

Montana University System's Flexible Benefits Program

**2005 – 2006**

**Retiree Health Plan  
Schedule of Benefits**

# Glossary

## **Allowable fees**

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

## **Benefit year/year**

The period starting July 1 and ending June 30 of each year.

## **Certification/pre-certification**

A determination by the appropriate medical plan claims administrator that an inpatient hospital stay is medically necessary. Pre-certification is done in advance of a non-emergency admission by contacting the plan claims administrator.

## **Coinsurance**

A percentage of allowable and covered fees that a member is responsible for paying, after paying any applicable deductible. The medical plan pays the remaining allowable fees.

## **Copayment**

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

## **Covered medical expenses or fees**

Fees for medical services that are determined to be medically necessary, covered by the plan and within allowable fees.

## **Deductible**

A set dollar amount of allowable and covered fees that a member and family must pay each benefit year before the medical plan begins to share the costs. Deductible does not apply to services for which there is a copayment nor to a few other specified services.

## **Formulary**

A list of prescription drugs that are preferred because of their effectiveness and cost. Copayments and coinsurance rates are lower for formulary drugs than for nonformulary drugs.

## **In-network providers**

Providers (including facilities) who (which) contract with a managed care plan to manage and/or delivery care according to the fees and other terms of the contract. Managed Care Plan benefits for services of an in-network provider are higher than for those of an out-of-network provider.

## **Managed care medical plan**

Plans that coordinate medical care with a Primary Care Provider and offer differing levels of benefits for in-network and out-of-network providers.

## **Out-of-network provider**

Any provider who renders services to a managed care member, but is not an in-network provider.

## **Coinsurance maximum**

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## **Participating provider (called extended network provider in the PEAK plan)**

A provider who has a contract with a health plan administrator to accept allowable fees as payment in full and not bill members for amounts above allowable fees. A participating provider of a managed care plan can be either an in-network provider (whose allowable fees are paid at the higher in-network level) or an out-of-network provider (whose allowable fees are paid at the lower out-of-network level).

## **Preferred hospital or facility**

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

## **Primary Care Provider**

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

## **Prior authorization**

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



# SCHEDULE OF BENEFITS

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## MEDICAL PLAN

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

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

### **MEDICAL PLAN COSTS YOU PAY:**

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#### **Annual Deductible\***

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

#### **Coinsurance Percentages\***

General (Including facilities that are neither preferred or nonpreferred)

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

#### **Annual Coinsurance Maximums**

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

#### **Copayment\* (on outpatient visits)**

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

### **MEDICAL PLAN SERVICE**

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#### **Hospital Services** *(Inpatient facility charges)*

*(Pre-certification of hospitalization is strongly recommended.)*

Room Charges

Ancillary Services

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

#### **Hospital and Surgi-Center**

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

#### **Physician/Professional Provider Services** (not listed elsewhere)

Office Visit

Inpatient Physician Services

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

Lab/Ancillary/Miscellaneous Charges

Second Surgical Opinion

# BENEFIT YEAR 2005-2006

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## MEDICAL RATES

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

**TRADITIONAL**  
Administered by

**PLANS**  
Allegiance

Premium Plan	Basic Plan	\$1500 Deductible
\$400/Member \$800/Family	\$575 / Member \$1,150 / Family	\$1,500/member \$3,000/family
25%	25%	25%
20%	20%	20%
Average of \$1,250 / Member (20%-35% of \$5,000 in allowable fees)	Average of \$2,500 / Member (20%-35% of \$10,000 in allowable fees)	Average \$5,400 / Member (20%-25% of \$24,000 in allowable fees)
Average of \$2,500/Family (20%-35% of \$10,000 in allowable fees)	Average of \$5,000 / Family (20%-35% of \$20,000 in allowable fees)	Average of \$10,800 / Family (20%-25% of \$48,000 in allowable fees)
NA	NA (See exceptions below)	

### Coinsurance

20% – 25%

(depending on whether a preferred, non preferred or other facility see above)

20% – 25%

20% – 25%

20% – 25%

25%

25%

25%

0%

(Plan pays 100% of allowable fee, no deductible)

# SCHEDULE OF BENEFITS



## MEDICAL PLAN COSTS YOU PAY:

### Emergency Services

Ambulance Services for Medical Emergency

Emergency Room  
Facility Charges

Professional Charges

### Urgent Care Services

Facility/professional Charges

Lab & Diagnostic Charges

### Maternity Services

Hospital Charges

Physician Charges (delivery and inpatient)

Prenatal Office Visits

### Routine Newborn Care

Inpatient Facility and Professional Charges

### Preventive Services

Adult Exams and Tests (age 19+)

Mammogram, gyn exam and pap, proctoscopic, sigmoidoscopic and colonoscopic exams, limited routine lab work, such as PSA tests, and basic blood panel.  
For managed care plans only, bone density tests.

Immunizations and Pneumonia and Flu shots

Child Checkups through age 2

### Mental Illness Services

Inpatient Services

*(Pre-certification is strongly recommended)*

**Max:** One inpatient day may be exchanged for two partial hospitalization days.

Outpatient Services

### Chemical Dependency

Inpatient Services

*(Pre-certification is strongly recommended.)*

Outpatient Services in 24 months

\* Dollar benefit max for inpatient services of \$4,000/in 24 months, \$8,000/lifetime

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

# BENEFIT YEAR 2005-2006

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## TRADITIONAL PLANS

25%

\$25 / visit  
(waived if immediately  
admitted to hospital)  
deductible and coinsurance apply

25%

25%

25%

20% – 25%

25%

25%

20 – 25%

0% (no deductible) plan pays 100% of routine care for days that both mother and child are confined to the hospital

0% (no deductible) up to max on:

gyno exam & PAP **Max:** \$75 / yr.  
mammogram up to allowable  
prostrate exam **Max:** \$50 / yr.

25% (deductible applies) on:

routine lab (PSA, blood panel),  
proctoscopy, sigmoidoscopy, and  
colonoscopy **Max:** one / 10 years starting at age 50

0% (no deductible) up to max

**Max:** \$250 / yr. up to age 19

\$75 / yr. age 19 +

\$50 / yr. on pneumonia and flu shots

0% (no deductible) up to max

**Max:** \$500 first 2 years of life

20% – 25%

**Max:** 30 days / yr.

(No max for severe conditions)

20% – 25%

**Max:** 40 visits / yr.

(No max for severe conditions)

25%

**Max:** Dollar limit\*

25%

**Max:** \$1,000 / year

# SCHEDULE OF BENEFITS

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## MEDICAL PLAN COSTS YOU PAY:

### Rehabilitative Services

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

Inpatient Services

*(Pre-certification is strongly recommended.)*

Outpatient Services

### Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

### Extended Care Services

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

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

Hospice

Skilled Nursing

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

### Miscellaneous Services

Allergy Shots

Dietary / Nutritional Counseling

*(When medically necessary and physician ordered)*

Durable Medical Equipment, Prosthetic Appliances and Orthotics

*(Prior authorization required for most managed care plans for amounts > \$500)*

*(Prior authorization strongly recommended for traditional plans for amounts > \$1,000)*

PKU Supplies

*(Includes treatment and medical foods)*

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

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

Obesity Management

*(Prior authorization required by all plans)*

Infertility Treatment (biological infertility only)

*(Prior authorization required for all plans with coverage)*

Treatment of TMJ (Temporomandibular Joint Syndrome), transplant Services

### Organ Transplants

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

# BENEFIT YEAR 2005-2006

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## TRADITIONAL PLANS

20% – 25%  
**Max:** 30 days / yr.  
 Respiratory, Cardiac, & Pulmonary rehab. not  
 subject to max

25%  
 (20% – 25% if hospital based)

Member pays charges over \$25 / visit

Member pays charges over \$25 / visit

Member pays charges over \$25 / visit  
**Max:** 15 visits / yr. in any combination  
 for alternative health care

25%  
**Max:** 90 day / yr.; 180 / lifetime

25% (20% – 25% if hospital-based)

25% (20% – 25% if hospital-based)  
**Max:** 180 days / confinement

25%  
 (no deductible)

Not covered  
 (except through campus wellness program)

25%  
**Max:** \$100 for foot orthotics (per foot) / 24 month period.

25%

0% (no deductible) up to max  
 (Plan pays 100% of allowable fees)  
**Max:** \$250 / yr.

Not covered  
 (Except bariatric surgery and through campus)  
 Wellness Program **Max:** \$25,000 on surgery / lifetime

Not covered

25% non-surgical treatment only  
**Max:** \$1,000/lifetime

25%  
 See choices Group Benefit Plan  
 for benefit description / limitations

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

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

The things to consider are:

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

If so consider this low cost supplemental coverage.

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



# PREFERRED HOSPITALS/FACILITIES – TRADITIONAL PLAN

This is subject to change. See [www.abpmtpa.com](http://www.abpmtpa.com) for updates.

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

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

<b>Preferred</b>	<b>20% Coinsurance</b>	:	Central Montana Surgery Center
Anaconda	Community Hospital of Anaconda	:	Libby
Big Timber	Pioneer Medical Center	:	Livingston
Billings	Health South Surgery Center	:	Malta
	Deaconess Billings Clinic	:	Miles City
	St. Vincent's Healthcare Center	:	Missoula
	Yellowstone Surgery Center	:	Missoula Community Medical Center
Bozeman	Bozeman Deaconess Hospital	:	Providence Surgery Center
	Rocky Mountain Surgical Center	:	St. Patrick's Hospital and Health Sciences
Butte	St. James Community Hospital	:	Big Sky Surgery Center
	Summit Surgery Center	:	Philipsburg
Choteau	Teton Medical Center	:	Plains
Columbus	Stillwater Community Hospital	:	Polson
Conrad	Pondera Medical Center	:	Red Lodge
Deer Lodge	Powell County Memorial Hospital	:	Ronan
Dillon	Barrett Hospital and Health Care	:	Roundup
Glasgow	Frances Mahon Deaconess Hospital	:	Sheridan
Great Falls	Benefis Health Care	:	Superior
	Great Falls Clinic Surgery Center	:	Whitefish
Hamilton	Marcus Daly Memorial Hospital	:	<b>All other</b>
Hardin	Big Horn County Memorial Hospital	:	<b>25% Coinsurance</b>
Harlowton	Bair Memorial Clinic	:	<b>(General)</b>
	Wheatland Memorial Hospital	:	
Havre	Northern Montana Hospital	:	
Helena	Helena Surgi Center	:	
	St. Peter's Community hospital	:	
	Montana Childrens Hospital & Home	:	
Kalispell	Heathcenter Northwest	:	
	Kalispell Regional Medical Center	:	

# NOTICES

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

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

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

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

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

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

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

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

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

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

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

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

# Glossary

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# RESOURCES

**MONTANA UNIVERSITY SYSTEM  
OFFICE OF THE COMMISSIONER OF HIGHER EDUCATION**

(406) 444-6570 Phone (406) 444-0222 Fax  
[www.montana.edu/choices/](http://www.montana.edu/choices/)

General benefits information and contacts.

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**ALLEGIANCE**

Customer service, prior authorization and claims processing 1-877-778-8600  
Precertification 1-800-342-6510  
[www.abpmtpa.com](http://www.abpmtpa.com)

Traditional Plans Contacts

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**MEDICAL CASE MANAGEMENT**

406-44-3853

Medical Case Management For Traditional Plan

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**PHARMACARE (FORMALY ECKERD) MAIL ORDER PRESCRIPTION DRUG PROGRAM**

Customer Service 1-888-645-9303  
[www.ehs.com](http://www.ehs.com)

**RIDGEWAY MAIL ORDER PRESCRIPTION DRUG PROGRAM**

Customer Service 1-800-630-3214

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

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**VISION SERVICE PLAN (VSP)**

Customer Service 1-800-228-1018  
[www.vsp.com](http://www.vsp.com)

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**UNUM LIFE INSURANCE**

1-800-822-9103  
[www.unum.com](http://www.unum.com)

Long Term Care claims and information.