Montana University System's Flexible Benefits Program

Effective July 1, 2008

Group Benefit Plan

MONTANA UNIVERSITY SYSTEM

GROUP BENEFITS PLAN

EFFECTIVE JULY 1, 2008

THE MONTANA UNIVERSITY SYSTEM

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To: Plan Participants

The Montana University System offers a comprehensive Employee Group Benefits Plan called "Choices" or "Plan." The Plan offers a choice of two Traditional (major medical indemnity) Plans with differing Deductibles and up to four Managed Care Medical Plans where available, a Prescription Drug Plan, a Basic (preventive) Dental Plan option, a Premium 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 Plan, Supplemental Life insurance, Dependent Life Insurance, additional AD&D Insurance, Long-Term Care Insurance, and Health Care and Dependent Care Reimbursement Accounts.

There is a separate Plan Description Amendment for each Managed Care Plan. For Plan Participants on a Managed Care Plan, the Plan Description Amendment for that plan replaces Section 6 (for medical benefits, not dental benefits) and Section 7. There are also separate Life Insurance, Accidental Death and Dismemberment, and Long-Term Disability Plan Descriptions.

All medical plans, the Prescription Drug 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. The Vision Plan is an insured plan. 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 insurance 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 (or Description Amendment for Managed Care Plans) to see what services are covered, what services have benefit limits (defined in the current 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 Precertify 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 your benefits on-line at www.montana.edu/choices/ or call your medical Claims Administrator at the toll free number listed on the back cover.

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. If you are in a Managed Care Plan, using Network Providers protects you from un-allowed fees and provides the best benefit (smallest Copayment or Coinsurance).

   If you want 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 Campus Wellness Programs. Your Campus Wellness Program **may** offer health screenings, exercise programs, and assistance in making lifestyle changes. 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 professional staff members** regularly scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of more than six months in a 12-month period.

2. **Temporary faculty or professional staff members** regularly scheduled to work at least 20 hours per week or 40 hours over two weeks for a continuous period of six months or more, or who actually do so regardless of schedule.

3. **Seasonal faculty or professional staff members** regularly scheduled to work at least 20 hours per week or 40 hours over two weeks for six months or more per year, or who actually do so regardless of schedule.

4. **Academic or professional Employees with an individual contract under the authority of the Board of Regents** which provides for eligibility under one of the above requirements.

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

B. ELIGIBLE DEPENDENTS

An Eligible Employee, defined above, who enrolls 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. **Spouse or Adult Dependent** – The Subscriber's legal spouse as defined by Montana law or, one Adult Dependent of the Subscriber who meets the following criteria:
   a. Is at least 18 years of age;

b. Has proof of joint ownership or joint tenancy with the Subscriber 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. Is ineligible for any other comparable group insurance coverage;
e. Does not have a parental relationship with the Subscriber, and is not otherwise related to the Subscriber by blood or marriage;
f. Has a financially-interdependent relationship with the Subscriber as evidenced by at least **two** (2) of the following conditions:
    1) Joint ownership or lease of a residence;
    2) At least two 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
        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.

A Subscriber claiming an Adult Dependent must submit a Declaration of Adult Dependent form to the Campus Benefit Representative/Human Resource Office for approval. The Commissioner of Higher Education may waive criteria "b" above: (1) if all of the other criteria have been met, and (2) upon a showing of other clear and convincing evidence of an interdependent relationship between the Subscriber and the Adult Dependent.

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 child under the age of 25 who is unmarried and who meets all of the following criteria:

a. 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 this 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.

b. Is not an employee eligible for coverage under a group health plan offered by the Dependent child's employer for which the child's premium contribution amount is greater than the premium amount for coverage as a Dependent under this Plan.

c. Is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance.

d. Is not entitled to benefits under Medicare or Medicaid.

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

C. DISABLED DEPENDENT CHILD

An unmarried Dependent Child who is mentally or physically handicapped may continue coverage after age 25, 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 31 days of the child's 25th 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. IMPORTANT NOTICE – RESPONSIBLITY FOR REMOVING INELIGIBLE DEPENDENTS

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 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.**

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 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 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.

If the Employee waives coverage or fails to enroll Eligible Dependents without other medical coverage, any Pre-existing Medical Condition that develops prior to later enrollment in this Plan may be subject to the coverage limitations described in provisions F. and G. of this Section.

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

PREMIUM PAYMENT: The Montana University System 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 and optional AD&D insurance 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.

The following are exceptions to pre-tax premium payment. That portion of an Employee's salary deducted for coverage of an Adult Dependent or child age 19-24 who is not a dependent for IRS purposes must be post tax. Also, that portion of the employer contribution, which pays for benefits of

Dependents who are not recognized by the IRS, is imputed income to the Employee.

EFFECTIVE DATE: For an Employee and any Eligible Dependents enrolled within the 31-day initial enrollment period, medical, prescription drug, dental, and optional vision 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 provisions F. and G. for information on the period of limited coverage for a Pre-existing Condition. *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 open enrollment period or until he or she has a Special Enrollment event described below. **If the Employee waives coverage, he or she forfeits employer contribution toward benefits until any later enrollment**.

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

1. Employee only Medical Plan B
2. Employee only Basic Dental
3. Basic Life/AD&D $10,000
4. Long Term Disability Option 1

B. OPEN ENROLLMENT

Each spring, the Montana University System and various campuses will designate an open enrollment period. During this period, an Eligible Employee may enroll him or herself and any Eligible Dependents in the Plan. A COBRA or Retiree Subscriber may also enroll Eligible Dependents. During open enrollment, any Subscribers 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 Enrollment Booklet 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 the 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 63-day Special Enrollment period as provided by the Health Insurance Portability and

Accountability Act when one of the Special Enrollment events listed below occurs. The 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 Human Resource/Benefits Office during this 63-day period, and required enrollment forms must be submitted within two weeks of the request.

1. **Marriage -** An Employee who marries and is eligible but not enrolled in the Plan may enroll self, the new spouse, and any other Eligible Dependents. A Subscriber who marries may enroll the new spouse and any other Eligible Dependents and change benefit elections, subject to any Plan restrictions. **Coverage will be effective on the date of marriage**. *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 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 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 date a qualifying Declaration of Adult Dependency form is submitted to the appropriate campus Human Resources/Benefits Office.** *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 and change benefit elections, subject to any Plan restrictions. Coverage of a child born to a Subscriber, covered spouse, or covered Adult Dependent automatically begins at birth and continues for a 31-day period. An eligible newborn must be enrolled and any required Employee contribution toward premium paid for coverage to continue beyond 31 days. **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 18. **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 or CHIP 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.);
      - loss of eligibility for another group (or individual) health plan due to no longer residing, living or working in the plan's service area; or
      - loss of all coverage under the other plan due to exceeding the plan's lifetime maximum benefits.

   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.
Coverage will be effective on the date coverage under the other health plan is lost.

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 order** provided the child is enrolled within 63 days of the date of the order, a copy of the order is presented to the campus Human Resources/Benefits Office and any required premium is paid. **Otherwise the Effective Date is the date any required enrollment forms are submitted to the campus Human Resources/Benefits Office.**

Qualified Medical Child Support Order – A Qualified Medical Child Support Order requiring a Subscriber or a Subscriber's spouse or declared Adult Dependent to provide medical insurance for the child allows the Subscriber to enroll the child within 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 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 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.**

Other events that make a Dependent eligible under the Plan – Any other event that makes a Dependent of a Subscriber eligible under the terms of the Plan allows the Subscriber to enroll the Dependent within 63 days of the event. **Coverage may be made effective on the date of the event** if documentation of the event is presented to the applicable campus Human Resources/Benefits Office and any required premium is paid.

Otherwise the Effective Date is the date any required enrollment forms are submitted to the campus Human Resources/Benefits Office.

A substantial adverse change in other medical insurance benefits – A major decrease in benefits, a major increase in costs or a combination thereof in other medical coverage of an Eligible Dependent may allow the Subscriber to enroll the Eligible Dependent in this Plan within 63 days of the change. Subscribers should contact their Human Resources/Benefits Office for a determination. **Coverage may be made effective on the date of the change in the other coverage or the first date after the change on which the Dependent may end the other coverage without loss of already paid premium.**

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

Employee Subscribers in the Montana University System 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 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.

Subscribers have 63 days from the date of the status change to contact their campus Human Resources/Benefits Office and complete required forms to make an election change except that forms for a Special Enrollment, described in provision C., may be submitted within two weeks after a request made within the 63 days. **The Subscriber is responsible for removing an ineligible Dependent within 30 days as described in Section 1.**

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. Election changes for Special Enrollment and mid-year enrollment described in provisions C. and D. are effective on the dates indicated. Other allowed election changes may be made effective as of the first pay period after the election form is received. Premium paid pre-tax may not be retroactively adjusted to provide a refund back more than 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 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-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 spouse or death of an Adult Dependent.** Elections may be changed to Special Enroll Dependent Children who lose eligibility under a former 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 30 days. A deceased Dependent should be removed from coverage within 30 days to avoid paying un-reimbursable premium. 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 30 days to remove an ineligible Dependent Child. A deceased Dependent Child should be removed from coverage within 30 days to avoid paying un-reimbursable premium. 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.

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 A. of this Section.

F. PRE-EXISTING CONDITIONS

Plan benefits will not be available for any Pre-existing Medical Condition of a Plan Participant until the Participant has been covered by the Plan for a one-year period (365 days), as reduced by any Creditable Coverage described in G. below.

A Pre-existing Condition means any condition (whether physical or mental), disease, Injury, or Illness for which a Plan Participant has received medical advice, diagnosis, care, or treatment in the six (6) month period immediately preceding enrollment, with the following exceptions:

EXCEPTIONS TO PRE-EXISTING CONDITIONS: The Pre-existing Condition exclusion does not apply to: 1) pregnancy; 2) a newborn child or child adopted or placed for adoption before attaining 18 years of age, if such child is enrolled in the Plan within 63 day of the birth, adoption or placement for adoption or had Creditable Coverage with another plan at any time during the first 30 days after birth, adoption or placement for adoption and enrolled in the Plan within 63 days of that Creditable Coverage; or 3) a condition based solely on genetic information. However, the Pre-existing condition exclusion does apply if an individual is diagnosed with a condition, as described above, even if the condition relates to genetic information.

G. CREDITABLE COVERAGE PROCEDURES

This provision advises Plan Participants of their Creditable Coverage rights under the federal Health Insurance Portability and Accountability Act.

CREDITABLE COVERAGE: 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 reducing, on a day for day basis, any exclusion or limitation imposed by this Plan for any Pre-existing Condition for which the Eligible Employee or Dependent had applicable Creditable Coverage under any prior insurance or health care coverage.

An Eligible Employee or Dependent has a right to request and receive a Certification of Creditable Coverage from any insurance carrier or health care plan under which he/she had coverage on or after July 1, 1996.

If the Eligible Employee or Dependent is unable to obtain a Certification of Creditable Coverage from a prior insurance carrier or health care plan, the Claims Administrator on behalf of the Plan Administrator may provide assistance in obtaining it.

CREDITABLE COVERAGE REVIEW: Upon the Plan's receipt of a Certification of Creditable Coverage regarding prior coverage by any enrollee for coverage under this Plan, the Plan acting on its own or through a firm contracted to provide services to the Plan, will send to such enrollee a written confirmation of the amount of prior Creditable Coverage, if any, to which the enrollee will be entitled against any Pre-existing Condition exclusionary or limitation period under this Plan. Such written confirmation will be provided to the enrollee within thirty (30) days of receipt of the Certification by the Plan.

If an enrollee disagrees with the Plan's calculation of any prior Creditable Coverage, the enrollee will send written notice of the disagreement to the Plan, together with a written request for review of the calculation, within

fifteen (15) days of receipt of the Plan's written confirmation. Failure to submit a written notice of disagreement and request for review of the calculation within the time limit required in this provision will be deemed a waiver of any further review.

Upon receipt by the Plan of a notice of disagreement and request for review, the Plan will review the calculations, and will either affirm those calculations or revise its calculation and determination of prior Creditable Coverage. The Plan Administrator will notify the enrollee, in writing, of its decision after review within thirty (30) days after receipt of the notice of disagreement and request for review. The Plan Administrator's decision regarding prior Creditable Coverage will be final and binding upon the Plan and any Plan Participant.

DETERMINATION OF PRIOR CREDITABLE COVERAGE WHEN A CERTIFICATE IS UNAVAILABLE: If an enrollee is unable to obtain a Certification of Creditable Coverage for prior coverage, after having exhausted all reasonable efforts to obtain one, the enrollee may request in writing that the Plan make a determination whether he or she is entitled to prior Creditable Coverage based upon other evidence and information. Such request must be submitted to and received by the Claims Administrator on behalf of the Plan Administrator within sixty (60) days of the Effective Date of coverage of that enrollee.

Upon receipt of such a request, the Plan will require that the enrollee provide to the Claims Administrator on behalf of the Plan Administrator, all other evidence in support of the enrollee's request within sixty (60) days of the initial request. A longer period of time, up to an additional sixty (60) days, may be granted to submit evidence upon written request and good cause. Evidence submitted must include a sworn affidavit by the enrollee, or by that enrollee's parent or guardian if the enrollee is a minor, or is incompetent or unable to execute such an affidavit. The affidavit will contain the following information:

1. The name of the prior insurance carrier(s), benefit plan(s) or other payer(s) of medical benefits under which prior Creditable Coverage is asserted to exist.

2. The date(s) that coverage commenced and ended under any such prior insurance, benefit plan or other payer.

3. The address, if known, of the insurance carrier(s), benefit plan(s), or other payer(s).

4. The nature of the coverage under the prior insurance, benefit plan(s), or other benefit payer(s).

5. A description of the efforts undertaken to obtain Certifications of prior Creditable Coverage, and the results of those efforts.

6. The names, and addresses or telephone numbers, of former employers, insurance agents, human resource personnel, third party administrators, HMOs or medical Providers that may have knowledge of the asserted prior coverage.

7. Any other information that the enrollee deems relevant.

The affidavit, together with any other documentation submitted, including, but not limited to summary plan descriptions or policies indicating prior coverage, pay stubs indicating deduction of premium amounts, explanation of benefits from prior coverage, written statements from persons with knowledge of prior coverage, and medical bills indicating payment by insurance or benefit plans, will be reviewed and considered by the Plan. The Plan will provide a written determination of prior Creditable Coverage, if any, within thirty (30) days after the submission of the last item of evidence on behalf of the enrollee, or ninety (90) days from the enrollee's initial request for determination under this section, whichever occurs first. The Plan's determination will be final and binding upon the Plan and all Plan Participants covered under the Plan.

"Creditable Coverage" means health or medical coverage, prior to the date of enrollment in this Plan and after any 63-day break in coverage 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, including a plan established by a State, United States Government, foreign country, or any political subdivision thereof
10. A health benefit plan under the Peace Corps Act
11. State Children's Health Insurance Program

CERTIFICATION OF CREDITABLE COVERAGE PROVIDED BY PLAN: The Plan will provide Certification of Creditable Coverage for coverage under this Plan as required by the United States Public Health Service to any Plan Participant or the Plan Participant's designated and authorized

agent, guardian, conservator, health care plan or health insurance as follows:

1. At the time the Plan Participant ceases to be covered under this Plan; and,

2. At the time the Plan Participant ceases coverage under this Plan due to exhaustion of the lifetime maximum for benefits for all causes; and

3. At the time a Plan Participant ceases to be covered by the COBRA Continuation Coverage provided by this Plan, if any; and,

4. At any other time that a request is made on behalf of the Plan Participant for such certification, but not later than twenty four (24) months after cessation of coverage as set out in subparagraphs 1, 2 or 3 above, whichever is later.

Section 3
LEAVE, LAYOFF, COVERAGE TERMINATION, RE-ENROLLMENT, SURVIVING SPOUSE AND RETIREMENT OPTIONS

A. SICK, FMLA AND WORKER'S COMPENSATION LEAVE

An Employee enrolled in the Plan who (a) is on approved sick leave under a Board of Regents personnel policy or labor contract, (b) is on approved leave covered by the Family Medical Leave Act or (c) is on approved leave and is receiving Worker's Compensation benefits for an Injury sustained during Montana University System 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:

1. Union contract, or

2. The Family Medical Leave Act (FMLA), which provides up to 12 weeks of employer contribution.

The Employee may change enrollment elections (as provided in Section 2, E.) to drop some or all optional and/or Dependent coverage within 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 Worker's 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. EXTENDED LEAVE OF ABSENCE

An Employee enrolled in the Plan who is granted an extended leave under a 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 Booklet*s.

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, E) to drop optional and/or Dependent coverage within 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.

C. STATE AND FEDERAL COVERED MILITARY LEAVE

USERRA: When an Employee enrolled in the Plan is absent from employment with the Montana University System 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 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 Montana University System 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 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 Montana University System, 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 USERA 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.

D. TEMPORARY LAYOFF

A classified staff member enrolled in the Plan who is placed on temporary layoff under the provisions of a Board of Regents personnel policy or labor contract may remain covered under the Plan for **six** 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, E) to drop optional and/or Dependent coverage within 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.

E. 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 30 days of full time service) with the Armed Forces of any country. See State and Federal Covered Military Leave rights described in Section C. of this Section.

4. The day the Plan is terminated by the 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 12:01a.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 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, C.

F. 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 months, may reenroll 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.

If there is a lapse in medical coverage of more than 63 days, a new Pre-existing Condition limitation period will apply as described in Section 2 - F. and G. with two exceptions. There is no new Pre-existing Condition limitation period (except to the extent it would exist if coverage had not terminated) for Employees and Dependents re-enrolled immediately following leave covered by the Family Medical Leave Act.

No new Pre-existing Condition exclusion (except to the extent it would exist if coverage had not terminated) will be imposed in connection with timely re-enrollment in the Plan by an Employee or Dependent whose coverage was terminated due to service in the armed forces, provided the Employee or Dependent gives timely notice of return to work (as defined by USERRA or MMSERA) and actually returns to work at the end of the military service and the subsequent return-to-work period allowed by USERRA or MMSERA.

FOLLOWING TERMINATION OF EMPLOYMENT:
Eligible Employees rehired within 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 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.*

If there is a lapse in medical coverage of more than 63 days, a new Pre-existing Condition limitation period will apply as described in Section 2, F. and G.

G. SURVIVING DEPENDENT CONTINUATION OF COVERAGE

A covered surviving 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 spouse or Adult Dependent occurs within 63 days of the death. A child born to the surviving 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 63 days of birth.

A surviving spouse/Adult Dependent's medical plan options are the same as the Retiree options listed below. A surviving spouse/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, 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 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 spouse's COBRA rights are waived if the surviving 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 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.

H. RETIREE COVERAGE

ELIGIBILITY: A person retiring from a unit of the Montana University System or any agency or organization affiliated with the Montana University System or the 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 a State Retirement Benefit from the Teachers Retirement System (TRS) or the Public Employee Retirement System (PERS) at the time he or she leaves employment with the Montana University System. Retirees who are in the Optional Retirement Plan (ORP) (through TIAA-CREF) or any other defined contribution plan must have worked five or more years and be age 50 or have worked 25 years with the Montana University System to be eligible for Retiree insurance benefits.

CONTINUATION OF COVERAGE: An eligible Retiree must make arrangements with his or her campus Human Resources (HR)/Benefits Office to continue coverage as a Retiree on a self-pay basis within 63 days of retirement. ***There is no Employer contribution toward Retiree benefits.*** The right to continue coverage under the Plan is a one-time opportunity. **RETIREES WHO FAIL TO CONTINUE COVERAGE WITHIN 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 spouse are Medicare enrolled. Retiree coverage may be canceled by the Montana University System 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 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 HR/Benefits Office to facilitate premium and enrollment adjustments. Any person not correctly enrolled with Medicare will be given 63 days to obtain the missing coverage. After 63 days, the nonenrolled 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 the Traditional Plans as outlined in the Choices Retiree Workbook. All plans include the Prescription Drug Plan. Retirees have the option to add the Premium 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 Premium Dental coverage or wait until the COBRA dental coverage expires and add Premium 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 Schedule of Benefits.

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. However, the Retiree can continue dental coverage for self and covered Dependent under COBRA while electing Retiree medical coverage.

Section 4
CONTINUATION OF COVERAGE – COBRA AND CONVERSION RIGHTS

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. A covered Employee's or covered Retiree's Adult Dependent is not eligible for COBRA continuation coverage.**

The Plan Administrator is the Office of the Commissioner of Higher Education, 100 N. Park Avenue, Suite 320, Helena, MT 59620; 406-444-2574. COBRA continuation coverage for the Traditional Medical Plan and the Dental Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, 406-721-2222. COBRA continuation coverage for Managed Care 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 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 or Benefits Office or on the website, www.abpmtpa.com/mus, and return the completed Choices Enrollment Form to the Campus Human Resources or Benefits Office within **sixty** (60) days of the date of the qualifying event.

The HR/Campus Benefits Office must notify the COBRA Administrator on behalf of the Plan of any of the following events they receive notice of:

1. Death of the Retiree.
2. The divorce or legal separation of the Employee or Retiree from his/her 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 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 coverage. New benefit elections may be made during the open 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 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 (19^{th}) through the twenty-ninth (29^{th}) 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 employer 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 employer.

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 11 months of COBRA continuation coverage, for a total maximum of 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, unless the other group health plan contains a provision excluding or limiting coverage for a Pre-existing Condition of the qualified beneficiary that is covered under this Plan. However, if the exclusionary period does not apply due to prior Creditable Coverage, COBRA continuation coverage ends. Coverage will not be terminated as stated until the pre-existing exclusionary period of the other coverage is no longer applicable for any qualified beneficiary.

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 employer 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 or Benefits Office.

B. CONVERSION RIGHTS

A Plan Participant (Employee, Retiree, or Dependent) may be entitled to have issued to him/her, without evidence of good health, an individual policy of medical insurance covering himself/herself. Also, at his/her option, a Plan Participant may have coverage for those of his/her Dependents covered under the Plan on the date of termination of his/her coverage who does not continue to be eligible for coverage under the Plan.

A Plan Participant is eligible if:

1. The Plan Participant is on this Plan for three (3) consecutive months;
2. The Plan Participant loses all eligibility under this Plan, including eligibility under Retiree, surviving spouse/surviving Dependent, and COBRA continuation of coverage provisions; and
3. The Plan Participant is not eligible for any other medical benefits as described below.

A Plan Participant is not eligible if:

1. The Plan is terminated;
2. The Plan Participant is age 65 or older; or
3. The Plan Participant fails to pay the required premium.
4. The Plan Participant is eligible for Medicare or other medical expense benefits offered by any group plan, individual policy, prepayment plan, government program, or any other plan.

Application for such coverage must be made and the first premium paid to the designated insurance carrier within 31 days after such termination.

Rules governing this policy are established by the insurance company contracted by the Plan to provide such services. All details concerning this policy will be furnished upon request to your Campus Human Resources or Benefits Office.

Section 5
HIPAA PRIVACY AND SECURITY STANDARDS

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.

A. DEFINITIONS

Protected Health Information (PHI) means information, including demographic information that identifies an individual and is created or received by a health care Provider, health plan, employer, or health care clearinghouse; and relates to the physical or mental health of an individual; health care that individual has received; or the payment for health care provided to that individual. PHI does not include employment records held by MUS in its role as an employer.

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 (ex: 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. PRIVACY CERTIFICATION

The Montana University System (MUS) hereby certifies that the Plan Descriptions have been amended to comply with the privacy regulations by incorporation of the following provisions. MUS agrees to:

1. Not use or further disclose and to contractually prohibit third party Claims Administrators or health plans which provide contractual services from using or further disclosing the information other than as permitted or required by the Plan Description 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 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 and auditing, and customer service activities. Plan administration can include management of carve-

out plans, such as dental or vision coverage.

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, or justification of charges; or utilization review activities.

c. Plan administration does not include disclosure of information to 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 agents, including a subcontractor to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to MUS with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. Make available PHI as required to allow the Plan Participant a right of access to his or her PHI as required and permitted by the regulations;

6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;

7. Make available the information required to provide an accounting of disclosures as required by the regulations;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;

9. If feasible, return or destroy all PHI received from the Plan that MUS still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or

destruction of the information infeasible; and

10. Ensure that the adequate separation required between the Plan and MUS is established. To fulfill this requirement, MUS will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Description or Employees designated by the Plan Administrator(s) 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(s) 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

MUS hereby certifies that its Plan Descriptions have been amended to comply with the security regulations by incorporation of the following provisions. MUS agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR ''164.308, 310 and 312.

2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.

3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR ''164.308, 310, 312, 314 and 316.

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 PHI of which MUS becomes aware.

Section 6
HOW TO OBTAIN BENEFITS

This Section describes how to obtain medical benefits for Plan Participants enrolled in a Traditional (medical indemnity) Plan. Separate Plan Description Amendments describe how to obtain medical benefits for Plan Participants on a Managed Care Plan. This Section also describes the claims appeal process for all Plan Participants on the Dental Plan. When applied to medical benefits, the term "Plan Participant" means Traditional Plan Participant in this Section.

Payment of benefits will be made on the basis of submission of required information to the Traditional Plan Claims Administrator, Allegiance Benefit Plan Management 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 on the Traditional Plan, will receive a single card for medical benefits from Allegiance and a separate card for dental benefits from Delta Dental. Plan Participants on a Managed Care Plan will receive a medical Identification Card from the Managed Care Plan Administrator and a separate dental Identification Card from Delta Dental. 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 Claims Administrator or the campus Human Resources/ Benefits office to verify coverage. Replacement cards may be ordered by calling the Claims Administrator at 1-877-778-8600 or through the web site, below.

2. **CHOOSE A PARTICIPATING PROVIDER AND PREFERRED FACILITY FOR MEDICAL CARE WHEN POSSIBLE**. Providers who are Participating Providers with the Claim 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 Schedule of Benefits.

To locate a Participating Provider, go to the Allegiance web site, at www.abpmtpa.com/mus. To identify a Preferred Facility, see the current Schedule of Benefits or visit the MUS web site at www.montana.edu/choices/.

3. 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
c. Outpatient Rehabilitative Care (Benefits in excess of $2,000 per Benefit Year)

IF PRIOR AUTHORIZATION IS NOT OBTAINED FOR THE SERVICES LISTED ABOVE, CHARGES IN CONNECTION WITH, OR RELATED TO, THESE SEVICES 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 Traditional 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 $1,000
e. Home Health Care services
f. Organ or Tissue Transplant

Prior Authorization may be obtained from the 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.

Mail these documents to:

Attention: Claims Administration
Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, Montana 59806-3018

Be sure to include your name, address, and the Subscriber's Identification Number.

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, commercial/private automobile transportation and extended benefits for outpatient rehabilitative care are not covered without Prior Authorization.

4. PRECERTIFY NON-EMERGENCY ADMISSIONS AND NOTIFY THE CLAIM 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 Precertification review of a planned Inpatient stay.

Precertification 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.

To Precertify or provide notice of an emergency admission, call the Utilization Management Administrator at 1-800-342-6510 for pre-admission certification review.

Most certifications occur over the phone. Once a final decision is made, a notice of the number of Precertified days, if any, will be sent to the Physician, to the Plan Participant, to the Claims Administrator and to the facility. Precertification is not required and therefore, cannot be appealed. However, a pre-service claim can be filed for Prior Authorization as described in C. (Claim Decisions on Claims and Eligibility) 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. Therefore, although not required, Precertification and Plan notification of emergency admissions are strongly recommended to obtain coverage information prior to incurring the charges or additional charges.

NOTE: Precertification 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 Traditional Plan Participants are informed at the time claims are Precertified that Precertification 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 Administrator 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. This certification for additional days, like the initial certification, is not required and cannot be appealed.

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

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

Case Management services are provided by the Plan to Traditional Plan Participants with major or long term Illness or Injuries who can benefit from the services. Appropriate candidates are primarily identified through the Precertification process or through review of large claims and 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;
d. Educate patients about their condition, treatment options, and benefit plan;
c. Assist the Physician with monitoring compliance and patient progression along the recovery continuum;
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 Star Point Case Manager, at 1-877-792-7827. 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 encouraged within the first trimester.

6. 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; or
b. significant medical risks; or
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 Summary Plan Document 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 Claims Administrator within twelve (12) months after the date services or treatment are received or completed. 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 Claims Administrator, to support the Medical Necessity of the treatment or

service being provided and sufficient to enable the Claims Administrator to adjudicate the claim pursuant to applicable terms and conditions of the Plan.

When completed, the claim must be sent to the Claims Administrator, Allegiance Benefit Plan Management, Inc., at P.O. Box 4786, Missoula, Montana 59806-3018, (406) 721-2222 or 1-877-778-8600 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

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 CLAIM 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. CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

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.

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 PLAN DESCRIPTION.

PRE-SERVICE CLAIMS - Pre-Service Claims must be submitted to the Plan before the Plan Participant receives medical treatment or service. A Pre-Service Claim under this Plan is a Prior Authorization determination before a Plan Participant obtains medical care or treatment.

Initial claims decisions on Pre-Service Claims will be made within fifteen (15) days of the Plan's receipt of the claim.

POST-SERVICE CLAIMS - A Post-Service Claim is any claim for a medical benefit under the Plan for which the Plan does not require Prior Authorization prior to obtaining medical care or treatment, and for which the Plan Participant obtained medical treatment before submitting the claim(s).

Initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan'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 Plan's control, if the Plan gives written notice to the Plan Participant of the circumstances for the extension and the date by which the Plan expects to make a decision. If an extension is necessary because the Claimant did not submit the information necessary for the Plan 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 to provide the specified information to the Plan. Once the Plan receives information sufficient to make that initial claims determination, the Plan will provide timely notice of the determination to the Plan Participant.

CONCURRENT CARE (OR CONTINUED STAY) REVIEW - For patients who face early termination or reduction of benefits for a course of treatment previously certified by the Plan, a decision by the Plan to reduce or terminate benefits for ongoing care is considered an adverse benefit determination, subject to appeal rights. (Note: Exhaustion of the Plan's benefit maximums is not an adverse benefit determination.) The Plan will notify the Plan Participant sufficiently in advance to allow an appeal before the benefit is reduced or terminated. The appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially Precertified period.

D. APPEALING AN UN-REIMBURSED CLAIM

If a claim is denied in whole or in part, the Plan Participant will receive

written notice of the adverse benefit determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

1. The reason the claim was denied;

2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the claims decision was based which resulted in the denial or partial denial;

3. Any additional information needed to perfect the claim and why such information is needed; and

4. An explanation of the Plan Participant's right to appeal the adverse benefit determination for a full and fair review.

If a Plan Participant does not understand the reason for any adverse benefit determination, he or she should contact the Claims Administrator at the address or telephone number shown on the EOB form.

To initiate the first level of review on a Pre-Service Claim adverse benefit determination, the Plan Participant must submit a written appeal or a request for review to the Plan within thirty (30) days after the adverse determination. The Plan Participant should include any additional information supporting the appeal and forward this information to the Claims Administrator by the end of the 30-day period. Failure to appeal the adverse benefit determination within the 30-day period will render the determination final and any appeal received after the end of this 30-day period will not be considered.

To initiate the first level of benefit review on a Post-Service Claim adverse benefit determination, the Plan Participant must submit a written appeal or a request for review to the Plan within ninety (90) days after the adverse determination. The Plan Participant should include any additional information supporting the appeal or any the information required by the Plan which was not initially provided and forward all additional information to the Claims Administrator by the end of the 90-day time period. Failure to appeal the adverse benefit determination within the 90-day period will render the determination final. Any appeal received after the end of the 90-day period will not be considered.

Appeals or requests for review of adverse benefit determinations must be submitted to the Plan in writing, and supporting materials may be submitted via mail, the electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

E. FIRST LEVEL OF BENEFIT DETERMINATION REVIEW

The first level of benefit determination review is done by the Claims

Administrator. The Claims Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Plan Participant within thirty (30) days for a Pre-Service Claim or sixty (60) days for a Post-Service Claim following the date of receipt of the written appeal by the Plan.

If, based on the Claims Administrator's review, the initial adverse benefit determination remains the same, and the Plan Participant does not agree with that benefit determination, the Plan Participant may initiate the second level of benefit review. The Plan Participant must request the second review in writing and send it to the Claims Administrator not later than thirty (30) days for a Pre-Service Claim or ninety (90) days for a Post-Service Claim after receipt of the Claims Administrator's decision from the first level of review. ***Failure to initiate the second level of benefit review within the appropriate time period will render the determination final***.

F. SECOND LEVEL OF BENEFIT DETERMINATION REVIEW

The Plan Administrator will review the claim in question along with any additional information submitted by the Plan Participant. The Plan will conduct a full and fair review of the claim by the Plan Administrator who 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, when appropriate or if required by law, 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 an appropriately trained health care professional who was neither 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 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 appeal is received by the Plan. Such notice will contain the same information as notices for the initial determination.

All claim payments are based upon the terms contained in the Plan Description on file with the Plan Administrator and the Claims Administrator. 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 Plan to adjudicate the claim.

Section 7
TRADITIONAL MEDICAL PLAN DESCRIPTION

This Section describes how to obtain medical benefits for Plan Participants enrolled in a Traditional (medical indemnity) Plan. Separate Plan Description Amendments describe the medical benefits for Plan Participants enrolled in a Managed Care Plan. "Plan Participant" means Traditional Plan Participant in this Section.

A. COVERED MEDICAL EXPENSES

The following are Covered Medical Expenses of Traditional Plans offered by the Montana University System 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 Schedule of Benefits, and which meet other requirements of this Plan Description (such as applicable limitations on Pre-existing Medical Conditions and coordination of benefit provisions); 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 open enrollment (described in Section 2, B.), Subscribers may choose a medical plan for the upcoming Benefit Year from among several medical plan options. Traditional Plan options for active Employees include Plan A and Plan B (See Section 3, provision H for Retiree plan options). These plans cover the same services, but have differing annual (Benefit-Year) Deductibles that must be met before the plan begins to pay (with limited exceptions below). 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 Traditional 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. See the current Schedule of Benefits for Plan A and Plan B Deductibles.

EXEMPTIONS FROM DEDUCTIBLE – Covered Medical Expenses for the following services are exempt from Deductible:

1. Second surgical opinion;
2. Gynecological exams and PAPs, mammograms and prostate exams;
3. Immunizations and Allergy shots;
4. Education Programs on disease processes (when ordered by a Physician;
5. Alternative health care visits – acupuncture, naturopathic and chiropractic;
6. Nursery and Physician's services for newborn well-baby care for the days in which both the mother and baby are confined in the Hospital; and
7. Well child checkups through age 7.

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 Coinsurance 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. The Premium Plan has a lower Coinsurance Maximum than the Basic Plan (See the current Schedule of Benefits).

EXEMPTIONS FROM COINSURANCE – The Covered Medical Expenses shown above as exempt from Deductible are also exempt from Coinsurance with the exception of expenses for allergy shots.

EXEMPTIONS FROM COINSURANCE MAXIMUM – Covered Medical Expenses for Durable Medical Equipment, Prosthetic Appliances and Orthotics do not accumulate to the Coinsurance Maximum and the Coinsurance will apply after the Coinsurance Maximum is reached.

EMERGENCY ROOM COPAYMENT – A fixed dollar Copayment, specified in the current Schedule of Benefits, applies to Covered Medical Expenses for each visit to a Hospital emergency room unless the emergency room

treatment is immediately followed by Inpatient Admission. Covered Medical Expenses that exceed the Copayment amount are subject to annual Deductible and Coinsurance. The Copayment is not credited toward the annual Deductible or Coinsurance Maximum.

D. MAXIMUM BENEFITS

There is a Maximum Lifetime Benefit, including pharmacy and dental benefits, of $2,000,000 per Plan Participant, or $4,000,000 per Family. This maximum is across all medical, pharmacy, and dental plans offered by the Montana University System Benefits Plan. Some Covered Medical Expenses contain their own payment or service maximums in the form of annual or lifetime dollar limits, or limits on the number of allowed visits or services. For the Traditional Plan, these limits are contained in the description of the specific services below and/or in the current 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 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 Traditional Plan as described in Provisions A, B, C and D above:

1. Inpatient Hospital Services – ***The Plan strongly recommends that all Inpatient care be Precertified 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 if no semi-private room is available or when confinement in a private room is Medically Necessary) and general nursing services, or confinement in an intensive care unit.
b. Medically Necessary Hospital miscellaneous services and supplies furnished by the Hospital including hemodialysis and x-ray.
c. Nursery neonatal unit services, including: general nursing services, Hospital miscellaneous services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities or premature delivery.

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, Precertification of any Inpatient Admission is strongly recommended to obtain coverage information prior to incurring charges.

2. **Inpatient Care – (*Precertification 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 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 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. This includes, but is 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.

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., 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. Surgery -- ***(Precertification of all Inpatient Admissions is strongly recommended)*** -- Surgical procedures provided in any licensed facility, are covered as described below (See the Bariatric Surgery Provision for benefits for bariatric surgery):

a. If more than one surgical procedure is performed during one 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 any minor procedures. When two surgeons of different specialties perform distinctly different procedures in one 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 at 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 or complexity to the operating sessions and 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 among 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; and

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 determined to be Medically Necessary by the attending Physician and surgeon for care following a mastectomy, a lumpectomy, or a lymph node(s) removal for the treatment of breast cancer.

10. Reconstructive Breast Surgery – **(*Precertification 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 resulting from a mastectomy that was required due to cancer of the breast;
b. All stages of one reconstructive breast surgery on the non-diseased breast to establish symmetry with the diseased breast;
c. Chemotherapy; and
d. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Specifically excluded from this benefit are expenses for the following:

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

11. Voluntary Sterilization – For covered Plan Participants, spouses, and Adult Dependents only.

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 and Transportation for Out-of-State Medical Care not Available In State – Ambulance Service is 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.

If a covered Plan Participant's Illness or Injury requires treatment services which are not available in the state in which the Plan Participant resides, the Plan will cover commercial and personal automobile transportation expenses to the nearest out-of-state licensed medical facility that provides the necessary treatment services. Coverage includes out-of-state 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 for treatment to a licensed medical facility located in the State in which the Plan Participant resides is not covered.

Commercial and personal automobile transportation benefits are limited to the following circumstances up to a maximum of $1,500 in any one Benefit Year for:

a. One visit for treatment or surgery and one preparatory or follow-up visit for an Illness or Injury which cannot be treated at a licensed medical facility in the State in which the Plan Participant resides.
b. One visit for an Illness or Injury, which is an allergic condition for which no treatment is available in the State in which the Plan Participant resides.

If the Plan Participant is a child under 18 years of age, commercial transportation charges for a parent or legal guardian may be allowed as a commercial transportation benefit.

COMMERICAL/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 Traditional Plan's Claims Administrator. This form is available from campus Human Resources/Benefits Offices or the Claims Administrator.

14. 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 Traditional Plan for the same services provided by a Physician; and
b. Services of a dentist or oral surgeon for the initial repair or replacement of sound natural teeth, which are damaged as a result of an accident (Services must be completed within 12 months following the accident).

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

15. 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. For Durable Medical Equipment for which purchase is not feasible, reasonable rental charges will be paid. Case Manager may determine reasonable rate.
c. Replacement or repair of Durable Medical Equipment or Orthopedic Appliances.

Prior Authorization of charges that may exceed $1,000 is strongly recommended. Please refer to Section 6, How to Obtain Benefits.

16. 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.

17. 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.

18. 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.

19. **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.

20. **Radiation therapy or chemotherapy.**

21. **Oxygen, other gases and their administration.**

22. **Anesthetics and administration of an anesthetic.**

23. **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.

24. **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 benefit is limited as specified in the current Summary of Benefits.

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

    Home health services provided by a Home Health Agency include:

    a. Nursing services by an RN or LPN under the supervision of an RN;
    b. Physical, Speech, or Occupational Therapy;
    c. Skilled Nursing Care services; and
    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; and
      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.

25. Hospice Care – The Hospice Care benefit is limited as specified in the current Summary 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 Nurse who serves as an intermediary between the hospice care program and the attending Physician);
c. A Nurse;
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 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 a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), or a public health Nurse who is under the direct supervision of a Registered Nurse;

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.

26. Care by a Skilled Nursing Facility (Extended Care Unit or Facility, or Transitional Care Unit) – ***Precertification 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 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.

27. Alternative Health Care Services – The following alternative health care services are covered with the limitations specified below.

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.

NATUROPATHIC SERVICES – Professional naturopathic services performed by a licensed naturopath.

The limitations below apply to all three alternative health care services:

a. The number of visits in a Benefit Year for all professional chiropractic, acupuncture, and naturopathic services combined is limited as specified in the current Schedule of Benefits.

b. These covered professional services are not subject to Deductible or Coinsurance but benefits are limited to a dollar amount per visit specified in the current Schedule of Benefits. Any ancillary lab or x-ray is covered like other lab and x-ray services and not subject to the per visit limit.

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. Pregnancy is not subject to the Pre-existing Medical Condition limitation. Coverage includes:

a. Prenatal office visits;
b. Services of a Physician or other licensed Provider, Hospital or Birthing Center for maternity care; and
c. Nursery and Physician's services for newborn well-baby care, including circumcision and PKU testing for the days in which both the mother and baby are confined in the Hospital. The Deductible and Coinsurance are waived for routine newborn charges.

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 is provided to enhance prenatal care and to provide information to help participants have a healthy pregnancy. A call during the first trimester to the Utilization Management Administrator initiates this program, conducted by Registered Nurses trained in maternal health care.

29. Preventive Health Care Benefits

a. Well-Child Care without Immunizations

If a Dependent Child on the Traditional Plan, who is less than seven (7) years old, incurs examination expenses for preventive well-child health care, the Plan will pay 100 percent of charges up to the Allowable Fee, but not to exceed a dollar limit specified in the current Schedule of Benefits for the first seven years of life for each 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, but not to exceed a dollar limit per Benefit Year specified in the current Schedule of Benefits for each child (up to age 19) and not to exceed a dollar limit per Benefit Year specified in the current Schedule of Benefits for each adult (age 19 and older). 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 screens, the Plan will pay 100 percent of charges up to the Allowable Fee up to the limit listed for the specific services in the current Schedule of Benefits. Deductible and Coinsurance do not apply.

1) Pap smear and/or routine pelvic exam as recommended by a Physician, but not to exceed the dollar limit for such exams each Benefit Year specified in the current Schedule of Benefits.

2) Routine mammogram as recommended by a Physician paid in full up to the Allowable Fee.

3) Routine prostate exam as recommended by a Physician up to a maximum dollar benefit for such an exam each Benefit Year specified in the current Schedule of Benefits.

If a Plan Participant receives any of the following covered preventive services, Deductible and the standard Coinsurance percentage applies.

1) Routine lab, including but not limited to a PSA or blood panel. PSA and blood panels are available free every other year through the MUS Wellness Program.

2) Proctoscopy, sigmoidoscopy, or colonoscopy. Preventive colonoscopy is limited to one colonoscopy every 10 Benefit Years when recommended by a Physician for Plan Participants ages 50 and older.

d. Education Programs on Disease Processes

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 family members to help manage and monitor the care of the person(s) in the family with the disease. Claims should be submitted in the name of the patient with the disease. Benefits are limited to a dollar amount per Benefit Year specified in the current Schedule of Benefits. Deductible and Coinsurance do not apply.

e. Free Health Screens Available from Campus Wellness Programs

1) Colon cancer screen/fecal occult blood screens are paid in full when obtained through the Campus Wellness Program.

This screen is normally recommended for individuals ages 50 and older.

2) Blood pressure exams are paid in full when obtained through the Campus Wellness Program.

3) Cholesterol screens with full blood panel are paid in full every two years when this test is 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 foot in any 24 months specified in the current Schedule of Benefits.

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

INPATIENT BENEFITS – ***Precertification of all Inpatient Admissions is strongly recommended as described in Section 6.***
Inpatient benefits for all rehabilitative care, except cardiac, respiratory and pulmonary rehabilitative care, are limited to the number of days of Inpatient rehabilitation care per Benefit Year specified in the current 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 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.

Prior Authorization is required for benefits that exceed $2,000 per Benefit Year. Please refer to Section 6 – How to Obtain Benefits. If Authorized as Medically Necessary, benefits exceeding $2,000 per Benefit Year are payable up to the annual dollar maximum shown in

the Schedule of Benefits for the current Benefit Year. If Prior Authorization is not obtained or charges are found not to be Medically Necessary, charges for benefits exceeding $2,000 per Benefit Year will be denied. Adverse Prior Authorization determinations cannot be appealed.

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.

32. Prescription Drugs -- Prescription drugs dispensed by a medical facility as part of Inpatient Covered Medical Services are covered under the Traditional 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 **(*Precertification of all Inpatient Admissions is strongly recommended).*** Outpatient services for the treatment of Severe Mental Illness are also covered by the Plan. **Residential Care is not a Covered Service.**

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** -- ***Precertification 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 up to the number of days of service specified in the current Schedule of Benefits. **Residential Care or treatment is not a Covered Service**.

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;
3) Physician, psychiatrist, licensed clinical psychologist, licensed social worker, or licensed professional counselor.

Benefits for Outpatient services are limited to the number of visits per Benefit Year specified in the current 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, not to exceed an aggregate dollar limits specified in the current Schedule of Benefits ***Precertification is strongly recommended- see c below.***

b. **BENEFITS FOR OUTPATIENT SERVICES** (subject to Allowable Fees, Deductible and Coinsurance) are limited to a dollar maximum per Benefit Year specified in the current Schedule of Benefits.

c. **CONDITIONS**:

1) Inpatient services must be provided by a Hospital, Psychiatric Hospital, a Freestanding Inpatient Facility, or a licensed 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. **Residential Care or treatment is not a Covered Service.**

2) **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.

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.

A 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 Department of Health and Environmental Sciences, State of Montana, or by the appropriate authority within the state where services are provided. Programs approved only by the Department of Institutions 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; and
    2) Independent of the Physician who first advised the surgery; and

b. The specialist makes a personal examination of the covered person.

37. Treatment of Temporomandibular Joint Syndrome (TMJ) – Services for the non-surgical treatment of TMJ (e.g., initial diagnostic exams, splints, therapies, evaluation and management, and appliances) are covered, subject to Deductible and Coinsurance up to a benefit limit per lifetime specified in the current Schedule of Benefits.

Surgical Treatment of TMJ that cannot be treated non-surgically is also a Covered Medical Service. ***Prior Authorization is strongly recommended for surgical treatment of TMJ.*** Please refer to 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 up to any maximums specified in the current 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 Traditional 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 Traditional Plan, expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not ordinarily covered under this Traditional 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 lifetime benefit still available to the recipient.

If both the donor and the recipient are covered under this Traditional 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 up to the lifetime maximum benefit specified in the current 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 member 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 up to the benefit limitation will be provided for bariatric surgery for Morbid Obesity/Clinically Severe Obesity, as defined above, and a directly related pre-surgical assessment , 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 3 years for a Plan Participant who has been continuously covered under the Choices employee group benefits plan for at least 18 consecutive months, is defined as *the following*:

    a. Body mass index (BMI)* exceeding 40 combined with at least two of the following conditions which must be documented by a Physician as life-threatening:

        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 meet *either* criterion a (physician-supervised nutrition and exercise program) *or* criterion b (multidisciplinary surgical preparatory regimen):

    a. *Physician-supervised nutrition and exercise program*: Plan Participant has participated in physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral

modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet *all* of the following criteria:

i. Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; *and*

ii. Nutrition and exercise program(s) must be for a cumulative total of 6 months or longer in duration and occur within 2 years prior to surgery, with participation in one program of at least three consecutive months. (Precertification may be made prior to completion of nutrition and exercise program as long as a cumulative of six months participation in nutrition and exercise program(s) will be completed prior to the date of surgery.); *and*

iii. Plan Participant's participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the Plan Participant's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. Note: A physician's summary letter is not sufficient documentation. Documentation should include medical records of physician's contemporaneous assessment of patient's progress throughout the course of the nutrition and exercise program. For Plan Participants who participate in a physician-administered nutrition and exercise program (e.g., MediFast, OptiFast), program records documenting the Plan Participant's participation and progress may substitute for physician medical records; or

b. *Multidisciplinary surgical preparatory regimen*: Proximate to the time of surgery, Plan Participant must participate in organized multidisciplinary surgical preparatory regimen of at least three months duration meeting *all* of the following criteria, in order to improve surgical outcomes, reduce the potential for surgical complications, and establish the Plan Participant's ability to comply with post-operative medical care and dietary restrictions:

i. Consultation with a dietician or nutritionist; *and*

ii. Reduced-calorie diet program supervised by dietician or nutritionist; *and*

iii. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by exercise therapist or other qualified professional; *and*

iv. Behavior modification program supervised by qualified professional; *and*

v. Documentation in the medical record of the Plan Participant's participation in the multidisciplinary surgical preparatory regimen. (A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the Plan Participant, and the physician's assessment of the Plan Participant's progress at the completion of the multidisciplinary surgical preparatory regimen.) and

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 postoperative regimen. Note: The presence of depression due to obesity is not normally considered a contraindication to obesity 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 obesity surgery *and* who are at increased risk of adverse consequences of a RYGB due to the presence of *any* of the following comorbid medical conditions:

1. Hepatic cirrhosis with elevated liver function tests; or

2. Inflammatory bowel disease (Crohn's disease or ulcerative colitis); *or*

3. Radiation enteritis; *or*

4. Demonstrated complications from extensive adhesions involving the intestines from prior major abdominal surgery, multiple minor surgeries, or major trauma; *or*

5. Poorly controlled systemic disease (American Society of Anesthesiology (ASA) Class IV) (see Appendix).

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. Glasses or Contacts following Cataract Surgery – One pair of glasses or pair of contacts following cataract surgery. Benefits are limited to corrective lens and up to $200 for 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 Montana University System Plan.

43. Contraceptive Management - "Contraceptive Management" means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation or placement of any contraceptive device.

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

G. GENERAL EXCLUSIONS/LIMITATIONS

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

1. Expenses 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 Services, except as specifically stated as a Covered Medical Expense of this Traditional Plan.

2. Expenses for eye refractions or the fitting or cost of eyeglasses. This exclusion will not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery

3. Expenses for health examinations and routine/screening physicals except expenses for the preventive services listed as a Covered Medical Expense.

4. Expenses for dental treatment whether or not covered by the Dental Plan (Section 8), except as listed as a Specific Covered Medical Services under the "Dental Services" provision.

5. Home health care expenses for:

   a. Services that are primarily for the convenience of the Plan Participant's family.

   b. Services that consist primarily of Custodial Care or of the duties of a housekeeper, companion, or sitter.

   c. Transportation services.

6. Charges by the Plan Participant for all services and supplies resulting from any Illness or Injury which occurs in the course of employment for wage or profit, or 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:

a. Coverage for the Plan Participant under Workers' Compensation provides benefits for only a portion of the services Incurred;

b. The Plan Participant's employer/volunteer organization has failed to obtain such coverage required by law;

c. The Plan Participant waived his/her rights to such coverage or benefits;

d. The Plan Participant fails to file a claim within the filing period allowed by law for such benefits;

e. The Plan Participant fails to comply with any other provision of the law to obtain such coverage or benefits;

f. The Plan Participant is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective; or

g. The Plan Participant is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

This exclusion will not apply to: household and domestic employment, 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.

7. Any expense or charge for service or supplies, which are provided or paid for by 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; or

   c. A group health plan established by a government for its own civilian Employees and their Dependents.

8. 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 caused during service in the armed forces of any country.

9. Any loss, expense, or charge:

    a. That is incurred while a l 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.

10. Any loss, expense, or charge that results from cosmetic or reconstructive surgery performed primarily to improve appearance or to change or restore bodily form without materially correcting a bodily malfunction or to prevent or treat a mental or nervous disorder through a change in bodily form, except:

    a. For repair of congenital defects of newborn children.

    b. For repair of defects that result from surgery for which benefits are paid under this Traditional Plan.

    c. For services specifically included as Covered Services.

11. Any expense that is in excess of the Allowable Fee.

12. Services rendered or started, or supplies furnished prior to the Effective Date of coverage under the Traditional Plan, or after coverage is terminated under the Traditional Plan,

13. 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.

14. 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.

15. Any expense or charge for orthopedic shoes or other supportive device for the feet, except as provided under the Orthotic Devices provision.

16. Any loss, expense or charge for sex transformation or any treatment related to sexual dysfunction.

17. Any expense or charge for Custodial Care, developmental care, or domiciliary care.

18. Any expense or charge for the promotion of fertility, including:

    a. Reversal of surgical sterilization;

    b. Any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer, or any similar treatment or method.

19. Chelation therapy expenses, except for acute arsenic, gold, mercury, or lead poisoning.

20. Any expense or charge for non-surgical treatment of temporomandibular joint (TMJ) syndrome in excess of the lifetime maximum. Surgical treatment of TMJ is covered if Medically Necessary. Prior Authorization is strongly recommend for surgical treatment of TMJ. Please refer to Section 6 - How to Obtain Benefits.

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 sickness, except as provided under the rehabilitation care provision and the Disease Process Education Benefit. Cognitive rehabilitation therapy is not covered.

22. 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.

23. Expenses for hearing aids, batteries, and related supplies.

24. Expenses for any surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, photo refractive keratectomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism.

25. Expenses for smoking cessation products, unless provided by Campus Wellness Programs.

26. Prescription drug expenses covered by the Prescription Drug Plan described in Section 9, except oral contraceptives provided through a Title 10 clinic or similar Federal program.

27. Charges for preparation of reports or itemized bills in connection with Covered Medical Expense, unless specifically requested and approved by the Plan.

28. Expenses for non-prescription contraceptives supplies or devices, or the removal of contraceptive devices, unless Medically Necessary.

29. Massage therapy expenses.

30. Expenses for homeopathic services, products, and botanical preparations.

31. Expenses for Residential Care, treatment, or services.

32. Expenses for 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 this Traditional Plan pays for general nursing services by Hospital staff); or

    b. When a 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.

33. Charges for marital counseling, family counseling without the patient present, recreational counseling, or milieu therapy.

34. Expenses incurred by persons other than the covered Plan Participant receiving treatment, service, or supplies.

35. Charges for services rendered by a Physician or Licensed Health Care Provider who is a close relative of the covered Plan Participant, or resides in the same household as the Plan Participant and who does not regularly charge the Plan Participant for services. A close relative is defined as a spouse, Adult Dependent, parent, brother, sister, child, or in law of the Plan Participant.

36. 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.

37. Charges for services, treatment, or supplies not considered legal in the United States.

38. Transportation expenses, except for commercial and private automobile transportation described in the provision titled, "Ambulance Services and Transportation for Out-of-State Medical Care not Available In State."

39. Expenses for services or supplies that are not specifically listed as a Covered Medical Service of this Traditional Plan.

40. Expenses for the following treatments, services or supplies:

    a. Expenses related to or connected with treatments, services, or supplies that are excluded under this Traditional 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 Traditional Plan.

41. Expenses related to or connected with treatments, services or supplies for artificial organ implant procedures.

42. Expenses to reverse a voluntary sterilization.

43. Expenses for group therapy except for treatment of Chemical Dependency.

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. Dental expenditures will be included in the Lifetime Maximum Benefit of $2,000,000 per Plan Participant or $4,000,000 per Family described in Section 7, D. See Section C below for specific dental maximums.

A. DENTAL PLAN OPTIONS

There are two Dental Plan options:

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

   The Premium Plan also covers:
   - Implant procedures performed by a Dentist for endosseous, transosseus, 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. Implant procedures are subject to a lifetime maximum amount for each covered individual as specified in provision C of this Section.

   - 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 and Oral Surgery services listed in provision F of this Section.

B. DENTAL PLAN COVERAGE

The Dental Plan will pay only for the covered services as shown in the Premium and Basic Plan Schedules not to exceed the allowance specified in provision D, E and F.

Covered dental charges are those charges within Plan allowances specified in provision D for covered dental services listed in provisions E., F., and not excluded in provision G and H, 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. You 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

	Premium Plan	***Basic Plan***
Annual Maximum Benefit (per individual)	$1,500	$750
Implant Lifetime Maximum (per individual)	$1,500	Not covered
Orthodontia Lifetime Maximum (per individual)	$1,500	Not covered

D. CONTRACT ALLOWANCE

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

Orthodontia services (Premium Plan Only) are payable at 50% of the Contract Allowance for authorized services, subject to a $1,500 lifetime 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.

E. SCHEDULE OF MAXIMUM BENEFITS FOR THE PREMIUM PLAN

Procedure Code	Description	Maximum Allowance
D0120	Periodic oral evaluation - established patient	$36
D0140	Limited oral evaluation - problem focused	$52
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 *(limited to one per dentist, all other evaluations will be benefited as D0120)*	$58
D0160	Detailed and extensive oral evaluation - problem focused, by report	$124
D0180	Comprehensive periodontal evaluation - new or established patient (*limited to one per dentist, all other evaluations will be benefited as D0120)*	$64
D0210	Intraoral - complete series (including bitewings)	$98
D0220	Intraoral - periapical first film	$23
D0230	Intraoral - periapical each additional film	$18
D0240	Intraoral - occlusal film	$22
D0250	Extraoral - first film	$52
D0260	Extraoral – each additional film	$40
D0270	Bitewings – one film	$20
D0272	Bitewings - two films	$33
D0273	Bitewings - three films	$40
D0274	Bitewings - four films	$47
D0277	Vertical bitewings - 7 to 8 films	$65
D0330	Panoramic film	$81
D0340	Cephalometric film	$78
D0350	Oral/facial photographic images	$29
D0470	Diagnostic casts	$81

Procedure Code	Description	Maximum Allowance
D1110	Prophylaxis - adult	$74
D1120	Prophylaxis – child *(through age 13)*	$52
D1203	Topical application of fluoride (prophylaxis not included) – child *(through age 13)*	$24
D1204	Topical application of fluoride (prophylaxis not included) – adult *(ages 14 through 18)*	$25
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$28
D1351	Sealant - per tooth *(through 15 years old; the fee is considered to include any necessary repair or replacement within two years)*	$40
D1510	Space maintainer - fixed - unilateral	$213
D1515	Space maintainer - fixed - bilateral	$346
D1520	Space maintainer - removable - unilateral	$350
D1525	Space maintainer - removable - bilateral	$479
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
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

Procedure Code	Description	Maximum Allowance
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 *(considered part of crown fee except in exceptional circumstances or for endodontically treated teeth)*	$95
D2951	Pin retention - per tooth, in addition to restoration	$38
D2952	Post and core in addition to crown, indirectly	$159

Procedure Code	Description	Maximum Allowance
	fabricated	
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) *(included as part of the final restoration if done on the same day as the final restoration)*	$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
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

Procedure Code	Description	Maximum Allowance
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 *(allowable amount for multiple procedures in a quadrant will not be more than D4260)*	$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 *(limited to two sites per quadrant)*	$407
D4271	Free soft tissue graft procedure (including donor site surgery) *(limited to two sites per quadrant)*	$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

Procedure Code	Description	Maximum Allowance
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
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

Procedure Code	Description	Maximum Allowance
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
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	$550

Procedure Code	Description	Maximum Allowance
	(high noble metal)	
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	Recement implant/abutment supported crown	$38
D6093	Recement 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 *(an alternate benefit of*	$429

Procedure Code	Description	Maximum Allowance
	D6240 will be given)	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$350
D6600	Inlay - porcelain/ceramic, two surfaces *(an alternate benefit of D6602 will be given)*	$375
D6601	Inlay - porcelain/ceramic, three or more surfaces *(an alternate benefit of D6603 will be given)*	$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 *(an alternate benefit of D6610 will be given)*	$390
D6609	Onlay - porcelain/ceramic, three or more surfaces *(an alternate benefit of D6611 will be given)*	$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
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 *(an alternate benefit of D6780 will be given)*	$410
D6790	Crown - full cast high noble metal	$410

Procedure Code	Description	Maximum Allowance
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 *(usually in preparation for prosthesis)*	$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

Procedure Code	Description	Maximum Allowance
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
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

Procedure Code	Description	Maximum Allowance
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
D7910	Suture of recent small wounds up to 5 cm *(when performed in conjunction with extractions, this service is considered to be included as part of the extraction)*	$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	$60
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$92

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.

F. SCHEDULE OF MAXIMUM BENEFITS FOR THE BASIC PLAN

Procedure Code	Description	Maximum Allowance
D0120	Periodic oral evaluation - established patient	$36
D0140	Limited oral evaluation - problem focused	$52
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 *(limited to one per dentist, all other evaluations will be benefited as D0120)*	$58
D0160	Detailed and extensive oral evaluation - problem focused, by report	$124
D0180	Comprehensive periodontal evaluation - new or established patient (*limited to one per dentist, all other evaluations will be benefited as D0120)*	$64
D0210	Intraoral - complete series (including bitewings)	$98
D0220	Intraoral - periapical first film	$23
D0230	Intraoral - periapical each additional film	$18
D0240	Intraoral - occlusal film	$22
D0250	Extraoral - first film	$52
D0260	Extraoral - each additional film	$40
D0270	Bitewings – one film	$20
D0272	Bitewings - two films	$33
D0273	Bitewings - three films	$40
D0274	Bitewings - four films	$47
D0277	Vertical bitewings - 7 to 8 films	$65
D0330	Panoramic film	$81
D1110	Prophylaxis – adult	$74
D1120	Prophylaxis – child *(through age 13)*	$52
D1203	Topical application of fluoride (prophylaxis not included) – child *(through age 13)*	$24
D1204	Topical application of fluoride (prophylaxis not included) – adult *(ages 14 through 18 years old)*	$25
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$28
D1351	Sealant - per tooth *(through 15 years old; the fee is considered to include any necessary repair or replacement within two years)*	$40
D1510	Space maintainer - fixed – unilateral	$213
D1515	Space maintainer - fixed – bilateral	$346
D1520	Space maintainer - removable – unilateral	$350
D1525	Space maintainer - removable – bilateral	$479

Procedure Code	Description	Maximum Allowance
D1550	Re-cementation of space maintainer	$56
D1555	Removal of fixed space maintainer	$56
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
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$60

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

G. LIMITATIONS

Preventive and Diagnostic Benefits *(Premium and Basic Plans)*

1. Routine oral examinations and cleanings, including periodontal cleanings, are not provided more than 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 panographic x-rays will be provided when required by the Dentist, but not more than one x-ray each 5 years will be paid by the Dental Plan.
3. Bitewing x-rays are limited to 2 per benefit year when provided to a covered individual under age 18 and 1 per benefit year for a covered individual age 18 and over.
4. Space maintainers are limited to once per lifetime for anyone under age 14.
5. Topical application of fluoride is limited to 2 in any 12 month period for anyone under age 19.
6. Sealants are limited as follows:
   i) They are available only to a covered individual through age 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 2 years of its application.

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

Implant Benefits *(Premium Plan)*
1. Implant Benefits are subject to all the limitations, exclusions and other terms and conditions in this Contract.
2. Delta Dental will not pay to replace any implant that the Enrollee 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 Section 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 covered individual was eligible under the prior Dental Plan.

Major Benefits *(Premium Plan)*
1. The Dental Plan will not pay to replace any crowns, jackets or cast restorations which the patient received in the previous 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 covered individual received in the previous 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 covered individual was eligible under the prior Dental Plan.

Orthodontia *(Premium 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 patient becomes covered will commence with the first payment due following the date the patient'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 covered individual 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 program.
4. X-rays or extractions are not subject to the Orthodontic maximum.

5. Surgical procedures are not subject to the Orthodontic maximum.

H. 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 broker 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 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-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 program.

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 Employer's 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 Benefits Plan are automatically enrolled in the Prescription Drug Plan. There is no separate premium cost. Pharmacy expenditures will be included in the Lifetime Maximum Benefit of $2,000,000 per Plan Participant or $4,000,000 per Family described in Section 7, D.

A. PHARMACY CARD PROGRAM

Plan Participants may receive a combined medical/prescription drug Identification Card in the mail. The card is an important document and should be protected from mutilation or loss. The Prescription Drug Plan's Pharmacy Benefit Manager (PBM) provides a Network of pharmacies throughout Montana and the United States. Plan Participants can present their ID card along with a prescription from a Physician, at any Network member pharmacy, and receive up to a 30-day supply of medication.

Plan Participants are responsible for charges credited toward the annual Deductible, and after the Deductible has been met, for a Copayment or percentage Coinsurance (whichever is greater) at the time the prescription is received. See the current Schedule of Benefits for the annual Deductible amount per Plan Participant & per family, Copayment amounts, and Coinsurance percentages. Note that there are four benefit levels. Also see the current per person and per family maximum you must pay in Copayments and Coinsurance in a Benefit Year before the Plan pays 100%. The Copayment and Coinsurance paid for Protocall Specialty Drugs purchased at a retail pharmacy does not apply to the out-of-pocket maximum,

It is to the Plan Participant's advantage to use generic drugs or drugs on the Formulary when available. Generic drugs will be substituted whenever possible if the written prescription allows for this. The pharmacist can tell the participant if the medication has a generic alternative available.

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 PBM's web site and send the completed form and proof of drug purchase to the PBM. Refer to the current Choices Enrollment Workbook for address and website information. The PBM will process the claim for reimbursement for the amount allowed under the Plan. Copies of the Direct Member Reimbursement form may also be requested from your campus payroll/personnel office.

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 90-day supply of medicine through the PBM. Certain medications are allowed for purchase at retail only (ie Proton Pump Inhibitors and Narcotics). Plan Participants are encouraged to use a local Network pharmacy if a prescription is needed quickly, or this is a first-time medication. To purchase a prescription through the mail service, Plan Participants should submit a prescription written for a 90-day supply plus any refills, a completed Patient Profile/Mail Order Form, and the appropriate Copayment to the Mail Service Pharmacy Program. Refer to the current Choices Enrollment Workbook for address and website information.

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

Diabetic kits are available at either mail service. One 90-day supply Copayment applies per kit.

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. Appropriate quantities of diabetic supplies: injectable insulin, test strips, syringes, needles, lancets, and alcohol swabs.

4. Self administered contraceptives requiring a written prescription.

5. Prenatal vitamins prescribed by a Physician.

6. Retin-A for individuals 25 years of age or younger.

7. Ostomy supplies and colostomy bags.

E. EXCLUSIONS

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

1. Expenses that fall under the General Exclusions and Limitations in Section 7. The Section 7 General Exclusions and Limitations apply to the Prescription Drug Program.

2. With the exception of diabetic supplies and insulin, expenses for all pharmaceuticals, drugs, and medical supplies that may be purchased over the counter without a written prescription.

3. Any expense for a prescription drug that is not Medically Necessary, experimental/investigational or considered appropriate for the treatment of an Injury or Illness.

4. Prescription drugs used for the promotion of pregnancy by hormone therapy.

5. Drugs or supplies prescribed for cosmetic purposes; Rogaine for hair loss, or Retin-A for individuals age 26 and over.

6. Growth hormones unless Prior Authorized by the Plan's Case Manager.

7. Any charge or prescription drug expense that has been paid by another group plan, workers' compensation program, or has been paid under the major 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 FDA.

12. Vitamins and fluoride supplements.

13. Anorexiants (any prescription drugs used for weight loss), unless part of a treatment plan for morbid obesity that is covered and has been authorized by a health plan offered by the MUS.

14. Infertility drugs (any prescription drugs used for infertility), unless authorized by a health plan offered by the MUS.

15. Prescription drugs to treat sexual dysfunction, unless authorized by a MUS Managed Care Plan.

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

An appeal may be filed if an adverse benefit determination has been rendered on a claim or if a member believes benefits to which he is entitled have not been provided under the Plan.

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 Claims Administrator. An appeal of an adverse benefit determination must be made within 180 days of the notification of such adverse determination.

An appeal should include the name of the patient, the CVS Caremark Identification Number, patient date of birth, a written statement of the issue, the name of the drug being appealed and any documents, records or other pertinent information related to the claim.

A written appeal and supporting documentation can be mailed or faxed to the Claims Administrator:

CVS Caremark
Appeals Department
620 Epsilong Drive
Pittsburgh, PA 15238

Fax: 1-800-230-0783.

Physicians may submit urgent appeal requests by calling the physician only toll-free number; 1-800-952-9684.

The Claims Administrator will review the appeal of an adverse benefit determination. The time frame for responding to the participant depends on the nature of the claim.

The Claims Administrator's decision will be communicated in writing to the participant. In the event that the Claims Administrator renders and adverse benefit determination on appeal, the Claims Administrator will provide written notification which will include:

- The specific reason for the determination
- Specific reference to pertinent Plan provisions used to make the determination
- A statement indicating that the participant is entitled to received, upon written request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits.
- If an internal rule, guideline, protocol or other similar criterion was used to make the determination, and notification that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon written request 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 participant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Pre-Service Claim Appeal

The Claims Administrator will make a decision on an appeal of an adverse benefit determination that was rendered on a pre-service claim within 30 days of receipt of the appeal.

Post-Service Claim Appeal

The Claims Administrator will make a decision on an appeal of an adverse benefit determination that was rendered on a post-service claim within 60 days of receipt of the appeal.

Urgent Care Claim Appeal

The Claims Administrator will make a decision on an appeal of an adverse benefit determination that was rendered on an urgent care claim within 72 hours of receipt of the appeal.

If the final appeal response from the Claims Administrator is adverse a Plan Participant may file a formal petition for administrative review. A petition for review of a denied claim must be in writing and state the reason or reasons for disputing the denial of a claim. The appeal must also include all relevant information and correspondence from the Pharmacy Benefit Manager. The petition for review of a denied claim must be filed with the following office within **60** days of the date of denial by the Pharmacy Benefit Manager (PBM):

Administrator Employee Benefits Plan
Office of the Commissioner of Higher Education
100 N. Park Avenue Suite 320
P O Box 203101
Helena, MT 59620-3101
Telephone (406) 444-2574

The Administrator of the Employee Benefits Plan will review the claim appeal petition and the arguments presented in correspondence. If necessary, the Administrator may confer with the applicant and with the PBM to clarify the issues presented in the appeal. The Administrator of the Employee Benefits Plan may also take any of the following actions when reviewing the claims appeal.

1. Take appropriate and immediate administrative action to resolve the appeal.

2. In some cases, the appellant's health plan administrator or the Employee Benefit Plan's Case Manager will be consulted in the appeal.

3. Form a review panel consisting of four members of the Inter-Unit Benefit Committee to review the arguments presented in the claim appeal petition. The Plan Participant may amend or supplement the original claim appeal petition and may present oral argument or evidence to the panel.

The right to continue an appeal may be forfeited for any of the following reasons:

1. Failure to file a petition within 60 days of denial by the PBM.

2. Failure to submit in a timely manner supporting evidence or records requested by the Plan Administrator that may be reasonably necessary to determine the merits of the appeal.

3. Failure to appear at the meeting of the claim review panel that was scheduled for the applicant so he or she may present supporting oral argument and evidence.

4. The Plan Administrator may waive any of the above requirements provided the applicant is incapacitated or unable to pursue the appeal for other good reasons.

A decision will be made by the Plan Administrator within 60 days of receiving the appeal, provided circumstances do not require an extension of time to review all the facts and conduct a formal scheduled hearing. In no case shall a decision be delivered later than 120 days from the date the petition was filed. A decision arrived at under this review procedure shall be considered final.

All claims appeals shall be confidential. Only the persons who are directly involved in deciding the merits of an appeal shall have access to any testimony, correspondence, and/or supporting medical records. All meetings related to the appeal shall be closed, unless this right is waived by the Claimant.

The appeal procedure shall be the sole process for resolving grievances against the Plan. All decisions arrived at under this appeals process shall be final.

Section 10
OPTIONAL VISION PLAN

COVERED VISION SERVICES

I. Examination Benefit

A. ***In-Network Benefit.*** A Member is entitled to a paid-in-full comprehensive spectacle eye examination, including dilation as necessary, performed by a Participating Provider.

B. ***Out-of-Network Benefit.*** A Member is entitled to a comprehensive spectacle eye examination with dilation as necessary, up to a $45.00 retail value. The Member must pay at the point-of-service and will be reimbursed up to $45.00 toward an eye examination after submitting a complete claim.

C. ***Enhanced Rural Out-***of-Network Benefit. A member is entitled to a comprehensive spectacle eye examination with dilation as necessary, up to a $85 retail value. The Member must pay at the point-of-service and will be reimbursed up to $85 toward an eye examination after submitting a complete claim. To qualify for the enhanced rural out-of-network benefit, employees must meet the definition of rural employee, meaning any MUS employee and dependents enrolled on the vision plan who reside more than 50 miles from the nearest network provider.

D. ***Member Pays***. There is a $10.00 co-payment for in-network benefit only.

E. ***Fitting and Follow up*** – Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.

1. **Standard** Contact lens – spherical clear contact lenses in conventional wear and planned replacement. Examples include but not limited to disposable, frequent replacement, etc. **Standard** benefit is paid-in-full for fit and two follow-up visits, $20 copayment.
2. **Premium** Contact Lens – all lens designs, materials and specialty fittings other than Standard Contact Lenses. **Premium** benefit is a $35.00 allowance applied toward fit and follow-up plus a $20 copayment. The member is responsible for 90% of the retail price, less the $35.00 allowance, plus a $20 copayment, at the time of service.

F. ***Out of Network, Fitting and Follow up*** – Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.

1. **Standard** Contact lens – spherical clear contact lenses in conventional wear and planned replacement. Examples include but not limited to disposable, frequent replacement, etc. **Standard** -member is entitled to be reimbursed up to $40.00 for fit and follow-up.
2. **Premium** Contact Lens – all lens designs, materials and specialty fittings other than Standard Contact Lenses. **Premium** - member is entitled to be reimbursed up to $40.00 for fit and follow-up.

G. ***Benefit Frequency.*** Once every Benefit Year.

II. Contact Lens Benefit

A. ***In-Network Benefit.*** In lieu of lenses, all Members are entitled to conventional, disposable or medically necessary contact lenses for the amounts below. The Member is responsible for the balance over the allowance amount at the time of service.
1. ***Conventional***-a $125.00 allowance applied toward conventional contact lenses. The Member is responsible for 85% of the balance amount over $125.00 at the time of service
2. ***Disposable***-a $125.00 allowance applied toward disposable contact lenses. The Member is responsible for 100% of the balance over $125.00 at the time of service.
3. ***Medically Necessary***-a paid in full benefit toward medically necessary contact lenses.

B. ***Out-of-Network Benefit***. In lieu of the lenses benefit, for contact lenses obtained from an out-of-network provider, a Member is entitled to the following:
1. ***Conventional*** -a Member is entitled to be reimbursed up to $80.00 ($100 for rural out-of-network) for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
2. ***Disposable***-a Member is entitled to be reimbursed up to $80.00 ($100 for rural out-of network) for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.
4. ***Medically Necessary***-a Member is entitled to be reimbursed up to $200.00 for materials. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.

C. ***Member Pays.*** There is no co-payment.

D. ***Benefit Frequency***. Once every Benefit Year.

III. Frame Benefit

A. ***In-Network Benefit.*** A Member is entitled to a $125.00 allowance toward a frame with the purchase of prescription lenses. The Member is responsible for 80% of the balance over the $125.00 at the time of service.

B. ***Out-of-Network Benefit.*** A Member is entitled to a reimbursement of up to $47.00 ($100 for rural out-of-network) toward any frame purchased from an out-of-network provider. The Member must pay the out-of-network provider at the point-of-service and file a complete claim to receive the reimbursement.

C. ***Member Pays***. There is no co-payment.

D. ***Benefit Frequency***. Once every two (2) Benefit Years.

IV. Lens Benefits

A. ***In-Network Benefit.*** A Member is entitled to single vision, bifocal, and trifocal lenses.

B. ***Member Pays***. There is $20.00 co-payment.

C. ***Lens Options*** A Member is entitled to the following lens options for the additional amounts set forth below:

Ultra Violet Coating	$15.00
Tint (Solid & Gradient)	$15.00
Standard Scratch Resistant	$15.00
Standard Polycarbonate	$40.00
Standard Progressives (add-on to bifocal)*	$65.00
Standard Anti-Reflective	$45.00
Other Add-Ons	20% discount

D. ***Out-of-Network Benefit.*** A Member is entitled to be reimbursed for the following: up to $45.00 for single vision; up to $55.00 for bifocal; up to $65.00 for trifocal. The Member must pay the out-of-network provider in full at the point-of-service and file a complete claim to receive the reimbursement.

E. ***Benefit Frequency***. Once every Benefit Year.

Note: Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits, no remaining balance. Lost or broken materials are not covered.

* Standard Progressive Lenses include, but are not limited to the following trade names: Access®, Adaptar®, AF Mini®, Continuous®, Vue®, Freedom®, Sola VIP®, Sola XL® and True Vision®.

V. Laser Vision Benefit

A Member is entitled to a 15% discount or a 5% discount on promotional pricing on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and the Member elects to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for the pre-operative and post-operative care which the Member will be responsible for and such fees are not subject to the 15% discount or the 5% discount on promotional pricing.

VI. Accessing the Benefit

1. To locate the nearest U.S. Laser Network provider, a Member must call 1-877-5LASER6.
2. After the Member has located a U.S. Laser Network provider, the Member should contact the U.S. Laser Network provider and identify himself or herself as an EyeMed Member. The Member should schedule a consultation with a U.S. Laser Network provider to determine if he or she is a good candidate for laser vision correction.
3. If it is determined that the Member is a good candidate for laser vision correction, the Member should schedule a treatment date with a U.S. Laser Network provider.
4. To activate the benefit, the Member must call the U.S. Laser Network again at 1-877-5LASER6 with his or her scheduled treatment date.
5. At the time the treatment is scheduled, the Member will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If the Member should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
6. At the time the Member remits the deposit, U.S. Laser Network will issue to the Member an authorization number confirming the EyeMed discount. This authorization number will be sent to the Member's U.S. Laser Network provider prior to treatment.
7. On the day of the treatment, it is the responsibility of the Member to pay or arrange to pay the balance of the fee.
8. After the treatment, the Member should follow all post-operative instructions carefully. In addition, the Member is responsible to schedule any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

VII. Additional Purchases and Out-of-Pocket Discount

Member will receive a 20% discount on items not covered by the plan at Participating EyeMed Providers, beyond plan coverage, which may not be combined with any other discounts or promotional offers, and

the discount does not apply to EyeMed's Providers professional services, contact lenses or services provided by laser providers. Members are also eligible for additional discounts on eyewear purchases. Once the initial benefit has been used, members are eligible for 40% off the retail price of a complete pair eyeglass purchase and 15% off conventional contact lenses.

VIII. Limitations and Exclusions

Benefits are not provided for services or materials arising from: Orthoptic or vision training; subnormal vision aids, and any associated supplemental testing. Medical and/or surgical treatment of the eye, eyes, or supporting structures. Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under the Plan. Services provided as a result of any Worker's Compensation law. Plano non-prescription lenses and non-prescription sunglasses (except for the 20% discount). Two pair of glasses in lieu of bifocals. Aniseikonic Lenses. Discounts are not available on frames where the manufacturer prohibits discounts.

SAMPLE SAVINGS

The following examples illustrate how your benefit would be applied to the services received at any participating EyeMed provider's office or location:

If a member chooses to receive:	
A comprehensive vision care examination:	the member pays $10.00
A frame up to a value of $125:	the member pays $0.00
One pair of bifocal lenses:	the member pays $20.00
Ultraviolet coating:	the member pays $15.00
The total cost to the member is:	**$45.00**

If a member chooses to receive:	
A comprehensive vision care examination:	the member pays $10.00
A frame up to a value of $155:	the member pays $24.00
A pair of single vision lenses:	the member pays $20.00
Standard anti-reflective coating:	the member pays $45.00
The total cost to the member is:	**$99.00**

The EyeMed network is always growing, and provider locations are subject to change. Therefore, we recommend calling EyeMed's Member Services Department 866-723-0513 or using the Provider Locator service through EyeMed's web site www.eyemedvisioncare.com to locate the EyeMed Provider closest to you.

Note: The benefits are underwritten by Fidelity Security Life. If you have any questions or concerns, please contact EyeMed Vision Care.

FILING CLAIMS

Using your Vision Benefit

Before you go to a participating EyeMed Provider location for an eye exam, glasses or contact lenses, it is recommended that you call ahead for an appointment. When you arrive, show the receptionist or sales associate your EyeMed Identification Card, or if you should forget to take your card, be sure to say that you are participating in the Montana University System vision care plan so that eligibility can be verified.

EyeMed Vision Care Customer Service can be reached seven days a week Monday through Saturday 6:00 am to 9:00 pm and Sunday 9:00 am to 6:00 pm Eastern Time at 866-723-0513.

When you receive services at a participating EyeMed Provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Time Frames for Responding to Appealed Claims

Activity	Time Frame
Claimant Appeal of Adverse Determination (Denial or Reduction)	180 calendar days
Plan Decision on Appeal	60 calendar days

EyeMed Vision Care has been determined to belong to the post service claims category. If a claim for benefits is denied, EyeMed Vision Care will notify the member in writing of the specific reasons for the denial. The member may request a full review by EyeMed Vision Care within 180 days of the date of a denial. The member's written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed Vision Care denial information or Explanation of Benefits, if applicable.

- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.

- Additional information from the member's eye care provider that will assist EyeMed Vision Care in completing its review of the

member's appeal, such as documents, records, questions or comments.

The appeal should be mailed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040

EyeMed Vision Care will review your appeal for benefits and notify you in writing of its decision, as well as the reasons for the decision, with reference to specific plan provisions.

Member Grievance Procedure

If the member is dissatisfied with the services provided by an EyeMed Vision Care Provider, the member should either write to EyeMed at the address indicated above or call the EyeMed Vision Care Member Services toll free telephone number at* 866-723-0513.** ***The EyeMed Vision Care Member Services representative will log the telephone call and attempt to reach a resolution to the issues raised by the member. If a resolution cannot be reached during the telephone call, the EyeMed Vision Care Member Services representative will document all of the issues or questions raised. EyeMed Vision Care will use its best efforts to communicate back with the member within four (4) business days with a decision or resolution to the issues or questions raised. If the member is not satisfied with the resolution, the member may file a formal appeal as set forth above related to a denial of benefits.

For more information on your rights and how to file a formal appeal under the Employee Retirement Income Security Act of 1974, as amended (ERISA), refer to the appropriate section of your Summary Plan Description.

Section 11
OPTIONAL REIMBURSEMENT ACCOUNTS

A. ELIGIBILITY

An Employee who:

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

B. OPERATION

At the time of initial enrollment in the Plan and during each open 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 Reimbursement 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, he or she elects to have placed in a Reimbursement 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 Reimbursement 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 Reimbursement 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 Montana University System contributes an amount determined from time to time 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. Remaining employer contributions, if any, may be used to purchase Dependent coverage and

other benefits available under the Plan, including Reimbursement Accounts, but may not be paid in cash. 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 break 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 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 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, any other medical expenses (except health care premiums) that could be deducted on Federal income tax returns. Examples of eligible medical care expenses are available on the EBR Web site, www.ebrworld.com/cafeteriaplans, or from their home page, www.ebrworld.com, click on the "Cafeteria Plans" button and proceed from there.

Eligible expenses must be *incurred* during the Benefit Year. A participating Employee may request reimbursement from (submit a claim to) the Medical Reimbursement Account at any time during the Benefit Year for up to the full annual amount. Requests must be for amounts of $10 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 open 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 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 a Choices Dependent Care Reimbursement Account may not exceed either the Employee's or spouse's taxable income.**

Examples of eligible Dependent care expenses are available on the EBR Web site, www.ebrworld.com/cafeteriaplans, or from their home page, www.ebrworld.com as indicated above for eligible medical expenses.

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.

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 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-E.

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 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.

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 2-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 2-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 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 Employee Benefit Resources (EBR) Web site at www.ebrworld.com/cafeteriaplans or from their home page at www.ebrworld.com. Click on the "Cafeteria Plans" button and proceed from there. 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 EBR of any change of address.

2. Obtain the correct claim form from either your campus Human Resources/l Benefits office or the EBR Web site.

3. Indicate the business name of your employer, 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 Employee Benefits Resources, LLP, P.O. Box 1193, Helena, Montana 59624, or fax to (406) 442-5089.
   Claims may also be dropped off at our Helena, Montana, office located at 828 Great Northern Boulevard, Third Floor.

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).

9. 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 Montana University System 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 Plan Description. 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 Dependent's, 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 Plan Description, 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 AND

AUTOPSY

The Claims Administrator shall, at Plan expense, have the right and opportunity to examine through its own medical examiner any Plan Participant as often as may be reasonably required during the time a claim is pending. The Claims Administrator has the right and opportunity to conduct an autopsy in case of death when not forbidden by law.

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, 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 Montana University System 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 MONTANA UNIVERSITY SYSTEM IS NOT LIABLE FOR ACTS, ERRORS, OR OMISSIONS BY MEDICAL PROVIDERS

The Montana University System 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 to Reimbursement is separate from and in addition to the Plan's right of Subrogation. If the Plan pays benefits for medical expenses on a Plan Participant's behalf, and another party was responsible or liable for payment of those medical expenses, the Plan has a right to be reimbursed by the Plan Participant for the amounts the Plan paid.

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, no-fault 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. The Plan Participant agrees to reimburse the Plan, in first priority, 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. Reimbursement to the Plan will be paid first, in its entirety, even if the Plan Participant is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages.

L. SUBROGATION

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 liable to the Plan Participant for a loss or benefits paid by the Plan. The Plan may proceed through litigation or settlement in

the name of the Plan Participant, with or without his or her consent, to recover benefits paid under the Plan.

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, no-fault 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 FOLLOWING PARAGRAPHS APPLY TO BOTH REIMBURSEMENT AND SUBROGATION:

1. Under the terms of this Plan, the Claims Administrator is not required to pay any claim where there is evidence of liability of a third party unless the Plan Participant signs the Plan's Third-Party Reimbursement Agreement and follows the requirements of this section. However, the Plan, in its discretion, may instruct the Claims Administrator not to withhold payment of benefits while the liability of a party other than the Plan Participant is being legally determined. If a repayment agreement is requested to be signed, the Plan's right of recovery through Reimbursement and/or Subrogation remains in effect regardless of whether the repayment agreement is actually signed.

2. 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.

3. 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 liable third party. This cooperation includes, but is not limited to, making full and complete disclosure in a timely manner of all material facts regarding the accident, Injury, condition or Illness to the Plan Administrator; reporting all efforts by any person to recover any such monies; providing the Plan Administrator with any and all requested documents, reports and other information in a timely

manner regarding any demand, litigation or settlement involving the recovery of benefits paid by the Plan; and notifying the Plan Administrator of the amount and source of funds received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.

4. 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, no-fault, 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.

5. 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.

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. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, made whole, common fund or similar statute, regulation, prior court decision or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

M. RIGHT TO TERMINATE COVERAGE FOR FALSE CLAIMS

Any MUS Employee Benefit Plan Participant or provider who submits bad faith or false claims, misrepresents facts, or attempts to perpetuate a fraud upon a MUS Employee Benefit Insurance 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.

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

A MUS Employee Benefit Plan Participant who evidences a pattern of appealing baseless, frivolous claims that were initially denied, may be dropped from the Plan. The Plan Administrator or his/her designee shall

issue a 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 30-day notice of termination of coverage from the Plan following an informal hearing with the Plan Administrator or his/her designee.

Section 13
COORDINATION OF BENEFITS

A. COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a program adopted by most group benefits plans in the United States 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. COB accomplishes this by applying certain basic rules:

1. The plan that pays benefits first (primary plan) is determined by using uniform order-of-benefit determination rules.

2. The primary plan then pays benefits as it would in the absence of duplicate coverage.

3. The plan that pays benefits second (secondary plan) pays the difference between what the primary plan paid and the maximum liability of the secondary plan not to exceed the total allowed amount. The secondary plan is never liable for more expenses than it would cover if it had been primary.

In the event of a motor vehicle or premises accident; or an act of violence with the intent to disrupt electronic, communications, or any other business system, this Plan will be secondary to any auto no fault and traditional auto fault type contracts, homeowners, commercial general liability insurance and any other medical benefits coverage.

The COB rules for the Plan are modeled after the rules recommended by the National Association of Insurance Commissioners (NAIC). Most group insurance plans in the United States have adopted provisions similar to the NAIC rules.

Plan as used herein means any plan providing benefits or services for or by reason of medical, dental, vision treatment or prescription drug benefits, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for covered persons in a group whether on an insured or uninsured basis, including but not limited to:

    a. Hospital indemnity benefits; and

b. Hospital reimbursement-type plans which permit the plan participant to elect indemnity at the time of claims; or

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans; or

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision; or

4. A licensed Health Maintenance Organization (HMO); or

5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or

6. Any coverage under a Governmental program, and any coverage required or provided by any statute; or

7. Automobile insurance; or

8. Individual automobile insurance coverage on an automobile leased or owned by the Montana University System or any reasonable third-party tort feasor; or

9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage; or

10. Homeowner or premise liability insurance, individual or commercial.

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 Claimant is covered by another group plan(s), 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:

1. When another group plan does not have a COB provision, that plan will be the primary plan.

2. When another group plan has a COB provision, the following will determine the primary plan:

   a. **Employee/Dependent** – The plan covering the Claimant as an Employee pays benefits first. The plan covering the Claimant as a Dependent pays benefits second.

   b. **Dependent Children of Parents Not Separated or Divorced/ Dual Coverage of Dependent Children** – The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered the parent longer pays first. The plan that covered the other parent for the shorter time pays second.

   c. **Dependent Children of Separated or Divorced Parents/ Dual Coverage of Dependent Children** – When parents are separated or divorced, the birthday rules do not apply. Instead:
      1) The plan of the parent with custody pays first;
      2) The plan of the spouse of the parent (stepparent) pays next; and
      3) The plan of the parent without custody pays last.

      However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the plan obligated to pay by the divorce decree has actual knowledge of the court decree, the plan covering the parent with such financial responsibility will pay first. Any other plan covering the Dependent Child shall pay second. Parents with a court decree making them financially responsible for the health care expenses of a child should notify the Claims Administrator of this fact so COB can be administered properly.

IF NONE OF THE ABOVE RULES APPLY -- THE PLAN WHICH HAS COVERED THE CLAIMANT FOR A LONGER PERIOD OF TIME WILL PAY BENEFITS FIRST, EXCEPT WHEN:

1. One plan covers the Claimant as a laid-off or retired Employee (or Dependent of such an Employee); and

2. The other plan has a COB rule for laid-off or retired Employees, then the plan that covers the Claimant as other than a laid-off or retired Employee (or Dependent of such Employee) will pay first.

OTHER COB PROVISIONS:

1. When one part of a plan coordinates benefits and another part does not, each part will be treated as a separate plan.

2. If COB reduces benefits under more than one provision of the Plan, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefits limit in plan provisions.

3. A Claimant must give the Claims Administrator any information that is needed to coordinate benefits as a condition to receive benefits from the Plan.

4. The Claims Administrator may release or receive any information on a Claimant that is needed to administer COB.

5. If benefits are paid by another plan and such benefits were the liability of the Montana University System Plan, the Montana University System Plan may reimburse the other plan. Amounts reimbursed are Plan benefits and may be used to satisfy Plan liability.

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 Covered Person is actually receiving Medicare Benefits.

For all purposes, this Plan will be primary to Medicare Part D

WORKING AGED: A covered Employee who is eligible for or enrolled in Medicare Part A or Part B as a result of age may be covered under this Plan and be covered under Medicare, in which case this Plan will pay primary. A covered Employee, eligible for or enrolled in Medicare Part A or Part B as a result 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 spouse, eligible for or enrolled in Medicare Part A or Part B as a result of age, of a covered Employee may also be covered under this Plan and be covered under Medicare, in which case the Plan again will pay primary. A covered Dependent spouse, eligible for Medicare Part A or Part B as a result 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 as a result 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 enrolled in Medicare Part A or Part B as a result of age and retired.

Medicare is primary for the Retiree's Dependent spouse when the Retiree is not eligible and/or enrolled for Medicare Part A or Part B as a result of age and the Retiree's Dependent spouse is eligible for Medicare Part A or Part B as a result 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 also entitled to and 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 MEDI-GAP 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 Traditional Plan only. If enrolled in a Managed Care Plan, see separate definitions contained in the Plan Description Amendment for that plan.

1. **Adult Dependent –** An individual who meets the criteria specified in Section 1-B-1 of this Plan Description**.**

2. **Allowable Fee –** The maximum amount considered for payment for any covered treatment, service or supply, subject however, to all Plan annual and lifetime maximum benefit limitations. The following criteria will apply to determination of the Allowable Fee:

    a. For services of a Licensed Physician or License Health Care Provider:

        1) A contracted amount as established by a preferred provider or other discounting contract; or,
        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 or B above apply, an amount equal to 80% of the Provider's average billed charge.

    b. For facility charges:

        1) The contracted amount as established by a preferred provider or other discounting contract; or,
        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; or,

        2) 125% of the current Medicare allowable fee if a contracted

amount does not exist; or,

3) The billed charge if less than A or B above.

d. For Durable Medical Equipment:

1) The contracted amount as established by a preferred provider or other discounting contract; or,
2) The allowable charge established by application of the Medicare Durable Medical Equipment Fee Schedule; or,
3) The billed charge if less than A or B above.

e. For Air Ambulance:

1) The contracted amount as established by a preferred provider or other discounting contract; or,
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.

3. **Ambulatory Surgical Center** -- A duly licensed facility that is equipped and operated solely as a setting for ambulatory surgery. The facility must have all of the following:

a. Staffing, which includes:
1) Direction by a staff of Physicians or surgeons (M.D.s or D.O.s);
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.

4. **Benefit Year –** The period commencing July 1 and ending June 30 of each year.

5. **Case Management and Case Manager** – Services of a professional Case Manager that involve working with members of a medical plan, their families, and their Physicians and other Providers, to identify the most appropriate, effective and cost-efficient treatment possible for catastrophic Illnesses and accidents. Case Management services are provided to Plan Participants by a Registered Nurse on the State Employee Benefits staff who provides contractual services to the MUS Benefits Plan.

   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 Traditional 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 Precertified by the Utilization Management Administrator, who identifies cases that may benefit from Case Management. Please refer to Section 6 – How to Obtain Benefits.

6. **Claimant** – The Plan Participant for whom the claim is filed.

7. **Claims Administrator** – A firm 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.

8. **Coinsurance –** The percentage of Covered Medical Expenses, which are not specifically exempted from Coinsurance, 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, the Plan Participant is responsible for paying after the Deductible has been met.

9. **Coinsurance Maximum** – The individual Coinsurance Maximum is the Plan Participant's accumulated Coinsurance obligation on the maximum amount of non-exempt, individual Covered Medical Expenses that are subject to Coinsurance in the Benefit Year. The family Coinsurance Maximum is the covered family's accumulated Coinsurance obligation on the maximum amount of non-exempt, family Covered Medical Expenses that are subject to Coinsurance in the Benefit Year. The Plan pays remaining Covered Medical Expenses incurred in the Benefit Year at 100%.

   For the Prescription Drug Plan, the individual Coinsurance Maximum is the maximum amount of Coinsurance dollars required per Plan Participant in the Benefit Year before the Plan pays remaining Covered Prescription Drug Expenses at 100%. The family Coinsurance Maximum is the maximum amount of Coinsurance dollars required per covered family in the Benefit Year before the Plan pays remaining Covered Prescription Drug Expenses at 100%.

   For both the Traditional Medical Plan and the Prescription Drug Plan, Plan payment for Covered Expenses (that are not specifically exempted from Coinsurance) will be reduced by the applicable Coinsurance percentage stated in the Schedule of Benefits, Choices Enrollment Workbook until the Coinsurance Maximum for the Plan is reached.

   Covered Medical Expenses for Durable Medical Equipment, Prosthetic Appliances and Orthotics do not accumulate to the Coinsurance Maximum and the Coinsurance will apply after the Coinsurance Maximum is reached:

10. **Copayment –** A fixed dollar portion of Covered Medical Expenses or Covered Prescription Drug Expenses that is the Plan Participant's responsibility to pay.

11. **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 in any benefit limitations specified for the service in this Plan Description or the Schedule of Benefits and meets other requirements of this Plan Description (such as applicable limitations on Pre-existing Conditions and coordination of benefit provisions).

    This includes any portion of that the Covered Medical Charge that may be applied to the Deductible, Copayment or used to satisfy the Coinsurance

Maximum. However, any expense which is not payable by another primary plan because of the Claimant'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 payor. 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.

12. **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 Traditional Plan by a Covered Provider; and
    d. Provided and coded in accordance with applicable standard medical and insurance practice.

13. **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 card or mail service programs are covered up to the Prescription Drug Plan's allowance for the drug or medicine.

14. **Creditable Coverage** -- Health or medical coverage, prior to the date of enrollment in this Plan and after any 63 day break in coverage under any of the following:
    a. A group health plan
    b. Health insurance coverage
    c. Medicare Part A or Part B
    d. Medicaid
    e. TRICARE
    f. A medical care program of the Indian Health Service or a tribal organization
    g. A state health benefits risk pool
    h. Federal Employees Health Benefits Program
    i. A public health plan, including a plan established by a State, United States Government, foreign country, or any political subdivision thereof

j. A health benefit plan under the Peace Corps Act
k. State Children's Health Insurance Program

15. **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 mainly 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; and
        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 should be routinely submitted for consideration.

16. **Deductible –** A fixed 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 begins paying benefits on Covered Medical Services that are not specifically exempt from Deductible. For the Prescription Drug Plan, Deductible is the fixed 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 begins paying benefits on non-mail-order Covered Prescription Drug Expenses. See the current Schedule of Benefits for Deductible amounts.

17. **Dependent or Eligible Dependent –** An individual who meets one or more of the definitions of Eligible Dependent in Section 1-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.

18. **Dependent Child or Eligible Dependent Child –** An individual who meets one or more of the definitions of Eligible Dependent Child in Section 1-B-2 or who meets the definition of a disabled Dependent Child in Section

1 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.

19. **Durable Medical Equipment** -- Durable therapeutic equipment that:
    a. is designed for prolonged use over a period of years;
    b. that serves a specific therapeutic purpose in the treatment of an Injury or Illness;
    c. is primarily and customarily used for a medical purpose;
    d. is appropriate for use in the home, and
    e. is not generally useful to a person in the absence of Illness or Injury)

20. **Employee or Eligible Employee --** An individual who meets the definition of an Eligible Employee in Section 1-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.

21. **Effective Date –** The date on which a new enrollee's coverage begins.

22. **Experimental/Investigational Services –** Experimental and Investigational Services are:
    a. Any drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

    b. Any drug, device, medical treatment or procedure for which the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

    c. That the drug, device or medical treatment or procedure is under study, prior to or in the absence of any clinical trial, to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or

    d. That based upon Reliable Evidence, the drug, device, medical treatment or procedure is the subject of an on-going phase I or phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not considered Experimental or Investigational); or

e. Based upon Reliable Evidence, any drug, device, medical treatment or procedure that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or

f. Any drug, device, medical treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, The Centers for Medicare and Medicaid Services (CMS), American Dental Association, American Medical Association).

Reliable Evidence means only reports and articles published in authoritative medical and scientific literature; 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; or the informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

23. **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.

24. **Freestanding Inpatient Facility** – A facility that:
    a. Is licensed or approved as such by the Montana Department of Health and Environmental Sciences 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; and
    e. Has a resident Physician or psychiatrist on duty or on call at all times.

25. **Hospital** – An institution that 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; and
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.

26. **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. Medical plan Identification Cards issued to MUS Plan Participants may also include information on the Prescription Drug Plan to avoid a separate Prescription Drug Plan Identification Card.

27. **Illness** – A bodily disorder, disease, physical sickness, Mental Illness, or functional nervous disorder.

28. **Injury –** Physical damage to the body, which is not caused by disease or bodily infirmity.

29. **Inpatient or Inpatient Admission** – A Medically Necessary stay (or admission for a stay) of 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 24 hour medical care. A stay that meets these requirements is Inpatient even if the facility does not charge for daily room and board.

30. **Managed Care Plan or Managed Care Medical Plan** – A health plan administered by a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), or other organization licensed in the State of Montana to provide managed health care benefits through a Network of Providers.

31. **Maximum Lifetime Benefit** – The maximum Medical, Dental and Pharmacy Benefit the MUS Employee Benefit Plan pays to any one Plan

Participant per lifetime. See the current Schedule of Benefits for the Maximum Lifetime Benefit in effect.

32. **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.

33. **Medically Necessary** – A service or supply provided or prescribed by a legally qualified Physician or other Licensed Heath Care Provider that is determined by the Claim Administrator and/or an independent medical review panel to be:
    a. Appropriate and consistent with the diagnosis in accord with accepted standards of community medical practice;

    b. Provided for the diagnosis or the direct care and treatment of the Plan Participant's condition, Illness, or Injury;

    c. In accordance with standards of good medical practice;

    d. Not primarily for the convenience of the Plan Participant or the Provider;

    e. The most appropriate supply or level of service that can be provided safely to the Plan Participant on a cost-effective basis.

    The fact that services were recommended or performed by a Physician or other Licensed Heath 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 u have any questions concerning proposed, non-emergent medical and dental services, follow the procedure for Prior Authorization described in Section 6.

34. **Medicare** – The health coverage program for the aged under Title XVIII of the Social Security Act as amended.

35. **Medicare Benefits** – Benefits for services and supplies which the Plan Participant receives or is eligible for under Medicare Part A or B (whether or not the Plan Participant has applied for or is enrolled in Medicare).

36. **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.

37. **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; or
    d. Eating disorders (except for bulimia and anorexia nervosa).

38. **Mental Illness, Severe** -- The following disorders are defined by the American Psychiatric Association as Severe Mental Illness:
    - ♦ Schizophrenia
    - ♦ Schizoaffective disorder
    - ♦ Bipolar disorder
    - ♦ Major depression
    - ♦ Panic disorder
    - ♦ Obsessive-compulsive disorder
    - ♦ Autism

39. **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.

40. **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.

41. **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 may be provided individually, in groups, or through social systems subject to medical review. Specific Occupational Therapy services include, but are not limited to:
    a. Teaching daily living skills;
    b. Developing perceptual-motor skills and sensory integrative functioning;
    c. Designing, fabricating, or applying splints or selective adaptive equipment, and training in the use of upper-extremity prosthetics or upper-extremity orthotic devices;
    d. Using specifically designed crafts and exercises to enhance functional performance; and
    e. Administering and interpreting tests such as manual muscle and range of motion.

42. **Outpatient** – Medical services provided or procedures performed on an Outpatient basis without an overnight stay.

43. **Participating Providers** -- Covered Providers who have agreed to accept a health plan's Allowable Fee as full compensation and not bill Plan Participants for amounts above the Allowable Fee. Plan Participants of the health 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 a health plan but not Network Providers of the same health plan because being part of the Network may involve additional contractual obligations.

44. **Pharmacy Benefit Manager –** The company retained by the Plan to manage its Prescription Drug Plan.

45. **Physical Therapy** – The treatment of disease or Injury by physical means hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a body part.

46. **Physician** – An individual who is:
    a. Licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO);
    b. Providing services which are Covered Medical Services of the Traditional Plan; and

c. Practicing within the scope of his or her license.

47. **Plan** – The Montana University System Employee Benefits Plan, including all the provisions contained in this Plan Description, Plan Description Amendments for Managed Care Plans, Plan Descriptions of other benefits such as life insurance, and associated contracts with Claims Administrators, Insurance companies, Utilization Management Administrators, the Pharmacy Benefits Manager 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.

48. **Plan Administrator** – The individual delegated the authority to administer the Plan employed in the office of the Commissioner of Higher Education.

49. **Plan Description** – This document and any amendments hereto, except where the term is used to refer to descriptions of separate benefit plans (such as life insurance) offered by the MUS Employee Benefit Plan.

50. **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.

51. **Plan Participant** – An enrolled Employee, Retiree, 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.

52. **Precertify (Precertification)** – A process described in Section 6 for contacting the Utilization Management Administrator for the Traditional Plan prior to an Inpatient Admission for any non-emergency Illness or Injury for a pre-admission certification review. Precertification and post-admission notification 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.

53. **Pre-existing (Medical) Condition** -- Any condition (whether physical or mental), disease, Injury, or Illness for which a Plan Participant has received medical advice, diagnosis, care, or treatment in the six (6) month period immediately preceding enrollment, with the following exceptions:
    a. Pregnancy;
    b. A newborn child or child adopted or placed for adoption before attaining 18 years of age, if such child is enrolled in the Plan within 63 day of the birth, adoption or placement for adoption or had Creditable Coverage with another plan at any time during the first 30 days after birth, adoption or placement for adoption and enrolled in the Plan within 63 days of that Creditable Coverage; or
    c. A condition based solely on genetic information. However, the Pre-Existing condition exclusion does apply if an individual is diagnosed with a condition, as described above, even if the condition relates to genetic information.

54. **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 Traditional Plan. Prior Authorization is recommended for a number of Covered Medical Services and required for a couple, as described in Section 6 and in the descriptions of the applicable services.

55. **Provider or Licensed Health Care Provider** -- An individual who is:
    a. Duly licensed in the area in which services are rendered;
    b. Providing services which are Covered Medical Services of the Traditional Plan; and
    c. Practicing within the scope of his or her license

56. **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 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.

57. **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, and Employee or former Employee at any time during the Employee's or former Employee's COBRA continuation of coverage.

58. **Qualified Medical Child Support Order** -- 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:
    a. Provides for child medical support for a child of a Subscriber, covered spouse or covered Adult Dependent under this Plan, or;
    b. 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
    c. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

59. **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 (day care), as described in Section 11.

60. **Residential Care** -- Subacute, 24-hour care where the principal focus of treatment is psychosocial and does not entail 24-hour medical or nursing intervention.

61. **Retiree and Eligible Retiree –** A Retiree is a former Employee who is retiring or has retired from a unit of the Montana University System including the Office of the Commissioner of Higher Education, or other agency or organization affiliated with the Montana University System 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.

62. **Skilled Nursing Care** – Confinement in a Skilled Nursing Care Facility:
    a. Upon the specific recommendation and under the general supervision of a legally qualified Physician or surgeon; and
    b. For the purpose of receiving medical care necessary for convalescence from the condition(s) causing or contributing to a precedent Hospital confinement.

63. **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:
    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. This condition is waived for otherwise Covered Medical Expenses incurred outside of the United States.

64. **Special Enrollment -** Enrollment required by the Health Insurance Portability and Accountability Act during a prescribed period (63-days for this Plan) following a Special Enrollment event listed in Section 2.

65. **Subscriber –** A Plan Participant whose eligibility for Plan coverage is based on his or her direct relationship to the Montana University System (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.

66. **Utilization Management** – A program designed to assure that Traditional Plan Participants receive the most effective and appropriate medical services and to reduce waste. The program involves Precertification (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.

67. **Utilization Management Administrator** – The company retained by the Plan to administer its Utilization Management program for the Traditional Plan, currently Star Point Health Care Group.