or other information the Claimant submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial Adverse Benefit Determination.

If the Plan Administrator considers, relies on or generates new or additional evidence in connection with its review of the Claimant's claim, the Plan will provide the Claimant with the new or additional evidence free of charge as soon as possible and with sufficient time to respond before a final determination is required to be provided by the Plan Administrator.

Consultation With An Expert

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

Access to Relevant Information

A Claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Adverse Benefit Determination. If the advice of a medical or vocational expert was obtained in connection with the initial Adverse Benefit Determination, the names of each such expert shall be provided on request by the Claimant, regardless of whether the advice was relied on by the Plan Administrator.

Expedited Methods for Urgent Care Claims

In light of the expedited timeframes for decision of urgent care claims, an urgent care appeal may be submitted to the selected Medical Claims Administrator by telephone as follows: Allegiance at 1-877-778-8600, Blue Cross and Blue Shield of Montana at 1-800-820-1674 or 406-447-8747, or Pacific Source Health Plan at 1-877-590-1596 or 406-442-6589. The claim should include at least the following information:

- the identity of the Claimant;
- a specific medical condition or symptom;
- a specific treatment, service, or product for which approval or payment is requested; and
- any reasons why the appeal should be processed on a more expedited basis.

The selected Medical Claims Administrator Plan shall decide the appeal of an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt by the Plan of the request for review.

F. TIMEFRAMES FOR DECIDING AN APPEAL OF ADVERSE BENEFIT DETERMINATION

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

1. Urgent Care Claim – No later than 72 hours from the date the selected Medical Claims Administrator received the Claimant’s appeal, taking into account the medical exigency.
2. Pre-Service Claim – No later than 30 days from the date the selected Medical Claims Administrator received the Claimant’s appeal.
3. Post-Service Claim – No later than 60 days from the date the selected Medical Claims Administrator received the Claimant’s appeal.
4. Concurrent Care Claim – If the claim involves urgent care, no later than 72 hours from the date the selected Medical Claims Administrator received the Claimant’s appeal, taking into account the medical exigency. If the claim did not involve urgent care, the time period for deciding a pre-service (non-urgent care) claim and a post-service claim, as applicable, will govern.
5. Rescission Claim – No later than 60 days from the date the Plan Administrator received the Claimant’s appeal.

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

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

G. FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

If, based on the Plan Administrator’s review, the initial Adverse Benefit Determination remains the same, in whole or in part, the internal Adverse Benefit Determination, the final Adverse Benefit Determination notice will include the following information:

1. The specific reason(s) for the final internal Adverse Benefit Determination, including a discussion of the decision. If the final internal Adverse Benefit Determination upholds a rescission, the notice will include the basis for the fraud or intentional misrepresentation of a material fact;
2. A reference to the specific Plan provision(s) or rule(s), including identification of any standard relied upon in the Plan to deny the claim (such as a medical necessity standard), on which the final internal Adverse Benefit Determination is based;
3. If applicable, a statement describing the Claimant’s right to request an external review and the time limits for requesting an external review;
4. If applicable, a statement that any internal rule, guidelines, protocol or similar criterion, Medical Policy or other medical information relied upon in making the final internal Adverse Benefit Determination will be provided, upon request and free of charge;
5. If applicable, a statement that an explanation for a final internal Adverse Benefit Determination that is based on an experimental or investigational treatment or similar exclusion or limitation or a medical necessity standard will be provided, upon request and free of charge;
6. If the final internal Adverse Benefit Determination involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant’s medical circumstances; or a statement that such explanation will be provided, upon request and free

of charge; and

7. A statement that reasonable access to and copies of all documents and records and other information or materials relevant to the final internal Adverse Benefit Determination will be provided upon request and free of charge.

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

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

All claim payments are based upon the terms contained in the SPD on file with the Plan Administrator and the Medical Claims Administrators. The Claimant may also request, free of charge, more detailed information, names of any medical professionals consulted, and copies of relevant documents, as defined in and required by law, which were used by the Medical Claims Administrators to adjudicate the claim.

Right To Request External Review:

Standard External Review

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

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

The Claimant will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request, and set forth the time limit for the Claimant to provide the additional information needed (the longer of the initial four month period within which to request an external review or, if later, forty-eight (48) hours, after the receipt of this notice).

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

Expedited External Review

Expedited external review may be requested when:

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

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

External Review by IRO

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

- the Claimant's medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating health care provider;
- the terms of the Claimant's summary plan description;
- evidence-based practice guidelines;
- any applicable clinical review criteria developed and used by the Plan; and
- the opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

Notice of Final External Review Decision

The IRO will provide written notice of the final external review decision to the Claimant and the selected Medical Claims Administrator within forty-five (45) days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the Plan's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final external review decision of the IRO.

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

Compliance with IRO Decision

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

Section 7 MEDICAL PLAN DESCRIPTION

This Section describes how to obtain medical benefits for Plan Participants.

A. COVERED MEDICAL EXPENSES

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

1. Expenses within Allowable Fees (Plan Participants are responsible for charges by non-Participating Providers in excess of Allowable Fees);
2. Expenses within the specified benefit limitations contained in this Section and the current *Choices* Enrollment Workbook Schedule of Benefits, and which meet other requirements of this Plan Description; and
3. Expenses for Covered Medical Services, defined in provisions E. and F. of this Section.

Covered Medical Expenses are paid or credited to the Plan Participant's Deductible, Coinsurance and Copayment obligations described below.

B. DEDUCTIBLE -- PLAN OPTIONS

DEDUCTIBLE -- During each annual benefits enrollment (described in Section 2, provision B.), Plan Participants may choose a medical plan for the upcoming Benefit Year from among several medical plan options (*See Section 3; provision H. for Retiree plan options*). Covered Medical Expenses incurred by a Plan Participant are credited toward Deductible until the Plan Participant meets the individual Deductible or until expenses credited toward Deductible for all covered family members meet the family Deductible. The Medical Plan does not begin paying benefits for a Plan Participant until either the Participant's annual Deductible is met or the family Deductible is met -- except for services exempted from Deductible below. Services from a non-network provider have a separate Deductible and Out-of-Pocket Maximum. A non-network provider can also balance bill the difference between the allowance and the charge.

EXEMPTIONS FROM DEDUCTIBLE -- Some covered Medical Expenses are exempt from Deductible. Review the current *Choices* Enrollment Workbook for specific exemptions.

C. COINSURANCE AND COPAYMENT

COINSURANCE -- After a Plan Participant has satisfied the annual Deductible, the Plan Participant pays a Coinsurance percentage of the Covered Medical Expenses he or she incurs (except for expenses exempted below) until the Out-of-Pocket Maximum is reached. A Plan Participant's Coinsurance Maximum has been reached when either: a) the Plan Participant accrues the maximum amount of individual Covered Medical Expenses that are subject to Coinsurance in the Benefit Year or b) the Plan Participant's covered family accrues the maximum amount of family Covered Medical Expenses that are subject to Coinsurance in the Benefit Year. The Plan then pays any remaining Covered Medical

Expenses the Plan Participant incurs in the Benefit Year. Services from a non-network provider have a separate 35% Coinsurance and Out-of-Pocket Maximum. A non-network provider can also balance bill the difference between the allowance and the charge.

EXEMPTIONS FROM COINSURANCE – Some covered Medical Expenses are exempt from Coinsurance. Review the current *Choices* Enrollment Workbook for specific exemptions.

PHYSICIAN/PROFESSIONAL PROVIDER COPAYMENT – A fixed dollar Copayment, specified in the current Enrollment Workbook Schedule of Benefits, applies to charges for the office visit only. All other covered Medical Expenses for services rendered during the office visit are subject to annual Deductible and Coinsurance. The Copayment is not credited toward the annual Deductible but it does apply towards the Out-of-Pocket Maximum.

EMERGENCY ROOM COPAYMENT – A fixed dollar Copayment, specified in the current Enrollment Workbook Schedule of Benefits, applies to charges for the emergency room itself. The Copayment is waived if the emergency room visit is immediately followed by Hospital Inpatient Admission. All other covered Medical Expenses for services at the Emergency Room are subject to annual Deductible and Coinsurance. The Copayment is not credited toward the annual Deductible but it does apply towards the Out-of-Pocket Maximum.

D. MAXIMUM BENEFITS

Some Covered Medical Expenses contain their own service maximums in the form of annual limits on the number of allowed visits or services. For the Medical Plan, these limits are contained in the description of the specific services below and/or in the current *Choices* Enrollment Workbook Schedule of Benefits.

E. DEFINITION OF COVERED MEDICAL SERVICES

Covered Medical Services are services, procedures, and supplies:

1. Listed in this Section as Covered Medical Services, and not specified as exclusions in this Section or in the current *Choices* Enrollment Workbook Schedule of Benefits;
2. Either Medically Necessary for the diagnosis or treatment of Injury, Illness or maternity; or services specified as covered preventive services in this Section;
3. Provided to a Plan Participant by a covered Licensed Health Care Provider practicing within the scope of his or her license; and
4. Provided and coded in accordance with applicable standard medical and medical insurance practice.

F. SPECIFIC COVERED MEDICAL SERVICES

Expenses for the following services, **which meet the above definition of Covered Medical Services**, are covered by this Medical Plan as described in provisions 1., 2., 3. and 4. above:

1. **Inpatient Hospital Services** – *The Plan strongly recommends that all Inpatient care be Pre-certified by the Utilization Management Administrator.* Please refer to Section 6 - How to Obtain Benefits. Inpatient Hospital services are Covered Medical Services when a Plan Participant is confined to a licensed Hospital for Medically Necessary treatment of an Injury or Illness requiring bed Inpatient care. Any Hospital confinement with a primary purpose of obtaining diagnostic tests, examination, Custodial Care, rest or rehabilitation shall not be considered a Covered Medical Service, except as otherwise provided in this Plan Description.

Hospital services include the following (other Hospital services are covered in other provisions):

- a. Daily room and board in a semi-private room or private room and general nursing services, or confinement in an intensive care unit.
- b. Medically Necessary Hospital expenses for miscellaneous services and supplies furnished by the Hospital including hemodialysis and x-ray.
- c. Nursery neonatal unit services, including general nursing services, Hospital expenses for miscellaneous services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities of a newborn Dependent, or premature birth of a newborn Dependent.

A benefit determination on a claim will be rendered only after the claim has been submitted to adjudicate whether it is eligible for coverage under the terms and conditions of the Plan. If it is determined not to be eligible, the Plan Participant will be responsible to pay for all charges that are determined to be ineligible. Therefore, although not required, Pre-certification of any Inpatient Admission is strongly recommended to obtain coverage information prior to incurring charges.

2. **Inpatient Care – (*Pre-certification of all Inpatient Admissions is strongly recommended*)** -- Health care services performed, prescribed, or supervised by a Licensed Health Care Provider including diagnostic, therapeutic, medical, preventive, referral, and consultative health care services (*See Surgery provision for surgical services*).
3. **Outpatient Hospital Services** – Outpatient Hospital services to a Plan Participant who is not admitted for Inpatient overnight bed patient care.
4. **Emergency Room** – Hospital emergency room services for care or treatment of Medical Emergency. Emergency room benefits are subject to a Copayment (defined in provision C. of this Section and the current *Choices* Enrollment Workbook Schedule of Benefits) as well as Deductible and Coinsurance.
5. **Outpatient Office and Urgent Care Clinic Services** -- Coverage includes health care services by a Physician, Naturopath, or Licensed Health Care Provider working in a Physician’s office or urgent care clinic, or by other office/clinic staff members under Physician direction. These services include, but are not limited to: diagnostic services including x-ray; treatment services including minor surgery; laboratory services; radiation services provided within the office or clinic and referral services. These services are subject to a Copayment (defined in provision C. of this Section and the current *Choices* Enrollment Workbook Schedule of Benefits) as well as Deductible and Coinsurance.

Prescription drugs intended for use in a Physician’s office or settings other than home use are covered when billed during the course of an evaluation or management encounter.

6. **Services of an Ambulatory Surgical Center** -- defined below.

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

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

7. **Diagnostic Services** – X-rays, laboratory tests, tissue exams, medical diagnostic procedures (e.g., MRI, CAT scans, EKG or EEG) ordered by a Physician, or other Provider licensed to order the test, for the treatment or care of an Illness or Injury and that are provided by a lab or other Outpatient facility other than the Physician’s or other Provider’s office or clinic.

8. **Surgical Services** -- (*Pre-certification of all Inpatient Admissions is strongly recommended*) -- Surgical procedures provided in any licensed facility are covered as described below (*See the Bariatric Surgery Provision No. 39. for benefits for bariatric surgery*):
 - a. If more than one surgical procedure is performed during the same operating session, charges up to the Allowable Fee for the major procedure will be covered plus one-half of charges up to the Allowable Fee for each of the lesser procedures. When two surgeons of different specialties perform distinctly different procedures in one operating session, claims will be reviewed before determination on coverage is made. There is no additional coverage for incidental surgery. “Incidental surgery” is a procedure which is an integral part of, or incidental to, the primary surgical service and performed during the same operative session. Surgery is not incidental if:
 1. It involves a major body system different from the primary surgical services, or
 2. It adds significant time and complexity to the operating session and amount of patient care.
 - b. If two or more surgeons acting as co-surgeons perform the same operations or procedures other than as an Assistant at Surgery, the Allowable Fee will be divided between them. This provision is subject to the limitations listed above.
 - c. “Assistant at Surgery” is a Physician or non-Physician assistant who actively assists the operating Physician in the performance of covered surgery. Assistant at Surgery charges will be covered as follows:
 1. If the Assistant at Surgery is a Physician, the Allowable Fee will be 20 percent of the Allowable Fee for the surgical procedure or the assistant’s charge, whichever is less.
 2. If the Assistant at Surgery is a non-Physician assistant or surgical technician, the Allowable Fee will be 10 percent of the Allowable Fee for the surgical procedure or the assistant’s charge, whichever is less;
 3. Benefits are not available when the Assistant at Surgery is present only because the facility requires such services.
 4. Benefits for the Assistant at Surgery will be paid only if such services were Medically Necessary.
 5. If two surgeons are paid as primary surgeons or co-surgeons for their multiple surgeries, no allowance as an Assistant at Surgery will be made to either of the surgeons. Any charges for an additional Assistant at Surgery will be subject to review.

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

10. **Reconstructive Breast Surgery** – (*Pre-certification of all Inpatient Admissions is strongly recommended*) -- Reconstructive breast surgery after a mastectomy is covered. Covered Medical Services include, but are not limited to, the following:
 - a. Reconstructive breast surgery means surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes but is not limited to augmentation mammoplasty, reduction mammoplasty and mastopexy;

- b. All stages of reconstruction of the breast, including re-pigmentation of the areola, on which a mastectomy has been performed;
- c. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- d. Chemotherapy or radiation therapy following surgical procedures; and
- e. Prostheses and treatment of physical complications at all stages of a mastectomy and breast reconstruction, including lymphedemas.

Specifically excluded from this benefit are expenses for the following if they are unrelated to producing a symmetrical appearance:

- a. Solely cosmetic procedures;
- b. Breast augmentation procedures;
- c. Implants for the non-affected breast; or
- d. Non-surgical prostheses or any other procedure.

11. Voluntary Sterilization – For covered Plan Participants.

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

13. Ambulance Services– Ambulance Services are covered to the nearest facility where care or treatment of a Medical Emergency can be rendered; or from one facility to another for a higher level of care.

14. Transportation for Out-of-Area Medical Care – If a covered Plan Participant’s Illness or Injury requires treatment services which are not available in the area in which the Plan Participant resides, the Plan will cover commercial and personal automobile transportation expenses to the nearest licensed medical facility that provides the necessary treatment services. Coverage includes out-of-area transportation by commercial airline, railroad or bus, or by personal automobile limited to round-trip mileage at the normal state reimbursement rate to (and from) the nearest licensed medical facility equipped to provide the necessary treatment services. Commercial and personal automobile transportation benefits are limited to a maximum of \$1,500 in any one Benefit Year. **This benefit is for travel by the patient only.**

COMMERCIAL/PERSONAL AUTO TRAVEL PRIOR AUTHORIZATION

Commercial or personal automobile transportation must be Prior Authorized. If Prior Authorization is not obtained, charges for travel will not be covered. Please refer to Section 6 - How to Obtain Benefits.

Plan Participants must complete a Travel Prior Authorization Application Form, and submit the completed form to the Benefits Office . This form is available from campus Human Resources, Benefits Office, or the Claims Administrator.

15. Dental Services – the Plan will cover charges up to the Allowable Fee for:

- a. Medically Necessary services of a dentist or an oral surgeon licensed to practice in the state where services are provided if payment would be made under this Medical Plan for the same services provided by a Physician.
- b. Services of a dentist or oral surgeon for treatment required because of accidental injury to sound natural teeth. Services must be completed within twelve (12) months of the date of the accident.

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

16. Durable Medical Equipment and Orthopedic Appliances – Charges up to the Allowable Fee for the following services and supplies requiring a Physician’s written prescription are covered:

- a. Purchase of Orthopedic Appliances, including but not limited to, casts, splints, braces, trusses, crutches and other Medically Necessary rigid or semi-rigid supports used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.
- b. Rental (up to the purchase price) of a Hospital-type bed, wheelchair, or other durable therapeutic equipment (provided the equipment is designed for prolonged use over a period of years, serves a specific therapeutic purpose in the treatment of an Injury or Illness, is primarily and customarily used for a medical purpose, is appropriate for use in the home, and is not generally useful to a person in the absence of Illness or Injury) or the purchase of this equipment if economically justified, whichever is less.
- c. For Durable Medical Equipment for which purchase is not feasible, reasonable rental charges will be paid. Case Manager may determine reasonable rate.
- d. Replacement or repair of Durable Medical Equipment or Orthopedic Appliances.

Prior Authorization of charges that may exceed \$2500 is strongly recommended. Please refer to Section 6, How to Obtain Benefits.

- 17. Prosthetic Appliances** – Purchase of prosthetic appliances, defined as devices that are designed to replace a natural body part lost or damaged due to Illness or Injury to restore full or partial bodily function or appearance, including but not limited to artificial limbs, eyes, and larynx, and replacement or repair of such prosthetic appliances.
- 18. Miscellaneous Supplies for Use Outside of a Hospital** –Specialized medical supplies ordered by a Physician for the Medically Necessary treatment of Injury or Illness obtained from a Physician’s office, Urgent Care Clinic, Hospital (or other Inpatient facility licensed to provide skilled 24 hour medical care), Ambulatory Surgical Center, or medical supply company, and which are not covered by the Prescription Drug Plan (Section 9) including specialized dressings, catheters, and supplies for renal dialysis equipment. Dental braces and corrective shoes are specific exclusions of this Plan.
- 19. Inborn Errors of Metabolism** – Treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist.
- 20. Blood Transfusion Service** – Blood transfusions, including the cost of blood, blood plasma, blood plasma expanders, and packed cells; storage charges for blood are covered when the patient has blood drawn and stored for the patient’s own use for a planned surgery. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Covered Medical Expenses.
- 21. Radiation therapy or chemotherapy.**
- 22. Oxygen, other gases and their administration.**
- 23. Anesthetics and administration of an anesthetic.**
- 24. Medical Records Services** – Reasonable services for producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Services that exceed limits imposed by applicable law will not be deemed to be reasonable.
- 25. Home Health Care** – Care provided for Medically Necessary services and supplies furnished by a home health agency in a covered Plan Participant’s home in accordance with a home health care plan as prescribed by a Physician. A home health agency is a public agency or a private organization that is licensed as a home health agency by a state or is certified to participate as such under Title XVIII of the Social Security Act. A home health care plan is a treatment plan for the continued care and treatment of the Plan Participant while under the care of a Physician. The

Physician must approve the home health care plan in writing and certify that the home health care is Medically Necessary. Custodial Care is not covered. The home health care benefit is limited as specified in the current Enrollment Workbook Schedule of Benefits.

Prior Authorization for home health care is strongly recommended. See Section 6 - How to Obtain Benefits.

Home health care services provided by a Home Health Agency include:

- a. Nursing services by an RN or Licensed Practical Nurse (LPN) under the supervision of an RN;
- b. Physical, Speech, or Occupational Therapy;
- c. Skilled Nursing Care services; or
- d. Medical supplies and equipment for use in the home.

NOT COVERED:

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

An independent medical review staff contracted by the Plan may, if necessary, determine what services are Custodial Care. When a confinement or visit is found to be mainly for Custodial Care, some services (such as prescription drugs, x-rays, and lab tests) may still be covered. All bills should be routinely submitted for consideration.

26. Hospice Care – The Hospice Care benefit is limited as specified in the current *Choices* Enrollment Workbook Schedule of Benefits. Hospice care services listed below that meet the conditions specified below and that are provided by a facility or service that:

- a. Arranges, coordinates, and/or provides hospice care services for terminally ill patients and their families through a hospice care team;
- b. Is licensed, accredited, or approved by the state to establish and manage hospice care programs; and
- c. Maintains records of hospice care services provided and bills for such services on a consolidated basis.

Hospice care team is a group that provides hospice care services and may include:

- a. A Physician;
- b. A patient care coordinator (Physician or RN or LPN who serves as an intermediary between the hospice care program and the attending Physician);
- c. An RN or LPN;
- d. A mental health specialist; and
- e. Lay volunteers.

Benefits for hospice care are subject to the following conditions:

- a. The services must be Medically Necessary;
- b. A Physician must order the services;
- c. The patient is terminally ill; and
- d. The patient is expected to live no more than six (6) months.

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

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

27. Care by a Skilled Nursing Facility (Extended Care Unit or Facility, or Transitional Care Unit) – *Pre-certification of all Inpatient Admissions is strongly recommended. See Section 6 on How to Obtain Benefits.*

If, because of an Injury or Illness, a covered Plan Participant requires Skilled Nursing Care confinement in a licensed Skilled Nursing Facility (defined below), expenses will be Covered Medical Expenses for the period of such confinement, but not to exceed the limits specified in the current *Choices* Enrollment Workbook Schedule of Benefits.

SKILLED NURSING FACILITY SERVICES include the following:

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

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

- a. It is currently licensed as a long-term care facility or Skilled Nursing Facility in the state in which the facility is located;
- b. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders; and

- c. It is certified by Medicare.

28. Maternity and Routine Newborn Care -- Precertification of all Inpatient Admissions is strongly recommended. See Section 6 on How to Obtain Benefits. If a Plan Participant incurs expense due to a pregnancy, including elective abortion, benefits will be payable in the same manner and subject to the same limitations and conditions as any other medical condition. .

Coverage includes:

- a. Prenatal office visits;
- b. Services of a Physician or other licensed Provider, Hospital, Physician Staffed Birthing Center or licensed certified nurse midwife for maternity care; and
- c. Nursery and Physician's services for newborn well-baby care, including circumcision and PKU testing in which both the Plan Participant and her newborn child are Inpatient because of the child's birth.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT -- Under federal law, group health plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following delivery by cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay that does not exceed 48 hours (or 96 hours).

A MATERNITY PROGRAM is available to Plan Participants. This program, the WellBaby Maternity Management Program, is provided to enhance prenatal care and to provide information to help participants have a healthy pregnancy during the first trimester.

29. Preventive Care Benefits

a. Well-Child Care without Immunizations

If a Dependent Child on the Medical Plan incurs examination expenses for preventive well-child health care, the Plan will pay 100 percent of charges up to the Allowable Fee for the Dependent child. Deductible and Coinsurance do not apply.

b. Immunizations for Adults and Children

If a Plan Participant receives services of a Physician or other Licensed Health Care Provider for preventive immunizations, the Plan will pay 100 percent of charges up to the Allowable Fee for the Dependent child or adult (up to age 19). Deductible and Coinsurance do not apply.

Preventive immunizations include (but are not limited to) diphtheria, chicken pox, tetanus, hepatitis B, pertussis, oral polio vaccine, measles, mumps, rubella, HPV, shingles, pneumonia, flu, and tests for tuberculosis.

Note: These immunizations are available through public health clinics at a lower cost.

c. Preventive Health Care for Adults (age 19 and older)

If a Plan Participant receives services for any of the following preventive health screenings, the Plan will pay 100 percent of charges up to the Allowable Fee. Deductible and Coinsurance do not apply.

- 1) Pap smear and/or routine pelvic exams recommended by a Physician for such exams each Benefit Year specified in the current *Choices* Enrollment Workbook Schedule of Benefits.
- 2) Routine mammogram as recommended by a Physician paid in full up to the Allowable Fee.
- 3) Routine breast cancer susceptibility gene (BRCA) testing, including counseling and evaluation for the routine BRCA test itself, if appropriate, for a woman as determined by her Licensed Health Care Provider or Physician.
- 4) Routine prostate exam as recommended by a Physician for such an exam each Benefit Year specified in the current *Choices* Enrollment Workbook Schedule of Benefits.
- 5) Routine colonoscopy, proctoscopy, sigmoidoscopy or fecal occult blood screen.
- 6) Routine lab work. See current *Choices* Enrollment Workbook Schedule of Benefits.

The complete list of recommended preventive services, as set forth in the recommendations of the U.S. Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration, can be viewed at <http://www.uspreventiveservicestaskforce.org//page/name/uspstf-a-and-b-recommendations>.

d. Education Programs on Disease Management

Programs conducted by Licensed Health Care Providers are covered for prescribed Outpatient self-management training and education for treatment of diabetes or other diseases. Education must be provided by a registered dietician or other Licensed Health Care Provider. This coverage applies to other plan members to help manage and monitor the care of the covered person(s) in the family with the disease. Claims should be submitted in the name of the patient with the disease. Benefits are specified in the current *Choices* Enrollment Workbook Schedule of Benefits. Deductible and Coinsurance do not apply.

e. Health Screens Available from Campus Wellness Programs

- 1) Blood pressure exams are paid in full when obtained through the Campus Wellness Program.
- 2) Cholesterol screens with full blood panel are obtained through the Campus Wellness Program.

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

31. Rehabilitative Care - including Medically Necessary Physical Therapy, Occupational Therapy, Speech Therapy, and cardiac, respiratory, or pulmonary rehabilitative care, Acupuncture, and Chiropractic services.

INPATIENT BENEFITS – *Precertification of all Inpatient Admissions is strongly recommended as described in Section 6.* Inpatient benefits for all rehabilitative care, except cardiac, respiratory or pulmonary rehabilitative care, are limited to the number of days of Inpatient rehabilitation care per Benefit Year specified in the current *Choices* Enrollment Workbook Schedule of Benefits. Inpatient care must be under the direction of a licensed Physician and the nature of the treatment (frequency, duration and/or variety) or the physical condition of the patient must be such that Outpatient treatment is not a realistic alternative

OUTPATIENT BENEFITS are limited to Medically Necessary services of a rehabilitation plan, including, but not limited to, Speech Therapy, Physical Therapy, and Occupational Therapy but not

to exceed the limits specified in the current *Choices* Enrollment Workbook Schedule of Benefits. Outpatient benefits apply to therapy services provided when the covered Plan Participant is not a registered bed patient of a rehabilitation unit. Services must be provided by a licensed therapist and must be Medically Necessary for an acute condition, with continuing, measurable progress in restoring body function and/or preventing disability following illness, injury, or loss of body part.

CHIROPRACTIC SERVICES – Professional services for spinal treatment performed by a licensed chiropractor. Spinal treatment means detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the body for the purpose of removing nerve interference or its effects where such interferences are the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

ACUPUNCTURE SERVICES – Professional acupuncture services performed by a licensed acupuncturist to treat illnesses using the insertion of needles at specified sites of the body.

REHABILITATION CARE DOES NOT INCLUDE: Custodial Care, diagnostic admissions, maintenance therapy, non-medical self-help therapy, sports conditioning, vocational education therapy, learning or developmental disabilities, social or cultural rehabilitation, visual, speech, or auditory disorders, or any treatment for Chemical Dependency or Mental Illness.

The limitations below apply to these rehabilitative services:

- a. The number of visits in a Benefit Year for professional chiropractic and acupuncture, services are limited, as specified in the current *Choices* Enrollment Workbook Schedule of Benefits.
- b. Acupuncture services are not subject to Deductible or Coinsurance, however, out-of-network chiropractic services, as specified in the current *Choices* Enrollment Workbook Schedule of Benefits, are subject to the out-of-network Deductible and coinsurance. Any ancillary lab or x-ray is covered like other lab and x-ray services and not subject to the per visit limit.

32. Prescription Drugs -- Prescription drugs dispensed by a medical facility as part of Inpatient Covered Medical Services are covered under the Medical Plan. Other prescription drugs and diabetic supplies are covered by a separate Prescription Drug Plan, described in Section 9.

33. Treatment of Severe Mental Illness – The Plan will cover charges up to the Allowable Fee for Medically Necessary Inpatient services provided by a Hospital, Psychiatric Hospital, Mental Health Treatment Center or Free Standing Inpatient Facility for the treatment of severe Mental Illness (***Pre-certification of all Inpatient Admissions is strongly recommended***). Outpatient services for the treatment of Severe Mental Illness are also covered by the Plan.

Benefits for Severe Mental Illness will be paid the same as any other Illness.

The following disorders are defined by the American Psychiatric Association as Severe Mental Illness:

- a. Schizophrenia
- b. Schizoaffective disorder
- c. Bipolar disorder
- d. Major depression
- e. Panic disorder
- f. Obsessive-compulsive disorder
- g. Autism

34. Treatment of Other Mental Illness – If a Plan Participant incurs expenses for the treatment of Mental Illness, other than Severe Mental Illness defined above, the Plan will pay as follows:

- a. **INPATIENT MENTAL ILLNESS TREATMENT** – ***Pre-certification of all Inpatient Admissions is strongly recommended.*** See Section 6, *How to Obtain Benefits*. Services for Medically

Necessary confinement as an Inpatient in a Hospital, Mental Health Treatment Center, Psychiatric Hospital or Free Standing Inpatient Facility for treatment of Mental Illness (including any in-Hospital/facility services of a Physician or other Licensed Health Care Provider) are covered as specified in the current *Choices* Enrollment Workbook Schedule of Benefits.

b. PARTIAL HOSPITALIZATION MENTAL ILLNESS TREATMENT

For treatment of conditions that qualify for Inpatient Mental Illness benefits, a Plan Participant may exchange one day of Inpatient Hospitalization for two days of partial Hospitalization. Two days of Partial Hospitalization count as one day toward the maximum number of Inpatient days covered per Benefit Year.

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

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

c. OUTPATIENT MENTAL ILLNESS TREATMENT – Outpatient services for Mental Illness are Covered Medical Services if provided by one of the following Providers:

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

Benefits for Outpatient services are specified in the current *Choices* Enrollment Workbook Schedule of Benefits.

d. PRECERTIFICATION OF INPATIENT ADMISSION – All admissions to an Inpatient facility are subject to a review of Medical Necessity by the Utilization Management Administrator. All denials of an admission or portion thereof, by the Utilization Management Administrator on behalf of the Plan, shall result in the denial of all benefits and reimbursements related to the denied admission or the applicable portion of the denied admission.

35. Chemical Dependency (Alcohol and Drug Abuse) Treatment

If a Plan Participant incurs expenses for the treatment of Chemical Dependency, the Plan will pay as follows:

a. FOR INPATIENT TREATMENT of substance abuse, alcohol or drug abuse, the Plan will pay Covered Medical Expenses, subject to Deductible and Coinsurance, as specified in the current *Choices* Enrollment Workbook Schedule of Benefits ***Pre-certification is strongly recommended- See provision c. below.***

b. BENEFITS FOR OUTPATIENT SERVICES (subject to Allowable Fees, Deductible and Coinsurance) as specified in the current *Choices* Enrollment Workbook Schedule of Benefits.

c. CONDITIONS:

- 1) Inpatient services must be provided by a Hospital, Psychiatric Hospital, a Freestanding Inpatient Facility, or a licensed Alcoholism/Chemical Dependency Treatment Center, (defined below) under a program in which a Physician directly supervises the staff or

approves individual client treatment plans. All facilities must be fully licensed by the state in which the services are performed.

- 2) **Pre-certification of Inpatient Admission.** All admissions to an Inpatient facility are subject to a review of Medical Necessity by the Utilization Management Administrator. All denials of an admission or portion thereof, by the Utilization Management Administrator on behalf of the Plan, shall result in the denial of all benefits and reimbursements related to the denied admission or the applicable portion of the denied admission.
- 3) The Plan will pay benefits for Outpatient services only if the services are provided by a Physician, psychiatrist, licensed clinical psychologist, licensed social worker, licensed professional counselor, or certified chemical dependency counselor.

An Alcoholism/Chemical Dependency Treatment center is a facility which provides a program for the treatment of alcoholism or drug addiction pursuant to a written treatment plan, approved and under the direct supervision of a Physician, and which facility is also:

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

36. Second Surgical Opinion – Voluntary Program

If a Plan Participant is advised by a Physician to have a surgical procedure performed, the Plan will pay 100 percent of the Allowable Fee for a second opinion on the need for surgery (including x-ray and laboratory services). Deductible and Coinsurance do not apply.

If the surgical opinion does not confirm that the proposed surgery is medically advisable, the Plan will pay benefits in the same manner for a third opinion.

Conditions – Benefits will be payable only if:

- a. The opinion is given by a specialist who is:
 - 1) Certified by the American Board of Medical Specialties in a field related to the proposed surgery;
 - 2) Independent of the Physician who first advised the surgery; and
- b. The specialist makes a personal examination of the Plan Participant.

37. Treatment of Temporomandibular Joint Syndrome (TMJ) –

Surgical Treatment of TMJ that cannot be treated non-surgically is a Covered Medical Service. ***Prior Authorization is strongly recommended for surgical treatment of TMJ.*** See Section 6 – *How to Obtain Benefits*. If determined to be Medically Necessary, standard benefits will apply to the surgery, subject to the Deductible and Coinsurance.

38. Organ or Tissue Transplants Services as specified in the current *Choices* Enrollment Workbook Schedule of Benefits - **Prior Authorization is strongly recommended.** See Section 6 – *How to Obtain Benefits*. Charges in connection with non-Experimental or non-Investigational organ or tissue transplant procedures are covered, subject to the following conditions:

- a. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar

criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

- b. If the donor is covered under this Medical Plan, expenses incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.
- c. If the recipient is covered under this Medical Plan, expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not ordinarily covered under this Medical Plan according to eligibility requirements, will be considered allowable expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the procedure based benefit still available to the recipient.

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

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

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

Treatment must be Prior Authorized as Medically Necessary by the Claims Administrator. If Prior Authorization is not obtained or charges are found not to be Medically Necessary, charges in connection with or related to bariatric surgery will not be covered. In addition, the Plan Participant must participate in case management through the Plan. Please refer to Section 6 - How to Obtain Benefits.

“Morbid Obesity” means a condition of persistent and uncontrollable weight gain that is potentially life-threatening and is defined as a body mass index (BMI) greater than 40. Body Mass Index (BMI) is calculated by dividing a person's weight (in kilograms) by his/her height squared (in meters).

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

- a. Non-surgical treatment of weight gain, weight reduction or weight maintenance including but not limited to prescription drugs, vitamins, food supplements, counseling, diet and educational programs, except those services covered through the Wellness Program.
- b. Any incurred expenses for which all of the conditions of the bariatric surgery benefit of this Plan have not been met.
- c. Any incurred expenses before a Prior Authorization has been approved by the Claims Administrator.
- d. Any redo or revision of a prior bariatric surgical procedure.
- e. A second bariatric surgical procedure, whether or not the first procedure was performed while covered under this Plan.

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

I. Roux-en-Y gastric bypass (RYGB) or laparoscopic adjustable silicone gastric banding (LASGB or Lap-Band):

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

Selection Criteria:

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

II. Vertical Banded Gastroplasty (VBG):

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

1. Hepatic cirrhosis with elevated liver function tests; Inflammatory bowel disease (Crohn's disease or ulcerative colitis);
2. Radiation enteritis; Demonstrated complications from extensive adhesions involving the intestines from prior major abdominal surgery, multiple minor surgeries, or major trauma; or
3. Poorly controlled systemic disease (American Society of Anesthesiology (ASA) Class IV)

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

41. Eyeglasses or Contacts following Cataract Surgery – One pair of eyeglasses or pair of contacts within six (6) months following cataract surgery. Benefits are limited to corrective lens and up to one (1) pair of eyeglass frames.

42. Alternate Care – The Plan Administrator may, at his or her sole discretion, authorize payments for services that are not listed as Covered Benefits. Such payments shall be made only upon mutual agreement by the Plan Participant and the MUS Plan Administrator.

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

Self-administered prescription contraceptives are covered by a separate Prescription Drug Plan described in Section 9.

G. GENERAL EXCLUSIONS AND LIMITATIONS

The Plan does not pay any of the following charges or expenses.

1. Charges by the Plan Participant for all services and supplies resulting from any work-related Illness or Injury which occurs in the course of employment for wage or profit or which occurs in the course of any volunteer work when the organization for whom the Plan Participant is volunteering has elected or is required by law to obtain coverage for such volunteer work under state or federal workers’ compensation laws or other legislation, including Employees’ compensation or liability laws of the United States (collectively called “Workers’ Compensation”). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though the Plan Participant:
 - a. Receives benefits for only a portion of the services incurred under Workers’ Compensation.
 - b. Does not have Workers’ Compensation coverage because the organization failed to obtain such coverage.
 - c. Waived his/her rights to such coverage or benefits.
 - d. Fails to file a claim within the filing period allowed by law.
 - e. Fails to comply with any other provision of the law to obtain coverage or benefits.
 - f. Is permitted to elect not to be covered by Workers’ Compensation but fails to make such an election.
 - g. Elects not to be covered by Workers’ Compensation and has affirmatively made that election.

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

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

- a. The Veterans' Administration, when services are provided to a veteran for a disability that is not service connected.
 - b. A military Hospital or facility, when services are provided to a Retiree (or Dependent of a Retiree) from the armed services.
 - c. A group health plan established by a government for its own civilian Employees and their Dependents.
3. Charges that are caused by or arising out of war or act of war (whether declared or undeclared), civil unrest, armed invasion or aggression or during service in the armed forces of any country.
 4. Any loss, expense, or charge:
 - a. That is incurred while a Plan Participant is on active duty or training in the Armed Forces, National Guard, or Reserves of any state or country; and
 - b. For which any governmental body or its agencies are liable.
 5. Any expense that is in excess of the Allowable Fee.
 6. Services rendered or started or supplies furnished prior to the Effective Date of coverage under the Medical Plan or after coverage is terminated under the Medical Plan.
 7. Any expense or charge for which a Plan Participant does not have to pay, or would not be an incurred expense in the absence of this Plan.
 8. Any expense or charge that is primarily for the Plan Participant's convenience or comfort or that of the Participant's family, caretaker, Physician, or other Licensed Health Care Provider.
 9. Expenses for smoking cessation products, unless provided by the MUS Tobacco Cessation Program.
 10. Charges for preparation of reports or itemized bills in connection with Covered Medical Expense, unless specifically requested and approved by the Plan.
 11. Expenses for homeopathic services, products, and botanical preparations.
 12. Expenses incurred by persons other than the covered Plan Participant receiving treatment, service, or supplies.
 13. Expenses for which the Plan Participant is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
 14. Charges for services, treatment, or supplies not considered legal in the United States.
 15. Expenses for services or supplies that are not specifically listed as a Covered Medical Service of this Medical Plan.
 16. Expenses for the following treatments, services or supplies:
 - a. Expenses related to or connected with treatments, services, or supplies that are excluded under this Medical Plan.
 - b. Treatments, services or supplies that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Medical Plan.

H. MEDICAL BENEFIT EXCLUSIONS

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

1. Charges in connection with the care or treatment of, surgery performed for, or as the result of, a cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a congenital anomaly for a covered Dependent child.**
2. Charges for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a Covered Benefit of this Plan.
3. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury.
4. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician including charges for e-visits or virtual office visits.
5. Charges for Licensed Health Care Providers' fees for any treatment which is not rendered by or in the physical presence of a Licensed Health Care Provider including charges for e-visits or virtual office visits.
6. Special duty nursing services are excluded:
 - a. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the hospital benefit of the Plan pays for general nursing services by Hospital staff); or
 - b. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring Skilled Nursing Care.
7. Charges in connection with the purchase or fitting of eyeglasses, contact lenses, hearing aids, or other communication aids and batteries or related supplies.
8. Charges for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for treatment required because of accidental bodily injury to sound natural teeth. Such expenses must be incurred within twelve (12) months of the date of accident. This exception will not in any event be deemed to include charges for treatment for the repair or replacement of a denture.
9. Charges related to or in connection with treatment of infertility, including, but not limited to, artificial insemination, in-vitro fertilization, Gamete Intrafallopian Transfer (G.I.F.T.), Zygote Intrafallopian Transfer (Z.I.F.T.), Artificial Response Technology (A.R.T.), or other ovum transplant procedures; gene manipulation therapy; procedures to restore or enhance fertility; assisted reproductive techniques or surgical procedures; expenses related to donor sperm and donor ova (collection, preparation, storage); and surrogate services.
10. Charges for family counseling without the patient present, recreational counseling or milieu therapy.
11. Charges resulting from or in connection with the reversal of a sterilization procedure.
12. Any expense or charge which results from appetite control, food addictions, eating disorders, except for cases of bulimia or anorexia that meet standard diagnostic criteria and present significant symptomatic medical problems, or any treatment of obesity, except surgical treatment for morbid

obesity. Coverage for surgical treatment of morbid obesity is provided only as specifically stated in the Bariatric Surgery provision of Covered Medical Services.

13. Any expense or charge for orthopedic shoes or other supportive device for the feet, except as provided under the Orthotic Devices provision.
14. Hair transplant procedures, wigs and artificial hairpieces. This exclusion will not apply to the purchase of one wig or artificial hairpiece purchased within three (3) months of cancer treatment.
15. Charges for any surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism.
16. Charges related to Custodial Care and transportation.
17. Charges for artificial organ implant procedures.
18. Complications that directly result from acting against medical advice, non-compliance with specific Physician's orders or leaving an inpatient facility against medical advice.
19. Equipment, including, but not limited to, motorized wheelchairs or beds, that exceeds the patient's needs for everyday living activities as defined by the Americans with Disabilities Act as amended from time to time, unless Medically Necessary by independent review, and not primarily for personal convenience.
20. Specialized computer equipment, including, but not limited to, Braille keyboards and voice recognition software, unless determined to be Medically Necessary, and not primarily for personal convenience.
21. Any expense or charge that is primarily for the Plan Participant's education, training, or development of skills needed to cope with an Injury or Illness, except as provided under the rehabilitation care provision and the Disease Process Education Benefit.
22. Expenses for smoking cessation products, unless provided by the MUS Tobacco Cessation Program. SAME as #9 above/general exclusions.
23. Expenses for homeopathic services, products, and botanical preparations. SAME as #11 above/general exclusions.
24. Nutrition-based therapy for alcoholism or drug addiction.
25. Health care services to treat alcohol or drug co-dependency.
26. Charges for the following (known as a "Never Event") when the condition is as a result of patient confinement or surgery:
 - 1) Removal of an object left in the body during surgery.
 - 2) Catheter-associated urinary tract infection.
 - 3) Pressure ulcers.
 - 4) Vascular catheter-associated infection.
 - 5) Infection inside the chest after coronary artery bypass graft surgery.
 - 6) Hospital acquired injuries such as fractures, dislocations, intracranial injuries, crushing injuries and burns.
 - 7) Amputation or removal of the wrong body part or organ.

27. Chelation therapy expenses, except for acute arsenic, gold, mercury, or lead poisoning.
28. Any expense or charge for non-surgical treatment of temporomandibular joint (TMJ) syndrome. Surgical treatment of TMJ is covered if Medically Necessary. **Prior Authorization is strongly recommended for surgical treatment of TMJ.** See Section 6 – How to Obtain Benefits.
28. Expenses or charges for genetic counseling with the exception of genetic counseling for routine BRCA testing. See Section 7 – Medical Plan Description, #29 (c) (3).

Section 8 DENTAL PLAN DESCRIPTION

This Section describes Dental Plan benefits. See Section 6 – How to Obtain Benefits for information on claims processing and claims appeal information. See provision C. below for specific dental maximums.

A. DENTAL PLAN OPTIONS

There are two Dental Plan options:

1. **Select Plan (available to all active employees and their families, as well as retired employees).**
The Select Plan covers Preventive & Diagnostic, Basic Restorative, Major Dental (e.g., dentures, bridges, crowns) and Oral Surgery listed in provision F. of this Section.

The Select Plan also covers:

- Implant procedures performed by a Dentist for endosseous, transosseous, subperiosteal and endodontic implants; implant connecting bars and implant repairs. Implants are defined as prosthetic appliances placed into or on the bone of the maxilla or mandible (upper or lower jaw) to retain or support dental prosthesis
- Orthodontia procedures performed by a Dentist involving the use of an active orthodontic appliance and post-treatment retentive appliances for treatment of malalignment of teeth and/or jaws which significantly interferes with their functions. Orthodontia procedures are subject to a lifetime maximum amount for each covered individual as specified in provision C. of this Section.

2. **Basic Plan (available to all active employees and their families).**
The Basic Plan covers **only** Preventive & Diagnostic services listed in provision G. of this Section.

B. DENTAL PLAN COVERAGE

The Dental Plan will pay only for the covered services as shown in the Select and Basic Plan Schedules not to exceed the allowance specified in provisions F., G. and H.

Covered dental charges are those charges within Plan allowances specified in provision E. for covered dental services listed in provisions F., G., and not excluded in provision H. or I., when performed by a duly licensed Physician, Dentist, or licensed denturist operating within the scope of his or her license.

Dental services must be for the treatment of accidentally injured or diseased teeth, or supporting bone or tissue.

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

In a situation where a more expensive course of treatment is performed than is Medically Necessary or if the treatment is more extensive than is customarily provided, the Plan will pay an amount for the

least expensive medically adequate course of treatment in accordance with Dental Plan allowances. The Plan Participant will be responsible for the difference between the higher cost of the service and the lower cost of the customary service or standard practice.

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

To locate a Delta Dental Dentist, go to the Delta Dental website at www.deltadentalins.com/MUS.

C. DENTAL MAXIMUM BENEFIT

	<i>Select Plan</i>	<i>Basic Plan</i>
Annual Maximum Benefit (per individual)	\$1,500	\$750
Orthodontia Lifetime Maximum (per individual)	\$1,500	N/A

D. COORDINATION OF BENEFITS

If a Plan Participant receives dental services that are covered under both MUS and another dental plan, coverage and benefits are governed by Coordination of Benefits rules. These rules determine which plan pays benefits first and which plan pays second. Depending on the situation, the MUS may be the primary or secondary dental plan. The primary plan pays benefits without regard to the secondary plan. When MUS is the secondary plan, it pays for covered services that have not been paid by the primary plan. The MUS will coordinate with the primary insurance carrier and pay for MUS-covered services according to MUS Plan provisions and limitations.

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

Follow the guidelines set forth in Section 13 “Coordination of Benefits” to determine if the MUS may be the primary or secondary dental plan.

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

E. CONTRACT ALLOWANCE

The Contract Allowance is the maximum amount allowed for dental services listed in provisions F. and G.

Orthodontia services (Select Plan Only) are payable at 50% of the Contract Allowance for authorized services, subject to a \$1,500 annual maximum per covered individual.

The Contract Allowance is the maximum amount the Dental Plan will use for calculating the benefits for a single procedure. The Contract Allowance for services provided:

- by Delta Dental PPO Dentists is the lesser of the Dentist’s submitted fee, the amount shown on the Schedule of Maximum Benefits or the PPO dentist’s Fee;
- by Delta Dental Premier Dentists (who are not PPO Dentists) is the lesser of the Dentist’s submitted fee, the amount shown on the Schedule of Maximum Benefits or the Dentist’s filed fee with Delta Dental in the Participating Dentist Agreement; or
- by non-Delta Dental Dentists is the lesser of the Dentist’s submitted fee or the amount shown on the Schedule of Maximum Benefits.

F. SCHEDULE OF MAXIMUM BENEFITS FOR THE SELECT PLAN

Procedure Code	Description	Maximum Allowance
D0120	Periodic oral evaluation - established patient	\$40
D0140	Limited oral evaluation - problem focused	\$58
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$36
D0150	Comprehensive oral evaluation - new or established patient <i>(limited to one per dentist, all other evaluations will be benefited as D0120)</i>	\$65
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$124
D0180	Comprehensive periodontal evaluation - new or established patient <i>(limited to one per dentist, all other evaluations will be benefited as D0120)</i>	\$72
D0210	Intraoral - complete series (including bitewings)	\$110
D0220	Intraoral - periapical first film	\$26
D0230	Intraoral - periapical each additional film	\$20
D0240	Intraoral - occlusal film	\$25
D0250	Extraoral - first film	\$58
D0260	Extraoral – each additional film	\$40
D0270	Bitewings – one film	\$22
D0272	Bitewings - two films	\$37
D0273	Bitewings - three films	\$45
D0274	Bitewings - four films	\$53
D0277	Vertical bitewings - 7 to 8 films	\$65
D0320	TMJ arthrogram including injection	\$622
D0330	Panoramic film	\$91
D0340	Cephalometric film	\$78
D0350	Oral/facial photographic images	\$29
D0470	Diagnostic casts	\$81
D1110	Prophylaxis – adult	\$83
D1120	Prophylaxis – child <i>(through age 13)</i>	\$58
D1203	Topical application of fluoride (prophylaxis not included) – child <i>(through age 13)</i>	\$27
D1204	Topical application of fluoride (prophylaxis not included) – adult <i>(ages 14 through 18)</i>	\$28
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	\$28
D1351	Sealant - per tooth <i>(through 15 years old; the fee is considered to include any necessary repair or replacement within two years)</i>	\$45
D1510	Space maintainer - fixed - unilateral	\$239
D1515	Space maintainer - fixed - bilateral	\$388
D1520	Space maintainer - removable - unilateral	\$393
D1525	Space maintainer - removable - bilateral	\$538
D1550	Re-cementation of space maintainer	\$56
D1555	Removal of fixed space maintainer	\$56
D2140	Amalgam - one surface, primary or permanent	\$93
D2150	Amalgam - two surfaces, primary or permanent	\$118
D2160	Amalgam - three surfaces, primary or permanent	\$147
D2161	Amalgam - four or more surfaces, primary or permanent	\$176
D2330	Resin-based composite - one surface, anterior	\$98
D2331	Resin-based composite - two surfaces, anterior	\$125
D2332	Resin-based composite - three surfaces, anterior	\$156
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$190
D2391	Resin-based composite - one surface, posterior	\$116
D2392	Resin-based composite - two surfaces, posterior	\$148
D2393	Resin-based composite - three surfaces, posterior	\$184
D2394	Resin-based composite - four or more surfaces, posterior	\$220
D2510	Inlay - metallic - one surface	\$292

Procedure Code	Description	Maximum Allowance
D2520	Inlay - metallic - two surfaces	\$335
D2530	Inlay - metallic - three or more surfaces	\$380
D2542	Onlay - metallic-two surfaces	\$371
D2543	Onlay - metallic-three surfaces	\$375
D2544	Onlay - metallic-four or more surfaces	\$440
D2610	Inlay - porcelain/ceramic - one surface	\$292
D2620	Inlay - porcelain/ceramic - two surfaces	\$335
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$380
D2642	Onlay - porcelain/ceramic - two surfaces	\$371
D2643	Onlay - porcelain/ceramic - three surfaces	\$375
D2644	Onlay - porcelain/ceramic - four or more surfaces	\$440
D2650	Inlay - resin-based composite - one surface	\$292
D2651	Inlay - resin-based composite - two surfaces	\$335
D2652	Inlay - resin-based composite - three or more surfaces	\$380
D2662	Onlay - resin-based composite - two surfaces	\$371
D2663	Onlay - resin-based composite - three surfaces	\$375
D2664	Onlay - - resin-based composite - four or more surfaces	\$440
D2740	Crown - porcelain/ceramic substrate	\$453
D2750	Crown - porcelain fused to high noble metal	\$423
D2751	Crown - porcelain fused to predominantly base metal	\$410
D2752	Crown - porcelain fused to noble metal	\$414
D2780	Crown - 3/4 cast high noble metal	\$406
D2781	Crown - 3/4 cast predominantly base metal	\$363
D2782	Crown - 3/4 cast noble metal	\$365
D2783	Crown - 3/4 porcelain/ceramic	\$410
D2790	Crown - full cast high noble metal	\$410
D2791	Crown - full cast predominantly base metal	\$402
D2792	Crown - full cast noble metal	\$406
D2794	Crown – titanium	\$410
D2910	Recement inlay, onlay, or partial coverage restoration	\$60
D2915	Recement cast or prefabricated post and core	\$60
D2920	Recement crown	\$61
D2930	Prefabricated stainless steel crown - primary tooth	\$148
D2931	Prefabricated stainless steel crown - permanent tooth	\$222
D2932	Prefabricated resin crown	\$221
D2933	Prefabricated stainless steel crown with resin window	\$222
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$222
D2940	Sedative filling	\$70
D2950	Core buildup, including any pins (<i>considered part of crown fee except in exceptional circumstances or for endodontically treated teeth</i>)	\$95
D2951	Pin retention - per tooth, in addition to restoration	\$38
D2952	Post and core in addition to crown, indirectly fabricated	\$159
D2954	Prefabricated post and core in addition to crown	\$127
D2960	Labial veneer (resin laminate) - chairside	\$622
D2961	Labial veneer (resin laminate) - laboratory	\$353
D2962	Labial veneer (porcelain laminate) - laboratory	\$452
D2971	Additional procedures to construct new crown under existing partial denture framework	By Report
D2980	Crown repair, by report	\$41
D3110	Pulp cap - direct (excluding final restoration) (<i>included as part of the final restoration if done on the same day as the final restoration</i>)	\$43
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$105
D3310	Root canal - Anterior (excluding final restoration)	\$489

Procedure Code	Description	Maximum Allowance
D3320	Root canal - Bicuspid (excluding final restoration)	\$566
D3330	Root canal - Molar (excluding final restoration)	\$695
D3346	Retreatment of previous root canal therapy - anterior	\$592
D3347	Retreatment of previous root canal therapy - bicuspid	\$674
D3348	Retreatment of previous root canal therapy - molar	\$814
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$202
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations,	\$128
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$360
D3410	Apicoectomy/periradicular surgery - anterior	\$435
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$480
D3425	Apicoectomy/periradicular surgery - molar (first root)	\$520
D3426	Apicoectomy/periradicular surgery (each additional root)	\$190
D3430	Retrograde filling - per root	\$116
D3450	Root amputation - per root	\$256
D3920	Hemisection (including any root removal), not including root canal therapy	\$240
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	\$358
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	\$113
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	\$400
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	\$300
D4249	Clinical crown lengthening - hard tissue (<i>allowable amount for multiple procedures in a quadrant will not be more than D4260</i>)	\$455
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	\$672
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	\$511
D4270	Pedicle soft tissue graft procedure (<i>limited to two sites per quadrant</i>)	\$407
D4271	Free soft tissue graft procedure (including donor site surgery) (<i>limited to two sites per quadrant</i>)	\$632
D4273	Subepithelial connective tissue graft procedure per tooth	\$632
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$154
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$97
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$59
D4910	Periodontal maintenance	\$84
D5110	Complete denture – maxillary	\$608
D5120	Complete denture – mandibular	\$608
D5130	Immediate denture – maxillary	\$666
D5140	Immediate denture – mandibular	\$666
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$436
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$436
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$650
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$650
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$488

Procedure Code	Description	Maximum Allowance
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$488
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$445
D5410	Adjust complete denture – maxillary	\$32
D5411	Adjust complete denture – mandibular	\$32
D5421	Adjust partial denture – maxillary	\$33
D5422	Adjust partial denture – mandibular	\$33
D5510	Repair broken complete denture base	\$86
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$76
D5610	Repair resin denture base	\$89
D5620	Repair cast framework	\$160
D5630	Repair or replace broken clasp	\$160
D5640	Replace broken teeth - per tooth	\$76
D5650	Add tooth to existing partial denture	\$114
D5660	Add clasp to existing partial denture	\$160
D5710	Rebase complete maxillary denture	\$320
D5711	Rebase complete mandibular denture	\$320
D5720	Rebase maxillary partial denture	\$314
D5721	Rebase mandibular partial denture	\$314
D5730	Reline complete maxillary denture (chairside)	\$200
D5731	Reline complete mandibular denture (chairside)	\$200
D5740	Reline maxillary partial denture (chairside)	\$200
D5741	Reline mandibular partial denture (chairside)	\$200
D5750	Reline complete maxillary denture (laboratory)	\$274
D5751	Reline complete mandibular denture (laboratory)	\$274
D5760	Reline maxillary partial denture (laboratory)	\$263
D5761	Reline mandibular partial denture (laboratory)	\$263
D5820	Interim partial denture (maxillary)	\$216
D5821	Interim partial denture (mandibular)	\$216
D5850	Tissue conditioning, maxillary	\$51
D5851	Tissue conditioning, mandibular	\$51
D5860	Overdenture - complete, by report	\$580
D5861	Overdenture - partial, by report	\$580
D6010	Surgical placement of implant body: endosteal implant	\$848
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	\$850
D6040	Surgical placement: eposteal implant	\$1,500
D6050	Surgical placement: transosteal implant	\$1,500
D6053	Implant/abutment supported removable denture for completely edentulous arch	\$750
D6054	Implant/abutment supported removable denture for partially edentulous arch	\$800
D6055	Dental implant supported connecting bar	\$819
D6056	Prefabricated abutment - includes placement	\$186
D6057	Custom abutment - includes placement	\$229
D6058	Abutment supported porcelain/ceramic crown	\$543
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	\$513
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	\$483
D6061	Abutment supported porcelain fused to metal crown (noble metal)	\$495
D6062	Abutment supported cast metal crown (high noble metal)	\$500
D6063	Abutment supported cast metal crown (predominantly base metal)	\$482
D6064	Abutment supported cast metal crown (noble metal)	\$490
D6065	Implant supported porcelain/ceramic crown	\$575

Procedure Code	Description	Maximum Allowance
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	\$563
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	\$538
D6068	Abutment supported retainer for porcelain/ceramic FPD	\$550
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	\$541
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	\$502
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	\$525
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	\$550
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	\$495
D6074	Abutment supported retainer for cast metal FPD (noble metal)	\$532
D6075	Implant supported retainer for ceramic FPD	\$550
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	\$538
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	\$521
D6078	Implant/abutment supported fixed denture for completely edentulous arch	\$1,395
D6079	Implant/abutment supported fixed denture for partially edentulous arch	\$1,214
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	\$79
D6090	Repair implant supported prosthesis, by report	\$253
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	By Report
D6092	Recent implant/abutment supported crown	\$38
D6093	Recent implant/abutment supported fixed partial denture	\$52
D6094	Abutment supported crown - (titanium)	By Report
D6095	Repair implant abutment, by report	\$250
D6100	Implant removal, by report	\$250
D6194	Abutment supported retainer crown for FPD - (titanium)	By Report
D6199	Unspecified implant procedure, by report	By Report
D6205	Pontic - indirect resin based composite	\$363
D6210	Pontic - cast high noble metal	\$399
D6211	Pontic - cast predominantly base metal	\$363
D6212	Pontic - cast noble metal	\$365
D6214	Pontic - titanium	\$399
D6240	Pontic - porcelain fused to high noble metal	\$424
D6241	Pontic - porcelain fused to predominantly base metal	\$391
D6242	Pontic - porcelain fused to noble metal	\$408
D6245	Pontic - porcelain/ceramic	\$429
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$350
D6600	Inlay - porcelain/ceramic, two surfaces	\$375
D6601	Inlay - porcelain/ceramic, three or more surfaces	\$394
D6602	Inlay - cast high noble metal, two surfaces	\$363
D6603	Inlay - cast high noble metal, three or more surfaces	\$383
D6604	Inlay - cast predominantly base metal, two surfaces	\$350
D6605	Inlay - cast predominantly base metal, three or more surfaces	\$353
D6606	Inlay - cast noble metal, two surfaces	\$358
D6607	Inlay - cast noble metal, three or more surfaces	\$365
D6608	Onlay -porcelain/ceramic, two surfaces	\$390
D6609	Onlay - porcelain/ceramic, three or more surfaces <i>will be given</i>)	\$438
D6610	Onlay - cast high noble metal, two surfaces	\$385
D6611	Onlay - cast high noble metal, three or more surfaces	\$425
D6612	Onlay - cast predominantly base metal, two surfaces	\$365

Procedure Code	Description	Maximum Allowance
D6613	Onlay - cast predominantly base metal, three or more surfaces	\$375
D6614	Onlay - cast noble metal, two surfaces	\$381
D6615	Onlay - cast noble metal, three or more surfaces	\$395
D6624	Inlay – titanium	\$383
D6634	Onlay – titanium	\$425
D6710	Crown - indirect resin based composite	By Report
D6750	Crown - porcelain fused to high noble metal	\$423
D6751	Crown - porcelain fused to predominantly base metal	\$410
D6752	Crown - porcelain fused to noble metal	\$414
D6780	Crown - 3/4 cast high noble metal	\$406
D6781	Crown - 3/4 cast predominantly based metal	\$363
D6782	Crown - 3/4 cast noble metal	\$365
D6783	Crown - 3/4 porcelain/ceramic	\$410
D6790	Crown - full cast high noble metal	\$410
D6791	Crown - full cast predominantly base metal	\$402
D6792	Crown - full cast noble metal	\$406
D6794	Crown – titanium	\$410
D6930	Recement fixed partial denture	\$54
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$138
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$116
D6973	Core build up for retainer, including any pins	\$92
D6980	Fixed partial denture repair, by report	\$131
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$94
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$160
D7220	Removal of impacted tooth - soft tissue	\$176
D7230	Removal of impacted tooth - partially bony	\$215
D7240	Removal of impacted tooth - completely bony	\$255
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$305
D7280	Surgical access of an unerupted tooth	\$291
D7283	Placement of device to facilitate eruption of impacted tooth	By Report
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$260
D7286	Biopsy of oral tissue – soft	\$198
D7290	Surgical repositioning of teeth	\$219
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$131
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$79
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant (<i>usually in preparation for prosthesis</i>)	\$375
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$225
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	\$800
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$1,500
D7410	Excision of benign lesion up to 1.25 cm	\$280
D7411	Excision of benign lesion greater than 1.25 cm	\$360
D7412	Excision of benign lesion, complicated	\$380
D7413	Excision of malignant lesion up to 1.25 cm	\$560
D7414	Excision of malignant lesion greater than 1.25 cm	\$616
D7415	Excision of malignant lesion, complicated	\$712
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	\$480

Procedure Code	Description	Maximum Allowance
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	\$627
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$403
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$538
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$380
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$582
D7465	Destruction of lesion(s) by physical or chemical method, by report	\$320
D7471	Removal of lateral exostosis (maxilla or mandible)	\$529
D7472	Removal of torus palatinus	\$529
D7473	Removal of torus mandibularis	\$529
D7510	Incision and drainage of abscess - intraoral soft tissue	\$146
D7520	Incision and drainage of abscess - extraoral soft tissue	\$282
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	\$206
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	\$360
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$400
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$560
D7610	Maxilla - open reduction (teeth immobilized, if present)	By Report
D7620	Maxilla - closed reduction (teeth immobilized, if present)	By Report
D7630	Mandible - open reduction (teeth immobilized, if present)	By Report
D7640	Mandible - closed reduction (teeth immobilized, if present)	By Report
D7650	Malar and/or zygomatic arch - open reduction	By Report
D7660	Malar and/or zygomatic arch - closed reduction	By Report
D7670	Alveolus closed reduction may include stabilization of teeth	By Report
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	By Report
D7850	Surgical discectomy, with/without implant	\$1,500
D7860	Arthrotomy	\$1,500
D7880	Occlusal orthotic device, by report	\$469
D7910	Suture of recent small wounds up to 5 cm (<i>when performed in conjunction with extractions, this service is considered to be included as part of the extraction</i>)	\$192
D7911	Complicated suture - up to 5 cm	\$360
D7912	Complicated suture - greater than 5 cm	\$580
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$210
D7970	Excision of hyperplastic tissue - per arch	\$274
D7971	Excision of pericoronal gingival	\$120
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$69
D9220	Deep sedation/general anesthesia - first 30 minutes	\$219
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$105
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	\$199
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	\$81
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$67
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	\$92
D9940	Occlusal guards, by report	\$245

Note: The CDT codes and nomenclature are copyright of the American Dental Association. *Notes in italic type have been added by Delta Dental for clarification.* The procedures described and maximum benefit allowed indicated on this table are subject to the terms of the contract and Delta Dental processing policies. These allowances may be further reduced due to maximums, limitations and exclusions.

By Report – The Dental Plan will determine the maximum benefit allowed based on a narrative report submitted by the dentist and subject to the Plan’s maximum allowance and annual and lifetime maximum.

G. SCHEDULE OF MAXIMUM BENEFITS FOR THE BASIC PLAN

Procedure Code	Description	Maximum Allowance
D0120	Periodic oral evaluation - established patient	\$40
D0140	Limited oral evaluation - problem focused	\$58
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$36
D0150	Comprehensive oral evaluation - new or established patient (<i>limited to one per dentist, all other evaluations will be benefited as D0120</i>)	\$65
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$124
D0180	Comprehensive periodontal evaluation - new or established patient (<i>limited to one per dentist, all other evaluations will be benefited as D0120</i>)	\$72
D0210	Intraoral - complete series (including bitewings)	\$110
D0220	Intraoral - periapical first film	\$26
D0230	Intraoral - periapical each additional film	\$20
D0240	Intraoral - occlusal film	\$25
D0250	Extraoral - first film	\$58
D0260	Extraoral - each additional film	\$40
D0270	Bitewings – one film	\$22
D0272	Bitewings - two films	\$37
D0273	Bitewings - three films	\$45
D0274	Bitewings - four films	\$53
D0277	Vertical bitewings - 7 to 8 films	\$65
D0330	Panoramic film	\$91
D1110	Prophylaxis – adult	\$83
D1120	Prophylaxis – child (<i>through age 13</i>)	\$58
D1203	Topical application of fluoride (prophylaxis not included) – child (<i>through age 13</i>)	\$27
D1204	Topical application of fluoride (prophylaxis not included) – adult (<i>ages 14 through 18 years old</i>)	\$28
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	\$28
D1351	Sealant - per tooth (<i>through 15 years old; the fee is considered to include any necessary repair or replacement within two years</i>)	\$45
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$67

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By Report – The Dental Plan will determine the maximum benefit allowed based on a narrative report submitted by the dentist.

H. LIMITATIONS

Preventive and Diagnostic Benefits (Select and Basic Plans)

1. Routine oral examinations and cleanings, including periodontal cleanings, are not provided more than two (2) per benefit year. Note that periodontal cleanings are covered as a Basic Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit.
2. Full mouth x-rays or panoramic x-rays will be provided when required by the Dentist, but not more than one x-ray each five (5) years will be paid by the Dental Plan.
3. Bitewing x-rays are limited to two (2) per Benefit Year when provided to a Plan Participant under age eighteen (18) and one (1) per Benefit Year for a Plan Participant age eighteen (18) and over.

4. Space maintainers are limited to once per lifetime for anyone under age fourteen (14).
5. Topical application of fluoride is limited to two (2) in any twelve (12) month period for anyone under age nineteen (19).
6. Sealants are limited as follows:
 - i) They are available only to a Plan Participant through age fifteen (15).
 - ii) They are limited to application to permanent molars with no caries (decay), without restorations and with the occlusal surface intact.
 - iii) They do not include the repair or replacement of a sealant on any tooth within two (2) years of its application.

Basic Benefits (Select Plan)

The Dental Plan will not pay to replace an amalgam, synthetic porcelain or plastic fillings or prefabricated stainless steel restorations within twenty-four (24) months of treatment if the service is provided by the same Dentist.

Implant Benefits (Select Plan)

1. Implant Benefits are subject to all the limitations, exclusions and other terms and conditions in this Dental Plan.
2. Delta Dental will not pay to replace any implant that the Plan Participant received in the previous five (5) years. Benefits are not payable for the removal of any implants.
3. Prosthodontic devices and procedures associated with but not included within the definition of "Implants" (*See provision A.*) are not subject to the Implant Maximum.
4. The initial installation of an implant is not a Benefit unless the implant is made necessary by natural, permanent teeth extraction occurring during a time the Plan Participant was eligible under the prior Dental Plan.

Major Benefits (Select Plan)

1. The Dental Plan will not pay to replace any crowns, jackets or cast restorations which the Plan Participant received in the previous five (5) years.
2. The Dental Plan limits payment for stainless steel crowns to services on baby teeth, however, after consultant's review, the Dental Plan may allow stainless steel crowns on permanent teeth.
3. The Dental Plan will not pay to replace any bridge or denture that the Plan Participant received in the previous five (5) years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.
4. The Dental Plan limits payment for dentures to a standard partial or denture (Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
5. The initial installation of a fixed bridge or partial denture is not a benefit unless the bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Plan Participant was eligible under the prior Dental Plan.

Orthodontia (Select Plan)

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

I. DENTAL EXCLUSIONS AND LIMITATIONS

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

1. Dental services not listed on the Schedule of Maximum Benefits in provisions E. and F. above.
2. Completion of the claim form or for broken appointments.
3. Treatment for cosmetic purposes.
4. Expense incurred after termination, except for prosthetic devices, bridges, and crowns, which were fitted and ordered prior to termination, and were delivered within thirty (30) days after the date of termination.
5. Prosthetic services and devices, including bridges and crowns, started before the Plan Participant became covered by the Plan.
6. After initial placement of a denture and required adjustment rebase and/or reline of the dentures, rebase and/or reline of a denture is not allowed more than once in every two (2) year period.
7. Replacement of lost or stolen prosthetics.
8. Charges for which a Plan Participant covered by this Dental Plan is not required to pay.
9. Any expense or charge, which is primarily for the education or training of a Plan Participant covered by this Dental Plan.
10. Treatment of injuries or illness covered under workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
11. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for cleft lip or cleft palate.
12. Treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment.
13. Any single procedure started prior to the date the covered individual became covered for such services under this Dental Plan.
14. Prescribed drugs, medication, pain killers or experimental procedures.
15. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
16. Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
17. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
18. Treatment performed by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.

19. Charges incurred for oral hygiene instruction, a plaque control program, dietary instruction, x-ray duplications, cancer screening or broken appointments.
20. Treatment rendered by a person who ordinarily resides in your household or who is related to you (or to your spouse) by blood, marriage or legal adoption.
21. The initial placement of any denture or fixed bridge, unless such placement is needed to replace one or more natural, permanent teeth extracted while the covered individual is covered under the Plan or was covered under the MUS prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
22. Services rendered or started, or supplies furnished prior to the Effective Date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided in provision B. of this Section.

Section 9

PRESCRIPTION DRUG PLAN

Plan Participants enrolled in a medical plan offered by the MUS are automatically enrolled in the Prescription Drug Plan also known as URx. There is no separate premium cost.

A. PHARMACY CARD PROGRAM

Plan Participants should receive a URx prescription drug ID card in the mail from MedImpact. The card is an important document and should be protected from mutilation or loss. The Prescription Drug Plan's Pharmacy Benefit Administrator (PBA) provides a Network of pharmacies throughout the United States. The PBA for the URx prescription drug plan is MedImpact. MedImpact can be contacted by calling 1-888-648-6764.

Plan Participants can present their ID card along with a prescription from a physician, at any Network member pharmacy, and receive up to a thirty (30) day supply of medication. Plan Participants are responsible for a Copayment or percentage Coinsurance at the time the prescription is received. See the current *Choices* Enrollment Workbook Schedule of Benefits for the Copayment amounts and Coinsurance percentages per Plan Participant and per family. Note that there are five benefit levels (A, B, C, D, and F) and two benefit levels for specialty medication (S-\$150 copay and S-\$300 copay). Also see the current per person and per family maximum the Plan Participant must pay in Copayments and Coinsurance in a Benefit Year before the Plan pays 100%. The Copayment and Coinsurance paid for Specialty Drugs purchased at a retail pharmacy does not apply to the out-of-pocket maximum, nor do tier D and F medication Copayment and Coinsurance amounts.

B. OUT-OF-NETWORK BENEFITS AVAILABLE TO CARD PROGRAM MEMBERS

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

1. Plan Participants must pay the full cost to the non-Network pharmacy at the time the prescription is received.
2. Plan Participants must obtain a Direct Member Reimbursement form from the PBA's web site and send the completed form and proof of drug purchase to the PBA. Refer to the current Enrollment Workbook for address and website information. The PBA will process the claim for reimbursement for the amount allowed under the Plan.
3. In no case will the reimbursement exceed the cost for the same drug purchased at a Network pharmacy.

C. MAIL SERVICE PHARMACY PROGRAM

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

Plan Participants have options for obtaining a ninety (90) day supply of ongoing medications. Plan participants can obtain a ninety (90) day supply of medication through a mail order program with Costco Mail Order/Retail or Ridgeway Pharmacy. Information for the mail order program can be accessed through the vendor websites or by contacting the vendor directly at the numbers listed below. With the mail order program, Plan Participants can save money on prescriptions for ongoing medications and will not be required to leave the house to get the prescriptions filled. The medication will be delivered right to the home.

1. Costco Mail Order or ninety (90) Day at Retail (Plan Participants are not required to be a member of Costco to use Costco Mail Order OR Costco Retail Pharmacies).\
 - a. Telephone: 1-800-607-6861.
 - b. Website: www.pharmacy.costco.com.
 - c. Stop into any retail Costco pharmacy and fill a ninety (90) day supply of medication.
2. Ridgeway Pharmacy Telephone and Website.
 - a. Telephone: 1-800-630-3214.
 - b. Website: www.ridgewayrx.com.

Some compound prescription drugs are available from the Mail Service Pharmacy Program. These prescriptions will take longer to dispense, so allow more time.

D. COVERED PRESCRIPTION DRUG EXPENSES

Expenses for drugs and medicines that are Medically Necessary for the treatment of an Injury or Illness, and which require a legal prescription authorized by a Physician and expenses for other pharmaceutical services listed below are covered under both the card and mail service programs. Expenses for these same drugs and medicines purchased outside the card or mail service programs are covered up to the Prescription Drug Plan's allowance for the drug or medicine. Covered pharmaceutical services include:

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

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

E. EXCLUSIONS

The Prescription Drug Plan **does not** cover the following:

1. Expenses that fall under, or are related to, the General Exclusions and Limitations in the medical plan's Summary Plan Description.
2. DME, with the exception of diabetic supplies and insulin.
3. Expenses for all pharmaceuticals, drugs and medical supplies that may be purchased over the counter without a written prescription.
4. Any expense for a prescription drug that is not Medically Necessary, or not considered appropriate for the treatment of an Injury or Illness, or is considered to be experimental/investigational.
5. Drugs or supplies prescribed for cosmetic purposes; (e.g., Rogaine for hair loss or Retin-A for individuals age 26 and over).
6. Growth hormones unless Prior Authorized by the PBA.
7. Any charge or prescription drug expense that has been paid by another group plan, workers' compensation program, or has been paid under the medical plan.
8. Hearing aids, batteries and related supplies.
9. Any expense or charge for which a Plan Participant does not have to pay or which would not be a Covered Medical Expense in the absence of this Plan.
10. Any expense incurred after Plan coverage terminates.

11. Investigational or Experimental Services or drugs, including compounded medications, for a use not approved by the Food and Drug Administration.
12. Vitamins and fluoride supplements.
13. Anorexiant (any prescription drugs used for weight loss), unless part of a treatment plan for morbid obesity that is covered and has been authorized by MUS.
14. Infertility drugs (any prescription drugs used for infertility).

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

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

An appeal of an Adverse Benefit Determination must be made in writing (or orally by the attending physician in the case of an Adverse Benefit Determination rendered on an Urgent Care Claim) and submitted to the PBA. Appeal of an Adverse Benefit Determination must be made within 180 days from receipt of the Adverse Benefit Determination. With the exception of urgent care claims, the appeal must be made in writing, should list the reasons why the Plan Participant does not agree with the Adverse Benefit Determination, and must be sent or mailed to URX/Appeals, MedImpact Healthcare Systems, Inc., 10181 Scripps Gateway Court, San Diego, CA 92131-2446 or Fax 1-858-790-6060.

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

Physicians may submit urgent appeal requests by calling 1-888-648-6764. The PBA will review the appeal of an Adverse Benefit Determination. The claim should include at least the following information: the identity of the Plan Participant, a specific medical condition or symptom, the name of the drug for which approval or payment is requested, and any reasons why the appeal should be processed on a more expedited basis.

The PBA shall decide the appeal of an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review.

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

The time period for the Plan Administrator to decide an appeal of an Adverse Benefit Determination and to notify the PBA, who will in turn notify the Plan Participant of the final internal Adverse Benefit Determination depends upon the type of claim on appeal.

1. **Urgent Care Claim** – No later than 72 hours from the date the PBA received the Plan Participant's appeal, taking into account the medical exigency.
2. **Pre-Service Claim** – No later than 30 days from the date the PBA received the Plan Participant's appeal.
3. **Post-Service Claim** – No later than 60 days from the date the PBA received the Claimant's appeal.
4. **Concurrent Care Claim** – If the claim involves urgent care, no later than 72 hours from the date the PBA received the Plan Participant's appeal, taking into account the medical exigency. If the claim did not involve urgent care, the time period for deciding a pre-service (non-urgent care) claim and a posts-service claim, as applicable, will govern.
5. **Rescission Claim** – No later than 60 days from the date the Plan Administrator received the Plan Participant's appeal.

These rules require the Plan Participant to initiate the appeal within the time frame applicable to the claim at issue. Failure to submit a written appeal or request for review within the relevant time period

may cause the Plan Participant to forfeit any right to any further review of an Adverse Benefit Determination under these procedures or in court and will render the determination final and any appeal received after the end of the relevant time period will not be considered.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the PBA in writing, and supporting materials may be submitted via mail, the electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

H. FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

The PBA's decision will be communicated in writing to the Plan Participant. In the event that the PBA renders an Adverse Benefit Determination on appeal, the PBA will provide written notification which will include:

- The specific reason(s) for the final internal Adverse Benefit Determination, including a discussion of the decision. If the final internal Adverse Benefit Determination upholds a rescission, the notice will include the basis for the fraud or intentional misrepresentation of a material fact;
- Specific reference to pertinent Plan provisions or rules, including identification of any standard relied upon in the Plan to deny the claim (such as a medical necessity standard), on which the final internal Adverse Benefit Determination is based;
- If applicable, a statement describing the Plan Participant's right to request an external review and the time limits for requesting an external review;
- A statement indicating that the Plan Participant is entitled to receive, upon written request, free of charge, reasonable access to and copies of all documents, records and other information or materials relevant to the final internal Adverse Benefit Determination;
- If an internal rule, guideline, protocol or other similar criterion, Medical Policy or other medical information was used to make the final internal Adverse Benefit Determination, a notification that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon written request;
- If applicable, a statement that an explanation for a final internal Adverse Benefit Determination that is based on an experimental treatment or similar exclusion or limitation or a medical necessity standard will be provided, upon request and free of charge;
- If the final internal Adverse Benefit Determination involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the Plan Participant's medical circumstances; or a statement that such explanation will be provided, upon request and free of charge, and
- If the determination is based on Medical Necessity, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

The Plan Administrator will review the claim in question and any additional information submitted by the Plan Participant. If necessary, the Plan Administrator may confer with the Plan Participant/appellant and with the PBA to clarify the issues presented in the appeal. The Plan Administrator will conduct a full and fair review of the claim. The Plan Administrator is neither the original decision maker nor the decision maker's subordinate. The Plan Administrator cannot give deference to the initial benefit determination. The Plan Administrator may consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental Treatment, the Plan Administrator will consult with a health care professional with appropriate training. That health care professional will not be the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Plan Participant's appeal, the Plan will provide written or electronic notice to the PBA of the final benefit determination, within a reasonable time, but no later than 30 days for a Pre-Service Claim or 60 days for a Post-Service Claim from the date the second level appeal is received by the

PBA. The PBA will provide this notice to the Plan Participant within the relevant time frame specified above. Such notice will contain the same information as notices for the initial determination.

All claims are based upon the terms contained in the SPD on file with the Plan Administrator and the PBA. The Plan Participant may also request, free of charge, more detailed information, names of any medical professionals consulted, and copies of relevant documents, as defined in and required by law, which were used by the PBA to adjudicate the claim.

Right to Request External Review

Standard External Review

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

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

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

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

Expedited External Review

Expedited external review may be requested when:

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

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

External Review by IRO

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

- the Plan Participant's medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, the Plan Participant, or the Participant's treating health care provider;
- the terms of the Participant's summary plan description;
- evidence-based practice guidelines;
- any applicable clinical review criteria developed and used by the Plan; and
- the opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

Notice of Final External Review Decision

The IRO will provide written notice of the final external review decision to the Plan Participant and the PBA within forty-five (45) days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the Plan's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final external review decision of the IRO.

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

Compliance with IRO Decision

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

Section 10 OPTIONAL VISION HARDWARE BENEFIT

Frame and Eyeglass Lens Benefit

- A. The Plan will pay up to a \$300.00 allowance toward the 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.

- B. **Benefit Frequency**. Once every Benefit Year. This benefit is in lieu of contact lenses.

Contact Lens Benefit

- A. The Plan will pay up to a \$150.00 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.

- B. **Benefit Frequency**. Once every Benefit Year. This benefit is in lieu of eyeglass frame and lenses.

FILING CLAIMS

Using the Vision Benefit

When 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. Claims are processed in the order in which they are received by the claims administrator. Benefits will be applied to the first claim received and will not be changed if additional purchases are made during the benefit year.

Section 11 FLEXIBLE SPENDING ACCOUNTS

A. ELIGIBILITY

An Employee who:

1. Meets the eligibility requirements of the MUS Benefit Plan (described in Section 1);
2. Enrolls in the Plan;
3. Does not opt out of IRS Section 125 pre-tax premium payment described in Section 2-A, and
4. Is entitled to make benefit elections under the terms of Sections 2 & 3 and may elect Flexible Spending Account benefits.

B. OPERATION

At the time of initial enrollment in the Plan and during each annual benefits enrollment, an Eligible Employee will be able to elect to have some of his or her upcoming pay contributed to a special fund or account called a Flexible Spending Account. These funds or accounts are set up to pay for eligible expenses of participating Employees and their eligible family members. Family members do not have to be covered under the Employee's medical plan to have expenses paid out of the account.

The portion of an Employee's pay which he or she elects to have placed in a Flexible Spending Account is not subject to federal or state income taxes or Social Security taxes. **As the Employee and eligible family members incur qualifying expenses, the Employee may submit claims to be reimbursed for those expenses using these tax-free dollars.** Expenses reimbursed from a Flexible Spending Account cannot be claimed as a federal or state income tax credit or deduction on tax returns.

C. EMPLOYEE CONTRIBUTION

The portion of a participating Employee's pay that the Employee chooses to contribute to a Flexible Spending Account for a Benefit Year (or, if enrolling mid-year, for the remainder of a Benefit Year) will be deducted from his or her pay each pay period on a pro rata basis over the course of the year (or remaining part of the year).

D. EMPLOYER CONTRIBUTION AND CAFETERIA PLAN PAYMENT OPTIONS

Each Benefit Year the MUS contributes an amount determined (annually) to the Employee Benefit Cafeteria Plan on behalf of each Eligible Employee. The employer contribution must be used for Employee-elected health, dental, basic life/AD&D, and long-term disability benefit options offered by the Plan. The employer contribution is made on a pro rata basis during the Benefit Year.

Any costs that exceed the employer contribution for elected:

1. Employee and Dependent medical and dental coverage,
2. Basic life/AD&D coverage,
3. Long Term Disability coverage,
4. Optional vision coverage and
5. Optional Accidental Death and Dismemberment coverage are also deducted from Employee pay pre-tax under IRS Section 125, unless the Employee opts out of pre-tax premium payment as indicated in Section 2, provision A. ***Opting out makes the Employee ineligible for a Reimbursement Account.***

E. MEDICAL REIMBURSEMENT ACCOUNT

A Medical Reimbursement Account allows a participating Employee to experience a tax savings on medical, dental, and vision expenses that are not covered under a health care plan. Each open enrollment, an Employee enrolling in or already enrolled in the MUS Benefit Plan must decide whether he or she wishes to participate in a Medical Reimbursement Account for the upcoming Benefit Year. At that time, the Employee must also specify or elect the amount to be reduced from his or her salary over the course of the Year to go into the account. The minimum and maximum amount that may be elected will be stated in the *Choices* Annual Benefits Enrollment Booklet for the Benefit Year. **If an Employee does not complete a new election, the Employee will be treated as having elected not to participate for the upcoming Benefit Year.**

ELIGIBLE MEDICAL EXPENSES: Expenses which are eligible for reimbursement include, but are not limited to: annual Deductibles, Coinsurance, Copayments, amounts remaining after a medical plan has paid maximum benefits, orthodontia expenses, hearing aids and exams, travel to and from a doctor's office, and any other medical expenses (except health care premiums) that could be deducted on Federal income tax returns.

Eligible expenses must be incurred during the Benefit Year. A participating Employee may request reimbursement from (submit a claim to) the Medical Flexible Spending Account at any time during the Benefit Year for up to the full annual amount. Requests must be for amounts of \$10.00 or more.

F. DEPENDENT CARE REIMBURSEMENT ACCOUNT

Individuals for whom care is an eligible expense under a Dependent Care Reimbursement Account include children under age 13 and older Dependents (including parents) if they are mentally or physically incapable of taking care of themselves.

Each enrollment, an Eligible Employee enrolling in, or already enrolled in, the MUS Benefit Plan must decide whether he or she wishes to participate in a Dependent Care Reimbursement Account for the upcoming Benefit Year. At that time, the Employee must also specify or elect the amount to be reduced from his or her salary over the course of the Year to go into the account. The minimum and maximum amount that may be elected will be stated in the *Choices* Annual Benefits Enrollment Booklet for the

Benefit Year. **If an Employee does not complete and return a new election form, the Employee will be treated as having elected not to participate for the upcoming Benefit Year.**

ELIGIBLE DEPENDENT CARE EXPENSES: Examples of eligible Dependent care expenses are most non-educational, non-medical daycare expenses. The purpose of the expenses must be to allow the Employee and spouse to work. **Dependent care expenses paid through the Plan's *Choices* Dependent Care Reimbursement Account may not exceed either the Employee's or spouse's taxable income.**

Eligible expenses must be *incurred* during the Benefit Year. Reimbursement of claims for eligible expenses can only be up to the amount in the account at the time the claim is submitted. The remaining portion of any partially paid claims will be paid when additional contributions are made.

ELIGIBLE PROVIDERS: Licensed day care centers and babysitters' services inside or outside the home. A participating Employee must supply the day care Provider's tax ID number on the claim form. Tax ID numbers are not required for tax-exempt Providers, such as church groups.

G. IRS RULES FOR REIMBURSEMENT ACCOUNTS

Expenses eligible for reimbursement must be incurred in the Benefit Year.

Reimbursements from a Reimbursement Account may only be for expenses allowed for that account. Only eligible medical expenses can be reimbursed from a medical Reimbursement Account, and only Dependent care expenses can be reimbursed from a Dependent care Reimbursement Account or pre-tax insurance premiums.

Expenses reimbursed from a Reimbursement Account may not be deducted on the Participant's federal income tax return. Please consult your tax advisor if this is a concern.

Participating in a medical and/or dependent care Reimbursement Account or pre-tax insurance premiums also results in Social Security taxes being reduced. This could affect a Participant's future Social Security benefits. Please consult your tax advisor if this is a concern.

MID-YEAR ELECTION CHANGES: Generally, Reimbursement Account elections, like other benefit elections whose costs are paid pre-tax, may not be changed after the beginning of the Benefit Year. However, there are certain limited situations when elections can be changed. Participants and Eligible Employees are permitted to change elections when a qualifying change in status (other than a health insurance cost or coverage change) occurs as described in Section 2, provision E. **Any change must be consistent with the Participant's change in status.**

USE IT OR LOSE IT RULE: If eligible expenses incurred in the Benefit Year are less than the amount contributed to the Reimbursement Account for the Benefit Year, the remaining account balance in excess of \$500.00 will be forfeited. The *Choices* Plan allows a run out period for submitting claims after The Benefit Year ends, but the expense must have been incurred in the Benefit Year. All claims must be faxed or postmarked by September 30 to qualify for reimbursement.

ROLL-OVER: Remaining account balances up to and including \$500.00 will roll-over to the next Benefit Year.

H. LEAVES, TERMINATION OF EMPLOYMENT AND REHIRE

LEAVE: Reimbursement Account benefits during a leave of absence may be continued like other Plan benefits as described in Section 3 through the remainder of the Benefit Year. After applicable sick, vacation or compensatory time pay is exhausted, contributions must be made on an after tax basis. If benefits are allowed to lapse, re-enrollment upon return to work will be as follows:

If the Employee returns to work in the same Benefit Year, any prior Reimbursement Account elections are reinstated under one of two Employee options:

1. Coverage is resumed at the original annual amount, and any missing contributions are made up by increasing the remaining monthly contributions.
2. Coverage is resumed at an annual amount reduced by the amount of the missing contributions.

No expenses incurred during the lapsed period of coverage are eligible for reimbursement. The Reimbursement Account election may only be changed if one of the changes in status described in Section 2, provision E. has occurred.

If the Employee returns to work in a new Benefit Year, new elections must be made.

TERMINATION: An Employee who terminates employment or otherwise loses eligibility for benefits may continue a medical Reimbursement Account through the remainder of the Benefit Year through one or a combination of the following payment options:

- a. making as many of the remaining monthly contributions to the Reimbursement Account as possible out of the final pay check, but only up through the end of the calendar year
- b. self-paying the monthly contribution with post tax dollars.

An Employee who terminates employment or otherwise loses eligibility for benefits may not continue a Dependent care Reimbursement Account, but may still request reimbursement for qualifying Dependent care expenses for the remainder of the Benefit Year from any remaining balance.

If a terminated Employee with a lapsed Reimbursement Account is rehired and reenrolls in the Reimbursement Account within the same Benefit Year and within 63 days of termination, any prior Reimbursement Account elections are reinstated at prior monthly contribution rates. The annual Reimbursement Account election will be reduced by the amount of the missing contributions and no expenses incurred during the lapsed period of coverage are eligible for reimbursement.

The Reimbursement Account election may only be changed if one of the changes in status described in Section 2, provision E. has occurred.

If a terminated Employee with a lapsed Reimbursement Account is rehired and reenrolls after 63 days of termination or in a new Benefit Year, he or she may make new Reimbursement Account elections, the same as any newly hired Employee. Only expenses incurred after re-enrollment are eligible for reimbursement.

I. HIGHLY COMPENSATED AND KEY EMPLOYEES

If an Employee meets the IRS Section 125 definition of a highly compensated or key Employee, the amount of contributions and benefits available may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses, or their Dependents. Employees who meet this definition will be notified by the Plan Administrator of these limitations if affected.

A complete copy of the Flexible Benefit Program Summary Plan Description and Plan Document are available from your payroll, benefits, or human resources office.

J. INTERNET-BASED RESOURCES

Reimbursement Plan related materials are available on the Allegiance Benefit Plan Management, Inc., website at www.allegianceflexadvantage.com. These forms and material include:

- An overview of cafeteria plans and their tax benefits.
- Cafeteria plan claim forms.
- Examples of expenses that qualify for reimbursement under a cafeteria plan.
- Examples of expenses that do not qualify for reimbursement under a cafeteria plan.
- Worksheets to help estimate annual medical care and Dependent care assistance costs.
- Accessible answers to frequently asked questions.
- Links to IRS publications relating to medical and Dependent care expenses.
- Instructions for completing and submitting reimbursement claims or requests.

K. SUGGESTIONS FOR FASTER CLAIMS PROCESSING

1. Notify Allegiance Benefit Plan Management, Inc., of any change of address.
2. Obtain the correct claim form from your campus Human Resources/ Benefits Office or the Allegiance Benefit Plan Management, Inc., website.
3. Indicate the campus name, your name, and actual Social Security number.
4. Provide information regarding the expenses for which you wish to be reimbursed on the claim form including: date of service, Provider, description of expenses, person for whom the expenses were incurred, and the amount of out-of-pocket expenses. Attach documentation to support the data on the claim form.
5. Make a copy of the claim form and all associated documentation for your records. Mail is occasionally lost by the Postal Service, and faxes sometimes do not come through.
6. Mail claims to Allegiance Benefit Plan Management, Inc. , 2806 South Garfield Street, P.O. Box 4346 Missoula, Montana 59806 or fax to 1-877-424-3539. Toll free customer assistance is 1-877-778-8600.
7. Carefully review account balances on claim check stubs.
8. Remember that the date of the service for which reimbursement is being claimed must be within the Benefit Year (or, if applicable, the two and a half month extension period described below).
8. Remember that all claims must be faxed or postmarked by September 30 following the Benefit Year in order to be eligible for reimbursement.

Section 12 GENERAL PROVISIONS

A. RIGHT TO TERMINATE OR CHANGE PLAN PROVISIONS

The MUS in its sole discretion and at any time through authorized agents may, within the limits of contract provisions and requirements for adequate public notice, terminate, amend, rescind, suspend, delay, or otherwise modify any or all benefits or provisions described in this SP D. The discretion includes, but is not limited to, the following:

1. To terminate any or all Medical, Dental, AD&D, LTD, or Life Insurance Benefits for any or all Plan Participants, including Employees, Retirees and/or Eligible Dependents, spouses or children.
2. To alter or postpone the amounts, schedules, or methods of calculation for payment of benefits.
3. To amend or rescind any provision of the Plan of benefits.
4. To increase or otherwise change the contributions, fees, or premiums required from units of the Montana University System, Office of the Commissioner of Higher Education, or other affiliated agencies or organization and/or Plan Participant.

B. COMPLIANCE WITH LAW AND REGULATIONS

Any provision of this SPD, which on its Effective Date is in conflict with the statutes of Montana or laws and regulations of the United States, is hereby amended to conform to the minimum requirements of such statutes, regulations, or laws.

C. RIGHT TO MEDICAL RECORDS

The Plan Administrator, Claims Administrator, and Utilization Management Administrator shall have full access to any and all medical, Hospital, or other records relating to the diagnosis, treatment, or services provided to the Plan Participant or to any other information that is needed to administer provisions of the Plan. Release of such information or records by the Plan Participant shall be a condition of receipt of benefits from the Plan. Medical records shall be held as confidential by the above parties and under penalty of law shall not be released or disclosed to any unauthorized persons, except as provided by law.

D. RIGHT TO CONDUCT MEDICAL EXAMINATIONS

The Claims Administrator shall, at Plan expense, have the right and opportunity to examine through its own medical examiner any Plan Participant whenever Illness or Injury is the basis of a claim. The Claims Administrator may exercise this right as often as may be reasonably required during the time a claim is pending.

E. RIGHT TO MAKE PAYMENTS

The Claims Administrator may make payment to: a) the Plan Participant, b) the Provider, c) the Plan Participant and Provider jointly, or d) upon the written direction of the Plan Participant, to any other person, firm, plan, or corporation. Any payment made by the Claims Administrator in good faith pursuant to this provision shall fully discharge the liability of the Plan to the extent of such payment.

F. RIGHT TO RECOVER PAYMENTS

Whenever payments have been made in error or in excess of the amount necessary to satisfy the liability of the Plan, the Claims Administrator shall have the right to recover any or all excess payment from the following:

1. From any person to whom such payments have been made.
2. From any other plan, government, or coverage company to which such payments have been made.
3. From any other firm, organization, or company to which such payments have been made.

The Plan can deduct the amount paid from the Plan Participant's future benefits, or from the benefits for any covered Family member, even if the erroneous payment was not made on that Family member's behalf.

G. NO OBLIGATION TO PROVIDE BENEFITS IF MEDICAL CARE IS NOT AVAILABLE

The MUS is not obligated to provide benefits or to arrange for the delivery of medical services if Hospital facilities are not available or if medical services are not available because of epidemic, disaster, or for any other reasons beyond the control of the Plan.

H. THE MUS IS NOT LIABLE FOR ACTS, ERRORS, OR OMISSIONS BY MEDICAL PROVIDERS

The MUS is not liable for any acts of commission or omission by any Hospital or medical Provider.

I. COVERAGE EXTENDS TO SERVICES OUTSIDE THE U. S.

The expenses for services provided outside the United States are covered in the same manner as expenses for services provided within the United States.

J. BENEFITS SHALL BE PROVIDED ON A NON-DISCRIMINATORY BASIS

Plan provisions will be administered without regard to the race, color, religion, creed, sex, national origin, age, handicap, marital status, or political belief of any person, except when such factors are reasonably applicable and necessary for medical reasons to be considered when Plan provisions are administered. Plan Participants and/or Providers shall be protected from any retaliation for reporting or appraising any unlawful discriminating practice.

K. REIMBURSEMENT

The Plan's right of reimbursement granted in §2-18-901, MCA, may not be enforced until the injured Plan Participant has been made whole from all available sources of third party recovery, as defined under Montana law. The Plan has no right to reimbursement or subrogation unless and until the Plan Participant has been made whole from all available sources of third party recovery, as defined under Montana law. The Plan has no right to reimbursement or subrogation unless and until the Plan Participant has been totally reimbursed for all losses, including payment of attorneys' fees and costs.

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. Reimbursement means to repay a party who has paid something on another's behalf. If the Plan pays benefits for medical or dental expenses on a Plan Participant's behalf, and another party was responsible or liable for payment of those medical or dental expenses, the Plan has a right to be reimbursed by the Plan Participant for the amounts the Plan paid only if the Plan Participant has been made whole.

Accordingly, if a Plan Participant, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity, liability coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any accident, Injury, condition or Illness for which benefits were provided by the Plan, the Plan Participant agrees to hold the money received in trust for the benefit of the Plan pending a determination whether the Plan Participant has been made whole. The Plan Participant agrees to reimburse the Plan from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Plan Participant or on his or her behalf or that will be paid as a result of said accident, Injury, condition or Illness in the event the Plan Participant has been made whole.

The Plan's right of reimbursement granted in §2-18-901, MCA, may not be enforced until the injured Plan Participant has been made whole from all available sources of third party recovery, as defined under Montana law. The Plan has no right to reimbursement or subrogation unless and until the Plan Participant has been made whole from all available sources of third party recovery, as defined under Montana law. The Plan has no right to reimbursement or subrogation unless and until the Plan Participant has been totally reimbursed for all losses, including payment of attorneys' fees and costs.

L. SUBROGATION

The Plan's right of subrogation granted in §2-18-901, MCA, may not be enforced until the injured Plan Participant has been made whole from all available sources of third party recovery, as defined under

Montana law. The Plan has no right to reimbursement or subrogation unless and until the Plan Participant has been totally reimbursed for all losses, including payment of attorneys' fees and costs.

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Plan Participant's rights and remedies in order to recover from any third party who is legally responsible to the Plan Participant for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Plan Participant, with or without his or her consent, to recover the money paid under the Plan.

In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to the Plan Participant's accident, Injury, condition or Illness, which the Plan paid, then the Plan is entitled to recover, by legal action or otherwise, the money paid; in effect, the Plan has the right to "stand in the shoes" of the Plan Participant for whom benefits were paid, and to take any action the Plan Participant could have undertaken to recover the money paid. The Plan only has a right to subrogation if the Plan Participant has been made whole.

In the event the Plan Participant has been made whole, the Plan Participant agrees to subrogate to the Plan any and all claims, causes of action or rights that he or she has or that may arise against any entity who has or may have caused, contributed to or aggravated the accident, Injury, condition or Illness for which the Plan has paid benefits, and to subrogate any claims, causes of action or rights the Plan Participant may have against any other coverage, including but not limited to liability coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event that a Plan Participant decides not to pursue a claim against any third party or insurer, the Plan Participant will notify the Plan, and specifically authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Plan Participant's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

The Plan's right of subrogation granted in §2-18-901, MCA, may not be enforced until the injured Plan Participant has been made whole from all available sources of third party recovery, as defined under Montana law. The Plan has no right to reimbursement or subrogation unless and until the Plan Participant has been totally reimbursed for all losses, including payment of attorneys' fees and costs.

The right to Subrogation under the Plan's provisions is distinguished from Coordination of Benefits when duplication of coverage is identified for the Plan Participant.

THE FOLLOWING PARAGRAPHS APPLY TO BOTH REIMBURSEMENT AND SUBROGATION:

2. The Plan's right of subrogation or reimbursement granted in §2-18-901, MCA, may not be enforced until the injured Plan Participant has been made whole from all available sources of third party recovery, as defined under Montana law. The Plan has no right to reimbursement or subrogation unless and until the Plan Participant has been totally reimbursed for all losses, including payment of attorneys' fees and costs.
3. Where there is evidence of liability of a third party, the Plan Participant agrees to follow the requirements of this section. The Plan will not withhold payment of benefits based on the liability of a party other than the Plan Participant. The Plan's right of recovery through either Reimbursement or Subrogation remains in effect as set forth in this section.

4. If the Plan makes a payment that the Plan Participant, or any other party on the Plan Participant's behalf, is or may be entitled to recover against any liable third party, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment, as set forth in this section.
5. The Plan's right of subrogation or reimbursement granted in §2-18-901, MCA, may not be enforced until the injured Plan Participant been made whole from all available sources of third party recovery, as defined under Montana law. The Plan has no right to reimbursement or subrogation unless and until the Plan Participant has been totally reimbursed for all losses, including payment of attorneys' fees and costs.
5. The Plan Participant will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any benefits paid by the Plan from any party other than the Plan Participant who is liable. This cooperation includes, but is not limited to, making full and complete disclosure and information to the Plan, upon request and in a timely manner, of all material facts regarding the accident, Injury, condition or Illness; with any and all requested documents, reports and other information regarding any demand, litigation or settlement involving the recovery of monies paid by the Plan; and notifying the Plan of the amount and source of any monies received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.
6. Plan Participants will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers, including but not limited to liability, uninsured and underinsured insurance coverage. The Plan Participant will notify the Plan immediately of the name and address of any attorney whom the Plan Participant engages to pursue any personal Injury claim on his or her behalf.
7. The Plan Participant will not act, fail to act, or engage in any conduct directly, indirectly, personally or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Plan Participant will not conceal or attempt to conceal the fact that recovery has occurred or will occur.
9. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Plan Participant pursuing a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation. This paragraph does not affect the Plan's consideration of attorney fees and costs in determining whether the Plan Participant has been made whole.

M. RIGHT TO TERMINATE COVERAGE FOR FALSE CLAIMS

Any Plan Participant or provider who submits bad faith or false claims, misrepresents facts, or attempts to perpetuate a fraud upon the MUS Benefits Plan may be subject to criminal charges or a civil action brought by the Plan Administrator or his/her designee as permitted under state and federal laws. Additionally, if a Plan Participant has been found to have committed such acts after an informal hearing with the Plan Administrator or his/her designee, they shall immediately become ineligible to remain on the Plan and coverage will be terminated. *See Section I, provision D., RESCISSION OF COVERAGE.*

N. RIGHT TO TERMINATE COVERAGE FOR A PATTERN OF FRIVOLOUS CLAIM APPEALS

A Plan Participant, who evidences a pattern of appealing baseless, frivolous claims that were initially denied, may become terminated from coverage on the Plan. The Plan Administrator or his/her designee shall issue a fifteen (15) day notice to the Plan Participant to cease and desist and abide by the plan terms or be dropped. If the Plan Participant continues to insist on appealing matters that are deemed frivolous, the Plan Administrator or his/her designee may issue a thirty (30) day notice of termination of coverage from the Plan following an informal hearing with the Plan Administrator or his/her designee. *See Section 1, provision D., RESCISSION OF COVERAGE*

Section 13

COORDINATION OF BENEFITS

A. COORDINATION OF BENEFITS

Coordination of Benefits (COB) sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. It is designed to eliminate problems that result from duplicate group health care coverage. COB limits the benefits that may be received by a Plan Participant covered by more than one group plan to no more than the total health care expenses allowed and divides responsibility for those expenses between the plans.

Standard COB

The plan that pays first according to the rules will pay as if there were no other plan or coverage involved. The secondary and subsequent plans will pay the balance up to 100% of the total Allowable charges, less any copayments, deductibles, or coinsurance. When there is a basis for a claim under this Plan and another plan or coverage, this Plan is a secondary plan. A secondary plan has its benefits determined after those of the other plan. The exception to this statement is if:

1. The other plan has rules coordinating its benefits with this Plan; and
2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other plan or coverage.

The Coordination of Benefits provision applies whether or not a claim is filed under other plan or plans. If needed, authorization is hereby given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

Plan, for purposes of COB, means this Plan or any one of the following plans:

1. Group and non-group health insurance contracts and subscriber contracts;
2. Group and non-group coverage through closed panel plans, licensed Health Maintenance Organizations (HMO) or other prepaid plans;
3. Group-type contracts;
4. The medical care components of long-term health care contracts, such as skilled nursing care;
5. Any coverage for students which is sponsored by or provided through a school or other educational institution; or
6. Medicare or other governmental benefits, and any coverage required or provided by any statute.

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

COB RULES

1. If a Plan Participant is covered by another plan as defined above, the benefits will be coordinated. One plan will be determined as the primary plan and will pay benefits first. The other plan(s) will be secondary.

2. The secondary plan(s) will limit benefits so that the sum of all benefits paid by the primary plan and by the secondary plan(s) do not exceed 100 percent (%) of the total Allowed amount.

ORDER OF BENEFIT DETERMINATION

Rules 1 through 5 below apply where there are multiple health plans, health insurance coverages, or medical plans with obligations to cover health care expenses for one person, regardless of that person's coverage status as either an employee, member, subscriber, retiree, or dependent.

1. **Non-Dependent/Dependent**

The Plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. **Child Covered Under More Than One Plan**

- a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - 1) The parents are married;
 - 2) The parents are not separated (whether or not they have ever been married); or
 - 3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.
- b. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
- c. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan becomes primary. This subparagraph will not apply with respect to any claim determination period, Benefit Period or Plan Year during which benefits are paid or provided before the entity has actual knowledge.
- d. If the parents are not married or are separated (whether or not they have ever been married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parent's spouses (if any) is:
 - 1) The plan of the custodial parent;
 - 2) The plan of the spouse of custodial parent.
 - 3) The plan of the non-custodial parent.
 - 4) The plan of the spouse of the non-custodial parent.

3. **Active or Inactive Employee**

The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.

4. **Longer or Shorter Length of Coverage.**

If the proceeding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.

- a. To determine the length of time a person has been covered under a plan, two plans will be treated as one if the Covered Person was eligible under the second within 24 hours after the first ended.

- b. The start of a new plan does not include:
- 1) A change in the amount or scope of a plan's benefits;
 - 2) A change in the entity that pays, provides, or administers the plan's benefits; or
 - 3) A change from one type of plan to another (such as from a single employer plan to that of a multiple-employer plan).

c. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

5. **No Rules Apply**

If none of these preceding rules determines the primary plan, the Allowable Expense will be determined equally between the plans.

B. COORDINATION WITH MEDICARE:

Medicare will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Plan Participant is actually receiving Medicare Benefits.

WORKING AGED: A covered Employee who is eligible for Medicare Part A or Part B because of age may be covered under this Plan and under Medicare in which case this Plan will pay primary. A covered Employee, eligible for Medicare Part A or Part B because of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate and cannot be reinstated.

A covered Dependent, eligible for Medicare Part A or Part B because of age may also be covered under this Plan and under Medicare in which case the Plan again will pay primary. A covered Dependent, eligible for Medicare Part A or Part B because of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate and cannot be reinstated.

FOR RETIRED PERSONS: Medicare is primary and the Plan will be secondary for the covered Retiree if he/she is an individual who is eligible for Medicare Part A or Part B because of age and retired.

Medicare is primary and the Plan will be secondary for the covered Retiree's Dependent spouse who is eligible for Medicare Part A or B if both the covered Retiree and his/her covered Dependent spouse are eligible for Medicare Part A or Part B because of age and retired.

Medicare is primary for the Retiree's Dependent spouse when the Retiree is not eligible for Medicare Part A or Part B because of age and the Retiree's Dependent spouse is eligible for Medicare Part A or Part B because of age.

FOR COVERED PERSONS WHO ARE DISABLED: The Plan will pay primary and Medicare will be secondary for a covered actively employed Employee or any covered Dependent who is eligible for Medicare by reason of disability and for whom Medicare requires the employer plan to pay primary.

The Plan is secondary and Medicare will be primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

END-STAGE RENAL DISEASE: This Plan will be primary only during the first thirty (30) months of Medicare coverage for Employees, Retirees, and their Dependents, for whom Medicare requires the employer plan to pay primary, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD).

Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above:

1. The Plan Participant has no dialysis for a period of twelve (12) consecutive months and then resumes dialysis, at which time the Plan will again become primary for a period of thirty (30) months; or
2. The Plan Participant undergoes a kidney transplant, at which time the Plan will again become primary for a period of thirty (30) months.

If a Plan Participant is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Plan Participant becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary and the Plan will be secondary.

C. COORDINATION WITH MEDICAID

If a Plan Participant is covered by Medicaid, the Plan will always be primary and Medicaid will always be secondary coverage.

D. COORDINATION WITH TRICARE/CHAMPVA

If a Plan Participant is also entitled to and covered under TRICARE/CHAMPVA, the Plan will always be primary and TRICARE/CHAMPVA will always be secondary coverage. TRICARE coverage will include programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

E. COORDINATION WITH VA BENEFITS

If the Plan Participant is eligible for Medicare and entitled to veterans' benefits through the Department of Veterans Affairs (VA), the Plan will always be primary and the VA will always be secondary for non-service connected medical claims. For these claims, the Plan will make payment to the VA as though the Plan was making payment secondary

F. COORDINATION WITH A MEDIGAP PLAN

If the Plan Participant is eligible for Medicare Parts A and B and also has a Medigap Supplemental policy, this Plan will always be secondary coverage to that policy.

Section 14 DEFINITIONS

Medical plan definitions in this Section apply to the Plan

1. **Acupuncture** – Professional services performed by a licensed acupuncturist to treat illnesses using the insertion of needles at specified sites of the body.
2. **Adult Dependent** - An individual who meets the criteria specified in Section 1, provision B. (1) of this Summary Plan Description.
3. **Allowable Fee** - The maximum amount considered for payment for any covered treatment, service or supply, subject, however, to all Plan maximum benefit limitations. The following criteria will apply to determination of the Allowable Fee:
 - a. For services of a Licensed Physician or Licensed Health Care Provider:
 - 1) A contracted amount as established by a preferred provider or other discounting contract;
 - 2) An amount established based upon a published prevailing fee schedule for the geographic area in which the claim was incurred and adopted by the Plan and Claims Administrator if a contracted amount does not exist, or
 - 3) If neither a. nor b. above apply, an amount equal to 80% of the Provider's average billed charge for the service.
 - b. For facility charges:
 - 1) The contracted amount as established by a preferred provider or other discounting contract;
 - 2) A schedule maintained by the Claims Administrator and based upon the average billed charge, reduced by a maximum of 20%, which percentage may be adjusted for type, size and geographic location of the facility.
 - c. For all prescription drugs not obtained through the Plan's Pharmacy Drug Program while undergoing either inpatient or outpatient treatment, including injectable drugs:
 - 1) The contracted amount as established by a preferred provider or other discounting contract;
 - 2) 125% of the current Medicare allowable fee, if a contracted amount does not exist, or
 - 3) The billed charge if less than c. (1) or c. (2) above.
 - d. For Durable Medical Equipment, Prosthetics and Orthotics:
 - 1) The contracted amount as established by a preferred provider or other discounting contract;
 - 2) The allowable charge established by application of the Medicare Durable Medical Equipment Fee Schedule, or
 - 3) The billed charge if less than d. (1) or d. (2) above.
 - e. For Air Ambulance:
 - 1) The contracted amount as established by a preferred provider or other discounting contract;
 - 2) 250% of the allowable charge established by application of the Medicare Ambulance Fee Schedule, or
 - 3) The billed charge if less than A or B above.
4. **Ambulatory Surgical Center** - A duly licensed facility that is equipped and operated solely as a setting for outpatient surgery. The facility must have all of the following:
 - a. Staffing, which includes:
 - 1) Direction by a staff of Physicians or surgeons (MD or DO);
 - 2) Presence of a Physician or surgeon during each surgical procedure and recovery period (and presence of a certified anesthesiologist when general or spinal anesthesia is required);

- 3) Provision of full-time skilled nursing services in the operating and recovery rooms (under the direction of RNs) and
 - 4) Extension of staff privileges to Physicians or surgeons who perform surgery in an area Hospital.
- b. Facility and equipment, which includes:
- 1) At least two operating rooms and one recovery room (but not a place for patients to stay overnight);
 - 2) Diagnostic x-ray and lab equipment (or a contract to use such equipment at an area medical facility) and
 - 3) Emergency equipment (including a defibrillator, a tracheotomy set, and a blood volume expander).
- c. Policies and procedures by which the facility:
- 1) Regularly charges patients for services and supplies, and
 - 2) Contracts with an area Hospital and displays written procedures for immediate transfer of emergency cases.
5. **Benefit Year** - The period commencing July 1 and ending June 30 of each year.
6. **Case Management and Case Manager** – Services of a professional Case Manager that involve working with members of a medical plan, their families, their Physicians and other Providers, to identify the most appropriate, effective and cost-efficient treatment possible for catastrophic Illnesses and accidents.

Use of Case Management services is voluntary, free of charge to the Plan Participant, and advantageous in several ways. Case management: (a) permits treatment options not normally available under the Plan through Plan exceptions; (b) provides another opinion on the most effective treatment options for a particular diagnosis; and (c) saves both the Plan and Plan Participant money by providing a third party to help identify the lower cost suppliers of medical goods and services, help coordinate services, and facilitate cost reductions.

The Plan strongly recommends, but does not require, that all Inpatient care be Pre-certified by the Utilization Management Administrator who identifies cases that may benefit from Case Management. Please refer to Section 6 – How to Obtain Benefits.

7. **CHIROPRACTIC SERVICES** – Professional services for spinal treatment performed by a licensed chiropractor. Spinal treatment means detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the body for the purpose of removing nerve interference or its effects where such interferences are the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.
8. **Claimant** - The Plan Participant for whom the claim is filed.
9. **Claims Administrator** – An entity employed by the Plan to administer one or more of its medical plans or the dental plan including consulting services to the Plan in connection with the operation of the medical or dental plan and any other functions, including the processing and payment of claims. The Claims Administrator provides ministerial duties only, exercises no discretion over Plan assets, and will not be considered a fiduciary as defined by any applicable State or Federal law or regulation.
10. **Coinsurance** - The percentage of Covered Medical Expenses, which are not specifically exempted from Coinsurance that the Plan Participant is responsible for paying after the Deductible has been met, and for the Prescription Drug Plan, the percentage of Covered Prescription Drug Expenses, which are not specifically exempted from Coinsurance that the Plan Participant is responsible for paying after the Deductible has been met.

11. **Copayment** - A fixed dollar portion of Covered Medical Expenses or Covered Prescription Drug Expenses that is the Plan Participant's responsibility to pay.
12. **Covered Medical Expense or Charge** - A medical expense or charge that is:
 - a. for a Covered Medical Service;
 - b. is within the Allowable Fee for the service, and
 - c. is within any benefit limitations specified for the service in this Summary Plan Description or the Schedule of Benefits and meets other requirements of this Summary Plan Description.

The Covered Medical Expense or Charge includes any portion of the Covered Medical Charge that may be applied to the Deductible or Copayment. However, any expense which is not payable by another primary plan because of the Plan Participant's failure to comply with cost-containment requirements (e.g., second surgical opinions, preadmission testing, preadmission review of Hospital confinement) will not be considered a Covered Medical Expense of this Plan as a secondary payer. Where a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered a Covered Expense.

13. **Covered Medical Service or Covered Service** - A medical service, procedure or supply:
 - a. listed as a Covered Medical Service in Section 7 and not specified as an exclusion in Section 7 or in the current Schedule of Benefits;
 - b. Medically Necessary for the diagnosis or treatment of Injury, Illness or maternity or, alternatively, a preventive service specified as covered in Section 7;
 - c. Provided to a Plan Participant enrolled in a Plan by a Covered Provider, and
 - d. Provided and coded in accordance with applicable standard medical and insurance practice.
14. **Covered Prescription Drug Expense or Charge** - An expense or charge for drugs and medicines that are Medically Necessary for the treatment of an Injury or Illness and which require a legal prescription authorized by a Physician, and expenses for other pharmaceutical services specifically listed as covered in Section 9 and not excluded in Section 9. Expenses for these same drugs and medicines purchased outside the prescription drug card or mail service programs are covered up to the Prescription Drug Plan's allowance for the drug or medicine.
15. **Creditable Coverage** - Health or medical coverage prior to the date of enrollment in this Plan and after any sixty-three (63) day break in coverage under any of the following:
 - a. A group health plan.
 - b. Health insurance coverage.
 - c. Medicare Part A, Part B or Part C.
 - d. Medicaid.
 - e. TRICARE.
 - f. A medical care program of the Indian Health Service or a tribal organization.
 - g. Federal Employee Health Benefits Program.
 - h. A public health plan, including any plan established by a state, U. S. government, foreign country, or any political subdivision of the foregoing.
 - i. A health benefit plan under the Peace Corps Act.
 - j. State Healthy Montana Kids Insurance Program.
16. **Custodial Care** - Services or treatment that, regardless of where it is provided:
 - a. Could be rendered safely by a person without medical skills, and
 - b. Is designed primarily to help the patient with daily living activities, including (but not limited to):
 - 1) Personal care such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomy; exercising; dressing; enema and using the toilet;
 - 2) Homemaking such as preparing meals or special diets;
 - 3) Moving the patient;
 - 4) Acting as companion or sitter;

- 5) Supervising medication that can usually be self-administered;
- 6) Oral hygiene, or
- 7) Ordinary skin and nail care.

An independent medical review staff contracted by the Plan may, if necessary, determine what services are Custodial Care. When a confinement or visit is found to be mainly for Custodial Care, some services (such as prescription drugs, x-rays, and lab tests) may still be covered. All bills or claims for services should be routinely submitted for consideration.

17. **Deductible** - A specified dollar amount of Covered Medical Expenses the Plan Participant is responsible for paying or a Covered family is responsible for paying in a Benefit Year before the Plan will pay any amount for any Covered Medical Services during each Benefit Year that are not specifically exempt from Deductible. For the Prescription Drug Plan, Deductible is the specified dollar amount of Covered Prescription Drug Expenses (excluding mail order expenses) that the Plan Participant is responsible for paying or a Covered family is responsible for paying in the Benefit Year before the Plan will pay any amount for any non-mail-order Covered Prescription Drug Expenses. See the current Enrollment Workbook Schedule of Benefits for Deductible amounts.
18. **Dependent or Eligible Dependent** - An individual who meets one or more of the definitions of Eligible Dependent in Section 1, provision B., except when the context clearly refers to a Dependent on another group plan as in the Coordination of Benefits Section or to Dependents eligible for benefits under either a Medical or Dependent Care Reimbursement Account with their own eligibility requirements.
19. **Dependent Child or Eligible Dependent Child** - An individual who meets one or more of the definitions of Eligible Dependent Child in Section 1, provision B.2 or who meets the definition of a disabled Dependent Child in Section 1, provision C., except when the context clearly refers to a Dependent on another group plan as in the Coordination of Benefits Section or to Dependents eligible for benefits under either a Medical or Dependent Care Reimbursement Account with their own eligibility requirements.
20. **Durable Medical Equipment or DME** - Durable therapeutic equipment which:
 - a. Is designed for prolonged use over a period of years;
 - b. Serves a specific therapeutic purpose in the treatment of an Injury or Illness;
 - c. Is primarily and customarily used to serve a medical purpose;
 - d. Is suitable for use at home, and
 - e. Is not generally useful to a person in the absence of Illness or Injury.
21. **Employee or Eligible Employee** - An individual who meets the definition of an Eligible Employee in Section, provision A., except when the context clearly refers to an Employee or Eligible Employee on another group plan as in the Coordination of Benefits Section or an Employee of an organization involved in administering the Plan.
22. **Effective Date** - The date on which a new enrollee's coverage begins.
23. **Experimental/Investigational Services** – are a drug, device, medical treatment, or procedure that meets any of the following:
 1. That cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA). Further, approval for marketing the drug or device has not been given at the time the drug or device is furnished.
 2. The patient informed consent document utilized was reviewed and approved by:
 - a. The treating facility's Institutional Review Board; or
 - b. Other body serving a similar function; or if
 - c. Federal law requires such review or approval.

3. That is under study, prior to or in the absence of any clinical trial to determine its:
 - A. Maximum tolerated dose;
 - B. Toxicity;
 - C. Safety;
 - D. Efficacy; or
 - E. Efficacy as compared with generally medically accepted means of treatment or diagnosis.

4. Based upon Reliable Evidence, is the subject of an ongoing Phase I or Phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not experimental or investigational). The routine patient care costs (conventional care) shall be provided by the patient's health plan.
 - i. "Routine" patient care costs are items or services that are covered benefits under the patient's health plan whether or not part of the clinical trial and, in the case of cancer treatment, are listed on the National Comprehensive Cancer Network web site as appropriate for treatment of the condition.
 - ii. The health care provider managing the clinical trial shall provide to the health plan, in advance of incurring any charges, copies of the trial protocol, informed consent and any other documents necessary to ascertain routine patient care costs versus costs incurred for patient care generated specifically by the clinical trial. The sponsor of the clinical trial shall provide its assessment of what it would deem routine care for review for coverage by the health plan.
 - iii. The Plan shall provide coverage for routine patient care costs incurred for drugs and devices provided to the patient during the clinical trial provided that those drugs or devices have been approved for treatment of the patient's condition by the U.S. Food and Drug Administration and to the extent those drugs or devices are not provided or paid for by the sponsor of the clinical trial, or the manufacturer, distributor, or provider of that drug or device.

5. Based upon Reliable Evidence, the prevailing opinion among experts is that further studies or clinical trials are necessary to determine its:
 - a. Maximum tolerated dose;
 - b. Toxicity;
 - c. Safety;
 - d. Efficacy; or
 - e. Efficacy as compared with generally medically accepted means of treatment or diagnosis.

6. Used in a manner outside the scope of use for which it was approved by the U.S. Food and Drug Administration, or other applicable regulatory authority. Such authorities include:
 - A. U.S. Department of Health and Human Services (HHS).
 - B. The Centers for Medicare and Medicaid Services (CMS).
 - C. American Dental Association.
 - D. American Medical Association.

"Reliable Evidence" means reports and articles published in authoritative medical and scientific literature. This includes:

1. The written protocol or protocols used by a treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure.
2. The informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

24. Experimental/Investigational Treatment - Coverage

Treatment that would otherwise be considered experimental/investigational will be covered if the proposed experimental/investigational treatment has been proposed by a Physician, has been reviewed by four (4) unrelated, independent board-certified Physicians actively practicing within the same specialty as the treating Physician, with unanimous agreement among the four (4) reviewing Physicians that:

- A. Because of the rarity of the disease or condition, there is no United States. FDA-approved regimen of treatment.
- B. All United States. FDA-approved regimens of treatment have been attempted within the twelve (12) month period immediately prior to the date the proposed experimental treatment is to begin without any significant clinical improvement in the patient's disease or condition.
- C. The proposed course of treatment is medically indicated, and is considered the standard of care in the United States for the disease or condition being treated, based upon published reports and articles in authoritative medical and scientific literature including but not limited to the following:
 - 1. The written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, treatment, device or procedure, and
 - 2. The informed consent documents used by the treating facility or of another facility studying substantially the same drug, treatment, supply, device or procedure.
- D. To a reasonable degree of medical certainty, there is a likelihood that the proposed treatment will clinically improve the disease or condition being treated.
- E. The patient is not considered to be terminal regardless of the treatment proposed or attempted.
- F. The treatment has been recognized by the National Comprehensive Cancer Network (NCCN) as the only available treatment that has demonstrated efficacy for the disease or condition in question.

25. **FMLA** – the Family and Medical Leave Act.

26. **Formulary** – A list of drugs judged to be appropriate and effective in treating a given Illness in a cost-effective manner. The decision to place or remove a drug from the Formulary is made by Physicians and professional pharmacists under contract with the Pharmacy Benefit Manager. As new drugs become available on the market, they are evaluated and often added to the Formulary as other drugs are replaced. A new drug will sometimes be non-Formulary when first filled and Formulary at the next refill. Formulary drugs may be removed as generic equivalents become available.

27. **Freestanding Inpatient Facility** – A facility that:

- a. Is licensed or approved as such by the Montana Department of Public Health and Human Services or by the appropriate licensing authority in the state where the service is provided.
- b. Has rooms for resident patients.
- c. Is equipped to treat Mental Illness or alcohol and drug abuse.
- d. Has a registered graduate Nurse (RN) always on duty.
- e. Has a resident Physician or psychiatrist on duty or on call at all times.

28. **Hospital** – An institution which meets all of the following conditions:

- a. It is engaged primarily in providing medical care and treatment to individuals suffering Illness or Injury on an emergency or Inpatient basis at the patient's expense.
- b. It is licensed as a Hospital or a critical access Hospital under the laws of the jurisdiction in which the facility is located.
- c. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an Illness or an Injury or provides for the facilities through arrangement or agreement with another Hospital.
- d. It provides treatment by or under the supervision of a Physician with nursing services by Registered Nurses as required under the laws of the jurisdiction in which the facility is licensed.

- e. It is a Provider of services under Medicare. This condition is waived for otherwise Covered Medical Expenses incurred outside of the United States.
 - f. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.
29. **Identification Card (& Identification Number)** – A card issued by the Claims Administrator for each MUS offered medical plan (and the dental plan) to Plan Subscribers who have elected that medical plan. Identification Cards contain such information as a unique Subscriber Identification Number, Dependent coverage, and other information required for claims administration.
30. **Illness** – A bodily disorder, disease, physical sickness, Mental Illness, or functional nervous disorder.
31. **Injury** – Physical damage to the body, which is not caused by disease or bodily infirmity.
32. **Inpatient or Inpatient Admission** – A Medically Necessary stay (or admission for a stay) of twenty-four (24) consecutive hours or more or overnight in any single or multiple departments or parts of a Hospital, Psychiatric Hospital, Free Standing Inpatient Facility, Mental Health Treatment Center, Chemical Dependency Treatment Center, birthing center, Skilled Nursing Care Facility or other facility licensed in the State of Montana to provide skilled twenty-four (24) hour medical care. A stay that meets these requirements is Inpatient even if the facility does not charge for daily room and board.
33. **Maximum Benefit** – The maximum Medical, Dental and Pharmacy Benefit amount payable under the Plan for any covered treatment, service or supply. *See the current Choices Enrollment Workbook Schedule of Benefits for the Maximum Benefit in effect.*
34. **Medicaid** – The program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.
35. **Medical Emergency** – A severe condition which (in the opinion of the Claims Administrator and/or an independent medical review panel):
- a. Results in symptoms which occur suddenly and unexpectedly, and
 - b. Requires the immediate care of a Physician or surgeon to prevent death or serious impairment of the health of the Plan Participant.
36. **Medically Necessary** – means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which must meet all of the following criteria:
- 1. For treatment or diagnosis of an Illness or Injury.
 - 2. Ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury.
 - 3. Not primarily for the convenience of the Plan Participant, Physician or other Licensed Health Care Provider.
 - 4. Uses the standard or level of services most appropriate for good medical practice that can be safely provided to the Plan Participant.
 - 5. Not of an Experimental/Investigational or solely educational nature.
 - 6. In accordance with the Plan’s Medical Policy.
 - 7. Not provided primarily for medical or other research.
 - 8. Does not involve excessive, unnecessary or repeated tests.
 - 9. Commonly and customarily recognized by the medical profession as appropriate and generally accepted as the common medical management used in the United States for the treatment or diagnosis of the diagnosed condition.
 - 10. Are approved procedures based upon the medical treatment circumstances or meets required guidelines or protocols of the U.S. Food and Drug Administration (FDA) or The Centers For Medicare/Medicaid Services (CMS).

The fact that services were recommended or performed by a Physician or other Licensed Health Care Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary will be made only after a claim for benefits is submitted. The Claims Administrator may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary. The Plan recommends that Plan Participants who have any questions concerning proposed, non-emergent medical and dental services follow the procedure for Prior Authorization described in Section 6.

37. **Medicare** – The programs established under the “Health Insurance for the Aged Act”, Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended. “Medicare” is used to pay for various medical expenses for qualified individuals.
38. **Medical Policy** - A policy adopted by the Plan which is created and updated by Physicians and other medical providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:
 - a. Final approval from the appropriate governmental regulatory agencies;
 - b. Scientific studies showing conclusive evidence of improved net health outcome, and
 - c. In accordance with any established standards of good medical practice.
39. **Medicare Benefits** – Benefits for services and supplies which the Plan Participant receives or is eligible for under Medicare, whether or not the Plan Participant has applied for or is enrolled in Medicare.
40. **Mental Health Treatment Center** – A facility that:
 - a. Is organized to treat Mental Illness by multiple techniques;
 - b. Requires a written treatment plan approved and monitored by an interdisciplinary team (including a Physician or surgeon, a psychiatric social worker, and a psychologist); and
 - c. Is either:
 - 1) Licensed as such by the state, or
 - 2) Affiliated with a Hospital under a contract with an established system of patient referral.
41. **Mental Illness or Mental and Nervous Disorder** - A clinically significant behavioral or psychological syndrome or pattern (which is a manifestation of a behavioral, psychological or biological dysfunction in a person) that is associated with:
 - a. Present distress or a painful symptom;
 - b. A disability or impairment in one or more areas of functioning, or
 - c. A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Illness does not include:

 - a. Developmental disorders.
 - b. Speech disorders.
 - c. Psychoactive substance use disorders.
 - d. Chemical dependency or other addictive behavior.
 - e. Eating disorders (except for bulimia and anorexia nervosa).
42. **Mental Illness, Severe** - The following disorders are defined by the American Psychiatric Association:
 - Schizophrenia.
 - Schizoaffective disorder.
 - Bipolar disorder.
 - Major depression.
 - Panic disorder.
 - Obsessive-compulsive disorder.
 - Autism.
43. **MMSERA** - The Montana Military Service Employment Rights Act (MMSERA), as amended.

44. **Naturopathic** - Professional services performed by a licensed naturopath in order to treat disease that employs no surgery or synthetic drugs in order to assist the natural healing process, using special diets, herbs, vitamins, etc.
45. **Network (of Providers), Preferred or In-Network** – A group of Covered Providers who have entered into a contract with a medical plan or other benefit plan, such as a vision plan (or with a Network administrator who has a contract with the medical or other benefit plan) to provide services to Plan Participants according to contract terms.
46. **Nurse or Registered Nurse** – A person who is duly licensed as a Registered graduate Nurse (RN) unless specifically identified as an LPN or a Nurse with some other licensure.
47. **Occupational Therapy** – The use of purposeful activity with an individual who is limited by physical Injury or Illness, psychosocial dysfunction, developmental or learning disability, or the aging process in order to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation. Occupational Therapy services must be ordered by a Physician and may be provided individually, in groups, or through social systems subject to medical review. Specific Occupational Therapy services include, but are not limited to:
- Teaching daily living skills;
 - Developing perceptual motor skills and sensory integrative functioning;
 - Designing, fabricating, or applying splints or selective adaptive equipment, and training in the use of upper-extremity prosthetics or upper-extremity orthotic devices;
 - Using specifically designed crafts and exercises to enhance functional performance, or
 - Administering and interpreting tests such as manual muscle and range of motion.
48. **Out-of-Pocket Maximum** – the out-of-pocket maximum is the Plan Participant’s accumulated obligation on individual Covered Medical Expenses in the Benefit Year. The out-of-pocket maximum includes deductible, co-insurance, and copayments. The family out-of-pocket maximum is the family’s accumulated obligation on Covered Medical Expenses in the Benefit Year. The Plan pays remaining Covered Medical Expenses in the Benefit Year.
49. **Outpatient** – Medical services provided or procedures performed on an Outpatient basis without an overnight stay.
50. **Participating Providers** - Covered Providers who have agreed to accept the Plan’s Allowable Fee as full compensation and not bill Plan Participants for amounts above the Allowable Fee. Plan Participants of the Plan will still be responsible for applicable Deductible, Coinsurance and Copayment, but not for amounts above the Allowable Fee. Providers may agree to be Participating Providers of the Plan but not Network Providers of the same plan because being part of the Network may involve additional contractual obligations.
51. **Pharmacy Benefit Administrator** - the Company retained by the Plan to manage its Prescription Drug Plan.
52. **Physical Therapy** – A plan of care provided by a licensed physical therapist. The aim is to return the Plan Participant to the highest level of motor functioning possible.
53. **Physician** – An individual who is:
- Licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO);
 - Providing services which are Covered Medical Services of the Plan, and
 - Practicing within the scope of his or her license.
54. **Plan** – The MUS Employee Group Health Benefits Plan, including all the provisions contained in this Plan Description, Plan Descriptions of other benefits such as life insurance and associated contracts

with Claims Administrators, Insurance Companies, Utilization Management Administrators, the Pharmacy Benefit Administrator and other companies and organizations retained to provide, administer or assist in the administration of MUS employee benefits, except when the context is clearly used to refer to another or generic group benefit plan (such as when describing Coordination of Benefits) or to a health or other insurance plan. Exceptions are left un-capitalized unless designating a specific plan.

55. **Plan Administrator** – The individual delegated the authority to administer the Plan employed in the Office of the Commissioner of Higher Education.
56. **Plan Description Amendment** – An amendment to this Plan Description. Managed Care Plan Description Amendments replace Sections 6 (for medical benefits only) and 7 for Plan Participants on a Managed Care Plan.
57. **Plan Participant** – An enrolled Employee, Retiree, Subscriber or an individual who has continued coverage under COBRA or other provisions of the Plan and the enrolled Eligible Dependents of these individuals for which Plan coverage has commenced and not terminated.
58. **Pre-certify (Pre-certification)** – A process described in Section 6 for contacting the Utilization Management Administrator for the Plan prior to an Inpatient Admission for any non-emergency Illness or Injury for a preadmission certification review. Precertification and post-admission notifications of an emergency admission are designed to:
 - a. Optimize efficient resource utilization;
 - b. Ensure that patients have equitable access to care;
 - c. Foster collaboration and communication among all members of the healthcare team in an effort to enhance Medically Necessary care in a cost effective manner;
 - d. Assist in identifying possible ways to reduce out-of-pocket expenses;
 - e. Help avoid reductions in benefits which may occur if the services are not Medically Necessary or the setting is not appropriate, and
 - f. If appropriate, refer a Case Manager to provide Case Management services.
59. **Prior Authorize (Prior Authorization)** - A process described in Section 6 to determine from the Claims Administrator whether a planned procedure or service meets criteria for benefits under the Plan. Prior Authorization is recommended for many Covered Medical Services and required to receive benefits for services as described in Section 6 and in the descriptions of the applicable services.
60. **Provider or Licensed Health Care Provider** - An individual who is:
 - a. Duly licensed or certified by any applicable government regulatory authority and practicing in the area in which services are rendered;
 - b. Providing services which are Covered Medical Services of the Plan, and
 - c. Practicing within the scope of his or her license.
61. **Psychiatric Hospital** – A licensed Hospital which, for compensation from or on behalf of its patients, provides therapeutic facilities for medical/psychiatric diagnosis, treatment and care of persons with psychiatric disorders or Mental Illness by or under the supervision of a staff of duly licensed Physicians/psychiatrists that continually provides twenty-four (24)hour-a-day nursing service by or under the supervision of registered graduate Nurses and which is not primarily a nursing home or place of rest for the aged, or for the treatment of pulmonary tuberculosis.
62. **Qualified Beneficiary** – An Employee, former Employee, or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA, Section 609(a) of ERISA in relation to QMCSO's, and Section 4 of this Plan Description. A Qualified Beneficiary also includes a child born to, adopted by, or placed for adoption with, an Employee or former Employee at any time during the Employee's or former Employee's COBRA Continuation Coverage.

63. **Qualified Medical Child Support Order (QMCSO)**- Any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:
- Provides for child medical support for a child of a Subscriber, covered spouse or covered Adult Dependent under this Plan;
 - Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan, and
 - Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.
64. **Reimbursement Account** – A personal account into which an Employee enrolled in the Plan may allocate salary dollars on a before-tax basis for use in reimbursing eligible Benefit Year expenses. A Health Care Reimbursement Account may be used to reimburse eligible health care expenses and a Dependent Care Reimbursement Account may be used to reimburse eligible expenses for Dependent care (e.g., day care) as described in Section 11.
65. **Rescission** – A cancellation or discontinuance of coverage that has a retroactive effect.
66. **Residential Care** – Sub-acute, twenty-four (24) hour care where the principal focus of treatment is psychosocial and does not entail twenty-four (24) hour medical or nursing intervention.
67. **Retiree and Eligible Retiree** – A Retiree is a former Employee who is retiring or has retired from a unit of the MUS including the Office of the Commissioner of Higher Education, or other agency or organization affiliated with the MUS or Board of Regents of Higher Education. An Eligible Retiree is a Retiree who meets the requirements described in Section 3 to continue certain group insurance benefits provided by the MUS for Eligible Retirees.
68. **Skilled Nursing Care** – Confinement in a Skilled Nursing Care Facility:
- Upon the specific recommendation and under the general supervision of a legally qualified Physician or surgeon, and
 - For the purpose of receiving medical care necessary for convalescence from the condition(s) causing or contributing to a precedent Hospital confinement.
69. **Skilled Nursing Care Facility (also called Extended Care Facility/Unit or Transitional Care Unit)** – An institution, or distinct part thereof, which meets all of the following conditions:
- It is currently licensed as a long-term care facility or Skilled Nursing Facility in the state in which the facility is located;
 - It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders; and
 - It is certified by Medicare. This condition is waived for otherwise Covered Medical Expenses incurred outside of the United States.
70. **Special Enrollment** - Enrollment required by the HIPAA during a prescribed period (sixty-three (63) days for this Plan) following a Special Enrollment event listed in Section 2.
71. **Subscriber** – A Plan Participant whose eligibility for Plan coverage is based on his or her direct relationship to the MUS (Employee or Retiree) rather than on Dependent status, or a Plan Participant who was covered as a Dependent, but continues coverage in his or her own name under surviving spouse, surviving Dependent or COBRA provisions of the Plan. The Subscriber is the person in whose name administrative records are kept and who is named as the Identification Card holder.
72. **Utilization Management** – A program designed to assure that Plan Participants receive the most effective and appropriate medical services and to reduce waste. The program involves Pre-certification

(defined above) of planned Inpatient Admissions called in prior to Admission, post-review of emergency or other Inpatient Admissions called in after the fact, continued stay review and Case Management (also defined above). All Utilization Management services are described in Section 6 and, with the exception of Case Management, are provided by the Utilization Management Administrator defined below.

73. **Utilization Management Administrator** – the Company retained by the Plan to administer its Utilization Management program for the Plan.
74. **USERRA** - The Uniformed Services Employment and Reemployment Rights Act, as amended.