

- 8. Consider seeking a second opinion for non-emergency surgical procedures.** It is the Plan Participants health at stake. The Plan Participant should know if another qualified medical specialist would not advise surgery or the same kind of surgery as the doctor recommends.
- 9. Request generic drug prescriptions when possible.** Generic drugs are usually less expensive than comparable name brands.
- 10. Review medical bills.** Make sure medical bills are correct and billed only for services received. If there is an error, the Plan Participant should call the Provider's billing office and bring the matter to their attention.
- 11. Finally, the most important thing the Plan Participant can do is guard their health.** Eat right, exercise, stop smoking, limit alcohol consumption, and participate in the MUS Wellness Programs. A healthy lifestyle can prevent or mitigate many common illnesses. Only the Plan Participant can make the choices that will improve their lifestyle and their health.

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Section 1 ELIGIBILITY

A. ELIGIBLE EMPLOYEE

An individual employed by the MUS is eligible to enroll in the Plan under the provisions of Section 2 – *Enrollment, Changes in Enrollment, Effective Dates of Coverage*, if qualified under one of the following categories:

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

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

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

B. ELIGIBLE DEPENDENTS

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

An Eligible Employee who enrolls in the Plan as a Subscriber may enroll the following Eligible Dependents according to the terms of Section 2 – *Enrollment, Changes in Enrollment, Effective Dates of Coverage* and continue the coverage of some or all Dependents along with continuation of the Employee’s coverage under Retiree or COBRA provisions of Sections 3 – *Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options* or 4 – *Continuation of Coverage Rights Under COBRA*.

1. **Legal Spouse** – The Subscriber’s legal spouse, legally married or certified common-law married (filed with the County Clerk and Recorder’s office), as defined by Montana state law.

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

2. **Child(ren)** – A Subscriber’s child will be an Eligible Dependent if the child meets the following criteria:

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

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

A Subscriber's child will be an Eligible Dependent until reaching the limiting age of twenty-six (26) without regard to student status, marital status, financial dependency, or residency status with the Subscriber or another individual. When a Dependent Child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

Proof of the above relationships must be provided in writing upon request of the campus Human Resources/Benefits Office or the Plan Administrator.

C. DISABLED DEPENDENT CHILD

An unmarried Dependent Child who is mentally or physically impaired and is enrolled in the Plan when they turn age twenty-six (26) may continue coverage on the Plan after age twenty-six (26), provided the child is incapable of self-supporting employment and is chiefly dependent upon the Subscriber for support and maintenance. Proof of incapacity **must** be submitted in writing to the Medical Plan Claims Administrator for review within thirty-one (31) days of the child's twenty-sixth (26th) birthday. The Medical Plan Claims Administrator will request additional proof of continued incapacity annually. The **Physician's Statement for Mentally or Physically Impaired Dependent Child** form is available online on the MUS *Choices* website at www.choices.mus.edu.

Note: A disabled Dependent Child, age twenty-six (26) or older, cannot be added to the Plan.

D. RESCISSION OF COVERAGE

The Plan is prohibited from rescinding coverage for Plan Participants covered under the Plan, except in cases where the Plan Participant has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the Plan and with advanced notice. The term "Rescission" means a cancellation or discontinuance of coverage that has a retroactive effect. Retroactive cancellation of coverage may occur with enrollment of a Dependent who is not eligible for coverage under the Plan's terms. Enrolling an ineligible Dependent or otherwise failing to comply with the Plan's requirements will constitute fraud or an intentional misrepresentation of a material fact that will trigger Rescission. It is the responsibility of the Subscriber to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, and relationships. It is the Subscriber's responsibility to update previously provided information and statements. The consequences of covering ineligible Dependents include liability for benefits already paid that may be asserted against the Subscriber. All claims for health care benefits incurred on or after the Rescission date will be rejected. The Rescission of coverage constitutes an Adverse Benefit Determination, and the Subscriber may file a claim under the Plan's internal claim and appeal procedures to challenge the Rescission.

E. ENROLLMENT AND RESPONSIBILITY FOR REMOVING INELIGIBLE DEPENDENTS

1. When a Subscriber enrolls a Dependent in the Plan, they represent the following:
 - a. The Dependent is eligible under the terms of the Plan; and
 - b. Evidence of eligibility **must** be provided in writing.
2. Further, the Subscriber understands:
 - a. The Plan relies on the Subscriber's representation of eligibility in accepting the enrollment of the Dependent; and

- b. Failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
 - c. Failure to provide evidence of eligibility will result in disenrollment of the Dependent, which may be retroactive to the date as of which the Dependent became ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan's provisions on Rescissions of coverage.
3. It is the responsibility of the Subscriber to contact their campus Human Resources/Benefits Office to remove from coverage a Dependent who ceases to be eligible (*Refer to provisions B. – Eligible Dependents and C. – Disabled Dependent Child of this Section.*) within thirty (30) days of the loss of eligibility. Failure to notify the campus Human Resources/Benefits Office of the Dependent's loss of Dependent status within sixty (60) days will result in the Dependent's loss of COBRA rights. COBRA Subscribers should contact their COBRA Administrator directly to report a Dependent's loss of Dependent status. (*Refer to Section 4 – Continuation of Coverage Rights Under COBRA.*) **After the month in which a Dependent's eligibility ends, the Subscriber will be held responsible for repayment of claims dollars paid for an ineligible Dependent's claims for services.**

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

Section 2

ENROLLMENT, CHANGES IN ENROLLMENT, EFFECTIVE DATES OF COVERAGE

A. NEW EMPLOYEE BENEFITS ENROLLMENT

ENROLLMENT OPTIONS: New benefits Eligible Employees have the option of enrolling themselves and Eligible Dependents as Plan Participants or waiving all coverage during a thirty (30) day initial benefits enrollment period that begins the day following the date of hire or the first date of eligibility under the Plan. If the Eligible Employee chooses to enroll, the Employee **must** enroll in the mandatory Plan benefits (Medical Plan, a Dental Plan (Basic or Select plan), a Basic Life/AD&D Insurance plan option, and a LTD Insurance plan option). Eligible Dependents may be enrolled in the Medical Plan and/or selected Dental Plan. During this initial benefits enrollment period, the Eligible Employee may also elect (and, if applicable, enroll Eligible Dependents in) optional benefits (Vision Hardware Plan, Supplemental Life Insurance, Supplemental AD&D Insurance, or FSAs) according to the provisions of those plans. **All benefit elections are irrevocable and cannot be changed until the next annual benefits enrollment period or the Plan Participant experiences a Qualifying Event, subject to Plan restrictions.**

PREMIUM PAYMENT: The MUS makes an employer contribution toward benefits for enrolled Eligible Employees. Enrollment in benefits with monthly premium costs exceeding the employer contribution authorizes the MUS to deduct the extra monthly premium costs from the Employee's pay through payroll deduction. Payroll deductions for Medical, Dental, Basic Life/AD&D Insurance, LTD Insurance, and optional Vision Hardware coverage are pre-tax benefit elections under IRS Code Section 125, unless the Employee opts out of pre-tax premium payment. Opting out precludes participation in a FSA (*Refer to Section 11 – Flexible Spending Accounts.*).

EFFECTIVE DATE: Benefits coverage **shall be effective on the enrollment date**, which is the date of hire if eligible on that date, or the first date of eligibility under the Plan. **Benefits enrollment for new benefits Eligible Employees and their Eligible Dependents must be completed within the thirty (30) day initial benefits enrollment period.**

Dependent verification documentation to support adding Eligible Dependents to the Plan will be required as proof of evidence of eligibility and must be received by the campus Human Resources/Benefits Office within the thirty (30) day initial benefits enrollment period.

IF THE EMPLOYEE CHOOSES TO WAIVE ALL COVERAGE: If a new benefits Eligible Employee chooses to waive coverage, the Employee waives all mandatory benefit coverages including Medical, Dental, Basic Life/AD&D, LTD, all optional benefits, and forfeits the employer contribution toward benefits until later enrollment. If a new benefits Eligible Employee waives coverage, the Employee may not enroll their Dependent Child(ren) in the Plan until the next annual benefits enrollment period or they have a Qualifying Event. When making the decision to waive all coverage, it is recommended the Employee discuss implications of waiving coverage with their campus Human Resources/Benefits Office as to better understand the benefits of the employer contribution. If a benefits Eligible Employee waives coverage under the Plan, the employer contribution must continue to be paid to the Plan (§ 2-18-703, MCA).

Note: The Plan has “closed enrollment” which means that a legal spouse may not be added to the Medical or Dental Plans after the thirty (30) day initial benefits enrollment period unless there is a Qualifying Event or Qualifying Life Event.

DEFAULT COVERAGE: If a new benefits Eligible Employee neither enrolls nor waives coverage within the thirty (30) day initial benefits enrollment period, the Employee will default to Employee only coverage, as defined in the current MUS *Choices* Enrollment Workbook. The cost of default coverage will be within the employer contribution. This coverage will consist of:

1. Employee Only – Medical Plan
2. Employee Only – Basic Dental Plan
3. Basic Life/AD&D – Option 1 (\$15,000)
4. LTD – Option 1 (60% of pay/180-day waiting period)

B. ANNUAL BENEFITS ENROLLMENT

Each year, the MUS will designate an annual benefits enrollment period. During annual benefits enrollment, the Subscriber may change their benefit elections, subject to Plan restrictions. All enrollments and benefit election changes are irrevocable and will be effective for the new Benefit Plan Year beginning July 1. (*Refer to the current MUS Choices Enrollment Workbook for Plan options and premium costs.*)

Note: The Plan has “closed enrollment” which means that a legal spouse may not be added to the Medical or Dental Plans during the annual benefits enrollment period unless there is a Qualifying Event or Qualifying Life Event.

PREMIUM PAYMENT: Enrolling in benefits commits the Subscriber to paying required Out-of-Pocket monthly premiums for benefit elections. For Eligible Employees, it authorizes the MUS to deduct monthly premium costs through payroll deduction that exceed the employer contribution. (*Refer to provision A. – New Employee Benefits Enrollment of this Section.*)

C. SPECIAL ENROLLMENT PERIOD (MID-YEAR CHANGE)

Subscribers on the Plan may make benefit election changes mid-year, subject to Plan restrictions, if:

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

An Eligible Dependent may be enrolled in the Plan during a sixty-three (63) day Special Enrollment period as provided by the Health Insurance Portability and Accountability Act (HIPAA) when one of the Special Enrollment events (Qualifying Event or Qualifying Life Event) occurs. The sixty-three

(63) day Special Enrollment period begins on the date of the Special Enrollment event. A request for Special Enrollment **must** be made through the Plan online benefits enrollment system during the sixty-three (63) day Special Enrollment period and all required evidence of eligibility documentation **must** be submitted to the campus Human Resources/Benefits Office within the sixty-three (63) day Special Enrollment period.

Dependent evidence of eligibility verification documentation to support the Special Enrollment request (mid-year change) will be required as proof of eligibility and must be received by the campus Human Resources/Benefits Office within the sixty-three (63) day Special Enrollment period.

QUALIFYING EVENTS AND PERMITTED BENEFIT ELECTION CHANGES: The following are qualifying changes in status and permitted changes in benefit elections:

1. **Marriage** – An Eligible Employee who marries but is not enrolled in the Plan may enroll self, the new legal spouse, and Eligible Dependents. A Subscriber who marries may enroll the new legal spouse and Eligible Dependents and change benefit elections, subject to Plan restrictions. **Coverage will be effective on the first day of the first calendar month following the Plan’s receipt of the request for Special Enrollment and receipt of Dependent verification documentation. Benefits enrollment must be completed within the sixty-three (63) day Special Enrollment period, including submission of evidence of eligibility documentation.** Benefit elections may be changed to reduce coverage if a Plan Participant becomes eligible for and moves to the new legal spouse’s health plan.
2. **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 other Eligible Dependents (legal spouse or children). The birth of a child of a Subscriber allows the Subscriber to enroll the newborn and other Eligible Dependents (legal spouse or children) and change benefit elections, subject to Plan restrictions. Coverage of a child born to a Subscriber, covered legal spouse, or covered Adult Dependent automatically begins on the date of birth and continues for a thirty-one (31) day period. To add the child beyond the first thirty-one (31) days, the Subscriber must affirmatively enroll the newborn child and pay required Employee contribution toward premiums paid for coverage to continue beyond thirty-one (31) days. **Coverage will be effective on the date of birth. The request for Special Enrollment must be completed within the sixty-three (63) day Special Enrollment period, including submission of evidence of eligibility documentation.**
3. **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 adopted child, and other Eligible Dependents (legal spouse or children). The adoption of a child by, or placement for adoption of a child, allows the Subscriber to enroll the adopted child and other Eligible Dependents (legal spouse or children) and change benefit elections, subject to Plan restrictions. This provision applies only to children under the age of eighteen (18). **Coverage will be effective on the date of the qualifying adoption or placement for adoption. The request for Special Enrollment must be completed within the sixty-three (63) day Special Enrollment period, including submission of evidence of eligibility documentation.**
4. **Divorce, legal separation, marriage annulment, dissolution of an Adult Dependent, death of a covered legal spouse or covered Adult Dependent** – Benefit elections may be changed for Special Enrollment for a Dependent Child who loses eligibility under a former legal spouse’s plan, subject to Plan restrictions. Benefit elections may be changed to drop coverage on deceased covered Dependents and on Dependents who are no longer eligible under the Plan, subject to Plan restrictions.

An ex-spouse, legally separated spouse or Adult Dependent (and associated Dependents) **must** be removed from coverage within thirty (30) days of the date of the event, i.e., date of divorce decree,

date of legal separation decree, or date of dissolution of Adult Dependent. The Subscriber **must** notify the Plan and provide verification documentation within thirty (30) days of the date of the event to enable the Plan to remove the ex-spouse, legally separated spouse or Adult Dependent (and associated Dependents) from coverage. **Termination of coverage is the last day of the month in which the event occurred. A Dependent should be removed from coverage within thirty (30) days of the event to avoid paying premium that cannot be reimbursed.** (Refer to “Effective Dates and Retroactive Premium Adjustments” below. Refer to Section 4 – Continuation of Coverage Rights Under COBRA.). Refer to separate Life and AD&D Insurance Plan Descriptions for claims procedures.)

5. **A Dependent Child dies or ceases to meet the Plan’s criteria as an Eligible Dependent –** Benefit elections **must** be changed within thirty (30) days of the event to remove an ineligible Dependent Child. **Termination of coverage is the last day of the month in which the event occurred. A Dependent Child should be removed from coverage within thirty (30) days to avoid paying premium that cannot be reimbursed.** (Refer to “Effective Dates and Retroactive Premium Adjustments” below. Refer to Section 4 – Continuation of Coverage Rights Under COBRA. Refer to separate Life and AD&D Insurance Plan Descriptions for claims procedures.)
6. **Loss of Eligibility for other Health Insurance Coverage –** Loss of other health insurance coverage by an Eligible Employee due to one of the following causes for an Employee who is eligible for the Plan but not enrolled in the Plan allows the Eligible Employee to enroll self and Eligible Dependents (legal spouse and/or children). 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 Plan restrictions:
 - a. The Employee or Eligible Dependent loses eligibility for other health insurance coverage (including Medicaid, Medicare benefits) due to:
 - employment events, such as termination of employment or reduction in work hours; or
 - a change in status resulting in loss of eligibility under other insurance coverage (such as divorce, a Dependent Child reaching a limiting age, etc.); or
 - loss of eligibility under other health insurance coverage due to no longer residing, living, or working in the plan’s service area.
 - b. The Eligible Employee or Eligible Dependent loses COBRA insurance coverage under another plan due to the COBRA continuation period is exhausted.
 - c. The Eligible Employee or Eligible Dependent loses other employer insurance coverage because the plan is terminated by the employer.

Coverage will be effective on the first day of the first calendar month following the Plan’s receipt of the request for Special Enrollment and receipt of Dependent verification documentation. Benefits enrollment must be completed within the sixty-three (63) day Special Enrollment period, including submission of evidence of eligibility documentation.

Loss of eligibility for other coverage when coverage was terminated due to failure of the Enrollee or Eligible Dependent to pay premiums on a timely basis or coverage was terminated for cause does not constitute a Qualifying Event.

Certificates of Creditable Coverage do not provide proof of loss of eligibility for other health insurance coverage and are not accepted as documentation for a Qualifying Event enrollment.

Voluntary cancellation of other insurance coverage does not constitute a Qualifying Event.

7. Eligible Dependents may enroll when coverage under Medicaid or any state children's Insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA/Healthy Montana Kids (HMK)) is terminated due to loss of eligibility. **Coverage will be effective on the first day of the first calendar month following the Plan's receipt of the request for Special Enrollment and receipt of Dependent verification documentation. Benefits enrollment must be completed within the sixty-three (63) day Special Enrollment period, including submission of evidence of eligibility documentation.**
8. Eligible Dependents may enroll when they become entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement shall be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (HMK or Medicaid). **Coverage will be effective on the first day of the first calendar month following the Plan's receipt of the request for Special Enrollment and receipt of Dependent verification documentation. Benefits enrollment must be completed within the sixty-three (63) day Special Enrollment period, including submission of evidence of eligibility documentation.**
9. **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 legal spouse allows the Subscriber to enroll the child, provided the child is an Eligible Dependent as defined in Section 1 – *Eligibility*. **Coverage may be made effective on the date of the court order** provided the child is enrolled within sixty-three (63) days of the date of the court order and a copy of the court order is provided to the campus Human Resources/Benefits Office.
10. **Qualified Medical Child Support Order** – A Qualified Medical Child Support Order (QMCSO) requiring a Subscriber or a Subscriber's legal spouse to provide medical insurance for the child allows the Subscriber to enroll the child within sixty-three (63) days of the Order, provided the child is an Eligible Dependent as defined in Section 1 – *Eligibility*. **Coverage may be made effective on the first day of the month following the date of the Order** provided the child is enrolled within sixty-three (63) days of the Order and a copy of the Order is provided to the campus Human Resources/Benefits Office.
11. **An Eligible Dependent becomes eligible for other health insurance coverage** – Benefit elections may be changed to decrease coverage if the Eligible Dependent leaves the Plan, subject to Plan restrictions. Coverage termination will be the last day of the month following receipt of proof of new eligibility for other health insurance coverage from the new employer is provided to the campus Human Resources/Benefits Office.
12. **An Eligible Dependent's other health insurance coverage suffers a major adverse change** – Benefit elections may be changed for Special Enrollment (as described above), subject to Plan restrictions.
13. **Plan Participant becomes eligible for Medicare** – The enrollee may cancel or reduce their benefits coverage under the Plan, subject to Plan restrictions.

EFFECTIVE DATES AND RETROACTIVE PREMIUM ADJUSTMENTS: 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. (*Refer to Section 3 – Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options. Refer to Section 1 – Eligibility, provision D. – Recission of Coverage.*) Benefit election changes for Special Enrollment (*Refer to provision C. – Special Enrollment Period of this Section.*) are effective on the dates indicated, subject to Plan restrictions. Premiums paid pre-tax may not be retroactively adjusted to provide a refund back more than thirty (30) days or beyond the start of the calendar year, whichever comes first.

PREMIUM PAYMENT: Enrolling in benefits commits the Subscriber to paying required Out-of-Pocket

premiums for benefit elections. For Employees, it authorizes the MUS to collect premium costs that exceed the employer contribution through payroll deduction. (*Refer to provision A. – New Employee Benefits Enrollment of this Section.*)

D. IRREVOCABLE BENEFIT ELECTIONS

Enrolling in benefits commits the Plan Participant to irrevocable benefit elections and monthly premium payments for the Benefit Plan Year. A Plan Participant cannot, under IRS regulations, start, stop, or make changes to benefit elections during the Benefit Plan Year without experiencing a Qualifying Event and the Plan permits for the Mid-Year change to the benefit election(s), subject to Plan restrictions.

E. CREDITABLE COVERAGE PROCEDURES

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

CREDITABLE COVERAGE/MEDICARE PART D/COB: An Eligible Employee, Retiree, or Dependent under the Plan may submit to the Plan, Certification of Creditable Coverage from prior health insurance or health care plan under which the Employee, Retiree, or Dependent had coverage, for the sole purpose of providing an end date to previous insurance or health care coverage. End dates are important to establish for Medicare Part D or Coordination of Benefits (COB). Certificates of Creditable Coverage do not provide proof of loss of eligibility for other health insurance coverage and are not accepted as documentation for a Qualifying Event enrollment.

F. ADDRESS CHANGES

INFORM THE PLAN OF ADDRESS CHANGES: To protect the Subscriber's family's rights, the Subscriber should keep the campus Human Resources/Benefits Office informed of changes in the addresses for self and covered Dependents.

Section 3

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

A. SICK AND WORKERS' COMPENSATION LEAVE

An Employee enrolled in the Plan who (a) is on approved sick leave under a Montana Board of Regents personnel policy or labor contract, (b) is on approved leave and is receiving Workers' Compensation benefits for an Injury sustained during MUS employment may remain covered under the Plan for up to one (1) year provided required monthly premium 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 the employer contribution is required by Union contract.

The Employee may change enrollment benefit elections (*Refer to Section 2 – Enrollment, Change in Enrollment, Effective Dates of Coverage.*) to drop some or all optional and/or Dependent coverage within sixty-three (63) days of the date leave begins or of the date applicable benefits (sick leave, vacation, MUS compensatory pay, or Workers' Compensation pay) cease.

(*Refer to provision F. – Coverage Termination of this Section. Refer to Section 4 – Continuation of Coverage Rights Under COBRA.*)

B. FAMILY AND MEDICAL LEAVE

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

For these FMLA provisions only, the following definitions apply:

1. “Member of the Armed Forces” includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation, or therapy.
2. “Next of Kin” means the nearest blood relative to the member.
3. “Parent” means Employee’s biological parent or someone who has acted as Employee’s parent in place of Employee’s biological parent.
4. “Serious health condition” means an Illness, Injury impairment, or physical or mental condition that involves:
 - A. Inpatient care in a Hospital, hospice, or residential medical facility; or
 - B. Continuing treatment by a Health Care Provider (a Doctor of Medicine or Osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the doctor practices or any other individual determined by the Secretary of Labor, and to provide health care services).
5. “Serious Injury or illness” means an Injury or Illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform their military duties.
6. “Son or daughter” means Employee’s biological child, adopted child, stepchild, foster child, a child placed in Employee’s legal custody, or a child for which Employee is acting as the parent in place of the child’s natural blood related parent. The child must be:
 - A. Under the age of eighteen (18); or
 - B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.
7. “Legal spouse” means Employee’s husband or wife as defined or recognized under State law in the State where the Employee resides.

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

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

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

Ordinarily, an Employee must provide thirty (30) days advanced notice when the requested leave is "foreseeable." If the leave is not foreseeable, the Employee must notify the Employer as soon as is practicable, generally within one (1) to two (2) working days. An employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee's serious health condition, the Employer may require second or third opinions, at the Employer's expense, and a certification of fitness to return to work prior to allowing the Employee to return to work.

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

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

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

C. EXTENDED LEAVE OF ABSENCE

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

Basic Life/AD&D, LTD, and Supplemental Life and AD&D coverages may not be continued beyond one (1) year (12 months) from the date the leave begins. (*Refer to the Life, AD&D, and LTD Plan Descriptions.*) 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 benefit elections (*Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage.*) to drop optional and/or Dependent coverage within sixty-three (63) days of the date leave begins. (*Refer to provision F. – Coverage Termination of this Section. Refer to Section 4 – Continuation of Coverage Rights Under COBRA.*)

D. STATE AND FEDERAL COVERED MILITARY LEAVE

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA): When an Employee enrolled in the Plan is absent from employment with the MUS due to service in the uniformed services and such absence or leave is subject to Federal USERRA requirements, the Employee may elect to continue Medical, Dental, and Vision Hardware coverage under the Plan for self and covered Eligible Dependents. The maximum period of coverage is the period of service and subsequent time USERRA provides for reporting back to work, not to exceed a twenty-four (24) month period beginning on the date the Employee’s absence begins.

PREMIUM PAYMENT: An Employee who elects to continue coverage shall not be required to pay more than 102% of the full premium associated with the same coverage for the Employer’s other Employees. After 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 contribution, except that an Employee who is called to service for less than thirty-one (31) days will only be responsible for the Employee monthly premium contribution made prior to such service. (*Refer to provision F. – Coverage Termination of this Section.*)

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

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

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

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

PREMIUM PAYMENT: An Employee who elects to continue Plan coverage may not be required to pay more than 102% of the full Plan monthly premium contribution 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.

EXCEPTION TO USERRA AND MMSERA: These provisions will not apply to 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.

(Refer to provision F. – Coverage Termination of this Section. Refer to Section 4 – Continuation of Coverage Rights Under COBRA.)

E. TEMPORARY LAYOFF

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

The Employee may change enrollment benefit elections *(as provided in Section 2, provision E.)* to drop optional and/or Dependent coverage within sixty-three (63) days of the date layoff begins or of the date any applicable vacation or compensatory pay ceases. *(Refer to provision F – Coverage Termination of this Section. Refer to Section 4 – Continuation of Coverage Rights Under COBRA.)*

F. COVERAGE TERMINATION

Coverage ends for a Subscriber at 12:01 a.m. on the day one (1) of the following events occurs (unless coverage is continued under COBRA provisions *(Refer to Section 4 – Continuation of Coverage Rights Under COBRA.)*):

1. The first day of the month following the month in which an Employee terminates employment; or
2. On the first day of the month in which the Subscriber's coverage terminates under the Plan; or
3. The first day of the month following the month for which required monthly premium contributions have not been paid; or
4. The day an Employee enters active duty (defined as more than thirty (30) days of full-time service) with the Armed Forces of any country. *(Refer to provision C. – Extended Leave of Absence of this Section.)*; or
5. The day the Plan is terminated by the Montana Board of Regents and a Plan of Benefits is no longer offered; or
6. The first day of the month following the month in which the Subscriber ceases to be eligible for coverage; or
7. The first day of the month following the date in which the Subscriber dies.

Coverage ends for an enrolled Dependent (unless coverage is continued under Surviving Dependent provisions below or under COBRA provisions *(Refer to Section 4 – Continuation of Coverage Rights Under COBRA)*) at 12:01 a.m. on the day 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; or
2. On the first day of the month in which the Subscriber's coverage terminates under the Plan; or
3. The first day of the month following the month for which the Subscriber fails to make required monthly premium contributions for Dependent coverage; or
4. The day the Plan is terminated by the Board of Regents and a Plan of Benefits is no longer offered; or

5. The first day of the month following the date the Employer terminates the Dependent's coverage; or
6. On the first day of the month following the date in which the Subscriber dies; or
7. The date the Dependent enters active duty (defined as more than thirty (30) days of full-time service) with the Armed Forces of any country.

(Refer to Section 1 – Eligibility, provision E. – Enrollment and Responsibility For Removing Ineligible Dependents.)

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

FOLLOWING APPROVED LEAVE OR TEMPORARY LAYOFF:

Employees who cancel or let their Medical, Dental, and/or Vision Hardware Plan coverages lapse, or who cancel coverage on their Eligible Dependents during one (1) of the above approved leaves or during a temporary layoff of no more than six (6) months, may re-enroll themselves and their formerly covered Eligible Dependents upon return to benefits-eligible employment. Upon re-enrollment, Employees and their formerly covered Eligible Dependents will be reinstated to the same benefit elections as before the approved leave or layoff.

REINSTATEMENT OF COVERAGE:

Benefits eligible Employees terminated and rehired within thirteen (13) weeks from their last day of coverage may re-enroll in the Plan and will be reinstated to the same benefit elections as before their termination. Eligible Dependents can only be added if there has been a Special Enrollment or Mid-Year Change Qualifying Event. *(Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage. Refer to separate Life, AD&D, and LTD insurance Plan Descriptions for re-enrollment requirements and restrictions.)*

Benefits eligible Employees rehired after thirteen (13) weeks from their last day of coverage may enroll in the Plan the same as a new benefits Eligible Employee and make new benefit elections and may enroll Eligible Dependents. *(Refer to separate Life, AD&D, and LTD insurance Plan Descriptions for re-enrollment requirements and restrictions.)*

H. SURVIVING DEPENDENT CONTINUATION OF COVERAGE

Pursuant to §2-18-704, MCA, a surviving Dependent of a Subscriber (Employee or Retiree) may continue certain Plan benefits (as described below).

The surviving legal spouse or Adult Dependent covered by the Plan at the time of the Subscriber's death may remain on the Plan and continue the Plan coverage options (Medical, Dental, and/or Vision Hardware Plans) they were on at the time of death on self and any Dependents covered by the Plan at the time of the Subscriber's death through self-payment of Plan monthly premiums, provided enrollment and monthly premium payment as a surviving legal spouse or Adult Dependent occurs within sixty-three (63) days of the death. A child born to the covered surviving legal spouse or Adult Dependent that was conceived before or a child for whom adoption proceedings were initiated before the Subscriber's death may also be enrolled in the Plan, provided the child is enrolled within sixty-three (63) days of birth or of the adoption event.

A covered surviving legal spouse or Adult Dependent may continue coverage for as long as they make the required self-payment of Plan monthly premiums as a survivor only or survivor and child(ren).

Surviving Dependent Child(ren) covered by the Plan at the time of the Subscriber's death may independently remain on the Plan and continue the Plan coverage options (Medical, Dental, and/or Vision Hardware) they were on at the time of death through self-payment of Plan monthly premiums as a survivor only until they cease to meet Dependent Child eligibility criteria (age twenty-six (26) (*Refer to Section 1 – Eligibility, provision B. – Eligible Dependents.*)), provided enrollment and monthly premium payment as a surviving Dependent occurs within sixty-three (63) days of the death.

Surviving Dependent coverage becomes effective on the first of the month following the Subscriber's death provided required self-payment of Plan monthly premiums is paid.

There is no Employer monthly premium contribution toward survivor benefits.

The right to continue coverage under the Plan, for Medical, Dental, and/or Vision Hardware, is a one-time opportunity.

EXCEPTION: A surviving Dependent who is Medicare-eligible is required to be enrolled in both Medicare Part A and Medicare Part B if continuing coverage on the Medical and Prescription Drug Plans and will be enrolled in the Medicare Retiree Plan coverage option(s) and will be required to self-pay the Medicare Retiree Plan monthly premiums as a survivor or survivor and child(ren).

SURVIVORS WHO FAIL TO CONTINUE COVERAGE WITHIN SIXTY-THREE (63) DAYS OF THE DEATH OR WHO ALLOW COVERAGE TO LAPSE DUE TO NONPAYMENT OF MONTHLY PREMIUMS MAY NOT LATER REJOIN THE PLAN.

COBRA ALTERNATIVE: Alternatively, a surviving legal spouse or Adult Dependent may elect to continue current coverage(s) (Medical, Dental, and/or Vision Hardware) for self and covered Eligible Dependents (or a Dependent Child could independently elect to continue coverage on self) under COBRA. (*Refer to Section 4 – Continuation of Coverage Rights Under COBRA.*) The surviving legal spouse's COBRA rights are waived if the surviving legal spouse elects surviving Dependent coverage. Similarly, a Dependent Child's COBRA rights are waived if the Dependent Child independently elects to continue surviving Dependent coverage on self.

I. RETIREE COVERAGE

ELIGIBILITY: A Plan Participant retiring from the MUS may continue certain Plan benefits (as described below). To be eligible as a Retiree, the Plan Participant **must** be eligible to receive benefits from their mandatory retirement plan, as specified below, at the time the Plan Participant leaves employment with the MUS. Retirees who are in the Montana University System Retirement Plan (MUS-RP) (with investment options through TIAA), the Public Employees' Retirement System (PERS), the Teachers' Retirement System (TRS) or other defined contribution plan sponsored by the MUS or the State of Montana **must**, in order to continue certain Plan benefits at the time they leave employment with the MUS, meet the following criteria for their specific retirement plan:

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

PERS Defined Benefit Plan:

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

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

TRS:

- For Tier One (1) members (hired before July 1, 2013): The Retiree must be at least age fifty (50) with five (5) years of membership service or under age sixty-five (65) with twenty-five (25) years of membership service.
- For Tier Two (2) members (hired after July 1, 2013): The Retiree must be at least age fifty-five (55) with five (5) years of membership service.

CONTINUATION OF COVERAGE AND COVERAGE OPTIONS: An Eligible Retiree **must** arrange with their campus Human Resources/Benefits Office to continue coverage as a Retiree on a self-pay basis within sixty-three (63) days of retirement. All Retiree status changes **must** be reported to the campus Human Resources/Benefits Office to facilitate premium and enrollment adjustments. A covered Retiree may continue coverage, as well as coverage for their covered legal spouse and/or their covered Dependent Child(ren), in the Medical Plan, with an option to continue enrollment in the Select Dental Plan and/or the Vision Hardware Plan. If a Retiree does not make a benefit election to continue enrollment in the Medical, Dental and/or Vision Hardware coverage when they first retire, the Retiree will permanently forfeit eligibility for these coverages. (*Refer to the Plan benefit options available to Retirees in the current MUS Choices Retiree Enrollment Workbook.*) ***The right to continue coverage under the Plan, for Medical, Dental, and/or Vision Hardware, is a one-time opportunity.***

RETIREE WHO FAIL TO CONTINUE COVERAGE WITHIN SIXTY-THREE (63) DAYS OR WHO ALLOW COVERAGE TO LAPSE DUE TO NONPAYMENT OF MONTHLY PREMIUMS MAY NOT LATER REJOIN THE PLAN.

EXCEPTION: A Retiree with the right to continue coverage under the MUS Plan, who chooses to continue coverage under spousal coverage in the MUS 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 the MUS Plan.

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

1. **Automatic Deductions** – When possible, the Eligible Retiree should arrange monthly automatic deductions from their retirement benefit, or directly from a checking or savings account via scheduled automated clearing house (ACH) transactions via the MUS' Direct Bill Administrator.
2. **Online Payments** – Eligible Retirees may submit monthly premium payments online from the MUS Choices website at www.choices.mus.edu.
3. **Manual Payments** – Eligible Retirees may make monthly premium payments with a manual check to MUS by mailing payments to the MUS Direct Bill Administrator, with the provided monthly billing statement.

Monthly premium rates vary depending on the number of covered Plan Participants, the benefit plans selected, and whether the Eligible Retiree and/or their covered Eligible Dependent(s) are enrolled in Medicare. Payment of claims while covered under Retiree coverage will be contingent upon the receipt by the MUS of the applicable monthly premium payment for such coverage. The monthly premium payment 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. Failure to submit the monthly premium payment within the allotted time will cause coverage to be canceled. ***Canceled or lapsed coverage cannot be reinstated.***

There is no Employer monthly premium contribution toward Retiree benefits.

MEDICARE ENROLLMENT STATUS: Eligible Retirees and/or their covered Dependents who are or become Medicare-eligible at retirement or after, are required to be enrolled in both Medicare Part A and Medicare Part B. All Medicare status changes **must** be reported to the campus Human Resources/Benefits Office to facilitate monthly premium and enrollment adjustments. A Plan Participant not enrolled in Medicare Part A and Medicare Part B has sixty-three (63) days from the date of their retirement or Medicare eligibility date, to obtain the missing coverage and will pay the non-Medicare Retiree monthly premiums. If Medicare enrollment is not completed within sixty-three (63) days from the date of the Employee's retirement or Retiree's or covered Dependent's Medicare eligibility date, the Plan Participant(s) will be disenrolled from the MUS *Choices* Medical and Prescription Drug Plans. Enrollment in the Select Dental Plan and/or Vision Hardware Plan may be continued if the Medicare-Eligible Retiree is enrolled in those plans at retirement or on the date of Medicare eligibility even if they are disenrolled from the MUS *Choices* Medical and Prescription Drug Plans due to not enrolling in Medicare Part A and Medicare Part B.

Enrollment in more than one Medicare Part D drug plan is NOT permitted.

MUS Eligible Retirees who have Medicare as their primary coverage cannot cover or continue medical coverage for their legal spouse or Adult Dependent if the legal spouse or Adult Dependent is also a MUS Eligible Retiree who has Medicare as their primary coverage. Medicare rules prohibit enrollment in more than one (1) Medicare Part D Prescription Drug Plan (dual coverage). Eligible Retirees who have Medicare as their primary coverage will need to choose to remain on their own MUS Medicare Retiree Plan or choose to enroll on their legal spouses or Adult Dependents MUS Medicare Retiree Plan as a Dependent.

PLAN BENEFITS COORDINATED WITH MEDICARE BENEFITS: *(Refer to Section 13 – Coordination of Benefits, provision B. – Coordination with Medicare.)*

COBRA ALTERNATIVE: Alternatively, at retirement, an Eligible Retiree and/or their covered Dependent(s) who are not Medicare-eligible may choose to continue their current Plan coverage(s) (Medical, Dental, and/or Vision Hardware) for self and/or their covered Dependent(s) under COBRA. *(Refer to Section 4 – Continuation of Coverage Rights Under COBRA.)* The Eligible Retiree and/or covered Dependent's COBRA rights are waived if the Eligible Retiree elects Retiree Plan coverage for self and their covered Dependent(s). If an Eligible Retiree chooses to enroll in COBRA coverage at retirement, the Eligible Retiree will permanently forfeit eligibility for all Retiree Plan coverages. At retirement, an Eligible Retiree **may not** choose to elect Retiree Plan coverage for some benefits and COBRA coverage for other benefits.

Section 4 CONTINUATION OF COVERAGE RIGHTS UNDER COBRA

A. CONTINUATION RIGHTS – COBRA

Under the Public Health Service Act, as amended, covered Eligible Employees and their covered Eligible Dependents may have the right to continue coverage beyond the time coverage would otherwise terminate due to a Qualifying Event. **Only covered Eligible Employees, their covered legal spouse and/or covered Eligible Dependent Child(ren) are Qualified Beneficiaries.** Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage under this provision will begin on the first day of the month immediately following the date the Employee and/or their covered Eligible Dependents coverage terminates.

The Plan Administrator is the Office of the Commissioner of Higher Education.

COBRA continuation coverage for the Medical Plan, the Dental Plans, and the Vision Hardware Plan is administered by the MUS COBRA administrator. COBRA elections may be completed online from the MUS *Choices* website at www.choices.mus.edu or by submitting a completed COBRA election form to the MUS COBRA administrator:

Qualifying Events for Eligible Employees (not Medicare-eligible) are the following events, if such event results in a loss of coverage under the Plan:

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

Qualifying Events for covered Eligible Dependents (not Medicare-eligible) are the following events, if such event results in a loss of coverage under the Plan:

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

NOTIFICATION RESPONSIBILITIES: An Employee **must** notify their employer of a Qualifying Event within **sixty (60) days** of the date of the Qualifying Event.

The campus Human Resources/Benefits Office **must** terminate the enrollment of the Plan Participant(s) within thirty (30) days after the applicable event or within thirty (30) days after the campus Human Resources/Benefits Office receives notice of the applicable event, whichever occurs later. Termination of the Plan Participant(s) will automatically generate a COBRA Qualifying Event Notice to continue coverage under the Plan.

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. A Qualified Beneficiary may continue current Medical, Dental, and/or Vision Hardware coverage. COBRA enrollees may drop some or all benefit elections and/or Dependent coverage during the annual benefits enrollment period. Notice of the right to COBRA continuation of coverage will be sent to the Plan Participant(s) 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 they elect 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 of coverage(s). ***There is no Employer monthly premium contribution toward COBRA benefits.*** Monthly premiums for continuation of coverage **must** be paid in advance each month to the COBRA Administrator, on behalf of the Plan Administrator. The monthly premium required under the provisions of COBRA is as follows:

1. **For a Qualified Beneficiary, up to eighteen (18) months**, the monthly premium is the same as applicable to other similarly situated non-COBRA Subscriber, plus an additional administrative expense of two percent (2%).
2. **For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration** within sixty (60) days after becoming covered under COBRA, the monthly premium may be up to a maximum of 150% of the monthly premium applicable to 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 premium for a qualified disabled Dependent will be 102% of the applicable monthly premium.
- b. If the second Qualifying Event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the monthly premium for a Qualified Beneficiary may be up to a maximum of 150% of the applicable monthly premium.

Payment of claims while covered under COBRA continuation coverage will be contingent upon the receipt by the MUS of the applicable monthly premium for such coverage. The monthly premium for continuation of coverage under this provision is due the first of the month for each month of coverage. A grace period of **thirty (30) days** from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the MUS. Failure to submit the monthly premium within the allotted time will cause coverage to be canceled. *Canceled or lapsed coverage cannot be reinstated.*

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE: If a Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the Qualifying Event or within sixty (60) days after the Qualifying Event, and the COBRA Administrator (on behalf of the Plan Administrator) is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The COBRA Administrator (on behalf of the Plan Administrator) **must** be provided with a copy of the Social Security Administration's disability determination letter within **sixty (60) days** after the date of the determination and before the end of the original eighteen-month (18-month) period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE: If another Qualifying event occurs while receiving COBRA continuation coverage, the legal spouse and Dependent Child(ren) of the former Employee can receive additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to the legal spouse and Dependent Child(ren) if the former Employee dies or becomes divorced or legally separated from the legal spouse. The extension is also available to a Dependent Child when that child ceases eligibility under the Plan as a Dependent Child. In all 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 a Qualified Beneficiary will cease on the earliest of the following:

1. On the first day of the month in which a Qualified Beneficiary becomes covered under another health insurance plan.
2. On the first day of the month in which a Qualified Beneficiary becomes Medicare-eligible for Medicare Part A and Medicare Part B if enrolled in the MUS *Choices* COBRA Medical and Prescription Drug Plans. COBRA enrollment in the Select Dental Plan and/or Vision Hardware Plan may be continued if a Medicare-eligible Qualified Beneficiary is enrolled in those plans at employment termination.
3. On the first day of the month in which timely payment of premiums required under the Plan with respect to COBRA continuation coverage for a Qualified Beneficiary is not made to the COBRA Administrator.
4. On the date the MUS ceases to provide group health plan coverage to Eligible Employees.

5. On the first day of the month following the receipt of written notice that a Qualified Beneficiary wishes to terminate COBRA continuation coverage.
6. On the date the maximum coverage period for COBRA continuation coverage ends, as follows:
 - a. Eighteen (18) months for a former Employee who is a Qualified Beneficiary due termination (or reduction of hours) of employment; or
 - b. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen (18) month period entitling that Dependent to an additional eighteen (18) months; or
 - 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' due to the Qualifying Event unless that Dependent is entitled to a longer period of COBRA continuation coverage without regard to disability; or
 - d. Twenty-nine (29) months for a Qualified Beneficiary if a disability extension period of COBRA continuation coverage has been granted for the Qualified Beneficiary; or
 - e. Thirty-six (36) months for all other Qualified Beneficiaries.
7. On the same basis the Plan can terminate for cause the coverage of a similarly situated non-COBRA Subscriber.

QUESTIONS: Questions about COBRA Continuation Coverage should be directed to the MUS COBRA Administrator or contact the nearest Regional or District Office of the U.S. DOL's Employee Benefits Security Administration (EBSA).

Section 5

HIPAA PRIVACY AND SECURITY

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

A. COMPLIANCE WITH HIPAA PRIVACY AND RECOVERY STANDARDS

Certain Authorized Employees of the MUS workforce perform services relating to administration of the Plan. To perform these services, it is necessary for these MUS Employees, at times, to have access to Protected Health Information (PHI) (as defined below).

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

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

Permitted Uses and Disclosures. PHI disclosed to Authorized Employees of the MUS workforce shall be used or disclosed by them only for the purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The term "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards. Generally, "payment" is defined as an activity undertaken by the Plan to collect money due to it or to determine or fulfill its

responsibility for payment of benefits under the Plan. “Health care operations” include activities related to payment and Plan administration. Plan administration functions do not include employment-related functions or functions with other benefit plans.

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

- Employees of the MUS Employee Benefits Division
- Campus Human Resources/Benefits Office Representatives
- Employees in the Information Technology Department who support the MUS Employee Benefits Division.

Updates Required. The Plan Administrator shall amend the Plan promptly with respect to changes in the Authorized Employees of the MUS workforce who are authorized to receive PHI.

Use and Disclosure Restricted. An Authorized Employee of the MUS workforce who receives PHI shall use or disclose the PHI only to the extent necessary to perform their duties with respect to the Plan’s administrative functions.

Resolution of Issues of Noncompliance. If Authorized Employees of the MUS workforce uses or discloses PHI other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including

- Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
- Applying appropriate sanctions against the Employee(s) causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment; Mitigating harm caused by the breach, to the extent practicable; and Documentation of the incident and all actions taken to resolve the issue and mitigate damages.

Summary Health Information means information summarizing claims history, expenses, or types of claims by Plan Participants 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 Plan Participant (e.g., birth date); phone numbers; e-mail addresses and related identifiers; Social Security numbers; medical record numbers; account or Subscriber numbers; vehicle identifiers; and photo or biometric identifier.

B. PRIVACY CERTIFICATION

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

1. Not use or further disclose the PHI other than as permitted or required by the Plan documents or as required by law. Such uses or disclosures may be for the purposes of Plan administration, including (but not limited to) the following:
 - a. Operational activities such as quality assurance or assessment and Utilization Management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing, or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews; legal services or auditing functions; business planning, management, and general administrative activities or customer service activities. Plan administration can include management of carve-out plans, such as Dental or Vision Hardware coverage. Genetic information will not be used or disclosed for underwriting purposes.
 - b. Payment activities such as determining eligibility or coverage; COB; determination of cost-sharing amounts; adjudicating or subrogating claims; claims management and collection activities; obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for Medical Necessity, coverage, or appropriateness of care, justification of charges, or utilization review activities.

- c. For purposes of this certification, Plan administration does not include disclosing Summary Health Information to help the MUS obtain premium bids; or to modify, amend, or terminate group health plan coverage. Plan administration does not include disclosure of information to the MUS as to whether the individual is a participant in, is an enrollee of, or has disenrolled from the Plan.
2. Ensure that an agent or subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the MUS with respect to such information.
 3. Not use or disclose PHI for employment-related actions and decisions or for any other benefit or Employee benefit plan of the MUS.
 4. Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law.
 5. Make available PHI to individual covered Plan Participants in accordance with Article 164.524 of the Privacy Standards.
 6. Make available PHI for amendment by individual covered Plan Participants and incorporate amendments to PHI in accordance with Article 164.526 of the Privacy Standards.
 7. Make available the PHI required to provide accounting of disclosures to individual covered Plan Participants in accordance with Article 164.528 of the Privacy Standards.
 8. Make available the PHI required to provide accounting of disclosures to individual covered Plan Participants in accordance with Article 164.528 of the Privacy Standards.
 9. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services (DHHS) for purposes of determining compliance with the Privacy Standards.
If feasible, return or destroy all PHI received from the Plan the MUS still retains in any form, and return no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction of the information unfeasible; and ensure the adequate separation between the Plan (including Authorized Employees of the MUS workforce) and the MUS, as required by Article 164.504(f)(2)(iii) of the Privacy Standards.
 10. To fulfill this requirement, MUS will restrict access to nonpublic personal information to the Plan Administrator designated in the SPD or Employees designated by the Plan Administrator who need to know that information to perform Plan administration and healthcare operations functions or assist eligible Plan Participants enrolling and dis-enrolling from the Plan. MUS will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator and an Employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies MUS establishes to secure such information.

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

C. SECURITY CERTIFICATION

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

1. Implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic PHI the MUS creates, maintains, or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards but shall generally mean PHI that is transmitted by or maintained in an electronic media.

2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that Electronic PHI is used and disclosed only as stated in the Privacy Certification section above.
3. Ensure that an agent or subcontractor to whom it provides Electronic PHI shall agree, in writing, to the same restrictions and conditions that apply to the MUS with respect to Electronic PHI including (but not limited to) direct liability for breach involving unsecured Electronic PHI.
4. Report to the Plan Administrator an attempted breach, or breach of security measures as described in this certification and any disclosure or attempted disclosure of Electronic PHI of which the MUS becomes aware.

Section 6

HOW TO OBTAIN BENEFITS

This Section describes how to obtain benefits for Plan Participants enrolled in the Plan. This Section also describes the Medical Plan claims appeal process for Plan Participants.

Payment of benefits will be made based on the submission of required information to the Plan Claims Administrators. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for Plan Claims Administrator contact information.)*

A. PRIOR TO RECEIVING SERVICES

1. **OBTAIN AN IDENTIFICATION CARD.** Make sure you have a current Identification Card (ID) that contains the correct Identification Number, Subscriber name, Dependent name(s), and Effective Date. Plan Participants will receive separate IDs for the Medical Plan, Prescription Drug Plan, Dental Plan, and Vision Hardware Plan.
2. If a new Plan Participant needs services before they receive an ID or the ID is lost, the Provider's office may contact the Plan Claims Administrator or the campus Human Resources/Benefits Office to verify coverage. Replacement IDs may be requested by contacting the Plan Claims Administrators.
3. **CHOOSE A PARTICIPATING IN-NETWORK PROVIDER FOR MEDICAL CARE WHEN POSSIBLE.** Participating Providers with the Medical Plan Claims Administrator will accept the Allowed Amount and not balance bill Plan Participants for charges more than the Allowed Amount for Covered Medical Services. For most Covered Medical Services (services without a specified benefit maximum), a Plan Participant who uses a Participating Provider will only be responsible for their portion of the Allowed Amount (Deductible, Coinsurance, and/or Copayments), not for charges over the Allowed Amount. A Plan Participant who uses a Participating Provider will pay a lower Coinsurance percentage. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits.)*
4. **DETERMINE IF A PLANNED NON-EMERGENCY SERVICE REQUIRES PRIOR AUTHORIZATION. ADVERSE PRIOR AUTHORIZATION DETERMINATIONS CANNOT BE APPEALED.**
Prior Authorization is required to receive benefits for:
 - a. Organ or Tissue Transplant.
 - b. Out-of-Area Medical Travel Expenses.
 - c. Bariatric Surgery.

If prior authorization is not obtained for the services listed above, charges connected with, or related to, these services will be denied.

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

- a. Surgery that could be considered Cosmetic.
- b. A procedure or service that could be considered Experimental or Investigational.
- c. Surgical treatment of Temporomandibular Joint Syndrome (TMJ).
- d. Durable Medical Equipment that costs more than \$2,500.
- e. Home Health Care or Skilled Nursing services.
- f. Gender Identity Disorder/Gender Dysphoria treatment and services.

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

- a. A written request from the Provider explaining the proposed service and/or the functional aspects of a surgery and why it is being done; and
- 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; and
- c. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding procedure codes; and
- d. The attending Physician's prescription, if applicable; or
- e. A Physician's referral letter, if applicable; and
- f. A letter of Medical Necessity; or
- g. A written treatment plan; and
- h. Other information deemed necessary to evaluate the Prior Authorization request.

Be sure to include the Plan Participant's name, address, and the Identification Number when submitting the above documentation to the Medical Plan Claims Administrator.

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. Transplant services and out-of-area medical travel expenses are **not covered** without Prior Authorization.

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

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

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

- a. Optimize efficient resource utilization.
- b. Ensure that patients have equitable access to care.
- c. Provide collaboration and communication among all members of the health care team 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. (*Refer to provision 6 – Case Management and Maternity Case Management Services of this Section.*)

To Pre-Certify or provide notice of an emergency admission, contact Utilization Management at the Medical Plan Claims Administrator.

Once a final decision is made, a written notice of the number of Pre-Certified days will be sent to the Physician, to the Plan Participant, and to the facility. Pre-Certification is not required and therefore cannot be appealed. However, a pre-service claim can be filed for Prior Authorization. (*Refer to Section 6 – How to Obtain Benefits, provision C. – Claims and Eligibility Procedures.*)

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 determined to be ineligible for payment under the Plan. Therefore, although not required, Pre-Certification and Plan notification of emergency admissions are strongly recommended to obtain coverage information prior to incurring charges.

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

CONTINUED STAY CERTIFICATION: At the time of Initial Pre-Certification, Utilization Management at the Medical Plan Claims Administrator will certify a certain number of days for the Inpatient stay. If the stay exceeds the number of days certified, certification for additional days should be obtained in the same manner as the pre-admission certification.

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

6. CASE MANAGEMENT AND MATERNITY CASE MANAGEMENT SERVICES

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

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

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

Focused Case Management, disease management, and health coaching services are provided by MUS care professionals (Benefits Department and Wellness Program) or contracted vendors. These professionals work with Plan Participants who can benefit from these services, as well as their attending Physician, and/or their family. to identify and arrange the most appropriate,

effective, and cost-efficient treatment possible. Services are focused on Plan Participants identified as having:

- a. a catastrophic Illness or Injury; 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. Qualifying adult Plan Participants enrolled in the Medical Plan may be individually contacted by a care professional. Program provisions require the care professional which provides these services keep all claims data and other medical information confidential. When offered focused Case Management, disease management, or health coaching services, Plan Participants are encouraged to carefully consider the benefit offerings, but can reject some, or all, proposals, or advice. Use of these services is voluntary and offered at no additional cost to Plan Participants and are helpful in several ways:

- a. These services can permit treatment options not normally available under the Plan through Plan exceptions. The Plan may, at its sole discretion, make payment for medical or dental services that are not listed as covered services or benefits of the SPD to provide quality care at a lesser cost. Such payments shall be made only upon agreement by the Plan Participant and the Plan; and
- b. Participation may save both the 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 to make arrangement for special treatment plans.

B. FILING A CLAIM

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

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

When completed, the claim **must** be sent to the Plan Claims Administrator.

A claim will not 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 PLAN CLAIMS ADMINISTRATOR.

The Plan has 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, all medical and other relevant records it deems necessary to properly adjudicate the claim.

C. CLAIMS AND ELIGIBILITY PROCEDURES

Claims will be considered for payment according to the Plan's applicable terms and conditions, industry-standard claims processing guidelines and administrative practices not inconsistent with the terms of the Plan. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims determinations will be made within the time periods stated below. For purposes of this section, a Plan Participant will include the 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 because of the assignment of benefits. A Claimant, for purposes of appeals regulations, is a Plan Participant who makes a claim under the following rules for internal claims and appeals and external review procedures, and expressly includes a Claimant's authorized representative, as defined below. A Plan Participant becomes a Claimant when making a request for a Plan benefit or benefits in accordance with these claims procedures.

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

"Authorized Representative" means a representative authorized by the Claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize the Authorized Representative when the Plan receives the written authorization.

INFORMATION REGARDING URGENT CARE CLAIMS IS PROVIDED TO THE CLAIMANT UNDER THE DISCLOSURE REQUIREMENTS OF APPLICABLE LAW; THE PLAN DOES NOT MAKE TREATMENT DECISIONS. A DECISION TO RECEIVE TREATMENT MUST BE MADE BETWEEN THE CLAIMANT AND THE HEALTHCARE PROVIDER; HOWEVER, THE PLAN WILL ONLY PAY BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS, AND EXCLUSIONS OF THE SPD.

Types of Medical Claims

Claims are classified by type of claim and the timeline in which a decision must be determined. The notice timeline provided depends on the type of claim. The initial benefit determination notice will be included in the Plan Participant's Explanation of Benefits (EOB) or in a letter from the Plan, whether adverse or not. There are five (5) types of claims:

1. **Pre-Service Claim** – A claim that **must** be submitted to the Medical Plan Claims Administrator before the Plan Participant receives medical treatment or service. A Pre-Service Claim under the Plan requires a Prior Authorization determination before a Plan Participant obtains medical care or

treatment.

2. **Urgent Care Claim** – A claim involving urgent care for medical care or treatment which may seriously jeopardize the Claimant’s life, health, or the ability to regain maximum function or may, in the opinion of a Physician with knowledge of the Claimant’s medical condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. **There are no pre-service urgent care requirements under the Plan, and therefore, there are no rights to appeal a pre-service urgent care claim denial.**
3. **Post-Service Claim** – A claim for a medical benefit under the Plan that is not a pre-service claim, an urgent care claim, or a concurrent care claim
4. **Rescission of Coverage** – A cancellation or discontinuation of coverage that has a retroactive effect based upon a Claimant’s fraud or intentional misrepresentation of a material fact. A cancellation or discontinuance of coverage that has a retroactive effect is not a Rescission if and to the extent that it is attributable to a failure to timely pay required monthly premiums or contributions toward the cost of coverage.
5. **Concurrent Care Claim** – A determination made by the Medical Plan Claims Administrator approving an ongoing course of medical treatment for the Claimant to be provided over time or for a specific number of treatments. A concurrent care claim is a claim that relates to the ongoing course of medical treatment (and the basis of the approved concurrent care determination), such as a request by the Claimant for an extension of the number of treatments or the termination by the Plan of the previously approved time for medical treatment.

Initial Claim Determination by Type of Claim and Notice

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

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

Urgent Care Claim Determination and Notice

a. Designation of Claim

Upon receipt of a pre-service claim, the Medical Plan Claims Administrator will determine if the claim involves urgent care. If a Physician with knowledge of the Claimant’s medical condition determines the claim involves urgent care, the Medical Plan Claims Administrator will treat the claim as an urgent care claim.

b. Notice of Determination

If the claim is treated as an urgent care claim, the Medical Plan Claims Administrator will provide the Claimant with notice of the determination, either verbally or in writing, as soon as possible consistent with the medical exigencies but no later than seventy-two (72) hours from the Medical

Plan Claims Administrator's receipt of the claim. If verbal notice is provided, the Medical Plan Claims Administrator will provide a written notice within three (3) days after the date the Medical Plan Claims Administrator notified the Claimant.

c. Notice of Incomplete or Improperly Submitted Claim

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

Post-Service Claim Determination and Notice

a. Notice of Determination

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

b. Notice of Extension

1. For reasons beyond the control of the Medical Plan Claims Administrator, the Medical Plan Claims Administrator may extend the thirty (30) day timeframe for an additional fifteen (15) day period for reasons beyond the Medical Plan Claims Administrator's control. The Medical Plan Claims Administrator will notify the Claimant in writing of the circumstances requiring an extension and the date by which the Medical Plan Claims Administrator expects to render a determination in such case.
2. For receipt of information from the Claimant to decide the claim if the extension is necessary due to the Claimant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed. The Claimant has forty-five (45) days from receipt of the notice to provide the information. The Medical Plan Claims Administrator will notify the Claimant of the initial claim determination no later than fifteen (15) days after the earlier of the date the Medical Plan Claims Administrator receives the specific information requested, or the due date for the information.

Concurrent Care Determination and Time Frame for Decision and Notice

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

1. In response to the Claimant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Claimant's claim involves urgent care, the Medical Plan Claims Administrator will review the claim and notify the Claimant of its determination no later than twenty-four (24) hours from the date the Medical Plan Claims Administrator received the Claimant's claim, provided the Claimant's claim was filed at least twenty-four (24) hours prior to the end of the approved time period or number of treatments.
2. If the Claimant's claim was not filed at least twenty-four (24) hours prior to the end of the approved time or number of treatments, the Claimant's claim will be treated as and decided within the timeframes for an urgent care claim. (*Refer to Initial Claim Determination by Type of Claim and Notice of this Section.*)
3. If the Claimant's claim did not involve urgent care, the time periods for deciding pre-service claims and post-service claims, as applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

Other than through a Plan amendment or termination, the Medical Plan Claims Administrator may not subsequently reduce or terminate an ongoing course of treatment for which the Claimant has received prior approval unless the Medical Plan Claims Administrator provides the Claimant with

written notice of the reduction or termination and the scheduled date of its occurrence sufficiently in advance to allow the Claimant to appeal the determination and obtain a decision before the reduction or termination occurs.

Rescission of Coverage Determination and Notice of Intent to Rescind

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

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

D. NOTICE OF AN ADVERSE BENEFIT DETERMINATION

A determination on a claim is "adverse" if it is a Rescission or a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Plan benefit. If a claim is denied in whole or in part, the Claimant will receive written notice of the Adverse Benefit Determination. A claim EOB will be provided by the Medical Plan Claims Administrator showing:

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

If a Claimant does not understand the reason for an Adverse Benefit Determination, they should contact the Medical Plan Claims Administrator.

E. APPEALING AN ADVERSE BENEFIT DETERMINATION

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

Important Appeal Deadline

If a Claimant disagrees with an Adverse Benefit Determination (including a Rescission), the Claimant may appeal the determination within one hundred-eighty (180) days from receipt of the Adverse Benefit Determination. Except for urgent care claims, the Claimant's appeal **must** be made in writing, should list the reasons why the Claimant does not agree with the Adverse Benefit Determination, and **must** be sent to the Medical Plan Claims Administrator.

How the Appeal Will Be Decided

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

Consideration of Comments

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

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

Consultation with An Expert

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

Access to Relevant Information

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

Expedited Methods for Urgent Care Claims

Considering the expedited timeframes for determination of urgent care claims, an urgent care appeal may be submitted to the Medical Plan Claims Administrator. The claim should include at least the following information:

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

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

F. TIMEFRAMES FOR DECIDING AN APPEAL OF ADVERSE BENEFIT DETERMINATION

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

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

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

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

G. FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

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

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

an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances; or a statement that such explanation will be provided, upon request and free of charge; and

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

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

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

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

Right to Request an External Review:

Standard External Review

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

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

The Claimant will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request, and set forth the time limit for the Claimant

to provide the additional information needed (the longer of the initial four-month period within which to request an external review or, if later, forty-eight (48) hours, after the receipt of this notice.

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

Expedited External Review

Expedited external review may be requested when:

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

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

External Review by IRO

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

1. The Claimant's medical records; and
2. The attending health care professional's recommendation; and
3. Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating Health Care Provider; and
4. The terms of the Claimant's SPD; and
5. Evidence-based practice guidelines; and
6. Applicable clinical review criteria developed and used by the Plan; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

Notice of Final External Review Decision

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

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

Compliance with IRO Decision

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

Section 7 MEDICAL PLAN DESCRIPTION

This Section describes the Medical Plan benefits for Plan Participants.

A. COVERED MEDICAL EXPENSES

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

1. Expenses within the Allowed Amount (Plan Participants are responsible for charges by Out-of-Network Providers exceeding the Allowed Amount (balance billing)); and
2. Expenses within the specified benefit limitations contained in this Section and the current MUS *Choices* Enrollment Workbook Schedule of Benefits, and which meet other requirements of the SPD; 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 (as described below).

B. DEDUCTIBLE

DEDUCTIBLE – During each annual benefits enrollment (*Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage, provision B. – Annual Benefits Enrollment.*), Plan Participants may choose to enroll in the Medical Plan for the upcoming Benefit Plan Year. Covered Medical Expenses incurred by a Plan Participant are credited toward the annual Deductible until the Plan Participant meets the individual Deductible or until expenses credited toward the Deductible for all covered Dependents meet the family Deductible. The Medical Plan does not begin paying benefits for a Plan Participant until either the Participant's annual Deductible or the family Deductible is met. Services from an Out-of-Network Provider have a separate annual Deductible and annual Out-of-Pocket Maximum. An Out-of-Network Provider can balance bill the difference between the Allowed Amount and the billed charge.

EXEMPTIONS FROM DEDUCTIBLE – Some Covered Medical Expenses are exempt from the annual Deductible. Review the current MUS *Choices* Enrollment Workbook Schedule of Benefits for specific exemptions.

C. COINSURANCE AND COPAYMENT

COINSURANCE – After a Plan Participant has satisfied the annual Deductible, the Plan Participant pays a Coinsurance percentage of the Covered Medical Expenses they incur until the Out-of-Pocket Maximum is reached. A Plan Participant's Coinsurance Maximum has been reached when either: a)

the Plan Participant accrues the maximum amount of individual Covered Medical Expenses that are subject to Coinsurance in the Benefit Plan Year or b) the Plan Participant's covered Dependents accrue the maximum amount of family Covered Medical Expenses that are subject to Coinsurance in the Benefit Plan Year. The Plan pays any remaining Covered Medical Expenses the Plan Participant incurs in the Benefit Plan Year. Services from an Out-of-Network Provider have a separate Coinsurance percentage and annual Out-of-Pocket Maximum. An Out-of-Network Provider can balance bill the difference between the Allowed Amount and the billed charge.

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

PRIMARY CARE PHYSICIAN/SPECIALIST PROVIDER COPAYMENT – A fixed dollar Copayment, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, applies to charges for the office visit only, for evaluation and management of the patient (consultation and examination by a provider in an office, clinic, telemedicine, or other outpatient setting). All other Covered Medical Expenses for services rendered during the office visit are subject to the annual Deductible and Coinsurance. The Copayment is not credited toward the annual Deductible, but it does apply toward the annual Out-of-Pocket Maximum.

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

URGENT CARE COPAYMENT – A fixed dollar Copayment, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, applies to charges for the urgent care visit only. All other Covered Medical Expenses for services rendered at the urgent care are subject to the annual Deductible and Coinsurance. The Copayment is not credited toward the annual Deductible, but it does apply toward the annual Out-of-Pocket Maximum.

D. BENEFIT MAXIMUMS

Some Covered Medical Expenses include benefit maximums in the form of annual limits on the number of allowed visits or dollar limits payable for services. For the Medical Plan, these benefit maximums are indicated in the description of the specific services below and/or in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

E. DEFINITION OF COVERED MEDICAL SERVICES

Covered Medical Services are visits, 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 MUS *Choices* Enrollment Workbook Schedule of Benefits; and
2. Either Medically Necessary for the diagnosis or treatment of Injury, Illness, or maternity; or services specified as covered preventive services in this Section; and
3. Provided to a Plan Participant by a covered Licensed Health Care Provider practicing within the scope of their license; and
4. Provided and coded in accordance with applicable standard medical and medical insurance practice.

F. SPECIFIC COVERED MEDICAL SERVICES

Expenses for the following services, **which meet the above definition of Covered Medical Services**, are covered by this Medical Plan (*Refer to provision E. – Definition of Covered Medical Expenses of this Section.*):

- 1. Inpatient Hospital Services – *The Plan strongly recommends all Inpatient care be Pre-Certified by Utilization Management at the Medical Plan Claims Administrator.*** (*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 Inpatient care. 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 the SPD.

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

- a. Daily room and board in a semi-private room or private room and general nursing services, or confinement in an intensive care unit. If private room accommodations are used, the daily room and board charge allowed will not exceed the facility's average semi-private room charges.
- b. Medically Necessary Hospital expenses for miscellaneous services and supplies furnished by the Hospital, including hemodialysis and x-ray.
- c. Nursery neonatal unit services, including general nursing services, Hospital expenses for miscellaneous services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities of a newborn Dependent, or premature birth of a newborn Dependent.

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

- 2. Inpatient Professional Care – *(Pre-Certification of all Inpatient Admissions is strongly recommended)*** – Health care services performed, prescribed, or supervised by a Licensed Health Care Provider including diagnostic, therapeutic, medical, referral, and consultative health care services. (*Refer to Surgery provision for surgical services.*)
- 3. Outpatient Hospital Services** – Outpatient Hospital services rendered to a Plan Participant who is not admitted for Inpatient care.
- 4. Emergency Room** – Hospital emergency room services for care or treatment of a Medical Emergency. Emergency room benefits are subject to a Copayment (*Refer to provision C. – Coinsurance and Copayment of this Section and the current MUS Choices Enrollment Workbook Schedule of Benefits*), as well as the annual Deductible and Coinsurance.
- 5. Outpatient Office and Urgent Care Clinic Services** – Coverage includes health care services for the evaluation and management of the patient (consultation and examination by a provider in an office, urgent care clinic, telemedicine, or other outpatient setting) by a Physician, Naturopath, or Licensed Health Care Provider, or by other office/clinic staff under a Physician's direction. These services include, but are not limited to, office visits, telemedicine visits, diagnostic services including x-ray; treatment services including minor surgery; laboratory services; radiation services provided within the office or clinic; and referral services. These services are subject to a Copayment (*Refer to provision C. – Coinsurance and Copayment of this Section and the current MUS Choices Enrollment Workbook Schedule of Benefits*), as well as the annual Deductible and Coinsurance.

Prescription drugs intended for use in a Physician's office or setting, other than home use, are covered when billed during an evaluation or management encounter, subject to the annual Deductible and

Coinsurance.

6. Services of an Ambulatory Surgical Center – defined below.

“Ambulatory Surgical Center” (same-day surgery center or Outpatient surgery center) means a licensed facility with a 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 performing Outpatient 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 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., magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, electrocardiogram (EKG) or electroencephalogram (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 an independent lab or other Outpatient facility, the Physician’s or other Provider’s office or clinic.

8. Surgical Services – *(Pre-Certification of all Inpatient Admissions is strongly recommended)* Surgical procedures provided in a licensed facility are covered (as described below) *(Refer to provision 39 – Bariatric Surgery of this Section.)*:

- a. If more than one (1) surgical procedure is performed during the same operating session, charges up to the Allowed Amount for the major procedure will be covered plus one-half (1/2) of charges up to the Allowed Amount for each of the lesser procedures. When two (2) surgeons of different specialties perform distinctly different procedures in one (1) operating session, claims will be reviewed before determination on coverage is made. There is no additional coverage for incidental surgical procedures. “Incidental surgery” is a procedure which is an integral part of, or incidental to, the primary surgical service and performed during the same operative session. Surgery is not incidental if:
 1. It involves a major body system different from the primary surgical services, or
 2. It adds significant time and complexity to the operating session and amount of patient care.
- b. If two (2) or more surgeons acting as co-surgeons perform the same operations or procedures other than as an Assistant at Surgery, the Allowed Amount will be divided between them. This provision is subject to the limitations listed above.
- c. “Assistant at Surgery” is a Physician or non-Physician assistant who actively assists the operating Physician in the performance of covered surgery. Assistant at Surgery charges will be covered as follows:
 1. If the Assistant at Surgery is a Physician, the Allowed Amount will be twenty (20) percent of the Allowed Amount 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 Allowed Amount will be ten (10) percent of the Allowed Amount for the surgical procedure or the assistant’s charge, whichever is less.

3. Benefits are not available when the Assistant at Surgery is present only because the facility requires such services.
 4. Benefits for the Assistant at Surgery will be paid only if such services were Medically Necessary.
 5. If two (2) 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. Charges for an additional Assistant at Surgery will be subject to review.
- 9. Post-mastectomy Care** – Inpatient care will be covered for the time that is determined to be Medically Necessary by the attending Physician and in consultation with the patient following a mastectomy, a lumpectomy, or a lymph node(s) dissection for the treatment of breast cancer.
- 10. Reconstructive Breast Surgery – (*Pre-Certification of all Inpatient Admissions is strongly recommended*)** – Reconstructive breast surgery after a mastectomy is covered. Covered Medical Services include, but are not limited to, the following:
- a. Reconstructive breast surgery means surgery performed because of a mastectomy to reestablish symmetry between the breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.
 - b. All stages of reconstruction of the breast, including re-pigmentation of the areola, on which a mastectomy has been performed.
 - c. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
 - d. Chemotherapy and/or radiation therapy following surgical procedures.
 - e. Prostheses and treatment of physical complications at all stages of a mastectomy and breast reconstruction, including lymphedemas.

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

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

- 11. Voluntary Sterilization** – For covered Plan Participants.
- 12. Nursing Services** – Private duty nursing services of a Registered Nurse (RN) for skilled care, with a treatment plan determined by a Physician.
- 13. Ambulance Services** – Ambulance Services are covered to the nearest facility where care or treatment of a Medical Emergency can be rendered; or from one facility to another for a higher level of care.
- 14. Travel Expenses for Out-of-Area Medical Care** – If a Plan Participant’s Covered Medical Expenses for an Illness or Injury requires treatment services which are not available in the area in which the Plan Participant resides, the Plan may reimburse travel expenses to seek services rendered by an Out-of-Area Provider . The Plan will reimburse travel expenses for meals, lodging, commercial and personal automobile, commercial airline, railroad, or bus transportation expenses to and from the nearest licensed medical facility that is equipped to provide the necessary treatment services. Travel expenses for Covered Medical Out-of-Area treatment Services are reimbursed at the State reimbursement rates and are limited to a maximum of \$1,500 per Benefit Plan Year or \$5,000 per transplant.

The travel benefit is for travel expenses for the patient only.

OUT-OF-AREA MEDICAL TRAVEL PRIOR AUTHORIZATION

*Out-of-Area travel expenses **must be Prior Authorized**. If Prior Authorization is not obtained, charges for travel expenses **will not be covered**. (Refer to Section 6 - How to Obtain Benefits.)*

Plan Participants **must** complete an Out-of-Area Medical Travel Prior Authorization Application Form and submit the completed form to the MUS Benefits Office prior to travel. The form is available on the MUS *Choices* website at www.choices.mus.edu.

15. Dental Services – The Plan will cover charges up to the Dental Fee Schedule Allowed Amount for:

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

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

16. Durable Medical Equipment and Orthopedic Appliances – Charges up to the Allowed Amount 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 part.
- 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 time, serves a specific therapeutic purpose in the treatment of an Injury or Illness, is primarily and customarily used for a medical purpose, and is appropriate for use in the home or the purchase of this equipment if economically justified, whichever is less).
- c. For Durable Medical Equipment for which purchase is not feasible, reasonable rental charges will be paid. The Plan Case Manager may determine a reasonable rate.
- d. Replacement or repair of Durable Medical Equipment or Orthopedic Appliances.

Prior Authorization of charges that may exceed \$2,500 is strongly recommended. (Refer to Section 6 – How to Obtain Benefits.)

17. Prosthetic Appliances – Purchase of prosthetic appliances, defined as devices that are designed to replace a natural body part lost or damaged due to Illness or Injury to restore full or partial bodily function or appearance, including (but not limited to) artificial limbs, eyes, and larynx, and replacement or repair of such prosthetic appliances.

18. Miscellaneous Supplies for Use Outside of a Hospital – Specialized medical supplies ordered by a Physician for the Medically Necessary treatment of Injury or Illness obtained from a Physician's office, Urgent Care Clinic, Hospital (or other Inpatient facility licensed to provide skilled twenty-four (24) hour medical care), Ambulatory Surgical Center, or medical supply company, and which are not covered by the Prescription Drug Plan (*Refer to Section 9- Prescription Drug Plan Description.*), including specialized dressings, catheters, and supplies for renal dialysis equipment. Dental braces and corrective shoes are specific exclusions of the Plan.

19. Inborn Errors of Metabolism – Treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist.

- 20. Blood Transfusion Services** – 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. Credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Covered Medical Expenses.
- 21. Radiation therapy and/or chemotherapy.**
- 22. Oxygen, other gases, and their administration.**
- 23. Anesthetics and administration of an anesthetic.**
- 24. Medical Records Services** – Reasonable services for producing medical records only if incurred for utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Services that exceed limits imposed by applicable law will not be deemed to be reasonable.
- 25. Home Health Care** – Care provided for Medically Necessary services and supplies furnished by a home health agency in a covered Plan Participant’s home in accordance with a home health care plan as prescribed by a Physician. A home health agency is a public agency or a private organization that is licensed as a home health agency by a state or is certified to participate as such under Title XVIII of the Social Security Act. A home health care plan is a treatment plan for the continued care and treatment of the Plan Participant while under the care of a Physician. The Physician must approve the home health care plan in writing and certify the home health care is Medically Necessary. The home health care benefit is limited, as specified in the current MUS Choices Enrollment Workbook Schedule of Benefits.

Prior Authorization for home health care is strongly recommended. (Refer to Section 6 – How to Obtain Benefits.)

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

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

Home health care services exclude the following:

- a. Services that are primarily for the convenience of the covered Plan Participant’s family.
- b. Transportation services.
- c. Respite Care
- d. 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 an individual without medical skills; and
 - 2) Is designed mainly to help the patient with daily living activities, including (but not limited to):
 - a) Personal care such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube, or gastrostomy; exercising; dressing; enema and using the toilet.
 - b) Homemaking such as preparing meals or special diets.
 - c) Moving the patient.
 - d) Acting as companion or sitter.
 - e) Supervising medication that can usually be self-administered.
 - f) Oral hygiene.
 - g) Ordinary skin and nail care.

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

26. Hospice Care – The Hospice Care benefit is limited, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits. Hospice care services provide a coordinated set of services that:

- a. Arranges, coordinates, and/or provides hospice care services for terminally ill patients and their families through a hospice care team; and
- 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.

A Hospice care team is an interdisciplinary group of personnel that provides hospice care services and may include:

- a. A Physician; and
- b. A patient care coordinator (Physician, RN or LPN who serves as an intermediary between the hospice care program and the attending Physician); and
- c. A RN or LPN; and
- 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; and
- b. A Physician must order the services; and
- c. The patient is terminally ill; and
- d. The patient is expected to live no more than six (6) months.

HOSPICE CARE SERVICES – Services that are designed to meet the physical, psychological, spiritual, and social needs of the terminally ill Plan Participant and their 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 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 RN, LPN, or a public health Nurse who is under the direct supervision of a RN.
- c. Physical 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 legal spouse, and children and, when assuming responsibility for patient care, parents, and siblings.

27. Care by a Skilled Nursing Facility (Extended Care Unit or Facility, or Transitional Care Unit)
– If, because of an Injury or Illness, a 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, as specified in the current MUS Choices Enrollment Workbook Schedule of Benefits.

Pre-Certification of all Inpatient Admissions is strongly recommended. (Refer to Section 6 – How to Obtain Benefits.)

SKILLED NURSING FACILITY SERVICES include the following:

- a. Room and board, including 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; and
- b. Medical services customarily provided by the Skilled Nursing Care Facility, except for 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 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; and
- b. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled individuals, Custodial or educational Care, or care of mental disorders; and
- c. It is certified by Medicare.

28. Maternity and Routine Newborn Care – If a Plan Participant incurs expenses due to a pregnancy, including elective abortion, benefits will be payable in the same manner and subject to the same limitations and conditions as other medical conditions.

Pre-Certification of all Inpatient Admissions is strongly recommended. (Refer to Section 6 – How to Obtain Benefits.)

Coverage includes:

- a. Prenatal office visits.
- b. Services of a Physician or other licensed Provider, Hospital, Physician Staffed Birthing Center, or licensed certified nurse midwife for maternity care.
- c. Nursery and Physician's services for newborn well-baby care, including circumcision and phenylketonuria (PKU) testing, while both the Plan Participant and the newborn child are Inpatient because of the child's birth.
- d. Breast pump and supplies. (Refer to Section 7 – Medical Plan Description, provision 45 – Breast Pump.)
- e. Comprehensive lactation support and counseling by a certified lactation consultant, under the general supervision of a licensed Physician (Medical Doctor (MD) or Doctor of Osteopathy (DO)) or a licensed mid-level practitioner (Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), or licensed Certified Nurse Midwife (CNM)) during pregnancy and/or during the postpartum period.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT -- Under federal law, group health plans may not restrict benefits for a Hospital length of stay related to childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours, as applicable). Plans 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 forty-eight (48) hours (or ninety-six (96) hours).

A WELLBABY MATERNITY PROGRAM is available to Medical Plan Participants. Services are 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 Medical Plan Participants who notify the MUS WellBaby Program Coordinator of the pregnancy. Notification should occur when pregnancy is diagnosed or as soon after as possible. **To receive the full benefits of this program, notification is required within the first trimester.**

29. Preventive Care Benefits

a. Well-Child Preventive Health Care

If a Dependent Child on the Medical Plan incurs examination expenses for preventive well-child health care, the Plan will pay up to the Allowed Amount for the Dependent Child (up to age nineteen (19)). Deductible, Copayment, and Coinsurance do not apply when utilizing an In-Network Provider.

b. Preventive Immunizations for Adults and Children

If a Medical Plan Participant receives services from a Physician or other Licensed Health Care Provider for preventive immunizations, the Plan will pay up to the Allowed Amount for the adult or Dependent Child. Deductible, Copayment, and Coinsurance do not apply when utilizing an In-Network Provider.

Preventive immunizations include, but are not limited to, diphtheria, chicken pox, tetanus, hepatitis A & B, pertussis, oral polio vaccine, measles, mumps, rubella, rotavirus, human papillomavirus (HPV), shingles, pneumonia, influenza, coronavirus disease (COVID), and tests for tuberculosis.

For recommended immunization schedules for all ages, visit the Centers for Disease Control (CDC) website.

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

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

If a Medical Plan Participant receives services for the following preventive health screenings as recommended by a Physician, the Plan will pay in full up to the Allowed Amount. Deductible, Copayment, and Coinsurance do not apply when utilizing an In-Network Provider. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for benefit guidelines.)*

- 1) Pap smear and/or routine pelvic exam.
- 2) Routine mammogram.
- 3) Routine breast cancer susceptibility gene (BRCA) testing, including genetic counseling and evaluation for the routine BRCA test, for a woman as determined by a Licensed Health Care Provider or Physician.
- 4) Routine prostate exam.
- 5) Routine colonoscopy, proctoscopy, sigmoidoscopy, or fecal occult blood screen.
- 6) Routine lab work.
- 7) Prescribed female contraceptives.

For a complete list of recommended preventive services, as set forth in the recommendations of the U.S. Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the CDC and Prevention, and the guidelines supported by the Health Resources and Services Administration visit the U.S Preventive Services Task Force website.

d. Disease Management Education Programs

Programs conducted by Licensed Health Care Providers are covered for prescribed Outpatient self-management training and education (such as dietary and nutritional counseling) 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 covered Medical Plan Participants to help manage and monitor the care of the covered Plan Participant(s) in the family with the disease. Claims should be submitted to the Medical Plan Claims Administrator in the name of the patient with the disease. Benefits are specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

e. Preventive Health Screenings (WellChecks) available through the MUS Wellness Program

Adult Medical Plan Participants over the age of eighteen (18) are eligible for two (2) WellCheck screenings per Benefit Plan Year (July 1 – June 30). These health screenings, offered at no cost to the Plan Participant, include:

- 1) Blood pressure tests when obtained through the MUS Wellness Program.
- 2) Basic blood panel and biometric screenings when obtained through the MUS Wellness Program.

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

31. Gender Identity Disorder/Gender Dysphoria Treatments and Services – Coverage includes charges for Medically Necessary surgical and non-surgical treatment such as:

- a. Psychotherapy; and
- b. Continuous hormone replacement therapy and corresponding testing to monitor the safety; and
- c. Gender Reassignment surgery which may be indicated for Plan Participants who provide the following documentation:
 - 1) A written psychological assessment from at least one qualified behavioral health Provider experienced in treating Gender Dysphoria, is needed for breast surgery. The assessment **must** document the Plan Participant meets **all** of the following criteria:
 - a) Persistent, well-documented Gender Dysphoria. (*Refer to Section 14 – Definitions.*)
 - b) Capacity to make a fully informed decision and to consent for treatment.
 - c) **Must** be at least eighteen (18) years of age (age of majority).
 - d) If significant medical or mental health concerns are present, they must be reasonably well controlled.
 - 2) A written psychological assessment from at least two (2) qualified behavioral health Providers experienced in treating Gender Dysphoria, who have independently assessed the Plan Participant, is required for genital surgery. The assessment **must** document that the Plan Participant meets **all** of the following criteria:
 - a) Persistent, well-documented Gender Dysphoria. (*Refer to Section 14 – Definitions.*)
 - b) Capacity to make a fully informed decision and to consent for treatment.
 - c) **Must** be at least eighteen (18) years of age (age of majority).
 - d) If significant medical or mental health concerns are present, they must be reasonably well controlled.
 - e) Complete at least twelve (12) months of successful continuous full-time real-life experience in the desired gender.

- f) Complete twelve (12) months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- 3) A Treatment plan that includes ongoing follow-up and care by a qualified behavioral health Provider experienced in treating Gender Dysphoria.
- d. When the above criteria are met, the following Gender Reassignment surgical procedures are Medically Necessary and covered as a proven benefit:
- 1) Male-to-Female (MtF)
 - a) Clitoroplasty (creation of clitoris)
 - b) Labiaplasty (creation of labia)
 - c) Orchiectomy (removal of testicles)
 - d) Penectomy (removal of penis)
 - e) Urethroplasty (creation of female urethra)
 - f) Vaginoplasty (creation of vagina)
 - g) Coloproctostomy
 - h) Vulvoplasty (correction of vulva)
 - 2) Female-to-Male (FtM)
 - a) Bilateral mastectomy or breast reduction*
 - b) Hysterectomy (removal of uterus)
 - c) Metoidioplasty (creation of penis, using clitoris)
 - d) Penile prosthesis
 - e) Phalloplasty (creation of penis)
 - f) Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
 - g) Scrotoplasty (creation of scrotum)
 - h) Testicular prosthesis
 - i) Urethroplasty (reconstruction of male urethra)
 - j) Vaginectomy (removal of vagina)
 - k) Vulvectomy (removal of vulva)

* Bilateral mastectomy or breast reduction may be done as a stand-alone procedure, without having genital reconstruction procedures. In those cases, the Plan Participant does not need to complete hormone therapy prior to procedure.

Expenses for treatment of Gender Identity Disorder are covered to the same extent as would be covered if the same covered treatment or service were rendered for another medical condition. Treatment is subject to all Plan provisions, including applicable annual Deductibles, Copayments, and Coinsurance percentage.

Benefits are limited to one (1) sex transformation reassignment per lifetime, which may include several staged procedures.

Certain ancillary procedures and services, when performed as part of Gender Reassignment, are excluded from coverage under the Medical Benefit Exclusions section of the Plan. It is important to review those exclusions.

Prior Authorization Review is strongly recommended for treatment of Gender Identity/Gender Dysphoria. (Refer to Section 14 – Definitions.) Certain Medically Necessary surgical procedures are initiated by referral and assessment. If you choose not to obtain a Prior Authorization Review, the claim may be denied if the service, treatment, or supply is not Medically Necessary or is excluded by the Plan when the claim is submitted.

32. Rehabilitative Care – Includes Medically Necessary Physical Therapy (PT) Occupational Therapy (OT), Speech Therapy (ST), and Medical Massage Therapy (MMT); cardiac, respiratory, and pulmonary rehabilitation; Acupuncture; and Chiropractic services.

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

Pre-Certification of all Inpatient Admissions is strongly recommended. (Refer to Section 6 – How to Obtain Benefits.)

OUTPATIENT BENEFITS – Outpatient benefits are limited to Medically Necessary services outlined in a rehabilitation treatment plan, not to exceed the benefit maximums, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits. Outpatient benefits apply to rehabilitative therapy services provided when the 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.

Outpatient rehabilitation therapy visits will not be covered when it is directed at the maintenance of the current level of functioning, chronic conditions, over-use conditions, musculoskeletal aches/pains, prevention of future injury, recreation (spa therapy), sports conditioning, and/or stress reduction.

The limitations below apply to **all** rehabilitative care services:

- a. The number of visits in a Benefit Plan Year for all Outpatient professional rehabilitative are limited, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.
- b. Ancillary lab or x-ray is covered like other lab and x-ray services and not subject to the per visit limit.

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

33. Prescription Drugs – Prescription drugs dispensed by a medical facility as part of Inpatient Covered Medical Services are covered under the Medical Plan. Other prescription drugs and diabetic supplies are covered by a separate Prescription Drug Plan. *(Refer to Section 9 – Prescription Drug Plan Description.)*

34. Treatment of Severe Mental Illness – The Plan will cover charges up to the Allowed Amount 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. Outpatient services for the treatment of Severe Mental Illness are also covered by the Plan.

Pre-Certification of all Inpatient Admissions is strongly recommended. (Refer to Section 6 – How to Obtain Benefits.)

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

35. 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** – 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 in-Hospital/facility services of a Physician or other Licensed Health Care Provider) are Covered Medical Expenses, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

Pre-Certification of all Inpatient Admissions is strongly recommended. (Refer to Section 6 – How to Obtain Benefits.)

- b. PARTIAL HOSPITALIZATION MENTAL ILLNESS TREATMENT**

For treatment of conditions that qualify for Inpatient Mental Illness benefits, a Plan Participant may exchange one day of Inpatient Hospitalization for two days of partial Hospitalization. Two (2) days of Partial Hospitalization count as one (1) day toward the maximum number of Inpatient days covered per Benefit Plan 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 (4) to eight (8) hours of therapy five (5) 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 patient.

- c. OUTPATIENT MENTAL ILLNESS TREATMENT** – Outpatient services for Mental Illness treatment are Covered Medical Services, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, when provided by one of the following Providers:
 - 1) Hospital; or
 - 2) Mental Health Treatment Center; or
 - 3) Physician, psychiatrist, licensed clinical psychologist, licensed social worker, or licensed professional counselor.
- d. PRE-CERTIFICATION OF INPATIENT ADMISSION** – All admissions to an Inpatient facility are subject to a review of Medical Necessity by Utilization Management at the Medical Plan Claims Administrator. All denials of an admission or portion thereof, by Utilization Management at the Medical Plan Claims 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.

36. 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. **INPATIENT CHEMICAL DEPENDENCY TREATMENT** – Services for Medically Necessary confinement as an Inpatient in a Hospital, Free-Standing Facility, or licensed Alcohol/Chemical Dependency Treatment Center for treatment of substance abuse, alcohol, or drug abuse (including in-Hospital/facility services of a Physician of other Licensed Health Care Provider) are Covered Medical Expenses, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

Pre-Certification of all Inpatient Admissions is strongly recommended. (Refer to Section 6 – How to Obtain Benefits.)

- b. **OUTPATIENT CHEMICAL DEPENDENCY TREATMENT** – Outpatient services for Chemical Dependency treatment are Covered Medical Expenses, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

c. BENEFIT CONDITIONS:

- 1) Inpatient services must be provided by a Hospital, Psychiatric Hospital, a Freestanding Inpatient Facility, or a licensed Alcohol/Chemical Dependency Treatment Center, (defined below) under a program in which a Physician directly supervises the staff or approves individual client treatment plans. All facilities must be fully licensed by the state in which the services are performed.
- 2) **Pre-Certification of Inpatient Admission** – All admissions to an Inpatient facility are subject to a review of Medical Necessity by Utilization Management at the Medical Plan Claims Administrator. All denials of an admission or portion thereof, by Utilization Management at the Medical Plan Claims 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 Chemical Dependency services only if the services are provided by a Physician, psychiatrist, licensed clinical psychologist, licensed social worker, licensed professional counselor, or certified chemical dependency/addiction counselor.

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

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

37. Second Surgical Opinion – Voluntary

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

If the second surgical opinion does not confirm the proposed surgery is medically advisable, the Plan will pay up to the Allowed Amount for a third opinion.

Benefit Conditions – Benefits will be payable only if:

- a. The opinion is provided 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.

b. The specialist makes a personal examination of the Plan Participant.

38. Treatment of Temporomandibular Joint Syndrome (TMJ) – Surgical Treatment of TMJ that cannot be treated non-surgically is a Covered Medical Service. ***Prior Authorization is strongly recommended for surgical treatment of TMJ.*** If determined to be Medically Necessary, standard benefits will apply to the surgery, subject to the annual Deductible and Coinsurance percentage, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits.

Pre-Certification of all Inpatient Admissions is strongly recommended. (Refer to Section 6 – *How to Obtain Benefits.*)

39. Organ or Tissue Transplant Services – *Prior Authorization is strongly recommended.* Charges related to non-Experimental or non-Investigational organ or tissue transplant procedures are covered, as specified in the current MUS *Choices* Enrollment Workbook Schedule of Benefits, subject to the following conditions:

- a. A second opinion is recommended prior to undergoing a 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 with the Physician who will be performing the actual surgery.
- b. If the donor is covered under the Medical Plan, expenses incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.
- c. If the recipient is covered under the Medical Plan, expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not covered under this Medical Plan according to eligibility requirements, will be considered allowable expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable more than the procedure-based benefit still available to the recipient.

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

The Allowed Amount 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.

Pre-Certification of all Inpatient Admissions is strongly recommended. (Refer to Section 6 – *How to Obtain Benefits.*)

39. Transplant Travel Expenses – If a Plan Participant's covered transplant expenses requires treatment services which are not available in the area in which the Plan Participant resides, the Plan may reimburse travel expenses to an Out-of-Area Provider. The Plan will reimburse travel expenses for meals, lodging, commercial and personal automobile, commercial airline, railroad, or bus transportation expenses to and from the nearest licensed medical facility that is equipped to provide the necessary treatment services. Travel expenses for covered transplant Out-of-Area treatment services are reimbursed at the State reimbursement rates and is limited to a maximum of \$5,000 per transplant.

The travel benefit is for travel expenses for the patient only.

OUT-OF-AREA MEDICAL TRAVEL PRIOR AUTHORIZATION – Out-of-Area travel expenses **must** be Prior Authorized. ***If Prior Authorization is not obtained, charges for travel expenses will not be covered.*** (Refer to Section 6 - *How to Obtain Benefits.*)

Plan Participants **must** complete an Out-of-Area Medical Travel Prior Authorization Application Form and submit the completed form to the MUS Benefits Office prior to travel. The form is available on the MUS *Choices* website at www.choices.mus.edu.

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

Treatment must be Prior Authorized as Medically Necessary by Utilization Management at the Medical Plan Claims Administrator. If Prior Authorization is not obtained or charges are found not to be Medically Necessary, all charges related to bariatric surgery will not be covered. In addition, the Plan Participant must participate in Case Management through the Plan.

“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 forty (40). BMI is calculated by dividing an individual’s weight (in kilograms) by their 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 MUS Wellness Program.
- b. Incurred expenses for which all conditions of the bariatric surgery benefit of the Plan have not been met.
- c. Incurred expenses before a Prior Authorization has been approved by the Medical Plan Claims Administrator.
- d. A redo or revision of a prior bariatric surgical procedure.
- e. A second bariatric surgical procedure, regardless if the first procedure was performed while covered under the Plan.

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

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

The Plan considers open or laparoscopic RYGB, or LASGB or Lap-Band, or vertical sleeve gastrectomy (gastric sleeve) Medically Necessary when the selection criteria listed below are met.

Selection Criteria:

1. Presence of severe obesity that has persisted for at least three (3) years for a Plan Participant who has been continuously covered under the MUS *Choices* Medical Plan for at least eighteen (18) consecutive months, is defined as meeting the following:
 - a. BMI exceeding forty (40); or
 - b. BMI exceeding thirty-five (35) combined with at least two (2) of these conditions:
 - 1) Clinically significant obstructive sleep apnea.
 - 2) Pickwickian syndrome.
 - 3) Congestive heart failure.
 - 4) Cardiomyopathy.
 - 5) Insulin dependent or oral medication dependent diabetes.

- 6) Severe musculoskeletal dysfunction.
- 7) Gastric Esophageal Reflux Disorder.
- 8) Pulmonary edema.
- 9) Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management); **and**
2. The Plan Participant has completed growth (eighteen (18) years of age or documentation of completion of bone growth); **and**
3. The Plan Participant has attempted weight loss in the past without successful long-term weight reduction; **and**
4. The Plan Participant **must** complete pre-surgical program as required by the bariatric center.
5. For Plan Participants who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary to exclude Plan Participants who are unable to provide informed consent or who are unable to comply with the pre- and post-operative regimen. **Note:** The presence of depression due to obesity is not normally considered a contraindication to bariatric surgery.

Vertical Banded Gastroplasty (VBG):

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

1. Hepatic cirrhosis with elevated liver function tests; inflammatory bowel disease (Crohn's disease or ulcerative colitis); or
 2. Radiation enteritis; demonstrated complications from extensive adhesions involving the intestines from prior major abdominal surgery, multiple minor surgeries, or major trauma; or
 3. Poorly controlled systemic disease (American Society of Anesthesiology (ASA) Class IV).
- 41. 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 Plan Participant, the covered Plan Participant'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.
- 42. Eyeglasses or Contact Lenses following Cataract Surgery** – Benefits are limited to one (1) pair of corrective eyeglass lenses and one (1) pair of eyeglass frames **or** one (1) pair of corrective contact lenses within six (6) months following cataract surgery.
- 43. Alternative Care** – The Plan Administrator may, at their sole discretion, authorize payments for services that are not listed as Covered Benefits. Such payments shall be made only upon agreement by the Plan Participant and the Plan Administrator.
- 44. Contraceptive Management** – “Contraceptive Management”, regardless of Medical Necessity, means Physician or Licensed Health Care Provider fees related to a prescription contraceptive device, obtaining a prescription for contraceptive drugs and U.S. Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, purchasing, fitting, injecting, implantation, or placement of a contraceptive device. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are included.

Self-administered prescription contraceptives are covered by a separate Prescription Drug Plan (*Refer to Section 9 – Prescription Drug Plan Description.*).

45. Breast Pump –

Standard Breast Pump – The Plan will cover the purchase or rental (up to ten (10) months or the purchase price) of *one* (1) standard breast pump, either manual, battery-powered, mobile hands-free (wearable), or electric, for covered pregnant or postpartum Medical Plan Participants per delivery or adoption, up to a \$300 maximum.

Hospital Grade Electric Breast Pump – The Plan will cover the *rental only* (up to three (3) months) of one (1) Hospital grade breast pump for postpartum Medical Plan Participants, in place of the above, when deemed appropriate by the ordering Physician under the Plan Participant's Durable Medical Equipment benefit (subject to the annual Deductible, Coinsurance percentage, and Out-of-Pocket Maximum). The Plan Participant **must** have a Physician's prescription and letter of medical necessity submitted for review.

A hospital grade breast pump may be appropriate in the following circumstances:

- 1) Premature hospitalized newborn.
 - a) When the infant is premature at 24-34 weeks of gestation, and the mother is pumping breast milk, awaiting the baby's ability to nurse directly from the breast.
 - b) When the infant is premature at 35-37 weeks of gestation and continues to experience difficulty coordinating suck and swallow, and the mother is pumping breast milk, awaiting the baby's ability to nurse and transfer milk efficiently from the breast, or
- 2) An infant with cardiac anomalies or a medical condition that makes them unable to sustain breast feeding due to poor coordination of suck and swallow, fatigue, neurologic disorder, or genetic abnormality (e.g., respiratory, cardiac, or genetic condition) that interferes with breast feeding, or
- 3) An infant with a congenital anomaly that interferes with the ability to nurse directly or efficiently from the breast and achieve good milk transfer (e.g., cleft lip or palate, and/or other anomalies of the tongue, mouth, or pharynx), or
- 4) There is an involuntary separation of an infant from its mother for more than twenty-four (24) hours due to Illness or Injury of the infant, if the mother is hospitalized and separated from the infant, or if the infant is readmitted to the Hospital within thirty (30) days after initial discharge.
- 5) For multiples (including twins), until breast-feeding at the breast is established consistently with good milk transfer, or
- 6) When the mother has an anatomical breast problem, which may resolve with the use of a Hospital grade breast pump (e.g., inverted nipple or mastitis), or
- 7) For infants for medical reasons who are temporarily unable to nurse directly from the breast (e.g., Neonatal Intensive Care Unit (NICU) babies) or during a hospitalization of the mother or baby which will interrupt nursing.
- 8) When the infant has poor weight gain, in the first four (4) weeks of life, related to milk production and pumping breast milk is an intervention and the infant has a documented weight loss of seven percent (7%) or greater in the first week of life or has not regained birthweight by two (2) weeks of age, or
- 9) When the infant has poor weight gain after four (4) weeks of age related to mother's milk production and pumping breast milk frequently throughout the day, along with baby's nursing at breast, will attempt to improve mother's supply.
- 10) For women who wish to breastfeed their adopted infant or infant born through surrogacy in attempt to induce lactation. The process involves nipple stimulation with use of an electric breast pump beginning at least two (2) months before the adoptive or natural mother expects to be breast-feeding.

A Hospital grade breast pump is **not Medically Necessary** when the above criteria are not met or when it is requested solely to allow for the mother's return to work or mother's or family

convenience or vacationing.

Prior Authorization of charges for a Hospital Grade Breast Pump is strongly recommended.

The following replacement supplies are eligible for coverage, the Plan will pay in full up to the Allowed Amount:

- 1) Tubing for breast pump.
- 2) Adapter for breast pump.
- 3) Cap for breast pump bottle.
- 4) Breast shield, splash protector, and flanges for use with breast pump.
- 5) Polycarbonate bottle for use with breast pump.
- 6) Locking ring for breast pump.

The following breast pump supplies are excluded from coverage:

- 1) Baby weight scales.
- 2) Batteries and battery packs.
- 3) Breast milk storage bags, ice packs, labels, labeling lids, and other similar products.
- 4) Breast pump cleaning charges or supplies, including soap, sprays, wipes, steam cleaning bags, and other similar products.
- 5) Creams, ointments, and similar other products that relieve breast or nipple irritation or inflammation.
- 6) Electric power adapter for travel.
- 7) Garments or other similar products that allow mobile hands-free (wearable) pump operation.
- 8) Nursing bras, bra pads, breast shells, nipple shield, and other similar products.
- 9) Travel bags and other similar travel or carrying accessories.

46. Vision Exam – Vision and eye health evaluation (preventive or medical), including (but not limited to) eye health examination, dilation, refraction, and prescription for eyeglasses or contact lenses. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for benefit guidelines.)*

47. Pediatric Treatment for Hearing Loss – Services for the diagnosis and treatment of Hearing Loss for a covered Dependent Child eighteen (18) years of age or younger, including (but not limited to) one (1) medically necessary hearing aid or Amplification Device per ear every three (3) years or as required by a licensed audiologist for the purpose of improving or assisting hearing by directing or amplifying sound in the ear canal; exams for the purpose of fitting a hearing device; tinnitus masking device; bone assisted hearing devices; ear molds; excluding hearing aid or Amplification Device batteries, cords, or related supplies.

G. GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The Plan **does not** pay the following charges or expenses.

1. Charges by the Plan Participant for all services and supplies resulting from a work-related Illness or Injury which occurs in the course of employment for wage or profit or which occurs in the course of 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 U.S. (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though the Plan Participant:
 - a. Receives benefits for only a portion of the services incurred under Workers' Compensation.
 - b. Does not have Workers' Compensation coverage because the organization failed to obtain such coverage.

- c. Waived their rights to such coverage or benefits.
- d. Fails to file a claim within the filing period allowed by law.
- e. Fails to comply with other provisions of the law to obtain coverage or benefits.
- f. Is permitted to elect not to be covered by Workers' Compensation but fails to make such an election.
- g. Elects not to be covered by Workers' Compensation and has affirmatively made that election.

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

2. An expense or charge for service or supplies which are provided or paid for by the federal government or its agencies, except for:
 - a. The Veterans' Administration, when services are provided to a veteran for a disability that is not service connected.
 - b. A military Hospital or facility, when services are provided to a Retiree (or Dependent of a Retiree) from the armed services.
 - c. A group health plan established by a government for its own civilian Employees and their Dependents.
3. Charges that are caused by or arising out of war or act of war (whether declared or undeclared), civil unrest, armed invasion, or aggression or during service in the armed forces of any country.
4. A loss, expense, or charge:
 - a. That is incurred while a Plan Participant is on active duty or training in the Armed Forces, National Guard, or Reserves of any state or country; and
 - b. For which a governmental body or its agencies are liable.
5. An expense that is more than the Allowed Amount.
6. Services rendered or started, or supplies furnished, prior to the Plan Participant's Effective Date of coverage under the Plan or after the Plan Participant's coverage is terminated under the Plan.
7. An expense or charge for which a Plan Participant does not have to pay or would not be an incurred expense in the absence of the Plan.
8. An expense or charge that is primarily for the Plan Participant's convenience or comfort or that of the Participant's family, caretaker, Physician, or other Licensed Health Care Provider.
9. Charges for preparation of reports or itemized bills relating to Covered Medical Expenses, unless specifically requested and approved by the Plan.
10. Expenses for homeopathic services, products, and botanical preparations.
11. Expenses incurred by individuals other than the covered Plan Participant receiving treatment, service, or supplies.
12. 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.
13. Charges for services, treatment, or supplies not considered legal in the U.S.

14. Expenses for services or supplies that are not specifically listed as a Covered Medical Service of this Medical Plan.
15. Expenses for the following treatments, services, or supplies:
 - a. Expenses related to or connected with treatments, services, or supplies that are excluded under this Medical Plan.
 - b. Treatments, services or supplies that are the result of a medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Medical Plan.

H. MEDICAL PLAN BENEFIT EXCLUSIONS

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

1. Charges related to care or treatment of, surgery performed for, or as the result of, a Cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a congenital anomaly for a covered Dependent Child.**
2. Charges for services, supplies, treatments, or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a Covered Benefit of the Plan.
3. Charges for non-Medically Necessary surgery, services, care, or treatment of Gender Identity Disorder/Gender Dysphoria, including (but not limited to) the following, that are considered Cosmetic and not Medically Necessary, when performed as part of Gender Reassignment:
 - a. Abdominoplasty
 - b. Blepharoplasty
 - c. Body Contouring (e.g., fat transfer, lipoplasty, panniculectomy)
 - d. Breast enlargement, including augmentation mammoplasty and breast implants
 - e. Brow lift, face/forehead lift and/or neck tightening
 - f. Calf implants
 - g. Cheek, chin, and nose implants
 - h. External penile prosthesis (vacuum and erection devices)
 - i. Injection of fillers or neurotoxins
 - j. Facial bone remodeling/reconstruction for facial feminization
 - k. Hair removal (e.g., electrolysis or laser)
 - l. Hair transplantation
 - m. Lip augmentation or lip reduction
 - n. Liposuction (suction-assisted lipectomy)
 - o. Mastopexy
 - p. Pectoral implants for chest masculinization
 - q. Pharmaceutical agents to treat hair loss or growth, sexual performance post-Gender Reassignment genital surgery (e.g., Cialis or Viagra)
 - r. Pubertal suppression therapy
 - s. Rhinoplasty
 - t. Skin resurfacing (e.g., dermabrasion, chemical peels, laser)
 - u. Surgical or hormone treatment for participants under age eighteen (18)
 - v. Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
 - w. Treatment received outside the U.S
 - x. Treatment not prior-authorized by the Plan

- y. Voice lessons or voice therapy
 - z. Voice modification surgery (e.g., laryngoplasty or glottoplasty (shortening of the vocal cords))
- 4. Charges for treatment of Gender Identity Disorder/Gender Dysphoria when the services are for the reversal of a prior Gender Reassignment surgery or reversal of a prior surgery to revise secondary sex characteristics.
- 5. Charges for penile implant devices and surgery, and related services except for surgical treatment of Gender Identity Disorder/Gender Dysphoria.
- 6. Charges for treatment for reproduction services, including (but not limited to) sperm preservation in advance of hormone treatment or Gender Dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus for Plan Participants who are seeking services for Gender Identity Disorder/Gender Dysphoria.
- 7. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or routine physical examinations, tests or treatments not connected with the actual Illness or Injury.
- 8. Charges for Physicians' fees for treatment which is not rendered by a Physician.
- 9. Special duty nursing services are excluded:
 - a. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or
 - b. When 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.
- 10. Charges related to the purchase or fitting of eyeglasses, contact lenses, or related supplies.
- 11. Charges related to Hearing Loss, including (but not limited to) hearing aids or Amplification Devices; services or treatment of Hearing Loss or for the purpose of improving or assisting hearing by directing or amplifying sound in the ear canal whether the ears are absent or deformed from trauma, surgery, disease or congenital defect, illness or injury; exams for the purpose of fitting a hearing aid or Amplification Device; tinnitus masking devices; bone assisted hearing devices; ear molds; hearing aid batteries, cords, or related supplies. This exclusion will not apply to the diagnosis or treatment of Hearing Loss, hearing aids or Amplification Devices for a covered Dependent Child eighteen (18) years of age or younger. (*Refer to Section 7 – Medical Plan Description, provision F. (47) – Specific Covered Medical Services.*)
- 12. Charges for Dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue, or alveolar processes; however, benefits will be payable for treatment required because of accidental bodily Injury to sound natural teeth. Such expenses **must** be incurred within twelve (12) months of the date of accident. This exception will not be deemed to include charges for treatment for the repair or replacement of a denture.
- 13. Charges related to or in connection with treatment of infertility, including (but not limited to) artificial insemination, in-vitro fertilization, Gamete Intrafallopian Transfer (G.I.F.T.), Zygote Intrafallopian Transfer (Z.I.F.T.), Artificial Response Technology (A.R.T.), or other ovum transplant procedures; gene manipulation therapy; procedures to restore or enhance fertility; assisted reproductive techniques or surgical procedures; expenses related to donor sperm and donor ova (collection, preparation, storage); and surrogate services.

14. Charges for family counseling without the patient present, recreational counseling, or milieu therapy.
15. Charges resulting from or related to the reversal of a sterilization procedure.
16. An expense or charge which results from appetite control or 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.
17. An expense or charge for orthopedic shoes or other supportive device for the feet, except as provided under the Orthotic Devices provision.
18. Hair transplant procedures, wigs, and artificial hairpieces. This exclusion will not apply to the purchase of one (1) wig or artificial hairpiece per lifetime if purchased for alopecia or within three (3) months of cancer treatment. A replacement wig or artificial hairpiece will be subject to review and may be allowed if normal wear and tear has made the prosthetic ineffective or if the patient's size changes (i.e., a child grows, and the prosthetic no longer fits).
19. Charges for surgical, medical or Hospital services and/or supplies rendered relating to radial keratotomy, LASIK or other procedure designed to correct farsightedness, nearsightedness, or astigmatism.
20. Charges related to Custodial Care and transportation.
21. Charges for artificial organ implant procedures.
22. Complications that directly result from acting against medical advice, non-compliance with specific Physician's orders or leaving an Inpatient facility against medical advice.
23. Equipment, including (but not limited to) motorized wheelchairs or beds, that exceeds the patient's needs for everyday living activities as defined by the Americans with Disabilities Act as amended from time to time, unless Medically Necessary by independent review, and not primarily for personal convenience.
24. Specialized computer equipment, including (but not limited to) Braille keyboards and voice recognition software, unless determined to be Medically Necessary, and not primarily for personal convenience.
25. An expense or charge that is primarily for the Plan Participant's education, training, or development of skills needed to cope with an Injury or Illness, except as provided under the rehabilitative care provision and the Disease Process Education Benefit.
26. Expenses for smoking cessation products, unless provided through the Prescription Drug Plan and based on the limitation of two (2) 90-day quit attempts per year (one-hundred eighty (180) days total).
27. Expenses for homeopathic services, products, and botanical preparations.
28. Nutrition-based therapy for alcoholism or drug addiction.
29. Health care services to treat alcohol or drug co-dependency.
30. Charges for the following (known as a "Never Event") when the condition is due to patient confinement or surgery:
 - a. Removal of an object left in the body during surgery.
 - b. Catheter-associated urinary tract infection.

- c. Pressure ulcers.
 - d. Vascular catheter-associated infection.
 - e. Infection inside the chest after coronary artery bypass graft surgery.
 - f. Hospital acquired Injuries such as fractures, dislocations, intracranial injuries, crushing Injuries and burns.
 - g. Amputation or removal of the wrong body part or organ.
31. Chelation therapy expenses, except for acute arsenic, gold, mercury, or lead poisoning.
32. An expense or charge for non-surgical treatment of TMJ syndrome. Surgical treatment of TMJ is covered if Medically Necessary. ***Prior Authorization is strongly recommended for surgical treatment of TMJ. (Refer to Section 6 – How to Obtain Benefits.)***
33. Expenses or charges for genetic counseling except for genetic counseling for routine BRCA testing. *(Refer to Section 7 – Medical Plan Description, provision 29 (c) (3).)*
34. Charges for electrical stimulation treatment are considered Experimental, Investigational, and/or unproven. Providers who commonly use this type of treatment in their practice include, but are not limited to: Physical Therapists, Chiropractors, and Acupuncturists. The types of electrical stimulation treatment that are excluded include, but are not limited to:
- a. H-Wave electrical stimulation
 - b. Threshold Electrical Stimulation (TES)
 - c. Microcurrent stimulation
 - d. Galvanic stimulation
 - e. Electroceutical therapy- identified by other names including (but not limited to) non-invasive neuron blockade, electroceutical neuron blockade, bioelectric treatment systems
 - f. Cranial Electrotherapy Stimulation (CES)
 - g. Auricular electrostimulation
 - h. Transcutaneous electrical stimulation (TENS)
 - i. Interferential Current Stimulation (IFCS)
 - j. Electric stimulation
 - k. Sympathetic therapy
 - l. Functional Neuromuscular Stimulation (FNS)

Section 8

DENTAL PLAN DESCRIPTION

This Section describes the Dental Plan benefits for Plan Participants. *(Refer to Section 6 – How to Obtain Benefits. Refer to provision C.- Dental Benefit Maximum of this Section. Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for Dental Plan contact information.)*

A. DENTAL PLAN OPTIONS

There are two (2) Dental Plan options:

1. **Basic Plan** (available to Eligible Employees and their covered Dependents).
The Basic Plan covers **only** Diagnostic and Preventive services listed in provision F. – *Basic Plan Dental Fee Schedule* of this Section.
2. **Select Plan** (available to Eligible Employees, Retirees, and their covered Dependents).
The Select Plan covers Diagnostic and Preventive, Basic Restorative, Major Dental (e.g., dentures, bridges, crowns) Services, and Oral Surgery listed in provision G. – *Select Plan Dental Fee Schedule* of this Section.

The **Select Plan** also covers:

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

B. DENTAL PLAN COVERAGE

The Dental Plan will pay only for the covered services as shown in the Basic and Select Plan Dental Fee Schedules, not to exceed the maximum reimbursement amount for the specified procedure code or the Plan limitations specified in provisions F. – *Basic Plan Dental Fee Schedule*, G. – *Select Plan Dental Fee Schedule*, and H. – *Dental Plan Benefit Limitations* of this Section.

Covered Dental charges are those charges within the Plan Dental Fee Schedule, specified in provision E. – *Dental Fee Schedule*, for covered Dental services listed in provisions F. – *Basic Plan Dental Fee Schedule*, G – *Select Plan Dental Fee Schedule*, and not excluded in provisions H. – *Dental Plan Benefit Limitations*., or I. – *Dental Plan Exclusions and Limitations* of this Section, when performed by a licensed Physician, Dentist, or licensed denturist operating within the scope of their license.

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

The Dental Plan Claims Administrator 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 customary, the Plan will pay an amount for the least expensive medically adequate course of treatment in accordance with the Dental Plan Fee Schedule. The Plan Participant will be responsible for the difference between the higher cost of the service and the lower cost of the customary service or standard practice.

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

C. DENTAL BENEFIT MAXIMUM

	<i>Basic Plan</i>	<i>Select Plan</i>
Annual Benefit Maximum (per covered individual)	\$750	\$2,000
Orthodontia Lifetime Maximum (per covered individual)	N/A	\$1,500

D. COORDINATION OF BENEFITS

If a Plan Participant receives Dental services that are covered under both the Plan and another Dental plan, coverage and benefits are governed by COB rules. These rules determine which plan pays benefits first and which plan pays second. Depending on the situation, the Plan may be the primary or secondary Dental Plan. The primary plan pays benefits without regard to the secondary plan. When the Plan is the secondary plan, the Plan will coordinate with the primary insurance carrier and pay for Plan-covered services according to Plan provisions and limitations.

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

Follow the guidelines set forth in Section 13 – *Coordination of Benefits* to determine if the Plan may be the primary or secondary Dental Plan.

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

E. DENTAL FEE SCHEDULE

The Dental Fee Schedule’s dollar amount is the maximum reimbursement by the Plan for the specified Dental services listed in provisions F. – *Basic Plan Dental Fee Schedule* and G. – *Select Plan Dental Fee Schedule* of this Section.

Orthodontia services (Select Plan only) are payable at 50% of the Dental Fee Schedule for authorized services, subject to a \$1,500 annual maximum per covered Plan Participant.

The Dental Fee Schedule is the maximum reimbursement amount the Dental Plan will use for calculating the benefits for a single procedure. The maximum reimbursement amount for services provided:

- by a Preferred Provider Organization (PPO) Dentist is the lesser of the Dentist’s submitted fee, the amount shown on the Dental Fee Schedule or the PPO Dentist’s fee; or
- by a Premier Dentist is the lesser of the Dentist’s submitted fee, the amount shown on the Dental Fee Schedule or the Dentist’s filed fee in the Participating Dentist Agreement; or
- by a non-Participating Dentist is the lesser of the Dentist’s submitted fee or the amount shown on the Dental Fee Schedule.

F. BASIC PLAN DENTAL FEE SCHEDULE

Procedure Code	Description	Fee Schedule
D0120	Periodic oral evaluation - established patient	\$44
D0140	Limited oral evaluation - problem focused	\$59
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$47
D0150	Comprehensive oral evaluation - new or established patient	\$65
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$139
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$52
D0180	Comprehensive periodontal evaluation - new or established patient	\$72
D0190	Screening of a patient	\$28
D0191	Assessment of a patient	\$28
D0210	Intraoral - complete series of radiographic images (including bitewings)	\$122
D0220	Intraoral - periapical first radiographic image	\$26
D0230	Intraoral - periapical each additional radiographic image	\$20
D0240	Intraoral - occlusal radiographic image	\$25
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source and detector	\$58
D0270	Bitewing - single radiographic image	\$23
D0272	Bitewings - two radiographic images	\$41
D0273	Bitewings - three radiographic images	\$49
D0274	Bitewings - four radiographic images	\$54
D0277	Vertical bitewings - 7 to 8 radiographic images	\$75
D0310	Sialography	\$411
D0320	Temporomandibular joint (TMJ) arthrogram, including injection	\$622
D0321	Other temporomandibular joint (TMJ) radiographic images, by report	\$224
D0322	Tomographic survey	\$355
D0330	Panoramic radiographic image	\$97

Procedure Code	Description	Fee Schedule
D0419	Assessment of salivary flow by measurement	\$4
D0460	Pulp vitality tests	\$28
D0472	Accession of tissue, gross examination, preparation, and transmission of written report	\$79
D0473	Accession of tissue, gross and microscopic examination, preparation, and transmission of written report	\$165
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of written report	\$204
D0601	Caries risk assessment and documentation, with a finding of low risk	\$11
D0602	Caries risk assessment and documentation, with a finding of moderate risk	\$11
D0603	Caries risk assessment and documentation, with a finding of high risk	\$11
D1110	Prophylaxis - adult	\$87
D1120	Prophylaxis - child (<i>through age 13</i>)	\$58
D1206	Topical application of fluoride varnish (<i>child through age 18</i>)	\$31
D1208	Topical application of fluoride - excluding varnish (<i>child through age 18</i>)	\$28
D1351	Sealant - per tooth (<i>through 15 years old</i>)	\$45
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	\$54
D1354	Interim caries arresting medicament application - per tooth	\$29
D1510	Space maintainer - fixed - unilateral - per quadrant	\$280
D1516	Space maintainer - fixed - bilateral, maxillary	\$388
D1517	Space maintainer - fixed - bilateral, mandibular	\$388
D1520	Space maintainer - removable, unilateral - per quadrant	\$393
D1526	Space maintainer - removable bilateral, maxillary	\$538
D1527	Space maintainer - removable - bilateral, mandibular	\$538
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	\$63
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	\$63
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	\$63
D1556	Removal of fixed unilateral space maintainer - per quadrant	\$63
D1557	Removal of fixed bilateral space maintainer - maxillary	\$63
D1558	Removal of fixed bilateral space maintainer - mandibular	\$63
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	\$239
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	\$95
D9310	Consultation - diagnostic service provided by dentist or Physician other than requesting dentist or Physician	\$67

Note: The CDT codes and nomenclature are copyright of the American Dental Association. *Notes in italic type have been added for clarification.* The procedures described, and the Dental Fee Schedule Maximum Benefit indicated on this table, are subject to the terms of the contract and processing policies. These Fee Schedule amounts 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 Fee Schedule Maximum Benefit and annual maximum.

G. SELECT PLAN DENTAL FEE SCHEDULE

Procedure Code	Description	Fee Schedule
D0120	Periodic oral evaluation - established patient	\$44
D0140	Limited oral evaluation - problem focused	\$59
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$47
D0150	Comprehensive oral evaluation - new or established patient	\$65
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$139
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$52
D0180	Comprehensive periodontal evaluation - new or established patient	\$72
D0190	Screening of a patient	\$28
D0191	Assessment of a patient	\$28
D0210	Intraoral - complete series of radiographic images (including bitewings)	\$122
D0220	Intraoral - periapical first radiographic image	\$26
D0230	Intraoral - periapical each additional radiographic image	\$20
D0240	Intraoral - occlusal radiographic image	\$25
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source and detector	\$58
D0270	Bitewing - single radiographic image	\$23
D0272	Bitewings - two radiographic images	\$41
D0273	Bitewings - three radiographic images	\$49
D0274	Bitewings - four radiographic images	\$54
D0277	Vertical bitewings - 7 to 8 radiographic images	\$75
D0310	Sialography	\$411
D0320	Temporomandibular joint (TMJ) arthrogram, including injection	\$622
D0321	Other temporomandibular joint (TMJ) radiographic images, by report	\$224
D0322	Tomographic survey	\$355
D0330	Panoramic radiographic image	\$97
D0340	2D cephalometric radiographic image - acquisition, measurement, and analysis	\$88
D0350	2D oral/facial photographic images obtained intra-orally or extra-orally	\$33
D0419	Assessment of salivary flow by measurement	\$4
D0460	Pulp vitality tests	\$28
D0470	Diagnostic casts	\$91
D0472	Accession of tissue, gross examination, preparation, and transmission of written report	\$79
D0473	Accession of tissue, gross and microscopic examination, preparation, and transmission of written report	\$165
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of written report	\$204
D0601	Caries risk assessment and documentation, with a finding of low risk	\$11
D0602	Caries risk assessment and documentation, with a finding of moderate risk	\$11
D0603	Caries risk assessment and documentation, with a finding of high risk	\$11
D1110	Prophylaxis - adult	\$87
D1120	Prophylaxis - child (<i>through age 13</i>)	\$58
D1206	Topical application of fluoride varnish (<i>child through age 18</i>)	\$31
D1208	Topical application of fluoride - excluding varnish (<i>child through age 18</i>)	\$28
D1351	Sealant - per tooth (<i>through 15 years old</i>)	\$45
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth (<i>child through age 15</i>)	\$54
D1354	Interim caries arresting medicament application - per tooth	\$29
D1510	Space maintainer - fixed - unilateral - per quadrant	\$280
D1516	Space maintainer - fixed - bilateral, maxillary	\$388
D1517	Space maintainer - fixed - bilateral, mandibular	\$388
D1520	Space maintainer - removable, unilateral - per quadrant	\$393

Procedure Code	Description	Fee Schedule
D1526	Space maintainer - removable bilateral, maxillary	\$538
D1527	Space maintainer - removable - bilateral, mandibular	\$538
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	\$63
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	\$63
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	\$63
D1556	Removal of fixed unilateral space maintainer - per quadrant	\$63
D1557	Removal of fixed bilateral space maintainer - maxillary	\$63
D1558	Removal of fixed bilateral space maintainer - mandibular	\$63
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	\$239
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	\$109
D2331	Resin-based composite - two surfaces, anterior	\$141
D2332	Resin-based composite - three surfaces, anterior	\$170
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$209
D2391	Resin-based composite - one surface, posterior	\$124
D2392	Resin-based composite - two surfaces, posterior	\$159
D2393	Resin-based composite - three surfaces, posterior	\$203
D2394	Resin-based composite - four or more surfaces, posterior	\$238
D2510	Inlay - metallic - one surface	\$292
D2520	Inlay - metallic - two surfaces	\$344
D2530	Inlay - metallic - three or more surfaces	\$494
D2542	Onlay - metallic - two surfaces	\$419
D2543	Onlay - metallic - three surfaces	\$375
D2544	Onlay - metallic-four or more surfaces	\$545
D2610	Inlay - porcelain/ceramic - one surface	\$292
D2620	Inlay - porcelain/ceramic - two surfaces	\$335
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$380
D2642	Onlay - porcelain/ceramic - two surfaces	\$453
D2643	Onlay - porcelain/ceramic - three surfaces	\$580
D2644	Onlay - porcelain/ceramic - four or more surfaces	\$525
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
D2710	Crown - resin-based composite (indirect)	\$284
D2712	Crown - ¾ resin-based composite (indirect)	\$698
D2720	Crown - resin with high noble metal	\$500
D2721	Crown - resin with predominantly base metal	\$369
D2722	Crown - resin with noble metal	\$343
D2740	Crown - porcelain/ceramic substrate	\$492
D2750	Crown - porcelain fused to high noble metal	\$463
D2751	Crown - porcelain fused to predominantly base metal	\$410
D2752	Crown - porcelain fused to noble metal	\$434
D2753	Crown - porcelain fused to titanium and titanium alloys	\$459
D2780	Crown - ¾ cast high noble metal	\$516
D2781	Crown - ¾ cast predominantly base metal	\$363
D2782	Crown - ¾ cast noble metal	\$463
D2783	Crown - ¾ porcelain/ceramic	\$488

Procedure Code	Description	Fee Schedule
D2790	Crown - full cast high noble metal	\$515
D2791	Crown - full cast predominantly base metal	\$402
D2792	Crown - full cast noble metal	\$535
D2794	Crown - titanium and titanium alloys	\$474
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	\$81
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$65
D2920	Re-cement or re-bond crown	\$62
D2921	Reattachment of tooth fragment, incisal edge, or cusp	\$143
D2929	Prefabricated porcelain/ceramic crown - primary tooth	\$252
D2930	Prefabricated stainless-steel crown - primary tooth	\$186
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	Protective restoration (sedative filling)	\$70
D2941	Interim therapeutic restoration - primary dentition	\$70
D2950	Core buildup, including pins when required	\$151
D2951	Pin retention - per tooth, in addition to restoration	\$38
D2952	Post and core in addition to crown, indirectly fabricated	\$263
D2954	Prefabricated post and core in addition to crown	\$189
D2960	Labial veneer (resin laminate) - chairside	\$622
D2961	Labial veneer (resin laminate) - laboratory	\$754
D2962	Labial veneer (porcelain laminate) - laboratory	\$898
D2971	Additional procedures to construct new crown under existing partial denture framework	By Report
D2980	Crown repair necessitated by restorative material failure	\$94
D2981	Inlay repair necessitated by restorative material failure	\$81
D2982	Onlay repair necessitated by restorative material failure	\$162
D2983	Veneer repair necessitated by restorative material failure	\$112
D3110	Pulp cap - direct (excluding final restoration)	\$49
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$121
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$183
D3310	Endodontic therapy (root canal) anterior tooth (excluding final restoration)	\$538
D3320	Endodontic therapy (root canal) premolar tooth (excluding final restoration)	\$656
D3330	Endodontic therapy (root canal) molar tooth (excluding final restoration)	\$858
D3346	Retreatment of previous root canal therapy - anterior	\$759
D3347	Retreatment of previous root canal therapy - premolar	\$828
D3348	Retreatment of previous root canal therapy - molar	\$1,027
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$520
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$240
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$376
D3410	Apicoectomy - anterior	\$762
D3421	Apicoectomy - premolar (first root)	\$903
D3425	Apicoectomy - molar (first root)	\$765
D3426	Apicoectomy (each additional root)	\$280
D3430	Retrograde filling - per root	\$153
D3450	Root amputation - per root	\$720
D3471	Surgical repair of root resorption - anterior	\$359

Procedure Code	Description	Fee Schedule
D3472	Surgical repair of root resorption - premolar	\$359
D3473	Surgical repair of root resorption - molar	\$359
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	\$359
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	\$359
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	\$359
D3920	Hemisection (including root removal), not including root canal therapy	\$240
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$364
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$136
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$113
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$400
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$308
D4245	Apically positioned flap	\$320
D4249	Clinical crown lengthening - hard tissue	\$455
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$1,000
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$651
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	\$390
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	\$213
D4265	Biologic materials to aid in soft and osseous tissue regeneration	\$207
D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	\$160
D4268	Surgical revision procedure, per tooth	\$237
D4270	Pedicle soft tissue graft procedure (<i>limited to two sites per quadrant</i>)	\$620
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	\$669
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	\$386
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	\$616
D4276	Combined connective tissue and double pedicle graft, per tooth	\$826
D4277	Free soft tissue graft procedure (including recipient and donor surgical site) first tooth, implant, or edentulous tooth position in graft	\$768
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) - each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$474
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant, or edentulous tooth in same graft site	\$379
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$480
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$170
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$112
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	\$95
D4355	Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit	\$104

Procedure Code	Description	Fee Schedule
D4910	Periodontal maintenance	\$96
D5110	Complete denture - maxillary	\$658
D5120	Complete denture - mandibular	\$662
D5130	Immediate denture - maxillary	\$764
D5140	Immediate denture - mandibular	\$777
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$442
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$535
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including conventional clasps, rests, and teeth)	\$703
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including conventional clasps, rests, and teeth)	\$695
D5221	Immediate maxillary partial denture - resin base (including conventional clasps, rests, and teeth)	\$523
D5222	Immediate mandibular partial denture - resin base (including conventional clasps, rests, and teeth)	\$706
D5223	Immediate maxillary partial denture - cast metal framework with resin denture base (including conventional clasps, rests, and teeth)	\$780
D5224	Immediate mandibular partial denture - cast metal framework with resin denture base (including conventional clasps, rests, and teeth)	\$780
D5225	Maxillary partial denture - flexible base (including clasps, rests, and teeth)	\$488
D5226	Mandibular partial denture - flexible base (including clasps, rests, and teeth)	\$617
D5282	Removable unilateral partial denture - one-piece cast metal (including clasps and teeth), maxillary	\$445
D5283	Removable unilateral partial denture - one-piece cast metal (including clasps and teeth), mandibular	\$445
D5284	Removable unilateral partial denture - one-piece flexible base (including clasps and teeth) - per quadrant	\$401
D5286	Removable unilateral partial denture - one-piece resin (including clasps and teeth) - per quadrant	\$401
D5410	Adjust complete denture - maxillary	\$32
D5411	Adjust complete denture - mandibular	\$32
D5421	Adjust partial denture - maxillary	\$46
D5422	Adjust partial denture - mandibular	\$33
D5511	Repair broken complete denture base, mandibular	\$86
D5512	Repair broken complete denture base, maxillary	\$86
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$80
D5611	Repair resin partial denture base, mandibular	\$89
D5612	Repair resin partial denture base, maxillary	\$89
D5621	Repair cast partial framework, mandibular	\$160
D5622	Repair cast partial framework, maxillary	\$160
D5630	Repair or replace broken retentive clasping materials - per tooth	\$160
D5640	Replace broken teeth - per tooth	\$99
D5650	Add tooth to existing partial denture	\$114
D5660	Add clasp to existing partial denture - per tooth	\$160
D5710	Rebase complete maxillary denture	\$320
D5711	Rebase complete mandibular denture	\$320
D5720	Rebase maxillary partial denture	\$314
D5721	Rebase mandibular partial denture	\$360
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

Procedure Code	Description	Fee Schedule
D5750	Reline complete maxillary denture (laboratory)	\$278
D5751	Reline complete mandibular denture (laboratory)	\$274
D5760	Reline maxillary partial denture (laboratory)	\$263
D5761	Reline mandibular partial denture (laboratory)	\$276
D5820	Interim partial denture (maxillary)	\$216
D5821	Interim partial denture (mandibular)	\$233
D5850	Tissue conditioning, maxillary	\$51
D5851	Tissue conditioning, mandibular	\$51
D5863	Overdenture - complete maxillary	\$930
D5864	Overdenture - partial maxillary	\$788
D5865	Overdenture - complete mandibular	\$861
D5866	Overdenture - partial mandibular	\$725
D6010	Surgical placement of implant body: endosteal implant	\$855
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	\$850
D6013	Surgical placement of mini implant	\$463
D6040	Surgical placement of eposteal implant	\$1,500
D6050	Surgical placement of transosteal implant	\$1,500
D6055	Connecting bar - implant supported or abutment supported	\$1,014
D6056	Prefabricated abutment - includes placement	\$243
D6057	Custom fabricated abutment - includes placement	\$338
D6058	Abutment supported porcelain/ceramic crown	\$543
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	\$556
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	\$954
D6061	Abutment supported porcelain fused to metal crown (noble metal)	\$604
D6062	Abutment supported cast metal crown (high noble metal)	\$588
D6063	Abutment supported cast metal crown (predominantly base metal)	\$513
D6064	Abutment supported cast metal crown (noble metal)	\$494
D6065	Implant supported porcelain/ceramic crown	\$619
D6066	Implant supported crown - porcelain fused to high noble metal alloys	\$633
D6067	Implant supported crown - high noble alloys	\$599
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)	\$529
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	\$670
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	\$518
D6074	Abutment supported retainer for cast metal FPD (noble metal)	\$532
D6075	Implant supported retainer for ceramic FPD	\$800
D6076	Implant supported retainer for FPD - high noble alloys	\$1,072
D6077	Implant supported retainer for metal FPD - high noble alloys	\$699
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	\$79
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	\$106
D6082	Implant supported crown - porcelain fused to predominantly base alloys	\$954
D6083	Implant supported crown - porcelain fused to noble alloys	\$523
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	By Report

Procedure Code	Description	Fee Schedule
D6086	Implant supported crown - predominantly base alloys	\$513
D6087	Implant supported crown - noble alloys	\$494
D6088	Implant supported crown - titanium and titanium alloys	By Report
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	Re-cement or re-bond implant/abutment supported crown	\$42
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	\$62
D6094	Abutment supported crown - titanium and titanium alloys	By Report
D6095	Repair implant abutment, by report	\$250
D6097	Abutment supported crown - porcelain fuse to titanium and titanium alloys	By Report
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	\$502
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	\$529
D6100	Implant removal, by report	\$250
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	\$348
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	\$511
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	\$1,070
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	\$1,340
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	\$948
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	\$999
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	\$1,500
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	\$1,500
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	\$1,500
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	\$1,500
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	\$518
D6121	Implant supported retainer for metal FPD - predominantly base alloys	\$518
D6122	Implant supported retainer for metal FPD - noble alloys	\$532
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	By Report
D6190	Radiographic/surgical implant index, by report	\$100
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	By Report
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	\$538
D6199	Unspecified implant procedure, by report	\$50
D6205	Pontic - indirect resin-based composite	\$363
D6210	Pontic - cast high noble metal	\$622
D6211	Pontic - cast predominantly base metal	\$383
D6212	Pontic - cast noble metal	\$365
D6214	Pontic - titanium and titanium alloys	\$528
D6240	Pontic - porcelain fused to high noble metal	\$491
D6241	Pontic - porcelain fused to predominantly base metal	\$425
D6242	Pontic - porcelain fused to noble metal	\$463
D6243	Pontic - porcelain fused to titanium and titanium alloys	\$463
D6245	Pontic - porcelain/ceramic	\$481
D6250	Pontic - resin with high noble metal	\$525
D6251	Pontic - resin with predominantly base metal	\$351
D6252	Pontic - resin with noble metal	\$427
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$350
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	\$257
D6549	Retainer - for resin bonded fixed prosthesis	\$186
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$375

Procedure Code	Description	Fee Schedule
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$394
D6602	Retainer inlay - cast high noble metal, two surfaces	\$500
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$383
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$350
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	\$353
D6606	Retainer inlay - cast noble metal, two surfaces	\$358
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$365
D6608	Retainer onlay - porcelain/ceramic, two surfaces	\$390
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$596
D6610	Retainer onlay - cast high noble metal, two surfaces	\$423
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$486
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$365
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$375
D6614	Retainer onlay - cast noble metal, two surfaces	\$381
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$395
D6624	Retainer inlay - titanium	\$383
D6634	Retainer onlay - titanium	\$425
D6710	Retainer crown - indirect resin-based composite	By Report
D6720	Retainer crown - resin with high noble metal	\$432
D6721	Retainer crown - resin with predominantly base metal	\$353
D6722	Retainer crown - resin with noble metal	\$442
D6740	Retainer crown - porcelain/ceramic	\$492
D6750	Retainer crown - porcelain fused to high noble metal	\$499
D6751	Retainer crown - porcelain fused to predominantly base metal	\$410
D6752	Retainer crown - porcelain fused to noble metal	\$490
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	\$456
D6780	Retainer crown - 3/4 cast high noble metal	\$452
D6781	Retainer crown - 3/4 cast predominantly based metal	\$363
D6782	Retainer crown - 3/4 cast noble metal	\$365
D6783	Retainer crown - 3/4 porcelain/ceramic	\$473
D6784	Retainer crown - 3/4 titanium and titanium alloys	\$498
D6790	Retainer crown - full cast high noble metal	\$498
D6791	Retainer crown - full cast predominantly base metal	\$402
D6792	Retainer crown - full cast noble metal	\$475
D6794	Retainer crown - titanium and titanium alloys	\$548
D6930	Re-cement or re-bond fixed partial denture	\$54
D6940	Stress breaker	\$122
D6980	Fixed partial denture repair necessitated by restorative material failure	\$131
D7111	Extraction, coronal remnants - primary teeth	\$68
D7140	Extraction, erupted tooth, or exposed root (elevation and/or forceps removal)	\$115
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap in indicated	\$199
D7220	Removal of impacted tooth - soft tissue	\$237
D7230	Removal of impacted tooth - partially bony	\$283
D7240	Removal of impacted tooth - completely bony	\$326
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$457
D7250	Removal of residual tooth roots (cutting procedure)	\$197
D7251	Coronectomy - intentional partial tooth removal	\$458
D7260	Oroantral fistula closure	\$960
D7261	Primary closure of sinus perforation	\$421
D7280	Surgical access of an unerupted tooth	\$318
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$214
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$541

Procedure Code	Description	Fee Schedule
D7286	Biopsy of oral tissue - soft	\$209
D7290	Surgical repositioning of teeth	\$269
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$36
D7296	Corticotomy - one to three teeth or tooth spaces, per quadrant	\$400
D7297	Corticotomy - four or more teeth or tooth spaces, per quadrant	\$400
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$187
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$176
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$375
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$225
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	\$800
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$1,500
D7410	Excision of benign lesion up to 1.25 cm	\$280
D7411	Excision of benign lesion greater than 1.25 cm	\$360
D7412	Excision of benign lesion, complicated	\$494
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	\$621
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	\$580
D7485	Reduction of osseous tuberosity	\$346
D7510	Incision and drainage of abscess - intraoral soft tissue	\$154
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	\$1,024
D7610	Maxilla - open reduction (teeth immobilized, if present)	By Report
D7620	Maxilla - closed reduction (teeth immobilized, if present)	By Report
D7630	Mandible - open reduction (teeth immobilized, if present)	By Report
D7640	Mandible - closed reduction (teeth immobilized, if present)	By Report
D7650	Malar and/or zygomatic arch - open reduction	By Report
D7660	Malar and/or zygomatic arch - closed reduction	By Report
D7670	Alveolus - closed reduction, may include stabilization of teeth	By Report
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	By Report
D7830	Manipulation under anesthesia	By Report
D7840	Condylectomy	\$1,500
D7850	Surgical discectomy, with/without implant	\$1,500

Procedure Code	Description	Fee Schedule
D7860	Arthrotomy	\$1,500
D7865	Arthroplasty	By Report
D7870	Arthrocentesis	By Report
D7880	Occlusal orthotic device, by report	\$469
D7899	Unspecified TMD therapy, by report	By Report
D7910	Suture of recent small wounds up to 5 cm	\$192
D7911	Complicated suture - up to 5 cm	\$360
D7912	Complicated suture - greater than 5 cm	\$580
D7920	Skin graft (identify defect covered, location and type of graft)	\$213
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	\$1,360
D7952	Sinus augmentation via a vertical approach	\$400
D7953	Bone replacement graft for ridge preservation - per site	\$264
D7955	Repair of maxillofacial soft and/or hard tissue defect	\$304
D7961	Buccal/labial frenectomy (frenulectomy)	\$217
D7962	Lingual frenectomy (frenulectomy)	\$217
D7970	Excision of hyperplastic tissue - per arch	\$287
D7971	Excision of pericoronal gingiva	\$120
D7972	Surgical reduction of fibrous tuberosity	\$217
D7979	Non-surgical sialolithotomy	\$373
D8010	Limited orthodontic treatment of the primary dentition	By Report
D8020	Limited orthodontic treatment of the transitional dentition	By Report
D8030	Limited orthodontic treatment of the adolescent dentition	By Report
D8040	Limited orthodontic treatment of the adult dentition	By Report
D8050	Interceptive orthodontic treatment of the primary dentition	By Report
D8060	Interceptive orthodontic treatment of the transitional dentition	By Report
D8070	Comprehensive orthodontic treatment of the transitional dentition	By Report
D8080	Comprehensive orthodontic treatment of the adolescent dentition	By Report
D8090	Comprehensive orthodontic treatment of the adult dentition	By Report
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	By Report
D8210	Removable appliance therapy	By Report
D8220	Fixed appliance therapy	By Report
D8660	Pre-orthodontic treatment examination to monitor growth and development	By Report
D8670	Periodic orthodontic treatment visit	By Report
D8680	Orthodontic retention (removal of appliances, construction, and placement of retainer(s))	By Report
D8681	Removable orthodontic retainer adjustment	By Report
D8690	Orthodontic treatment (alternative billing to a contract fee)	By Report
D8999	Unspecified orthodontic procedure, by report	By Report
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$70
D9120	Fixed partial denture sectioning	\$86
D9222	Deep sedation/general anesthesia - first 15 minutes	\$280
D9223	Deep sedation/general anesthesia - each subsequent 15-minute increment	\$134
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	\$252
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15-minute increment	\$111
D9310	Consultation - diagnostic service provided by dentist or Physician other than requesting dentist or Physician	\$67
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	\$92
D9942	Repair and/or relin of occlusal guard	\$40

Procedure Code	Description	Fee Schedule
D9944	Occlusal guard - hard appliance, full arch	\$273
D9945	Occlusal guard - soft appliance, full arch	\$146
D9946	Occlusal guard - hard appliance, partial arch	\$320
D9950	Occlusion analysis - mounted case	\$187
D9951	Occlusal adjustment - limited	\$51
D9952	Occlusal adjustment - complete	\$406
<p><i>Note:</i> The CDT codes and nomenclature are copyright of the American Dental Association. <i>Notes in italic type have been added for clarification.</i> The procedures described, and the Dental Fee Schedule Maximum Benefit indicated on this table, are subject to the terms of the contract and processing policies. These Fee Schedule amounts may be further reduced due to maximums, limitations, and exclusions.</p> <p>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 Fee Schedule Maximum Benefit and annual and lifetime maximum.</p>		

H. DENTAL PLAN BENEFIT LIMITATIONS

Diagnostic & Preventive Benefits (*Basic and Select Plans*)

1. Routine oral examinations and cleanings, including periodontal cleanings, are not provided more than two (2) per Benefit Plan Year. *Note:* Periodontal cleanings are covered as a Basic Restorative Benefit and routine cleanings are covered as a Diagnostic and Preventive Benefit.
2. Full mouth x-rays or panoramic x-rays will be provided when required by the Dentist, but not more than one (1) x-ray each five (5) years will be paid by the Dental Plan.
3. Bitewing x-rays are limited to two (2) per Benefit Plan Year when provided to a Plan Participant under age eighteen (18) and one (1) per Benefit Plan Year for a Plan Participant age eighteen (18) and over.
4. Space maintainers are limited to once per lifetime for a Plan Participant under age fourteen (14).
5. Topical application of fluoride is limited to two (2) in a twelve (12) month period for a Plan Participant under age nineteen (19).
6. Sealants are limited as follows:
 - a. They are available only to a Plan Participant through age fifteen (15).
 - b. They are limited to application to permanent molars with no caries (decay), without restorations and with the occlusal surface intact.
 - c. They do not include the repair or replacement of a sealant on a tooth within two (2) years of its application.
7. The Plan allows anesthesia coverage for pediatric dental work for a Dependent through age eighteen (18), as necessary and upon review, based on age, disability, or the amount of work that must be done at one time. Charges for these services will be subject to the Medical Plan annual Deductible, Coinsurance, and Out-of-Pocket Maximum.

Basic Restorative Benefits (*Select Plan*)

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

Major Benefits (*Select Plan*)

1. The Dental Plan will not pay to replace crowns, jackets or cast restorations which the Plan Participant received in the previous five (5) years.
2. The Dental Plan limits payment for stainless-steel crowns to services on baby teeth, however, after consultant's review, the Dental Plan may allow stainless-steel crowns on permanent teeth.
3. The Dental Plan will not pay to replace a bridge or denture the Plan Participant received in the previous five (5) years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.

4. The Dental Plan limits payment for dentures to a standard partial or denture. A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
5. The initial installation of a fixed bridge or partial denture is not a benefit unless the bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Plan Participant was eligible under the Dental Plan.
6. Implant Benefits are subject to all limitations, exclusions and other terms and conditions in this Dental Plan.
7. The Dental Plan will not pay to replace an implant the Plan Participant received in the previous five (5) years. Benefits are not payable for the removal of an implants.
8. The initial installation of an implant is not a Benefit unless the implant is made necessary by natural, permanent teeth extraction occurring during a time the Plan Participant was eligible under the Dental Plan.

Orthodontia Benefits (*Select Plan*)

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

I. DENTAL PLAN EXCLUSIONS AND LIMITATIONS

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

1. Dental services not listed on the Dental Fee Schedule in provisions F. – *Basic Plan Dental Fee Schedule* or G – *Select Plan Dental Fee Schedule*, or for Dental services that exceed the limitations in provision H. – *Dental Plan Benefit Limitations* of this Section.
2. Completion of the claim form or for missed appointments.
3. Treatment for Cosmetic purposes.
4. Expense incurred after termination, except for prosthetic devices, bridges, and crowns, which were fitted and ordered prior to termination, and were delivered within thirty (30) days after the date of termination.
5. Prosthetic services and devices, including bridges and crowns, started before the Plan Participant became covered by the Plan.
6. After initial placement of a denture and required adjustment rebase and/or reline of the dentures, rebase and/or reline of a denture is not allowed more than once in every two (2) year period.
7. Replacement of lost or stolen prosthetics.
8. Charges for which a Plan Participant covered by this Dental Plan is not required to pay.
9. An 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 a 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. A single procedure started prior to the date the covered Plan Participant became covered for such services under this Dental Plan.
14. Prescribed drugs, medication, pain killers or Experimental procedures.
15. Charges by a Hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in a facility.
16. Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia related to 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 an individual 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 missed appointments.
20. Treatment rendered by an individual who ordinarily resides in your household or who is related to you (or to your legal spouse) by blood, marriage, or legal adoption.
21. The initial placement of a denture or fixed bridge, unless such placement is needed to replace one or more natural, permanent teeth extracted while the covered Plan Participant is covered under the Dental Plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. A 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. – *Dental Plan Coverage* of this Section.

Section 9

PRESCRIPTION DRUG PLAN DESCRIPTION

Plan Participants enrolled in the Medical Plan are automatically enrolled in the Prescription Drug Plan (PDP). There is no separate monthly premium cost for the PDP.

A. PRESCRIPTION DRUG PLAN BENEFITS

Plan Participants will receive a prescription drug ID card from the PDP's Pharmacy Benefit Manager (PBM). Plan Participants can present their prescription drug card, along with a

prescription from a Physician, at a participating In-Network retail pharmacy, for either a thirty-four (34) day supply or ninety (90) day supply of medication. The PBM provides a participating In-Network of pharmacies throughout the U.S. (*Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.*)

The PBM offers a preferred Specialty Pharmacy who can assist Plan Participants who take medications that require special handling and/or administration to treat certain chronic illnesses or complex conditions. (*Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.*)

The PDP has five (5) benefit tier levels:

Tier \$0 – Preventive medications (ACA, certain statins, metformin, omeprazole).

Tier 1 – Low cost, high value generic and select brand name medications that provide high clinical value.

Tier 2 – Preferred brand name and select generic medications that are less cost effective.

Tier 3 – Non-preferred brand name and generic medications that provide the least value because of high cost or low clinical value, or both.

Tier 4 – Specialty medications for certain chronic illnesses or complex diseases.

Plan Participants are responsible for a Copayment or Coinsurance percentage at the time the prescription is purchased. The Coinsurance amount paid for Specialty medications purchased at a retail pharmacy or a non-preferred specialty pharmacy does not apply to the pharmacy Out-of-Pocket maximum, nor does the Tier 3 Coinsurance amounts. (*Refer to the current MUS Choices Enrollment Workbook Prescription Drug Plan Schedule of Benefits for Copayment amounts, Coinsurance percentage, and annual Out-of-Pocket maximums.*)

Plan Participants are NOT permitted to be enrolled in more than one Medicare Part D drug plan.

B. OUT-OF-NETWORK BENEFITS

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. Out-of-Network pharmacies may submit the claim electronically, if available.
2. If an Out-of-Network pharmacy is unable to submit the claim electronically, Plan Participants **must** pay the full cost to the Out-of-Network pharmacy at the time the prescription is received.
3. Plan Participants **must** obtain a Direct Member Reimbursement form from the PBM's website and send the completed form and proof of drug purchase to the PBM. (*Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.*) The PBM will process the claim for reimbursement for the amount allowed under the Plan.
4. In no case will the reimbursement exceed the cost for the same drug purchased at a participating In-Network pharmacy.

Pharmacies that have been excluded from the pharmacy Network are excluded from the Out-of-Network reimbursement process. Prescriptions filled at an excluded pharmacy will not be covered and the patient will be responsible for all charges (applicable to Commercial Plan enrollees only).

C. COPAY MAX PLUS PROGRAM

The MUS PDP offers a Copay Max Plus Program to obtain copay assistance on your behalf for certain eligible medications. This copay assistance program will manage expenses for eligible medications that have manufacturer-funded copay assistance programs available, while lowering the Plan's overall cost.

Under the Copay Max Plus Program, the amount you pay for eligible medications may be set to the maximum of the current MUS Formulary benefit tier levels, \$0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, you will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including copay assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your annual Out-of-Pocket maximum. Instead, only those payments made directly by you will count toward your Out-of-Pocket maximum. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your MUS Formulary benefit tier levels. If a specialty medication does not qualify or is removed from the copay assistance program, the copay will default to the medications current MUS Formulary benefit tier levels.

MedicareRx Plan (Part D) Plan Participants are not eligible for the Copay Max Plus Program.

D. MAIL ORDER PHARMACY PROGRAM

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

Information for the mail order program can be accessed through the vendor websites or by contacting the pharmacy mail order program vendor directly. (*Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.*) With the mail order program, Plan Participants can save money on prescriptions for ongoing maintenance medications and the medication will be mailed directly to the Plan Participant.

Some compound prescription drugs are available from the mail order pharmacy program. These prescriptions will take longer to dispense, so allow more time.

E. COVERED PRESCRIPTION DRUG EXPENSES

Expenses for prescription drugs 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 retail and mail order pharmacy programs. Expenses for these same prescription drugs purchased outside the retail or mail order pharmacy programs are covered up to the PDP's allowed amount for the drug. Covered pharmaceutical services include:

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

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

F. EXCLUSIONS

The PDP **does not** cover the following:

1. Expenses that fall under, or are related to, the General Exclusions and Limitations in the Medical Plan's SPD.
2. Durable Medical Equipment (DME), except for diabetic supplies.
3. Expenses for all pharmaceuticals, drugs and medical supplies that may be purchased over the counter without a written prescription.
4. An expense for a prescription drug that is not Medically Necessary, or not considered appropriate for the treatment of an Injury or Illness or is Experimental/Investigational.
5. Drugs or supplies prescribed for Cosmetic purposes; (e.g., Rogaine for hair loss or Retin-A for individuals age twenty-six (26) and over).
6. Growth hormones unless Prior Authorized by the PBM.
7. A charge or prescription drug expense that has been paid by another health insurance plan, workers' compensation program, or has been paid under the Medical Plan.
8. Hearing aids, Amplifications Devices, ear molds, batteries, cords, and related supplies.
9. An 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 the Plan.
10. An expense incurred prior to the Plan Participant's Effective Date or after the Plan Participant's 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 (prescription drugs used for weight loss) unless part of a treatment plan for morbid obesity that is covered and has been authorized by the Plan.
14. Infertility drugs (prescription drugs used for infertility).

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

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

An appeal of an Adverse Benefit Determination **must** be made in writing (or orally by the attending Physician in the case of an Adverse Benefit Determination rendered on an urgent care claim) and submitted to the PBM. Appeal of an Adverse Benefit Determination **must** be made within one-hundred eighty (180) days from receipt of the Adverse Benefit Determination. Except for urgent care claims, the appeal **must** be made in writing, should list the reasons why the Plan Participant does not agree with the Adverse Benefit Determination, and **must** be sent to the PBM Plan Administrator.

(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.)

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

Physicians may submit urgent appeal requests to the PBM Plan Administrator. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for PBM contact information.)* The PBM will review the appeal of an Adverse Benefit Determination. The claim should include at least the following information: the identity of the Plan Participant, a specific medical condition or symptom,

the name of the prescription drug for which approval or payment is requested, and reasons why the appeal should be processed on a more expedited basis.

The PBM shall decide the appeal of an urgent care claim as soon as possible, considering the medical exigencies, but no later than seventy-two (72) hours after receipt of the request for review.

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

The timeline for the PBM to decide an appeal of an Adverse Benefit Determination and to notify the Plan Participant of the final internal Adverse Benefit Determination depends upon the type of claim on appeal.

1. **Urgent Care Claim** – No later than seventy-two (72) hours from the date the PBM received the Plan Participant’s appeal, considering the medical exigency.
2. **Pre-Service Claim** – No later than thirty (30) days from the date the PBM received the Plan Participant’s appeal.
3. **Post-Service Claim** – No later than sixty (60) days from the date the PBM received the Claimant’s appeal.
4. **Rescission of Coverage Claim** – No later than sixty (60) days from the date the Plan Administrator received the Plan Participant’s appeal.

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

Appeals or requests for review of Adverse Benefit Determinations **must** be submitted to the PBM in writing, along with supporting materials.

I. FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

The PBM’s determination will be communicated in writing to the Plan Participant. If the PBM renders an Adverse Benefit Determination on appeal, the PBM will provide written notification which will include:

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

Participant's medical circumstances; or a statement that such explanation will be provided, upon request and free of charge.

- If the determination is based on Medical Necessity, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

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

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

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

Right to Request External Review:

Standard External Review

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

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

The Plan Participant will be notified of the results of the preliminary review within one (1) business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request, and set forth the time limit for the Plan Participant to provide the additional information needed (the longer of the initial four-month period within which to request an external review or, if later, forty-eight (48) hours, after the receipt of this notice.

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

Expedited External Review

Expedited external review may be requested when:

- an Adverse Benefit Determination involves a medical condition where the timeframe completing an expedited internal appeal would seriously jeopardize the Plan Participant's life, health, or ability to regain maximum function, and a request for an internal appeal has been filed; or
- a final internal Adverse Benefit Determination involves (1) a medical condition where the timeframe for completing an expedited internal appeal would seriously jeopardize the Plan Participant's life, health, or ability to regain maximum function; or (2) an admission, availability of care, continued stay, or health care item or service for which the Plan Participant received emergency services, but has not been discharged from a facility.

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

External Review by IRO

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

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

Notice of Final External Review Decision

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

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

Compliance with IRO Decision

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

Section 10 VISION HARDWARE PLAN DESCRIPTION

A. VISION HARDWARE PLAN COVERAGE

Eyeglass Frame and Prescription Eyeglass Lens Benefit – The Plan will pay up to a \$300.00 allowance toward the purchase of Vision Hardware, which includes:

1. One (1) eyeglass frame for prescription eyeglass lenses.
2. One (1) pair of prescription plastic or glass lenses, including: single vision, bifocal, trifocal, progressive, polycarbonate, and oversize lenses.
3. Prescription lens enhancements, including ultraviolet, scratch-resistant, and anti-reflective coatings; photochromatic; tinting.

Benefit Frequency – One (1) pair per Benefit Plan Year. This benefit is in lieu of prescription contact lenses.

Prescription Contact Lens Benefit – The Plan will pay up to a \$200.00 allowance toward contact lens fitting and the purchase of one (1) pair of prescription contact lenses or a single purchase of a supply of prescription Conventional, Disposable or Medically Necessary* contact lenses.

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

Benefit Frequency – One (1) purchase per Benefit Plan Year. This benefit is in lieu of an eyeglass frame and prescription lenses.

The Plan Participant may be responsible for the charges at the time of service.

B. VISION HARDWARE PLAN EXCLUSIONS

The Vision Hardware Plan **does not** cover expenses for the following:

1. Non-prescription eyeglass lenses or contact lenses.
2. Eyeglass lens polarization or mirror coating.
3. Eyeglass or contact lens cases.
4. Dispensing fees.
5. Magnification or low vision aids.
6. An eye examination, medical or surgical treatment of the eyes.

7. Safety glasses or lenses required for employment.
8. An eye examination, or corrective eyewear, required by employer as a condition of employment.
9. Charges incurred over the benefit allowance.
10. Orthoptic or vision training and associated supplemental testing.
11. More than one (1) eyeglass frame or one (1) pair of prescription lenses per Benefit Plan Year, in lieu of prescription contact lenses.
12. More than one (1) pair of prescription contact lenses or single purchase of a supply of prescription contact lenses per Benefit Plan Year, in lieu of an eyeglass frame and prescription lenses.
13. Experimental or non-conventional treatment or device.

C. FILING VISION HARDWARE CLAIMS

When a Plan Participant purchases Vision Hardware from an Out-of-Network Provider, a walk-out statement should be provided by the Provider and submitted to the Vision Hardware Plan Claims Administrator for reimbursement. (*Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for Vision Hardware Plan contact information.*) Claims are processed in the order in which they are received by the Vision Hardware Plan Claims Administrator and **must** be received within twelve (12) months from the original date of purchase. Benefits will be applied to the first claim received and will not be changed if additional purchases are made during the Benefit Plan Year.

Section 11 FLEXIBLE SPENDING ACCOUNTS

A. ELIGIBILITY

An Employee who:

1. Meets the eligibility requirements of the Plan (*Refer to Section 1 – Eligibility.*); and
2. Enrolls in the Plan; and
3. Does not opt out of IRS Section 125 pre-tax premium payment (*Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage, provision A. – New Employee Benefits Enrollment.*); and
4. Is entitled to make benefit elections under the terms of Sections 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage & 3 – Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options and may elect Flexible Spending Account (FSA) benefits.

B. OPERATION

At the time of initial enrollment in the Plan and during each annual benefits enrollment, an Eligible Employee may elect amounts to be withheld from their earnings to be contributed monthly to a Health Care or Limited Purpose FSA, and/or Dependent Care FSA. These accounts are set up to pay for eligible expenses of Plan Participants and their eligible family members. Family members do not have to be covered under the Plan Participant's Medical Plan to have expenses paid out of the accounts.

The portion of a Plan Participants earnings which they elect to have contributed monthly into a FSA is not subject to federal or state income taxes or Social Security taxes. As the Plan Participant and eligible family members incur qualifying expenses, the Plan Participant may submit claims to be reimbursed for those expenses using tax-free dollars. Expenses reimbursed from a FSA cannot be claimed as a federal or state income tax credit or deduction on tax returns.

An Employee who terminates employment or otherwise loses eligibility for benefits may continue a HCFSA or LPFSA through COBRA FSA for the remainder of the Benefit Plan Year through one (1) or a combination of the following payment options:

1. Make as many of the remaining monthly contributions to the HCFSA or LPFSA as possible out of the final paycheck, but only up through the end of the Benefit Plan Year or
2. Self-paying the monthly contribution with post-tax dollars.

An Employee who terminates employment or otherwise loses eligibility for benefits **may not** continue a DCFSA but may request reimbursement for qualifying Dependent Care expenses incurred up to the date of termination from the remaining balance.

REHIRE: If a terminated Employee is rehired within thirteen (13) weeks from their last day of coverage, prior FSA elections are reinstated at prior monthly contribution rates. The annual FSA election(s) will be reduced by the amount of the missing contributions and no expenses incurred during the lapsed period of coverage are eligible for reimbursement.

FSA election(s) may only be changed if one of the changes in status (*Refer to Section 2 – Enrollment, Changes in Enrollment, Effective Dates of Coverage.*) has occurred.

If a terminated Employee is rehired after thirteen (13) weeks from their last day of coverage, the Employee may make new FSA elections, the same as a new benefits Eligible 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 monthly contributions and benefits available may be limited so the Plan does not unfairly favor those who are highly paid, their legal spouses, or their Dependents. Employees who meet this definition will be notified by the Plan Administrator of these limitations if affected.

A copy of the FSA SPD is available on the MUS *Choices* website at www.choices.mus.edu.

J. ONLINE RESOURCES

FSA related materials are available from the FSA Plan Administrator. These forms and documents include:

- Health Care and Dependent Care FSA claim forms.
- Examples of expenses that qualify for reimbursement under a HCFSA, LPFSA, and DCFSA.
- Examples of expenses that do not qualify for reimbursement under an HCFSA, LPFSA, and DCFSA.
- Worksheets to help estimate annual HCFSA and DCFSA expenses.
- Accessible answers to frequently asked questions.
- Instructions for completing and submitting reimbursement claim forms.

K. CLAIMS PROCESSING GUIDELINES

1. Notify your campus Human Resources/Benefits Office of a change of address.
2. Obtain a claim form from the FSA Plan Administrator.
3. Provide information regarding the expenses for which you wish to be reimbursed on the claim form including date of service, Provider, individual for whom the expenses were incurred, and the amount of Out-of-Pocket expenses. Attach documentation to support the data on the claim form, such as a copy of an EOB from the Claims Administrator.
4. Make a copy of the claim form and all associated documentation for your records.

5. Submit claims to the FSA Plan Administrator *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for FSA contact information.)*
6. Review account balances on the FSA Plan Administrator website. *(Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for FSA contact information.)*
7. The date of service for which reimbursement is being claimed **must** be within the Benefit Plan Year (July 1 – June 30).
9. All claims **must** be received by the FSA Plan Administrator by September 30th following the Benefit Plan Year to be eligible for reimbursement.

Section 12 GENERAL PROVISIONS

A. RIGHT TO TERMINATE OR CHANGE PLAN PROVISIONS

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

1. To terminate some or all Medical, Dental, Vision Hardware, Life, AD&D, or LTD Insurance benefits for some or all Plan Participants, including Employees, Retirees, COBRA, and/or Eligible Dependents (legal spouse and/or children).
2. To alter or postpone the amounts, schedules, or methods of calculation for payment of benefits.
3. To amend or rescind benefit provisions of the Plan.
4. To increase or otherwise change the contributions, fees, or monthly premiums required from units of the MUS and/or the Plan Participant.

B. COMPLIANCE WITH LAW AND REGULATIONS

Any provision of the SPD, which on its Effective Date conflicts with the statutes of Montana or laws and regulations of the U.S., is hereby amended to conform to the minimum requirements of such statutes, regulations, or laws.

C. RIGHT TO MEDICAL RECORDS

The Plan Administrator, Medical Plan Claims Administrator, and Utilization Management at the Medical Plan Claims Administrator shall have full access to all medical or other records relating to the diagnosis, treatment, or services provided to the Plan Participant or to 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 unauthorized individuals, except as provided by law.

D. RIGHT TO CONDUCT MEDICAL EXAMINATIONS

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

E. RIGHT TO MAKE PAYMENTS

The Plan Claims Administrator(s) may make payment to 1) the Plan Participant, 2) the Provider, or 3) the Plan Participant and Provider jointly (lien). A payment made by the Plan Claims Administrator(s) 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 more than the amount necessary to satisfy the liability of the Plan, the Plan Claims Administrator(s) shall have the right to recover some or all excess payments from a Plan Participant to whom such payments have been made.

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

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

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

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

The MUS is not liable for acts of error or omission by a Hospital or medical Provider.

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

The expenses for services provided outside the U.S. are covered in the same manner as expenses for services provided within the U.S.

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 a Plan Participant, 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 retaliation for reporting or appraising an unlawful discriminating practice.

K. RIGHT TO TERMINATE COVERAGE FOR FALSE CLAIMS

A Plan Participant or Provider who submits bad faith or false claims, misrepresents facts, or attempts to perpetuate a fraud upon the Plan may be subject to criminal charges or a civil action brought by the Plan Administrator, or its 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 its designee, they shall immediately become ineligible to remain on the Plan and coverage will be terminated. (*Refer to Section 1 – Eligibility, provision D. – Rescission of Coverage.*)

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

A Plan Participant, who evidences a pattern of appealing baseless, frivolous claims that were initially denied, may become terminated from coverage on the Plan. The Plan Administrator or its designee shall issue a fifteen (15) day notice to the Plan Participant to cease and desist and abide by the Plan terms or terminated from the Plan. If the Plan Participant continues to insist on appealing matters that are deemed frivolous, the Plan Administrator or its designee may issue a thirty (30) day notice of

termination of coverage from the Plan following an informal hearing with the Plan Administrator or its designee. (Refer to Section 1 – Eligibility, provision D. – Rescission of Coverage.)

Section 13

COORDINATION OF BENEFITS

A. COORDINATION OF BENEFITS (COB)

The COB provision sets out rules for the order of payment of Covered Expenses when a Plan Participant is covered by two (2) or more plans, including Medicare, so payments from all Plans does not exceed the Allowed Amount. COB limits the benefits that may be received by a Plan Participant covered by more than one (1) plan to no more than the total health care expenses Allowed Amount and divides responsibility for those expenses between the plans. Only the amount paid by the Plan will be applied to the Plan benefit maximums.

Standard COB

The plan that pays first, the primary plan, according to COB rules will apply benefits and pay without taking the existence of another plan or coverage into consideration. The secondary and subsequent plans will pay the balance up to the total Allowed Amount, less any Copayments, Deductibles, Coinsurance, and/or benefit maximums. A secondary plan has benefits determined after those of the primary plan. The exception to this statement is if:

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

The COB provision applies even if a claim is not filed under the other plan or plans. If needed, authorization is provided to the Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

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

1. Group and individual health insurance plans; or
2. Group and individual health insurance coverage through closed panel plans, licensed Health Maintenance Organizations (HMO) or other prepaid plans; or
3. The medical care components of long-term health care contracts, such as Skilled Nursing Care. This does not include long-term care coverage for non-medical services, such as respite care, personal care, or Custodial Care; or
4. Coverage for students which is sponsored by or provided through a school or other educational institution. This does not include school accident-type coverages that cover students for accidents only (such as athletic Injuries); or
5. Medicare or other governmental benefits, and other coverage required or provided by a statute.

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

COB RULES

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

2. If the claim as applied to the primary plan is subject to a contracted or negotiated rate, the Allowed Amount is equal to that contracted or negotiated amount.
3. If the claim as applied to the primary plan is not subject to a contracted or negotiated rate, but the claim as applied to the secondary plan is subject to a contracted or negotiated rate, the Allowed Amount is equal to that contracted or negotiated amount of the secondary plan.
4. The secondary plan(s) will limit benefits, so the sum of all benefits paid by the primary plan and by the secondary plan(s) do not exceed 100% of the total contracted or negotiated rate (Allowed Amount), or total charge(s) for non-contracted providers.

ORDER OF BENEFIT DETERMINATION

Rules 1 through 5 below apply when there are multiple health insurance plan coverages, with obligations to cover health care expenses for one (1) Plan Participant, regardless of that Plan Participant's coverage status as either an Employee, Retiree, or Dependent.

1. Non-Dependent/Dependent

The plan that covers the Plan Participant other than as a Dependent (e.g., as an Employee or Retiree), is primary and the plan that covers the Plan Participant as a Dependent is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.

2. Dependent Child Covered Under More Than One (1) Plan

- a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - 1) The parents are married; or
 - 2) The parents are not separated (even if they have never been married); or
 - 3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.
- b. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
- c. If the specific terms of a court decree state that one (1) of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph will not apply with respect to a claim determination period, Benefit Period or Benefit Plan Year during which benefits are paid or provided before the entity has actual knowledge.
- d. If the parents are not married or are separated (even if they have never been married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses is:
 - 1) The plan of the custodial parent.
 - 2) The plan of the spouse of the custodial parent.
 - 3) The plan of the non-custodial parent.
 - 4) The plan of the spouse of the non-custodial parent.

3. Longer or Shorter Length of Coverage.

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

- a. To determine the length of time a Plan Participant has been covered under a plan, two (2) plans will be treated as one (1) if the covered Plan Participant was eligible under the second plan within twenty-four (24) hours after the first ended.
- b. The start of a new plan does not include:
 - 1) A change in the amount or scope of a plan's benefits; or
 - 2) A change in the entity that pays, provides, or administers the plan's benefits; or
 - 3) A change from one (1) type of plan to another (such as from a single employer plan to that of a multiple-employer plan).
- c. A Plan Participant's length of time covered under a plan is measured from the Plan Participant's first date of coverage under that plan. If that date is not readily available for a group plan, the date the Plan Participant first became a member of the group will be used as the date from which to determine the length of time the Plan Participant's coverage under the present plan has been in force.

4. No Rules Apply

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

B. COORDINATION WITH MEDICARE:

Medicare Part A and Medicare Part B will be considered a plan for the purposes of COB. The Plan will coordinate benefits with Medicare even if the Plan Participant is not actually receiving Medicare Benefits.

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

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

RETIREEES: Medicare is primary, and the Plan will be secondary, for the covered Retiree if the Retiree is a Plan Participant who is eligible for Medicare Part A and Medicare Part B because of age and retired.

Medicare is primary, and the Plan will be secondary, for the covered Retiree's covered Dependent who is eligible for Medicare Part A and Medicare Part B if both the covered Retiree and their covered Dependent are eligible for Medicare Part A and Medicare Part B because of age.

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

Retirees and/or their covered Dependents who are or become Medicare-eligible at retirement are required to be enrolled in both Medicare Part A and Medicare Part B. (*Refer to Section 3 – Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options, provision I. – Retiree Coverage.*)

MUS Retirees who have Medicare as primary coverage cannot cover or continue medical coverage for their legal spouse or Adult Dependent if the legal spouse or Adult Dependent is also a MUS Retiree

who has Medicare as primary coverage. Medicare rules prohibit enrollment in more than one (1) Medicare Part D drug plan (dual coverage). MUS Retirees who have Medicare as primary coverage will need to choose to remain on their own MUS Medicare Retiree plan or choose to enroll on their legal spouse's or Adult Dependent's MUS Medicare Retiree plan as a Dependent.

DISABLED PLAN PARTICIPANT: The Plan will be primary, and Medicare will be secondary, for a covered Employee or covered Dependent who is eligible for Medicare due to disability and for whom Medicare requires the employer plan to be primary.

The Plan is secondary, and Medicare will be primary, for the covered Retiree or covered Dependent who is eligible for Medicare due to disability.

END-STAGE RENAL DISEASE: The Plan will be primary only during the first thirty (30) months of Medicare coverage for Plan Participants for whom Medicare requires the employer plan to be primary if Medicare eligibility is due solely to End-Stage Renal Disease (ESRD). Thereafter, the Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period (as 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 due to disability, and Medicare is primary for that reason on the date the Plan Participant becomes eligible for Medicare due to ESRD, Medicare will continue to be primary, and the Plan will be secondary.

C. COORDINATION WITH MEDICAID

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

D. COORDINATION WITH TRICARE/CHAMPVA

If a Plan Participant is also entitled to and covered under TRICARE/Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), the Plan will be primary and TRICARE/CHAMPVA will be secondary. TRICARE coverage will include programs established under its authority, known as TRICARE Select, TRICARE Prime, TRICARE Reserve, and TRICARE for Life.

E. COORDINATION WITH VETERANS AFFAIRS BENEFITS

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

Section 14 DEFINITIONS

Medical Plan definitions in this Section apply to the Plan.

1. **Acupuncture** – Professional services performed by a licensed acupuncturist to treat Illnesses using the insertion of needles at specified sites of the body

2. **Allowed Amount** – The maximum amount considered for payment for covered treatment, service, or supply, subject to all Plan Maximum Benefit limitations
3. **Ambulatory Surgical Center** – A duly licensed facility that is equipped and operated solely as a setting for Outpatient surgery. The facility must have the following:
 - a. Staffing, which includes:
 - 1) Direction by a staff of Physicians or surgeons (MD or DO); and
 - 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); and
 - 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 (2) operating rooms and one (1) recovery room (but not a place for patients to stay overnight); and
 - 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. **Amplification Device** – A hearing device, hearing aid, or a wearable, non-disposable, non-experimental instrument or device designed to aid or compensate for impaired hearing and any parts, attachments, or accessories for the instrument or device, including ear molds but excluding batteries, cords, or related supplies.
5. **Benefit Plan Year** – The period commencing July 1 and ending June 30 of each year.
6. **Case Management and Case Manager** – Services of a professional Case Manager that involve working with Plan Participants of the Medical Plan, their families, their Physicians, and other Providers, to identify the most appropriate, effective, and cost-efficient treatment possible for catastrophic Illnesses and accidents.

Use of Case Management services is voluntary, free of charge to the Plan Participant, and advantageous in several ways. Case management: (1) permits treatment options not normally available under the Plan through Plan exceptions; (2) provides another opinion on the most effective treatment options for a specific diagnosis; and (3) 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 all Inpatient care be Pre-Certified by Utilization Management at the Medical Plan Claims Administrator who identifies cases that may benefit from Case Management. (*Refer to Section 6 – How to Obtain Benefits.*)

7. **Chiropractic Services** – Professional services for spinal treatment performed by a licensed chiropractor. Spinal treatment means detection or correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the body for removing nerve interference or its effects where such

interferences are the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

8. **Claimant** – The Plan Participant for whom the claim is filed.
9. **Claims Administrator** – An entity employed by the Plan to administer its Medical Plan, Dental Plan, or Vision Hardware Plan, including consulting services to the Plan regarding the operation of the Medical, Dental, or Vision Hardware Plan and other functions, including the processing and payment of claims. The Claims Administrator provides ministerial duties only, exercises no discretion over Plan assets, and will not be considered a fiduciary as defined by any applicable state or federal law or regulation.
10. **Coinsurance** – The percentage of the Allowed Amount for 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 PDP, the percentage of Covered Prescription Drug Expenses, which are not specifically exempted from Coinsurance the Plan Participant is responsible to pay.
11. **Copayment** – A fixed dollar amount of Covered Medical Expenses or Covered Prescription Drug Expenses the Plan Participant is responsible to pay.
12. **Cosmetic** – Surgery, procedures, treatment, or other services performed solely to change, enhance, or improve appearance rather than for the restoration of bodily function, including (but not limited to) those surgeries, procedures, treatments, and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological, or mental condition.
13. **Covered Medical Expense or Charge** – A medical expense or charge that is:
 - a. for a Covered Medical Service; and
 - b. is within the Allowed Amount for the service, and
 - c. is within benefit limitations specified for the service in the SPD or the Schedule of Benefits and meets other requirements of the SPD.

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

14. **Covered Medical Service or Covered Service** – A medical service, procedure or supply that is:
 - a. listed as a Covered Medical Service in Section 7 – *Medical Plan Description* and not specified as an exclusion in Section 7 – *Medical Plan Description* or in the current MUS Choices Enrollment Workbook Schedule of Benefits; and
 - b. Medically Necessary for the diagnosis or treatment of Injury, Illness, maternity, or a preventive service specified as covered in Section 7 – *Medical Plan Description*; and
 - c. Provided to a Plan Participant enrolled in a Plan by a Covered Provider, and
 - d. Provided and coded in accordance with applicable standard medical and insurance practice.
15. **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 – *Prescription Drug Plan Description* and not excluded in Section 9 – *Prescription Drug Plan Description*. Expenses for these same drugs and medicines purchased outside the prescription

drug card or mail order service programs are covered up to the PDP's allowance for the drug or medicine.

16. **Creditable Coverage** – Health insurance coverage prior to the date of enrollment in the Plan under any of the following:
- a. A group or individual health insurance plan coverage.
 - b. Medicare Part A, Part B or Part C.
 - c. Medicaid.
 - d. TRICARE/CHAMPVA.
 - e. A medical care program of the Indian Health Service or a tribal organization.
 - f. Federal Employee Health Benefits Program.
 - g. A public health plan, including a plan established by a state, U. S. government, foreign country, or political subdivision of the foregoing.
 - h. A health benefit plan under the Peace Corps Act.
 - i. State Children's Health Insurance Program.
17. **Custodial Care** – Services or treatment that, regardless of where it is provided:
- a. Could be rendered safely by an individual without medical skills; and
 - b. Is designed primarily to help the patient with daily living activities, including (but not limited to):
 - 1) Personal care such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube, or gastrostomy; exercising; dressing; enema and using the toilet.
 - 2) Homemaking such as preparing meals or special diets.
 - 3) Moving the patient.
 - 4) Acting as companion or sitter.
 - 5) Supervising medication that can usually be self-administered.
 - 6) Oral hygiene.
 - 7) Ordinary skin and nail care.
- An independent medical review staff contracted by the Plan may, if necessary, determine what services are Custodial Care. When a confinement or visit is found to be mainly for Custodial Care, some services (such as prescription drugs, x-rays, and lab tests) may still be covered. All bills or claims for services should be routinely submitted for consideration.
18. **Deductible** – A specified dollar amount of Covered Medical Expenses the Plan Participant is responsible to pay, or a covered Dependent is responsible to pay, in a Benefit Plan Year before the Plan will pay for Covered Medical Services during each Benefit Plan Year that are not specifically exempt from Deductible. (*Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for annual Deductible amounts.*)
19. **Dependent or Eligible Dependent** – An individual who meets one (1) or more of the definitions of Eligible Dependent in Section 1 – *Eligibility*, except when the context clearly refers to a Dependent on another health insurance plan as in the COB Section or to Dependents eligible for benefits under either a Health Care or Dependent Care Flexible Spending Account with their own eligibility requirements.
20. **Dependent Child or Eligible Dependent Child** – An individual who meets one (1) or more of the definitions of Eligible Dependent Child in Section 1 – *Eligibility* or who meets the definition of a disabled Dependent Child in Section 1 – *Eligibility*, except when the context clearly refers to a Dependent on another health insurance plan as in the COB Section or to Dependents eligible for benefits under either a HCFS, LPFS, or DCFS with their own eligibility requirements.
21. **Durable Medical Equipment (DME)** – Durable Medical Equipment which:
- a. Is designed for prolonged use over a period of years; and
 - b. Serves a specific therapeutic purpose in the treatment of an Injury or Illness; and
 - c. Is primarily and customarily used to serve a medical purpose; and
 - d. Is suitable for use at home, and
 - e. Is not generally useful to an individual in the absence of Illness or Injury.

22. **Effective Date** – The date on which a Plan Participants coverage begins.
23. **Employee or Eligible Employee** – An individual who meets the definition of an Eligible Employee in Section 1 – *Eligibility*, except when the context clearly refers to an Employee or Eligible Employee on another health insurance plan as in the COB Section or an Employee of an organization involved in administering the Plan.
24. **Experimental/Investigational Services** – A drug, device, medical treatment, or procedure that meets any of the following:
- a. That cannot be lawfully marketed without approval of the FDA. Further, approval for marketing the drug or device has not been provided at the time the drug or device is furnished.
 - b. The patient informed consent document utilized was reviewed and approved by:
 - 1) The treating facility’s Institutional Review Board; or
 - 2) Other body serving a similar function; or if
 - 3) Federal law requires such review or approval.
 - c. That is under study, prior to or in the absence of a clinical trial to determine its:
 - 1) Maximum tolerated dose; and
 - 2) Toxicity; and
 - 3) Safety; and
 - 4) Efficacy; or
 - 5) Efficacy as compared with generally medically accepted means of treatment or diagnosis.
 - d. Based upon Reliable Evidence is the subject of an ongoing Phase I or Phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not Experimental or Investigational). The routine patient care costs (conventional care) shall be provided by the patient’s health plan.
 - 1) “Routine” patient care costs are items or services that are covered benefits under the patient’s health plan whether part of the clinical trial and, in the case of cancer treatment, are listed on the National Comprehensive Cancer Network web site as appropriate for treatment of the condition.
 - 2) The Health Care Provider managing the clinical trial shall provide to the health plan, in advance of incurring charges, copies of the trial protocol, informed consent and other documents necessary to ascertain routine patient care costs versus costs incurred for patient care generated specifically by the clinical trial. The sponsor of the clinical trial shall provide its assessment of what it would deem routine care for review for coverage by the health plan.
 - 3) The Plan shall provide coverage for routine patient care costs incurred for drugs and devices provided to the patient during the clinical trial provided that those drugs or devices have been approved for treatment of the patient’s condition by the FDA and to the extent those drugs or devices are not provided or paid for by the sponsor of the clinical trial, or the manufacturer, distributor, or Provider of that drug or device.
 - e. Based upon Reliable Evidence, the prevailing opinion among experts is that further studies or clinical trials are necessary to determine its:
 - 1) Maximum tolerated dose; and
 - 2) Toxicity; and
 - 3) Safety; and
 - 4) Efficacy; or
 - 5) Efficacy as compared with generally medically accepted means of treatment or diagnosis.
 - f. Used in a manner outside the scope of use for which it was approved by the FDA, or other applicable regulatory authority. Such authorities include:

- 1) U.S. Department of Health and Human Services (HHS).
- 2) The Centers for Medicare and Medicaid Services (CMS).
- 3) American Dental Association.
- 4) American Medical Association.

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

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

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

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

26. **Fee Schedule** – A Fee Schedule is a listing of fees used by the Plan to reimburse Providers and suppliers for providing select health care services. The comprehensive listing of fee maximums is used to reimburse a Provider on a fee-for-service or flat-fee basis.

27. **Flexible Spending Account (FSA)** – A personal account into which an Employee enrolled in the Plan may allocate earnings on a pre-tax basis for use in reimbursing eligible Benefit Plan Year expenses. A HCFSAs may be used to reimburse eligible health care expenses; a LPFSA or HSA-Compatible FSA may be used to reimburse eligible Dental and Vision expenses; and a DDCFSAs may be used to reimburse eligible expenses for Dependent day care (e.g., day care, preschool, day camps, babysitter). (*Refer to Section 11 – Flexible Spending Accounts.*)

28. **Formulary** – A list of drugs deemed to be appropriate and effective in treating an 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.

29. **Freestanding Inpatient Facility** – A facility that:
- Is licensed or approved as such by the DPHHS or by the appropriate licensing authority in the state where the service is provided.
 - Has rooms for resident patients.
 - Is equipped to treat Mental Illness or alcohol and drug abuse.
 - Has a RN always on duty.
 - Has a resident Physician or psychiatrist on duty or on call.
30. **Gender Identity Disorder/Gender Dysphoria in Adolescents and Adults** – A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):
- A marked incongruence between one’s experience/expressed gender and assigned gender, of a least six (6) months duration, as manifested by **at least two (2)** of the following:
 - A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 - A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
 - A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender).
 - A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).
 - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender).
 - The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
31. **Gender Identity Disorder/Gender Dysphoria in Children** – A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):
- A marked incongruence between one’s experience/expressed gender and assigned gender, of a least six (6) months duration, as manifested by **at least six (6)** of the following (one of which must be criterion 29. a. 1.):
 - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender).
 - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 - A strong preference for cross-gender roles in make-believe play or fantasy play.
 - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
 - A strong preference for playmates of the other gender.
 - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
 - A strong dislike of one’s sexual anatomy.

- 8) A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- b. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.
32. **Gender Reassignment Surgery** – Surgery to change primary and/or secondary sex characteristics to affirm an individual's gender identity. Sex or Gender Reassignment surgery can be an important part of Medically Necessary treatment to alleviate Gender Dysphoria. May also be known as gender or Transgender Transition surgery, sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, Transgender surgery, and sex reassignment.
33. **Hearing Loss** – A disruption in the normal hearing process that may occur in the outer, middle, or inner ear, where sound waves are not converted to electrical signals and nerve impulses are not transmitted to the brain to be interpreted. Types of Hearing Loss are conductive, sensorineural, and mixed. Hearing Loss may be mild, moderate, severe, or profound.
34. **Hospital** – An institution which meets the following conditions:
- It is engaged primarily in providing medical care and treatment to individuals suffering Illness or Injury on an emergency, Outpatient, or Inpatient basis.
 - It is licensed as a Hospital, or a critical access Hospital, under the laws of the jurisdiction in which the facility is located.
 - 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.
 - It provides treatment by or under the supervision of a Physician with nursing services by RNs as required under the laws of the jurisdiction in which the facility is licensed.
 - It is a Provider of services under Medicare. This condition is waived for otherwise Covered Medical Expenses incurred outside of the U.S.
 - 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.
35. **Identification Card (& Identification Number)** – A card issued by the Claims Administrator for each MUS offered benefit plan (Medical Plan, Dental Plan, Vision Hardware Plan, and Prescription Drug Plan) to Plan Participants who have enrolled in that plan. ID Cards contain such information as a unique Subscriber Identification Number, Dependent coverage, and other information required for claims administration.
36. **Illness** – A bodily disorder, disease, physical sickness, Mental Illness, or functional nervous disorder.
37. **Injury** – Physical damage to the body, which is not caused by disease or bodily infirmity.
38. **Inpatient or Inpatient Admission** – A Medically Necessary stay (or admission for a stay) of twenty-four (24) consecutive hours or more in a single or multiple departments or parts of a Hospital, Psychiatric Hospital, Free Standing Inpatient Facility, Mental Health Treatment Center, Chemical Dependency Treatment Center, Skilled Nursing Care Facility, or other facility licensed in the state where the service is provided to provide skilled twenty-four (24) hour medical care. A stay that meets these requirements is Inpatient even if the facility does not charge for daily room and board.
39. **Medical Massage Therapy** – Professional Medical Massage Therapy services performed by a licensed massage therapist. Medical Massage Therapy is the manual manipulation of soft body tissues (muscle, connective tissue, tendons, and ligaments) to enhance a Plan Participant's health and well-being.

40. **Maximum Benefit** – The maximum Medical, Dental, Vision Hardware, and Pharmacy benefit amount payable under the Plan for covered treatment, service, or supply. (*Refer to the current MUS Choices Enrollment Workbook Schedule of Benefits for the Maximum Benefit.*)
41. **Medicaid** – The program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.
42. **Medical Emergency** – A severe condition which (in the opinion of the Medical Plan Claims Administrator and/or an independent medical review panel):
- Results in symptoms which occur suddenly and unexpectedly, and
 - Requires the immediate care of a Physician or surgeon to prevent death or serious impairment of the health of the Plan Participant.
43. **Medically Necessary** – Treatment, tests, services, or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under the Plan, and which must meet the following criteria:
- For treatment or diagnosis of an Illness or Injury.
 - Ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury.
 - Not primarily for the convenience of the Plan Participant, Physician, or other Licensed Health Care Provider.
 - Uses the standard or level of services most appropriate for good medical practice that can be safely provided to the Plan Participant.
 - Not of an Experimental/Investigational or solely educational nature.
 - In accordance with the Plan’s Medical Policy.
 - Not provided primarily for medical or other research.
 - Does not involve excessive, unnecessary, or repeated tests.
 - Commonly and customarily recognized by the medical profession as appropriate and generally accepted as the common medical management used in the U.S. for the treatment or diagnosis of the diagnosed condition.
 - Are approved procedures based upon the medical treatment circumstances or meets required guidelines or protocols of the FDA or CMS.

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

44. **Medicare** – The programs established under the “Health Insurance for the Aged Act”, Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended. “Medicare” is used to pay for various medical expenses for qualified individuals.
45. **Medical Policy** – A policy adopted by the Plan which is created and updated by Physicians and other medical Providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:
- Final approval from the appropriate governmental regulatory agencies; and
 - Scientific studies showing conclusive evidence of improved net health outcome; and
 - In accordance with established standards of good medical practice.
46. **Medicare Benefits** – Benefits for services and supplies which the Plan Participant receives or is eligible for under Medicare, regardless if the Plan Participant has applied for or is enrolled in Medicare.

47. **Mental Health Treatment Center** – A facility that:
- Is organized to treat Mental Illness by multiple techniques; and
 - Requires a written treatment plan approved and monitored by an interdisciplinary team (including a Physician, a psychiatric social worker, and a psychologist); and
 - Is either:
 - Licensed as such by the state, or
 - Affiliated with a Hospital under a contract with an established system of patient referral.
48. **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 an individual) that is associated with:
- Present distress or a painful symptom; or
 - A disability or impairment in one or more areas of functioning, or
 - A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.
- Mental Illness does not include:**
- Developmental disorders.
 - Speech disorders.
 - Psychoactive substance use disorders.
 - Chemical dependency or other addictive behavior.
 - Eating disorders (except for bulimia and anorexia nervosa).
49. **Mental Illness, Severe** – The following disorders are defined by the American Psychiatric Association:
- Schizophrenia.
 - Schizoaffective disorder.
 - Bipolar disorder.
 - Major depression.
 - Panic disorder.
 - Obsessive-compulsive disorder.
 - Autism.
50. **Naturopathic** – Professional services performed by a licensed naturopath to treat disease that employs no surgery or synthetic drugs to assist the natural healing process, using special diets, herbs, vitamins, etc.
51. **Network (of Providers), Preferred or In-Network** – A group of Covered Providers who have entered into a contract with the Medical Plan or other benefit plan, such as a Vision Hardware Plan (or with an In-Network administrator who has a contract with the medical or other benefit plan) to provide services to Plan Participants according to contract terms.
52. **Nurse or Registered Nurse** – An individual who is duly licensed as a RN unless specifically identified as an LPN or a Nurse with some other licensure.
53. **Occupational Therapy** – The use of purposeful activity with a Plan Participant who is limited by physical Injury or Illness, psychosocial dysfunction, developmental or learning disability, or the aging process to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation provided by a licensed occupational therapist. OT services must be ordered by a Physician and may be provided individually, in groups, or through social systems subject to medical review. Specific OT services include, but are not limited to:
- Teaching daily living skills.
 - Developing perceptual motor skills and sensory integrative functioning.
 - Designing, fabricating, or applying splints or selective adaptive equipment, and training in the use of upper-extremity prosthetics or upper-extremity orthotic devices.
 - Using specifically designed crafts and exercises to enhance functional performance.

- e. Administering and interpreting tests such as manual muscle and range of motion.
54. **Out-of-Pocket Maximum** – The Out-of-Pocket maximum is the Plan Participant’s accumulated obligation on individual Covered Medical Expenses in the Benefit Plan Year. The Out-of-Pocket maximum includes Deductible, Coinsurance, and Copayments. The family Out-of-Pocket maximum is the family’s accumulated obligation on Covered Medical Expenses in the Benefit Plan Year. The Plan pays the remaining Covered Medical Expenses in the Benefit Plan Year.
55. **Outpatient** – Medical services provided, or procedures performed, on an Outpatient basis without an overnight stay.
56. **Participating Providers** – Covered Providers who have agreed to accept the Plan’s Allowed Amount as full compensation and not bill Plan Participants for amounts above the Allowed Amount. Plan Participants of the Plan will still be responsible for applicable Deductible, Coinsurance and Copayment amounts, but not for amounts above the Allowed Amount. Providers may agree to be Participating Providers of the Plan but not In-Network Providers of the same plan because being part of the Network may involve additional contractual obligations.
57. **Pharmacy Benefit Administrator** – The company retained by the Plan to manage its Prescription Drug Plan.
58. **Physical Therapy** – The treatment of physical dysfunction or injury by physical methods such as the application of modalities, therapeutic exercise, and patient education and training rather than by drugs or surgery provided by a licensed physical therapist. The aim is for preservation, enhancement, or restoration of movement, mobility, and physical function and to return the Plan Participant to the highest level of motor functioning possible.
59. **Physician** – An individual who is:
- Licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO); and
 - Providing services which are Covered Medical Services of the Plan; and
 - Practicing within the scope of their license.
60. **Plan** – The MUS Group Benefits Plan, including all the provisions contained in the SPD, Plan Descriptions of other benefits such as life insurance, and associated contracts with Claims Administrators, Insurance Companies, Utilization Management at the Medical Plan Claims Administrator, the Pharmacy Benefit Administrator and other companies and organizations retained to provide, administer or assist in the administration of the Plan, except when the context is clearly used to refer to another or generic health insurance plan (such as when describing COB) or to a health or other insurance plan. Exceptions are left un-capitalized unless designating a specific plan.
61. **Plan Administrator** – The Office of the Commissioner of Higher Education is the Plan Administrator.
62. **Plan Description Amendment** – An amendment to the SPD.
63. **Plan Participant** – An enrolled Employee, Retiree, or individual who has continued coverage under COBRA or other provisions of the Plan and covered Eligible Dependents of these individuals for which Plan coverage has commenced and not terminated.
64. **Pre-Certify (Pre-Certification)** – A process (*Refer to Section 6 – How to Obtain Benefits.*) for contacting Utilization Management at the Medical Plan Claims Administrator for the Plan prior to an Inpatient Admission for a non-emergency Illness or Injury for a preadmission certification review. Pre-Certification and post-admission notifications of an emergency admission are designed to:
- Optimize efficient resource utilization; and
 - Ensure that patients have equitable access to care; and
 - Foster collaboration and communication among all members of the healthcare team, to enhance

- Medically Necessary care in a cost-effective manner; and
- d. Assist in identifying possible ways to reduce Out-of-Pocket expenses; and
- 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.

65. **Prior Authorize (Prior Authorization)** – A process (*Refer to Section 6 – How to Obtain Benefits.*) for contacting Utilization Management at the Medical Plan Claims Administrator to determine whether a planned procedure or service meets criteria for benefits under the Plan. Prior Authorization is recommended for many Covered Medical Services and required to receive benefits for services (*Refer to Section 6 – How to Obtain Benefits.*) and in the descriptions of the applicable services.
66. **Provider or Licensed Health Care Provider** – An individual who is:
- a. Duly licensed or certified by an applicable government regulatory authority and practicing in the area in which services are rendered; and
 - b. Providing services which are Covered Medical Services of the Plan; and
 - c. Practicing within the scope of their license.
67. **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 individuals with psychiatric disorders or Mental Illness by or under the supervision of a staff of duly licensed Physicians/psychiatrists that continually provides twenty-four (24) hour-a-day nursing service by or under the supervision of registered graduate Nurses and which is not primarily a nursing home or place of rest for the aged, or for the treatment of pulmonary tuberculosis.
68. **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 Employee Retirement Income Security Act (ERISA) in relation to QMCSO's, and Section 4 – *Continuation of Coverage Rights Under COBRA* of the SPD. A Qualified Beneficiary also includes a child born to, adopted by, or placed for adoption with, an Employee or former Employee during the Employee's or former Employee's COBRA Continuation of Coverage.
69. **Qualified Medical Child Support Order (QMCSO)** – A 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 an Employee or covered legal spouse under the Plan; and
 - b. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under the Plan; and
 - c. Is made pursuant to a law relating to medical child support as described in Section 1908 of the Social Security Act.
70. **Rescission** – A cancellation or discontinuance of coverage that has a retroactive effect.
71. **Residential Care** – Sub-acute, twenty-four (24) hour care where the principal focus of treatment is psychosocial and does not entail twenty-four (24) hour medical or nursing intervention.
72. **Retiree and Eligible Retiree** – A Retiree is a former Employee who is retiring or has retired from the MUS. An Eligible Retiree is a Retiree who meets the requirements (*Refer to Section 3 – Leave, Layoff, Coverage Termination, Re-Enrollment, Surviving Dependent, and Retirement Options.*) to continue certain Plan benefits provided by the MUS for Eligible Retirees.
73. **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. To receive medical care necessary for convalescence from the condition(s) causing or contributing to a precedent Hospital confinement.
74. **Skilled Nursing Care Facility (Extended Care Facility/Unit or Transitional Care Unit)** – An institution, or distinct part thereof, which meets 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; and
 - b. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled individuals, 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 U.S.
75. **Special Enrollment** – Enrollment required by the HIPAA during a prescribed period (sixty-three (63) days for the Plan) following a Special Enrollment event listed in Section 2 – *Enrollment, Changes in Enrollment, Effective Dates of Coverage*.
76. **Speech Therapy** – Training to help a Plan Participant with speech and language problems to speak more clearly. Treatment includes assessment of communication problems, speech disorders, voice, language, communication, and swallowing provided by a licensed speech therapist. Treatment may include physical exercises to strengthen the muscles used in speech (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.
77. **Subscriber** – A Plan Participant whose eligibility for Plan coverage is based on their direct relationship to the MUS (Employee or Retiree) rather than on Dependent status, or a Plan Participant who was covered as a Dependent but continues coverage in their own name under surviving legal spouse or Adult Dependent, surviving Dependent or COBRA provisions of the Plan. The Subscriber is the Plan Participant whose name administrative records are kept and who is named as the ID Card holder.
78. **Transgender** – A diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of Transgender people differs to varying degrees from the sex they were assigned at birth.
79. **Transition** – A period when individuals change from the gender role associated with their sex assigned at birth to a different gender role. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of Transition are varied and individualized. Suppression of puberty using hormone therapy is not considered Transition.
80. **Utilization Management** – A program designed to assure that Plan Participants receive the most effective and appropriate medical services and to reduce waste. The program involves Pre-Certification (defined above) of planned Inpatient Admissions called in prior to Admission, post-review of emergency or other Inpatient Admissions called in after the fact, continued stay review and Case Management (defined above). All Utilization Management services are described in Section 6 – *How to Obtain Benefits* and, except for Case Management, are provided by Utilization Management at the Medical Plan Claims Administrator defined below.
81. **Utilization Management Administrator** – The company retained by the Plan to administer its Utilization Management program for the Plan.