

*Montana Unified School Trust
Kalispell Benefit Summary*

2011-2012



KALISPELL INTRODUCTION

IMPORTANT NOTE

This summary is intended to be an easy-to-use reference for members and others interested in MUST Health Benefits. The Summary Plan Description and other materials specific to your plan supersede this general information with regard to individual participants' eligibility and benefits.

MUST is proud to offer a variety of plan designs, which enables educational communities to tailor benefits to fit local needs. Kalispell School District has elected the following plans:

- | | | |
|---|------------------|--------|
| • Option 1. Revised Major Medical Plan | RM1000-70-3000 | 70/30% |
| • Option 2. Revised Major Medical Plan | RM2000-70-4000 | 70/30% |
| • Option 3. Revised Major Medical Plan | RM3000-70-5000 | 70/30% |
| • Option 4. High Deductible Health Plan | HE3000-80-5000 | 80/20% |
| • Option 5. Basic Plan | BP6500-70-11,500 | 70/30% |

PRESCRIPTION DRUG BENEFITS

Revised Major Medical Plans

MUST contracts with Caremark to provide members the convenience and cost-savings of the Caremark purchasing network and the ease of purchasing prescription drugs with the MUST ID Card at participating pharmacies. The pharmacy benefits detailed below are included in Revised Major Medical Plans only. Generic drugs are not subject to deductibles.

Deductible

\$100

30-day supply filled at participating pharmacy

Generic	\$10
Preferred	\$20
Non-preferred	\$40

90-day supply filled via mail-order or at participating 90-day pharmacy

Generic	\$20
Preferred	\$40
Non-preferred	\$80

High Deductible Health Plan

Eligible prescription charges for High Deductible Health Plans apply to the medical deductible; once met, remaining charges are reimbursed at 80% until the out-of-pocket maximum is met. Further eligible charges will then be paid at 100%.

Basic Plan

Those on the Basic Plan can use the MUST ID card for certain pharmacy discounts.

PREVENTIVE BENEFITS

All MUST plans include a rich menu of preventive benefits. See page five for benefit details.

WELLNESS PROGRAM

MUST offers the Healthy Futures Wellness Program on a rotating schedule to approximately one-third of MUST groups per Benefit Period. The wellness program includes a blood screening and Health Risk Assessment to help identify participants' health risks. Participants with certain high-risk indicators receive personal contact and are provided health-improvement information.

MATERNITY PROGRAM

MUST medical participants are eligible for the free, confidential services of Avidyn Health's Precious Cargo Program, which provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. The result is an increased number of healthy, full-term deliveries and a decrease in costly, long-term hospital stays.

CASE MANAGEMENT

MUST contracts with case-management professionals who identify immediate and ongoing participant needs and plan courses-of-care with measurable goals and objectives. Case managers work with participants, families, providers, caregivers, and payers to arrange the most appropriate, effective, and cost-efficient treatment possible.

DISEASE MANAGEMENT

Members with conditions such as asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure, and peptic ulcer disease have access to a confidential disease-management program (Alere) that helps them take control of such medical conditions and maintain good health.

COBRA ADMINISTRATION

MUST administers COBRA provisions for continuation coverage.

PRIVACY

MUST is fully compliant with the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ABOUT OUR NETWORKS

Through our Third-Party Administrator (TPA), MUST contracts with provider networks in Montana, throughout the northwest, and across the United States. MUST members will experience the lowest out-of-pocket costs when utilizing network providers. Though members are free to see non-network providers, there are many advantages to using network providers.

- Network providers agree to accept MUST's allowable amount as payment in full. This means members are not subject to charges beyond MUST's allowable limits (often referred to as balance billing).
- Network providers agree to submit claims on members' behalf and MUST will make payments directly to those providers. Non-network providers are under no obligation to submit claims for members. Members will receive payment for claims received or services provided by a non-network provider (MUST does not pay these providers directly).
- A member will be subject to a 20% reduction in benefit level (referred to as a non-network differential) when he/she uses a non-network provider, which means MUST's allowable limit will be reduced by 20% and the member will be responsible for the balance.
- Balance-bill amounts and non-network differential charges do not accrue toward member deductibles and out-of-pocket maximums.

BENEFIT CHANGES

IMPORTANT NOTE

This overview is intended to provide a summary of the major changes MUST has made to its benefits for the 2011-2012 benefit period. The medical-benefits section on pages six and seven provides more information on the benefits offered by each type of plan. Please refer to your Summary Plan Description for a detailed description of MUST plan benefits.

- Annual and lifetime dollar limits have been removed for certain benefits in accordance with the terms of the Patient Protection and Affordable Care Act (PPACA). These include lifetime benefit dollar maximums, autism-spectrum disorder benefit dollar limits, diabetic education benefit dollar limits, laboratory-service maximums, transplant benefit limits, inpatient and outpatient rehabilitation benefit dollar limits. Some benefit maximums have been removed entirely while others have been limited to a maximum number of visits. See pages six and seven for more information by plan.
- Preventive benefits are no longer subject to deductibles or co-insurance when provided by network providers. See page five for coverage details.
- Services for surgical (bariatric) weight loss are no longer covered.
- Revised Major Medical (RM) Plans now accept a \$35 co-payment for office visits when members use network providers. With network providers, this benefit is, therefore, not subject to deductible or co-insurance and the co-payment covers all services billed as part of the office visit. With non-network providers, office visits are subject to co-insurance, non-network differential charges, and any charges that exceed MUST's allowable limits.
- RM Plans no longer offer a \$600 first-dollar Diagnostic Laboratory/X-Ray Benefit. These services are now subject to deductible and co-insurance as defined by the plan.
- Immunizations received at a city or county health department will be paid at 100% only if that health department is a network provider.
- The plan has added a new prescription Step Therapy Program in which certain generic drugs are promoted before brand-name drugs.
- Medical and pharmacy claims for High Deductible Health Plans (HDHPs) will be integrated so that, once members satisfy their out-of-pocket maximum, they will no longer have to pay for pharmacy costs at the point of sale and wait for reimbursement.

PREVENTIVE BENEFITS

The wellness/preventive services payable by this plan are designed to comply with terms of the Patient Protection and Affordable Care Act (PPACA), the current recommendations of the United States Preventive Services Task Force, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention.

The benefit levels below apply when provided by a network provider. If non-network providers are used, the member is subject to deductible, co-insurance, non-network differential charges, and any charges beyond MUST's allowable limits. Non-network differential charges and charges beyond MUST's allowable limits (often referred to as balance billing) do not apply to member deductibles and out-of-pocket maximums.

Benefit	
Immunizations	
Deductible, benefit percentage	Waived, 100%
Well-child care (to 36 months)	
Deductible, benefit percentage	Waived, 100%
Diabetic Education	
Deductible, benefit percentage	Waived, 100% (subject to deductible on HDHP)
Maximum	Five visits per benefit period
Women's Health	
Preventive mammogram	
Deductible, benefit percentage	Waived, 100%
Maximum	One per benefit period
Preventive Pap smear	
Deductible, benefit percentage	Waived, 100%
Maximum	One per benefit period
Colon Cancer Screening (age 50 and over)	
Fecal occult blood test	
Deductible, benefit percentage	Waived, 100%
Maximum	One per benefit period
Sigmoidoscopy	
Deductible, benefit percentage	Waived, 100%
Maximum	One every five years
Colonoscopy	
Deductible, benefit percentage	Waived, 100%
Maximum	One every 10 years
Virtual colonoscopy	
Deductible, benefit percentage	Waived, 100%
Maximum	One every five years

PREVENTIVE OFFICE VISITS

When both preventive services and diagnostic or therapeutic services occur during the same visit, a member pays deductibles, co-payments, and/or co-insurance for diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then deductibles and co-insurance will apply to the diagnostic or therapeutic service. Claims submitted outside the recommended frequency limits will be subject to deductible and co-insurance.

KALISPELL MEDICAL BENEFITS

All benefits are paid either at the negotiated network rate or up to allowable limits (MEE). Use network providers to get maximum benefit.

Benefit	Revised Major Medical (RM) Plan			High Deductible Health Plan (with embedded deductible)
	Option 1	Option 2	Option 3	Option 4
Kalispell Plan Option Number	Option 1	Option 2	Option 3	Option 4
Deductible – individual	\$1,000	\$2,000	\$3,000	\$3,000
Deductible – family	\$2,000	\$4,000	\$6,000	\$6,000
Out-of-pocket maximum – individual	\$3,000	\$4,000	\$5,000	\$5,000
Out-of-pocket maximum – family	\$6,000	\$8,000	\$10,000	\$10,000
Benefit percentages available	70/30%			80/20%
Non-preventive first-dollar benefit	N/A			N/A
Office Visits (physician/chemical dependency/mental illness)				
Deductible	Waived			Applies
Benefit percentage	<i>In network:</i> \$35 co-pay			80/20%
	<i>Out of network:</i> 70/30%			
First-dollar benefit (chemical dependency/mental illness only)*	First three visits paid at 100%			N/A
Accident				
Deductible, benefit percentage	Waived, 100%			Applies, 80/20%
Maximum benefit per accident	\$500 within 90 days of accident			N/A
Autism Spectrum Disorders				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Chemical Dependency (inpatient)				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Chiropractic/Acupuncture Visits				
Deductible, benefit percentage	Waived, 100%			Applies, 80/20%
Max payment per visit	\$25			\$25
Max visits per benefit period	25 (combined chiropractic/acupuncture)			25 (combined chiropractic/acupuncture)
Chiropractic X-Rays				
Deductible, benefit percentage	Waived, 100%			Applies, 80/20%
Max per benefit period	\$100			\$100
Diagnostic X-Ray				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Home Health/Hospice Care				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Max visits per benefit period	180 (combined home health/hospice)			180 (combined home health/hospice)
Hospital Services (inpatient/outpatient)				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Lab work				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Mental Illness (inpatient)				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Rehabilitation Services				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Maximum benefit period (outpatient/inpatient)	50 visits/60 days			50 visits/60 days
Skilled Nursing Facility				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Max days per benefit period	60			60
Transplants				
Deductible, benefit percentage	Applies, 70/30%			Applies, 80/20%
Lifetime maximum	N/A			N/A
Pharmacy	See page two for more details			Rx applies to med deductible and co-insurance

* For RM and Basic Plans: the first three outpatient chemical-dependency and/or mental-illness office visits are paid at 100%; subsequent office visits are paid at co-payment or coinsurance level.

Basic Plan	
Option 5	
\$6,500	
\$13,000	
\$11,500	
\$23,000	
70/30%	
\$300	
Applies	
70/30%	
First three visits paid at 100%	
Waived, 100%	
\$300 within 90 days of accident	
Applies, 70/30%	
Applies, 70/30%	
N/A	
N/A	
N/A	
N/A	
N/A	
Applies, 70/30% (\$5,000 maximum benefit)	
Applies, 70/30%	
90	
Applies, 70/30%	
Applies, 70/30%	
Applies, 70/30%	
Applies, 70/30%	
20 visits/30 days	
Applies, 70/30%	
60	
Applies, 70/30%	
70/30% on first \$500,000; 10/90% on subsequent charges above \$500,000	
No Rx coverage, but discounts available	

GLOSSARY

Allowable limits. Non-network provider charges are sometimes greater than MUST's plan allowance. In such an instance, MUST will only pay the provider's charges up to an amount determined by a calculation system known as Maximum Eligible Expense (MEE). Members are responsible for charges beyond allowable limits.

Benefit percentage. Once deductibles are satisfied, members and MUST split allowable charges up to the member's Maximum Out-of-Pocket amount. The benefit percentages listed herein are 80/20%, and 70/30%. The first number correlates to MUST's percentage and the second to the member's. For example, if the benefit percentage is 80/20%, MUST would pay 80% of allowable charges and the member would pay 20%.

Benefit period. Also known as the plan year, this refers to that duration of time between renewal periods during which members are covered for elected services.

Co-insurance. The member's portion of the benefit percentage. For example, if the benefit percentage is listed as 70/30%, MUST's portion is 70% while the member's co-insurance is 30%.

Co-payment. A flat rate that a member pays for a given service.

Deductible. The amount the member is expected to pay before the costs of services are shared by MUST (co-insurance) and range greatly depending upon the member group's plan elections.

Embedded deductible. When a member holds an HSA-qualified plan with an embedded deductible, any one member of a family can meet the individual deductible, at which point the plan starts to pay its share of claims for that member.

Health Savings Account (HSA). A certain kind of narrowly defined account earmarked specifically for pre-tax, health-related spending. HSAs are limited for use with qualifying high-deductible health plans.

Network provider. Also referred to as a participating provider, this is a provider who agrees to submit claims on the member's behalf and to accept MUST's allowable limit amount as payment in full. Using network providers ensures members the highest possible benefit by avoiding non-network differential charges and so-called balance billing. Non-network differential charges and balance-billed amounts do not accrue toward the member's deductibles and out-of-pocket maximums.

Out-of-pocket maximum. The maximum financial exposure a member is exposed to in a given benefit period, which means that, after this amount is met, the plan pays eligible claims at 100% up to allowable limits. Deductibles, co-insurance, and co-payments count toward this amount.

Preventive benefit. This includes any number of first-dollar benefits offered to all MUST members, which include coverage for certain screenings and immunizations billed by healthcare providers as preventive services.

Specialty drugs. A narrowly defined class of extremely high-cost, biologic drugs that often require special handling, administration, and careful adherence to treatment protocols.

Well-child care. Includes a host of physical/medical assessments and immunizations that are scheduled frequently during the first year of life and less frequently thereafter until the child reaches 36 months.

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