Montana University System's Flexible Benefits Program

2005 – 2006

Retiree Health Plan

Schedule of Benefits

Glossary

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A set dollar allowance for procedures/services that are covered by a medical or dental plan.

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A hospital or other licensed medical facility that has contractually agreed to lower fees for traditional plan members. Traditional plan members pay a lower coinsurance for these services, 20%, compared to 35% for services of a non-preferred hospital and 25% for services of a hospital/facility that is neither preferred or non-preferred.

Primary Care Provider
A provider that coordinates medical care for a member of a managed care plan.

Prior authorization
A process that determines whether a proposed service, medication, supply, or on-going treatment is covered.

SCHEDULE OF BENEFITS

MEDICAL PLAN

Traditional Plans-Allegiance • 1-877-778-8600 • Pre-certification 1-800-342-6510
www.abpmtpa.com • *See Plan Description for prior authorization requirements.*

Life time maximum benefit- $2,000,000 all plans.

MEDICAL PLAN COSTS YOU PAY:

Annual Deductible*

(Applies to all services, unless otherwise noted or a copayment is indicated)

Coinsurance Percentages*

General (Including facilities that are neither preferred or nonpreferred)

Preferred Facility Services *(See page for a list of preferred facilities)*

Annual Coinsurance Maximums

(Maximum coinsurance paid in the benefit year; excludes deductibles and copayments)

Copayment* (on outpatient visits)

**You pay deductible, coinsurance, and copayment on allowable fees only* (See Glossary page 45.)

MEDICAL PLAN SERVICE

Hospital Services *(Inpatient facility charges)*

(Pre-certification of hospitalization is strongly recommended.)

Room Charges

Ancillary Services

Surgical Services *(See Plan Description for surgeries requiring prior authorization)*

Hospital and Surgi-Center

Outpatient Services *(See Plan Description for surgeries requiring prior authorization)*

Physician/Professional Provider Services (not listed elsewhere)

Office Visit

Inpatient Physician Services
(See Plan Description for surgeries requiring prior authorization)

Lab/Ancillary/Miscellaneous Charges

Second Surgical Opinion

BENEFIT YEAR 2005-2006

MEDICAL RATES

Monthly Premiums	575 Deductible Under 65	400 Deductible 65+	1500 Deductible Under 65 (1500 deductible)	1500 Deductible 65+
Retiree	401.00	284.00	349.00	244.00
Retiree +1	541.00	444.00	470.00	387.00
Retiree +2	561.00	539.00	505.00	470.00
Retiree + Spouse	444.00	360.00	387.00	310.00
Retiree+Spouse+Children	603.00	431.00	525.00	372.00
Survivor	401.00	284.00	349.00	244.00
Survivor + Children	528.00	420.00	461.00	363.00

TRADITIONAL PLANS
Administered by Allegiance

Premium Plan	Basic Plan	$1500 Deductible
$400/Member $800/Family	$575 / Member $1,150 / Family	$1.500/member $3,000/family
25%	25%	25%
20%	20%	20%
Average of $1,250 / Member (20%-35% of $5,000 in allowable fees) Average of $2,500/Family (20%-35% of $10,000 in allowable fees)	Average of $2,500 / Member (20%-35% of $10,000 in allowable fees) Average of $5,000 / Family (20%-35% of $20,000 in allowable fees)	Average $5,400 / Member (20%-25% of $24,000 in allowable fees) Average of $10,800 / Family (20%-25% of $48,000 in allowable fees)
NA	NA (See exceptions below)	
Coinsurance		
20% – 25% (depending on whether a preferred, non preferred or other facility see above)		
20% – 25%		
20% – 25%		
20% – 25%		
25%		
25%		
25%		
0% (Plan pays 100% of allowable fee, no deductible)		

SCHEDULE OF BENEFITS

MEDICAL PLAN COSTS YOU PAY:

Emergency Services

Ambulance Services for Medical Emergency

Emergency Room
Facility Charges

Professional Charges

Urgent Care Services

Facility/professional Charges

Lab & Diagnostic Charges

Maternity Services

Hospital Charges

Physician Charges (delivery and inpatient)

Prenatal Office Visits

Routine Newborn Care

Inpatient Facility and Professional Charges

Preventive Services

Adult Exams and Tests (age 19+)
Mammogram, gyn exam and pap, proctoscopic, sigmoidoscopic and colonoscopic exams, limited routine lab work, such as PSA tests, and basic blood panel.
For managed care plans only, bone density tests.

Immunizations and Pneumonia and Flu shots

Child Checkups through age 2

Mental Illness Services

Inpatient Services
(Pre-certification is strongly recommended)
Max: One inpatient day may be exchanged for two partial hospitalization days.

Outpatient Services

Chemical Dependency

Inpatient Services
(Pre-certification is strongly recommended.)

Outpatient Services in 24 months

* Dollar benefit max for inpatient services of $4,000/in 24 months, $8,000/lifetime
** Dollar benefit max for combined inpatient/outpatient services of $6,000/year; $12,000/lifetime; $2,000/year after max is met.

BENEFIT YEAR 2005-2006

TRADITIONAL PLANS
25%
$25 / visit (waived if immediately admitted to hospital) deductible and coinsurance apply
25%
25%
25%
20% – 25%
25%
25%
20 – 25% 0% (no deductible) plan pays 100% of routine care for days that both mother and child are confined to the hospital
0% (no deductible) up to max on: gyno exam & PAP **Max:** $75 / yr. mammogram up to allowable prostrate exam **Max:** $50 / yr. 25% (deductible applies) on: routine lab (PSA, blood panel), proctoscopy, sigmoidoscopy, and colonoscopy **Max:** one / 10 years starting at age 50
0% (no deductible) up to max **Max:** $250 / yr. up to age 19 $75 / yr. age 19 + $50 / yr. on pneumonia and flu shots
0% (no deductible) up to max **Max:** $500 first 2 years of life
20% – 25% **Max:** 30 days / yr. (No max for severe conditions)
20% – 25% **Max:** 40 visits / yr. (No max for severe conditions)
25% **Max:** Dollar limit*
25% **Max:** $1,000 / year

SCHEDULE OF BENEFITS

MEDICAL PLAN COSTS YOU PAY:

Rehabilitative Services

Physical, Occupational, Cardiac, Respiratory, Pulmonary and Speech Therapy

Inpatient Services

(Pre-certification is strongly recommended.)

Outpatient Services

Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

Extended Care Services

Home Health Care Skilled nursing services, extended care unit or transitional care units

[Physician ordered / prior authorization is strongly recommended (or required) by most plans. See Plan Descriptions]

Hospice

Skilled Nursing

[Prior authorization or precertification is strongly recommended (or required) by most plans. See Plan Descriptions]

Miscellaneous Services

Allergy Shots

Dietary / Nutritional Counseling

(When medically necessary and physician ordered)

Durable Medical Equipment, Prosthetic Appliances and Orthotics

(Prior authorization required for most managed care plans for amounts > $500)
(Prior authorization strongly recommended for traditional plans for amounts > $1,000)

PKU Supplies

(Includes treatment and medical foods)

Education Programs on Disease Processes (when ordered by a physician)

(Prior authorization required for managed care plans and strongly recommended for traditional plans)

Obesity Management

(Prior authorization required by all plans)

Infertility Treatment (biological infertility only)

(Prior authorization required for all plans with coverage)

Treatment of TMJ (Temporomandibular Joint Syndrome), transplant Services

Organ Transplants

(Prior authorization required for managed care plans and strongly recommended for traditional plans)

BENEFIT YEAR 2005-2006

TRADITIONAL PLANS
20% – 25% **Max:** 30 days / yr. Respiratory, Cardiac, & Pulmonary rehab. not subject to max
25% (20% – 25% if hospital based)
Member pays charges over $25 / visit
Member pays charges over $25 / visit
Member pays charges over $25 / visit **Max:** 15 visits / yr. in any combination for alternative health care
25% **Max:** 90 day / yr.; 180 / lifetime
25% (20% – 25% if hospital-based)
25% (20% – 25% if hospital-based) **Max:** 180 days / confinement
25% (no deductible)
Not covered (except through campus wellness program)
25% **Max:** $100 for foot orthotics (per foot) / 24 month period.
25%
0% (no deductible) up to max (Plan pays 100% of allowable fees) **Max:** $250 / yr.
Not covered (Except bariatric surgery and through campus Wellness Program) **Max:** $25,000 on surgery / lifetime
Not covered
25% non-surgical treatment only Max: $1,000/lifetime
25% See choices Group Benefit Plan for benefit description / limitations

Optional Vision Plan Administrated by VSP 1-800-877-7195 www.vsp.com

The optional vision plan offers over 50 providers throughout the state. There is a $10 co-pay for an eye exam and a 20% discount on frames and lenses when purchased from a participating provider in conjunction with the eye exam. The plan offers a 15% discount on professional fees only, for contact lenses. There is a schedule for out of network exams, see your plan description for details.

The things to consider are:

- Are you or any of your family members going to need corrective lenses in the next year.
- Are you or a family member in need of updating your present prescription for corrective lenses.

If so consider this low cost supplemental coverage.

- The cost is $3.43 per month for you or your entire family.

PREFERED HOSPITALS/FACILITIES – TRADITIONAL PLAN

This is subject to change. See www.abpmtpa.com for updates.

The Montana Association of Health Care Purchasers (MAHCP), a consortium of large employers, the largest being the Montana University System (MUS), State of Montana, and North Western Energy, has used the collective purchasing power of it's members to negotiate favorable rates with Montana hospitals and surgery centers. In addition, Allegiance Benefit Plan Management and its contracting networks have also negotiated favorable rates with hospitals. Using these hospitals and surgery centers guarantees the lowest charges to our health plan and lower coinsurance for you.

This is a feature of the MUS indemnity plans (the Basic and Premium Plans) and not the Managed Care Plans. (Our Managed Care Plans, in some cases, have a discount arrangement with other hospitals.) It establishes a Preferred Provider Organization (PPO) with different coinsurance and out-of-pocket maximums depending on whether you use a preferred hospital, a non-preferred hospital, or other hospital or facility which is neither preferred or non-preferred.

Preferred	20% Coinsurance
Anaconda	Community Hospital of Anaconda
Big Timber	Pioneer Medical Center
Billings	Health South Surgery Center
	Deaconess Billings Clinic
	St. Vincent's Healthcare Center
	Yellowstone Surgery Center
Bozeman	Bozeman Deaconess Hospital
	Rocky Mountain Surgical Center
Butte	St. James Community Hospital
	Summit Surgery Center
Choteau	Teton Medical Center
Columbus	Stillwater Community Hospital
Conrad	Pondera Medical Center
Deer Lodge	Powell County Memorial Hospital
Dillon	Barrett Hospital and Health Care
Glasgow	Frances Mahon Deaconess Hospital
Great Falls	Benefis Health Care
	Great Falls Clinic Surgery Center
Hamilton	Marcus Daly Memorial Hospital
Hardin	Big Horn County Memorial Hospital
Harlowton	Bair Memorial Clinic
	Wheatland Memorial Hospital
Havre	Northern Montana Hospital
Helena	Helena Surgi Center
	St. Peter's Community hospital
	Montana Childrens Hospital & Home
Kalispell	Heathcenter Northwest
	Kalispell Regional Medical Center
	Centeral Montana Surgery Center
Libby	St. John's Lutheran Hospital
Livingston	Livingston Memorial Hospital
Malta	Phillips County Hospital
Miles City	Holy Rosary Healthcare
Missoula	Missoula Bone & Joint Surgery Center
	Missoula Community Medical Center
	Providence Surgery Center
	St. Patrick's Hospital and Health Sciences
	Big Sky Surgery Center
Philipsburg	Granite County Medical Center
Plains	Clark Fork Valley Hospital
Polson	St. Joseph Medical Center
Red Lodge	Beartooth Hospital and Health Center
Ronan	St. Luke Community Hospital
Roundup	Roundup Memorial Health Care
Sheridan	Ruby Valley Hospital
Superior	Mineral Community Hospital
Whitefish	North Valley Hospital

All other (General)	25% Coinsurance

NOTICES

Pre-existing Condition Exclusion. Your University System Choices Group Benefit Plan (Plan) may exclude certain medical conditions (either physical or mental) from coverage, if you or an eligible dependent received medical advice, diagnosis, treatment or care for that condition, including prescription medication, within a six (6) month period immediately preceding your enrollment. The enrollment date means the date you or your dependent becomes eligible for University System Group Benefits coverage.

Such pre-existing conditions may be excluded from coverage or be subject to a pre-existing condition limitation for a period of twelve (12) consecutive months beginning on your enrollment date.

Special Enrollment Periods. If you are waiving coverage for yourself or your eligible dependents as defined by your Choices Group Plan and this Enrollment Booklet (including your spouse) because you or they are currently covered under other health insurance or another health care plan, you may be able to enroll yourself or your dependents for coverage under the Plan in the future, provided that you request such coverage within sixty-three (63) days after such other coverage ends. Also, if you acquire an eligible dependent, as defined by your Plan, as a result of marriage, birth, adoption or placement for adoption of a child under the age of 18, you may enroll yourself and your newly acquired dependent children or spouse for coverage under the Plan, provided that such enrollment occurs within sixty-three (63) days after marriage, birth, adoption or placement for adoption.

Creditable Coverage. You or your eligible dependent, as defined by the Plan, may submit to the Plan Administrator, certification of Creditable Coverage from any prior health insurance or health care plan under which you or your eligible dependent had coverage, for the purpose of reducing, on a day-for-day basis, the pre-existing condition exclusion or limitation imposed by the Plan for any pre-existing condition for which you or your eligible dependent had applicable Creditable Coverage.

You or your eligible dependent have a right to request and receive a Certificate of Creditable Coverage from any insurance carrier or health care plan under which you or your eligible dependent had coverage.

If you are unable to obtain a Certificate of Creditable Coverage from your prior insurance carrier or health plan, the Plan Administrator will provide assistance to obtain the same from your prior carrier or health plan. The Plan also has written procedures to determine Creditable Coverage if you are unable to obtain a Certificate of Creditable Coverage. Please consult the Plan Administrator for more information regarding this procedure.

"Creditable Coverage" means health or medical coverage under which you or your eligible dependent was covered, prior to your enrollment date under the Plan, which prior coverage was under any of the following:

1. A group health plan
2. Health insurance coverage
3. Medicare Part A or Part B
4. Medicaid
5. TRICARE
6. A medical care program of the Indian Health Service or a tribal organization
7. A state health benefits risk pool
8. Federal Employees Health Benefits Program
9. A public health plan
10. A health benefit plan under the Peace Corps Act
11. State Children's Health Insurance Program

A "Certificate of Creditable Coverage" must include the following information in order for us to determine the exact number of days to be reduced from the **pre-existing condition exclusionary or limitation period.**

1. The name or names of the individuals who were previously covered.
2. The date the previous health coverage began.
3. The date the previous health coverage ended.

INSURANCE ID CARDS AND OTHER LIKE DOCUMENTS CANNOT BE ACCEPTED IN LIEU OF CERTIFICATES OF CREDIBLE COVERAGE BUT MAY BE USED AS EVIDENCE OF ANY PRIOR COVERAGE.

All questions about the Pre-existing Condition Exclusion or Limitation and Credible Coverage should be directed to your Campus Human Resources Office.

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RESOURCES

MONTANA UNIVERSITY SYSTEM
OFFICE OF THE COMMISSIONER OF HIGHER EDUCATION
(406) 444-6570 Phone (406) 444-0222 Fax
www.montana.edu/choices/

General benefits information and contacts.

ALLEGIANCE
Customer service, prior authorization and claims processing 1-877-778-8600
Precertification 1-800-342-6510
www.abpmtpa.com

Traditional Plans Contacts

MEDICAL CASE MANAGEMENT

406-444-3853

Medical Case Management For Traditional Plan

PHARMACARE (FORMALY ECKERD) MAIL ORDER PRESCRIPTION DRUG PROGRAM
Customer Service 1-888-645-9303
www.ehs.com

RIDGEWAY MAIL ORDER PRESCRIPTION DRUG PROGRAM
Customer Service 1-800-630-3214

Prescription drug refills, customer service, prior authorizations, and quantity overrides

VISION SERVICE PLAN (VSP)
Customer Service 1-800-228-1018
www.vsp.com

UNUM LIFE INSURANCE
1-800-822-9103
www.unum.com

Long Term Care claims and information.