

Benefit Administration Handbook

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Important Note

This handbook is intended as an easy-to-use reference for district clerks and others who coordinate MUST enrollment for their school districts. The Summary Plan Description and other materials specific to group plans supersede this general information with regard to individual participants' eligibility and benefits.

You may wish to keep a printed copy of this document in your office as a handy reference; however, the MUST Web site contains the most recent version. Simply visit www.mustbenefits.org/publications.

MUST Administration Contacts

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ELIGIBILITY AND ENROLLMENT GUIDELINES

Eligibility (Active Employee/Trustee)

An employee is eligible for coverage if he/she is an active employee working a minimum of 15 hours per week (in districts with four-day workweeks) or 17.5, 20, or 40 hours per week (in districts with five-day workweeks) during an academic year (refer to the Participation and Affiliation Agreement for definition of eligible classes for your district). The employee's effective date of coverage will be the first active day at work or the first day of the month following the employee's first active day at work. The effective date may be a different date if established pursuant to a collectively bargained contract.

A school-board trustee duly appointed and actively serving on the school board of trustees is also eligible for coverage. The trustee's effective date of coverage will be the first day of the month following the date of appointment to the board of trustees.

Spouse/Adult Dependent

An employee's or trustee's spouse is eligible if he/she is legally married to the employee/trustee. An adult who is not legally married to the employee/trustee may also be eligible for coverage as an adult dependent.

- A notarized Declaration of Adult Dependent Form will be required to determine eligibility for an unmarried, unrelated adult partner. This does not apply to eligible adult children. Dependent child eligibility is outlined in the next section.
- Common Law Marriage Affidavits are no longer sufficient to determine eligibility for spouses who are not legally married. However, spouses enrolled before July 1, 2006 under common law marriage provisions will be allowed to continue enrollment.

Dependent Child

A covered participant's dependent child is eligible for coverage if all of the following requirements are met:

1. The child is a natural child, stepchild, legally adopted child, or a child who has been placed with the participant for adoption and as part of the placement has been granted full legal custody prior to the dependent reaching 19 years-of-age. This requirement is waived if the participant is required to provide coverage due to a court order or divorce decree for a child not in his/her custody or not wholly dependent upon the participant.
2. The child is not on active military duty; and
3. The child is under 26 years of age. (The age limitation may be waived for dependents over the age of 26 who are mentally and/or physically disabled and who are dependent upon the participant for support and maintenance are eligible (MUST requires proof of incapacity).

Surviving Dependents

If an employee/trustee is covered under this plan when he/she dies, any of his/her dependent(s) covered at the time may continue to be eligible for coverage under this plan. Coverage for the surviving spouse and/or dependents will continue as long as they are eligible to receive the benefits of the deceased as provided by law.

- The member group should notify MUST of the death immediately.
- A new Enrollment Form must be completed by the surviving spouse or dependent.

— Note: Dependents do not qualify for life-insurance benefits.

Leaves of Absence

Temporary Layoff/ School-Approved Leaves of Absence

In the event of a temporary layoff or any school board approved leave of absence, including Family Medical Leave Act (FMLA) or other non-medical leave, the employee is considered an active participant and may remain covered for up to 12 weeks.

- The School District must provide a letter documenting the leave of absence approval, including minutes from the board meeting in which the leave was approved (if applicable). The notification should include the beginning and end dates of the leave.
- The participant is eligible for 18 months of COBRA coverage after 12 weeks of coverage as an active MUST participant have been exhausted.

Non-FMLA Injury or Illness

The participant may remain covered starting on the date total disability commences (as documented, usually requiring a doctor's statement) until the earliest of the following dates:

- Date the participant fails to make any required contribution; or
- Date the participant cancels his/her coverage or member group terminates participation in MUST; or
- A period of 12 months past the date the employee's active service ends. (Active service does not include vacation or sick leave.)

Disability

An active participant who can no longer work because of total disability and who is eligible for Social Security Disability should complete a MUST Change Form. A doctor's determination and a copy of the participant's Medicare card showing the effective date and the nature of the disability are required.

Military Service

Under the Uniformed Services Employment and Re-employment Rights Act (USERRA), an employee/trustee who has coverage under the plan and is absent from employment due to service with the uniformed services may elect to continue coverage for him/herself and his/her eligible dependents under COBRA (see Continuation of Benefits Under COBRA, pg. 12). The maximum period of coverage under such an election is the lesser of:

- The 24-month period beginning on the date on which the covered person's absence begins; or
- The period beginning on the date on which the covered person's absence begins and ending on the day after the date on which the covered person fails to apply for or return to a position of employment, as required by USERRA.

Refer to the Summary Plan Description (SPD) for details about premium payments and the employee's/trustee's coverage rights under USERRA. The SPD can be accessed through the MUST Web site by clicking the First Choice Health log-in button and logging in to the secure system.

High Deductible Health Plan

Some school districts have elected to include the Health Savings Account (HSA)-qualified High Deductible Health Plan as one of their MUST plan offerings.

A Health Savings Account (HSA) is like a hybrid of a Flexible Spending Account (FSA) and an Individual Retirement Account (IRA) or 401(k). Like an FSA, the money can be used for qualified medical expenses, but there is no “use it or lose it” limitation. Like a retirement account, the funds can be invested, and the funds always belong to the participant, even after leaving employment.

Eligibility and Other Considerations

- An eligible employee cannot be enrolled in another health-benefit plan, even Medicare, and be eligible for an HSA.
- School districts that wish to offer HSA-qualifying High Deductible Health Plans should consult with their Human Resources specialists or tax advisors to ensure employee benefits packages meet applicable IRS requirements.
- Only those enrolled in a qualifying High Deductible Health Plan (HDHP) can open a Health Savings Account. MUST has two High Deductible Health Plans available.
- Participants have a choice about which kind of HDHP they want to elect. There are basically two kinds: those with embedded deductibles and those without.
 - When a member holds a HDHP 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.
 - With a non-embedded deductible HDHP, the full family deductible must be reached by an individual or a combination of family members before MUST pays claims on the plan.
- Federal guidelines allow preventive services to be covered without meeting the HDHP deductible.
- The cost of prescription drugs can apply to the HDHP medical deductible and are covered once the deductible is satisfied.
- MUST administers the HDHP, but does not administer the Health Savings Account itself. The HSA must be opened at a qualified financial institution, such as Wells Fargo Bank or another institution of the participant’s choice.
- An HSA is a tax-favored account and, therefore, is subject to strict IRS rules. For example, there are limits on how much money can be deposited in an HSA each calendar year. If HSA funds are used for non-medical expenses, the participant may owe income taxes and penalties on that amount.
- HSAs can be funded by the employee, the employer, or both. However, all money in the account always belongs to the employee.
- Employees can deposit pre-tax money in the HSA through payroll deduction, but only if the employer has a Section 125 salary reduction (cafeteria) plan in place. Employees can also deposit post-tax dollars into the account and obtain a tax benefit by filing a special IRS form with their tax returns.

A great deal of information is available on the Internet. One of the best resources is the U.S. Treasury Department’s HSA Web site: www.treasury.gov/offices/public-affairs/hsa/.

MUST has partnered with Wells Fargo Bank for HSA administration. Their Web site (www.wfhbs.com) is another good source of information.

Enrollment (Active Employee/Trustee)

Initial Enrollment Period



The following forms are required for active employees/trustees to enroll in the MUST Plan. They must be submitted to MUST within 30 days of the date of hire or appointment.

1. MUST Enrollment Form
 - a. This form includes beneficiary information for the \$10,000 Basic Life insurance policy included with the MUST medical coverage (active employees/trustees only).
2. Life Insurance Enrollment Form (for those groups offering Option 1 and/or Option 2 life):
 - a. Employees/trustees whose group chooses Option 1 (Employer-paid) additional life insurance coverage are required to complete the Option 1 portion of the form.
 - b. Groups may give employees/trustees the option to elect additional Option 2 (Employee-paid) life insurance.
3. Multiple Coverage Inquiry (for those who have secondary coverage)
4. Acknowledgment Form (for those electing plans with certain limitations)
 - a. Basic Plan Acknowledgment
 - b. High Deductible Health Plan Acknowledgment

Sample forms are available on the next two pages. Please be certain all forms are completed fully. If a field is not applicable, mark "N/A" in the field.

For more information about life-insurance offerings, please see pg. 22.

Participant must complete this form if he/she answers yes in field 4 of Enrollment Form. Find at www.mustbenefits.org/forms

MULTIPLE COVERAGE INQUIRY		Third Party Administration One Union Square 600 University Street, Suite 1400 Seattle, WA 98101 1.800.430.3818 Fax: 1.888.206.3092 myFirstChoice.fchn.com www.fchn.com
 <p>Healthy Employees. Healthy Companies.™</p>	 <p>MONTANA UNIFIED SCHOOL TRUST</p>	
<p>Your group health plan has a coordination of benefits provision. In order to accurately process your claims, you must provide the information requested on this form. <u>This information must be completed and returned to the address above within 15 days; otherwise, claims will be denied.</u></p>		
Subscriber Name:	<input style="width: 100%;" type="text"/>	
School District:	<input style="width: 100%;" type="text"/>	
Subscriber Social Security Number:	<input style="width: 100%;" type="text"/>	
1. PLEASE ANSWER THIS QUESTION		
<p>Do you or any family member, have any other health insurance coverage or has any such coverage existed during the last twelve months?</p> <p>YES <input type="checkbox"/> If yes, please complete sections 2, 3, and 4.</p> <p>NO <input type="checkbox"/> If No, please sign and date page 2 of this form (Section 4), and return it to us within 15 days.</p>		
2. OTHER INSURANCE INFORMATION		
Name of Insurance Company:	<input style="width: 150px;" type="text"/>	Ins. Co. Phone Number: <input style="width: 100px;" type="text"/>
Insurance Company Address: <input style="width: 450px;" type="text"/>		
Name of Policyholder:	<input style="width: 150px;" type="text"/>	Date of Birth: <input style="width: 100px;" type="text"/>
Policyholder Identification #:	<input style="width: 100px;" type="text"/>	Policyholder Social Security #: <input style="width: 100px;" type="text"/>
Employer:	<input style="width: 150px;" type="text"/>	Employer Group ID #: <input style="width: 100px;" type="text"/>
Date Coverage became Effective:	<input style="width: 100px;" type="text"/>	Date Coverage Ended: <input style="width: 100px;" type="text"/>
Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Chiropractic <input type="checkbox"/> Pharmacy		
Type of Policy: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B		
Please Check One: Medicare Entitlement Eligibility: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD*		
*Initial Dialysis Treatment Date: <input style="width: 200px;" type="text"/>		

Special Enrollment Period

An employee, trustee, or eligible dependent is eligible to enroll in coverage under the Plan as a result of certain events that create special enrollment rights (see table below). HIPAA regulations also allow the participant to change plans as a result of the special enrollment qualifying event. The effective date of the new or changed coverage is the date of the qualifying event except in cases of coverage loss, in which case the first day of the following month becomes the effective date.

To qualify for special enrollment, the participant or clerk is required to notify **MUST** by phone, e-mail, or regular mail within 30 days of the qualifying event, and must ensure that the appropriate form (Enrollment Form or Change Form) is received by **MUST** within 60 days of the event.

The following table illustrates qualifying events and eligibility for participants and dependents.

Special Enrollment Qualifying Event	Participant Eligibility	Spouse Eligibility	Newly Acquired Dependent (by birth, adoption, marriage)	Eligible Dependent Not Covered on Plan
Birth of a child*	eligible	eligible	eligible	ineligible
Adoption of a child	eligible	eligible	eligible	ineligible
Involuntary loss of other coverage	eligible (proof of loss required)	eligible (proof of loss required)	N/A	eligible (proof of loss required)
Marriage of the employee/trustee	eligible	eligible	eligible	ineligible
Change in employment status	eligible	eligible	eligible	eligible
Death of a spouse	eligible	N/A	eligible	eligible

* Coverage for a newborn is automatically guaranteed for the first 31 days.

Annual Open Enrollment Period

An employee, trustee, or eligible dependent may enroll in coverage during the annual Open Enrollment Period. If a retiree is currently enrolled in the medical plan, he or she may change plans, add certain coverages, or enroll eligible dependents during Open Enrollment.

MUST will notify each member group of their annual Open Enrollment dates. The group must submit enrollment documents by the last day of the date range.

The following table illustrates requirements for adding coverage during Open Enrollment.

Qualifying Person	Add Dental (if district elects)	Add Vision (if district elects)	Add Medical
Current Employee	Eligible unless dental coverage dropped within last 24 months	Eligible unless vision coverage dropped within last 24 months	Eligible (Certificate of Creditable Coverage requested)
Dependent	Eligible unless dental coverage dropped within last 24 months	Eligible unless vision coverage dropped within last 24 months	Eligible (Certificate of Creditable Coverage requested)

(table continued on next page)

Qualifying Person	Add Dental (if district elects)	Add Vision (if district elects)	Add Medical
Retiree (if enrolled in medical plan)	Eligible unless dental coverage dropped within last 24 months	Eligible unless vision coverage dropped within last 24 months	Ineligible (Must already be enrolled)
Trustee	Eligible unless dental coverage dropped within last 24 months	Eligible unless vision coverage dropped within last 24 months	Eligible (Certificate of Creditable Coverage requested)

Pre-existing Condition Exclusion

An eligible person who previously chose to waive coverage but chooses to enroll during the Open Enrollment Period is considered a late enrollee and is subject to an 18-month pre-existing condition exclusion.

A Certificate of Creditable Coverage from the enrollee’s prior insurance carrier is required to waive the pre-existing condition exclusion. The MUST pre-existing condition exclusion period will be reduced on a day-for-day basis according to the amount of previous creditable coverage, provided there has been no more than a 63-day break in coverage.

Dental and Vision Coverage

Members in school districts offering dental and/or vision coverage can elect this coverage during Open Enrollment. However, if dental or vision coverage is dropped, there is a two-year waiting period before he or she can enroll again. Dental and vision coverage is available to all groups enrolled in the health plan, with rates tiered according to employee participation.

Plan Changes/Employee Benefit Election Forms

Members in school districts offering more than one plan can also change their plan option during Open Enrollment. If there will be a change in your group’s benefit plans, an Employee Benefit Election Form is available on our Web site to download and customize.

Reporting Changes

Changes in a participant’s name, address, and marital status can be reported simply by submitting a MUST Change Form. This form can also be used to change the participant’s beneficiary for the basic life insurance coverage included in the health benefit.

Identification Cards

Participant identification cards display the group name, group ID number, name of covered person, and type of coverage. To protect individuals’ privacy, Social Security Numbers are not displayed. Identification cards are issued for the following reasons:

- **New Enrollment.** Cards are provided for new participants, as well as any covered dependents over age 18, upon initial enrollment. New members also receive a packet of information that includes prescription-drug plan information, and other plan details.
- **Name Change.** A new card is issued to a member who changes his/her name due to a marriage, divorce, or

legal name change.

- **Plan Change.** A new card is issued to a member who makes changes to his/her coverage.
- **Lost/Stolen Cards.** If a member loses his/her identification card, he/she can contact our Administration Office at 1-800-845-7283 to request a new card.

Waiving Coverage

Waiving Health Benefits

- If an employee/trustee elects to waive coverage under the MUST health-benefit plan, he/she must do both of the following:
 - sign the Health Coverage Waiver on the back of the MUST Enrollment Form; and
 - fill out the employee name, address, city, state, zip code, group-number, and group-name fields on the front of the MUST Enrollment Form. This is for identification purposes.
- Signing the Health Coverage Waiver also waives the basic life-insurance coverage that is offered in conjunction with the health-benefit plan.
- Employees who waive basic life-insurance coverage are still eligible for Option 1 (employer-paid) or Option 2 (employee-paid) life coverage.

Waiving Life Insurance

- **Option 1 (Employer-paid) coverage.** Eligible participants who enroll in the MUST health plan are not allowed to waive the employer-paid life insurance (if offered by the member group through MUST). A Life Insurance Enrollment Form is required for all eligible participants.
- **Option 2 (Employee-paid) coverage.** No form is required to waive Employee-paid life insurance. The participant simply chooses whether or not to enroll and purchase this coverage.

Termination of Coverage

Employee Coverage

1. When an employee has terminated employment or otherwise loses eligibility for MUST coverage, the employer must notify MUST of the termination within 30 days using a MUST Termination Form.
 - a. Note: A Termination Form should not be used for employees who are retiring and wish to continue coverage or for employees who are eligible but choose to waive coverage or drop dependents.
2. The following information must be included on the Termination Form:
 - a. School district.
 - b. Employee's full name.
 - c. Current address.
 - d. Social Security Number.
 - e. Termination date.
 - f. Reason for termination.
3. The terminated participant will remain covered through the last day of the month. For example, if the employee's last day of work is March 1, he/she will remain covered through March 31.
4. Employees who become ineligible for coverage (i.e., through a reduction in work force or reduction in hours) will be offered COBRA (see Continuation of Coverage Under COBRA on pg. 12).

Dependent Coverage

A participant may terminate coverage for a dependent (a spouse or a child) by submitting a MUST Change Form.

The form must indicate the name of the dependent and the reason for termination. The participant can also waive coverage for the dependent by signing the waiver on the back. (Note: Waiving coverage makes the dependent ineligible for COBRA. Should only be waived if other coverage has been obtained.)

1. The covered employee, dependent, or district representative is responsible for notifying MUST within 60 days of the qualifying event that causes the dependent to become ineligible.
 - a. Note: No Change Form is required for dependent children reaching age 26. They will automatically be terminated on the last day of the month of the 26th birthday. Example: If a dependent turns 26 on October 14, coverage will terminate on October 31.
 - b. Terminated dependents remain covered through the end of the month in which they lose eligibility or in which the participant voluntarily drops the dependent's coverage.
2. A dependent whose coverage is terminating due to loss of eligibility under the MUST plan will be offered COBRA (see Continuation of Coverage under COBRA on pg. 12).
 - a. MUST will send a Certificate of Creditable Coverage for the period enrolled.
 - b. COBRA will not be offered to dependents for whom coverage was previously waived.
3. A covered spouse who is divorced or legally separated from the participant is no longer eligible and must be dropped from the participant's coverage. COBRA coverage will be offered to the terminated spouse (see pg. 12).

Retiree Eligibility and Enrollment

Eligibility and enrollment guidelines listed in the previous two sections apply in most cases to retirees. For information about dependents, changes, High Deductible Health Plan, and/or ID cards, see the corresponding sections above.

Retirees and their eligible dependents may continue coverage under MUST if eligibility requirements are met. To be eligible, the retiree

- Must be a covered employee or covered trustee under MUST on the day immediately prior to the date of retirement; or
- Must be eligible to continue coverage upon retirement under the Teacher's Retirement System (TRS) or Public Employee's Retirement System (PERS); or
- Must be eligible to continue coverage under the terms and conditions of the employment policies and practices of the member group with which the person was employed on the day immediately prior to retirement. Documentation (a letter or board minutes) indicating retiree eligibility is required.
 - Note: Retirees and retired trustees who terminate coverage may not re-enroll at a later date.

School board trustees are eligible to continue coverage as retirees if they served on the board for a minimum of two terms.

Change in Status – Active Employee to Retiree

When an employee becomes eligible for retirement under the appropriate retirement provisions and wishes to continue coverage with MUST, the employee should complete a MUST Change Form. Documentation certifying retiree status from TRS or PERS (or a letter/board minutes from group) must be submitted with the form. Employees who have additional life insurance through the plan may continue those benefits as well (refer to the Retiree Life section).

Retiree Life, AD&D, and Dependent Life Insurance

Retirees are ineligible for the Basic Life and Additional Death and Dismemberment (AD&D) insurance provided to active employees as part of the MUST health plan. However, participants who had additional Employer-paid and/or Employee-paid Life/AD&D and Dependent Life Insurance (see pg. 22) as active employees may elect to continue this coverage as retirees. See the table below for notification and billing procedures.

Retiree Optional Life, AD&D, and Dependent Life Insurance	
Amount of coverage	An amount not to exceed the amount of Life and AD&D insurance in effect on the day preceding the participant's retirement, up to a maximum of \$50,000 (in \$1,000 increments).
Cost per member per month	Cost is based on an age-banded scale.
Dependent life insurance	Provides coverage of \$5,000 for spouse and each dependent child. (Dependent life must have been active prior to the participant's retirement.) Retiree pays a standardized rate per month regardless of the number of dependents.
Notification of retirement and administrative setup	<ul style="list-style-type: none"> • Option 1 (employer-paid) life. The school district notifies MUST of the retirement. MUST, in turn, notifies the Life/AD&D insurance company. • Option 2 (employee-paid) life. The school district notifies the Life/AD&D company directly. <p>Note: The Life/AD&D company sends retirees letters explaining the rates and billing procedure.</p>
Billing procedure	The Life/AD&D company (not MUST) bills the retiree directly. Premiums may be paid on an annual, bi-annual, or quarterly basis.

For retirees age 65 and older, the life insurance benefit is reduced by the percentages shown in the table below.

Retiree's Age on January 1	Applicable Benefit Reduction
65 through 69	35%
70 through 74	50%
75 or older	65%

Medicare-Eligible Members

Medicare-eligible members (whether active employees or retirees) may continue coverage with MUST. The school district does not need to notify MUST about members becoming Medicare-eligible due to age; MUST automatically prints a monthly report to determine which participants and dependents are turning 65.

Retired members who turn 65 may have monthly premium rates reduced, depending upon the member group's rate structure. Active members over age 65 will not see a rate reduction until retirement.

Coordination of Benefits with Medicare

- MUST coordinates benefits with Medicare.
- An active employee 65 years or older may be covered under both MUST and Medicare. In such situations, MUST pays as the member's primary insurer and Medicare as the secondary.
 - An active employee 65 or older may elect to decline MUST coverage, in which case Medicare pays as the primary insurer.

- For retired members, Medicare is primary and MUST is secondary when entitled individuals are 65 or older.
- Medicare may be primary in certain instances for active or retired employees and their spouses under age 65, such as in the case of being diagnosed with End Stage Renal Disease (ESRD) or being disabled and receiving Social Security disability. Contact MUST if ESRD is diagnosed.
 - Note: Active and retired participants under age 65 who become eligible for Medicare are required to notify MUST within 30 days in order to properly coordinate benefits.

Medicare Advantage Plan

To be eligible for the Medicare Advantage Plan (offered jointly with New West Health Services), members must

- Be retired
- Be Medicare-eligible (in the case of a married couple, both members must be Medicare-eligible)
- Reside in Montana.

The Initial Eligibility period is three months prior to and three months after a MUST member’s 65th birthday. Late Enrollees may apply at Open Enrollment. The open-enrollment period is the same as the group’s open-enrollment period with MUST. To apply for this supplement plan, the member should contact New West Customer Service at 1-888-873-8049.

Continuation of Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA, provides a temporary extension of employer-provided health insurance coverage for qualified beneficiaries. COBRA is intended to provide health coverage for eligible ex-employees until new coverage can be obtained. All MUST member groups are eligible for COBRA.

COBRA will be offered to all covered employees or dependents losing eligibility for the employer’s plan due to a “COBRA qualifying event.” The type of COBRA qualifying event determines who the qualified beneficiaries are and how long coverage may be continued under COBRA. Qualifying events and coverage periods are summarized below. (See the Summary Plan Description for details. This document can be found by going to www.mustbenefits.org and clicking on the First Choice Health log-in button).

COBRA Qualifying Event	Length of Continuation Period
Termination of employment (other than for gross misconduct)	18 months
Reduction of hours worked	18 months
Military service (employee and dependents)	24 months
Disability under Social Security	18 months plus an additional 11 months for a total of 29 months
Divorce from employee	36 months
Legal separation	36 months
Dependent child reaches age 26*	36 months
Dependent of active participant loses coverage when participant chooses Medicare as primary coverage	36 months
Dependent of Deceased Employee**	36 months

**If the dependent of deceased employee is ineligible for retirement benefits.

The employer must notify MUST of the COBRA-qualifying event within 30 days of becoming aware of it. For more information, refer to the COBRA section of the Summary Plan Description (Continuation Coverage After Termination, “Notification Responsibilities”). The MUST administration office will then send a notice of COBRA continuation rights to the qualified beneficiary within 14 days of being notified about the qualifying event. The qualified beneficiary has 60 days from the date eligibility would be lost or 60 days from the date notification is received from MUST, whichever is later, to elect COBRA coverage. Failure to elect COBRA within the allowable timeframe nullifies the beneficiary’s rights to COBRA coverage.


Medical benefits available under COBRA are identical to those of any active participant in that member group. When COBRA is elected, the qualified beneficiary will be responsible for monthly premium(s) back to the date on which coverage was lost. Payment is then due on the first of each month. A grace period of 30 days is allowed before coverage is terminated for non-payment; however, coverage is considered inactive until full payment is received for that month.

Billing

MUST premium billing comprises two documents:

1. **Premium Statement.** This is a list of the employees to be covered for the billing month and their premiums.
2. **Account Summary.** This is a running total of all amounts from the premium statement, payments and retroactive changes (additions, terminations, changes).

Sample MUST Premium Statement

MEMBER EMPLOYER		Montana Unified School Trust 725 North Montana Ave. P.O. Box 4579 Helena, Montana 59604 Office (406) 442-0557 (800) 845-SAVE										Page: 1	
Sleeping Giant School District RM 1,000												NOTE: PLEASE RETURN A COPY WITH YOUR REMITTANCE FOR MONTH BEGINNING: Nov-05	
GROUP NUMBER 670-1985												Montana School Services Foundation Plan Administrator	
1	2	3	4	5	6	7	8	9	10	11	12	13	14
SOCIAL SECURITY NO.	EMPLOYEE NAME	HEALTH	DENTAL	VISION	LIFE	MISC	MEDICAL PREMIUM	DENTAL PREMIUM	VISION PREMIUM	LIFE & AD+D PREMIUM	MISC PREMIUM	TOTAL PREMIUM	DATE OF TERMINATION
000-00-0000	Rabbit, Ricochet	1	1	1	1		300.00	32.00	10.00	2.00	0.00	344.00	
000-00-0000	Hound, Huckleberry	3	3	F 3	1		570.00	66.00	14.00	2.75	0.00	652.75	
000-00-0000	Phooey, Hong Kong	2	2	2	1		600.00	63.00	21.00	2.75	0.00	686.75	
000-00-0000	Doo, Scooby	1	1	1	1		300.00	32.00	10.00	2.00	0.00	344.00	
000-00-0000	Ghost, Space	4	4	4	1		750.00	98.00	24.00	2.00	0.00	874.00	
000-00-0000	Pitstop, Penelope	8	8	8	0		330.00	63.00	21.00	0.00	0.00	414.00	
000-00-0000	Smurf, Smurfette	7	7	7	0		165.00	32.00	10.00	0.00	0.00	207.00	
000-00-0000	Doggie, Augie	5	5	5	0		300.00	32.00	10.00	0.00	0.00	342.00	
000-00-0000	Frog, Michigan J	4	4	4	1		750.00	98.00	24.00	2.00	0.00	874.00	
000-00-0000	McGraw, Quick Draw	0	0	0	1		0.00	0.00	0.00	2.00	0.00	2.00	
10 TOTALS:		9	9	9	8		4065.00	516.00	144.00	15.50	0.00	4740.50	
NEW TOTALS: _____													
INSTRUCTIONS TO CANCEL A COVERED EMPLOYEE						COVERAGE CODE							
1. Draw line first name from column 1 through column 13.						1-SINGLE		6-RETIREE TWO PARTY		DEDUCT TERMINATED EMPLOYEES PREMIUM - \$ _____			
2. Show date of termination in column 14.						2-TWO PARTY		7-MEDICARE SINGLE					
3. If employee terminated prior to 1st day of billing month deduct premium shown in column 13. There is no deduction for employee's terminating after 1st of month.						3-PARENT/CHILD(REN)		8-MEDICARE TWO PARTY					
						4-FAMILY		9-MEDICARE/ONE OVER 65					

I have reviewed this statement and certify that the enclosed payment is only for persons and certify that all terminations since the last statement have been reported to MUST or to reimbursement for any payments made on claims incurred by former employees who

Authorized Representative

X

Key

- | | | | |
|----------|---|----------|---|
| A | School district name and plan description | H | Employee's total premium |
| B | Billing group number | I | Instructions to terminate employee coverage |
| C | Month/year of premium | J | Coverage codes |
| D | Employee's SSN or assigned ID number | K | Total adjustments you made to statement |
| E | Employee name | L | Total amount of payment |
| F | Coverage level (see item J) | M | Signature, title, and date |

Sample MUST Account Summary

This sample Account Summary shows amounts paid for each month and cumulative totals for the Benefit Period.

MUST ACCOUNT SUMMARY

Sleeping Giant School District RM 1,000 670-1985
2005-2006 Plan Year

DESCRIPTION	DATE REC'D	# EE's COVER	PREMIUM BILLED	ADJ	FINAL PREMIUM	RECEIPT	BALANCE DUE/(CR)
BALANCE FORWARD							6,298.00
Payment	06/04/05					6,298.00	
MONTHLY PREM - JULY		11	6,298.50	-	6,298.50	6,298.00	
CUMULATIVE BALANCE 7/31/05			6,298.50	-	6,298.50	6,298.00	6,298.50
Payment	07/10/05					5,954.50	
Rabbit, Ricochet Change eff 07-01-05 from family to single coverage				(874.00)			
Ant, Atom Terminate eff 08-30-05				344.00			
MONTHLY PREM - AUG		10	5,424.50	(874.00)	4,550.50	5,954.50	
CUMULATIVE BALANCE 8/31/05			11,723.00	(874.00)	10,849.00	12,252.50	4,894.50
Payment	09/07/05					4,894.50	
MONTHLY PREM - SEP		10	5,424.50	-	5,424.50	4,894.50	
CUMULATIVE BALANCE 9/30/05			17,147.50	(874.00)	16,273.50	17,147.00	5,424.50
Payment	09/11/05					5,424.50	
MONTHLY PREM - OCT		10	5,424.50	-	5,424.50	5,424.50	
CUMULATIVE BALANCE 10/31/05			22,572.00	(874.00)	21,698.00	22,571.50	5,424.50
Payment	10/06/05					5,424.50	
McGraw, Quick Draw Change eff 09-01-05 to life only coverage				(688.00)			
McGraw, Quick Draw Backcredit Oct				2.00			
MONTHLY PREM - NOV		9	4,740.50	(694.00)	3,372.50	5,424.50	
CUMULATIVE BALANCE 11/30/05			27,312.50	(2,242.00)	25,070.50	27,996.00	3,372.50
MONTHLY PREM - DEC							
CUMULATIVE BALANCE 12/31/05							
MONTHLY PREM - JAN							
CUMULATIVE BALANCE 1/31/06							
MONTHLY PREM - FEB							
CUMULATIVE BALANCE 2/28/06							
MONTHLY PREM - MAR							
CUMULATIVE BALANCE 3/31/06							
MONTHLY PREM - APR							
CUMULATIVE BALANCE 4/30/06							
MONTHLY PREM - MAY							
CUMULATIVE BALANCE 5/31/06							
MONTHLY PREM - JUN							
CUMULATIVE BALANCE 6/30/06							

Key

- A** School district name and plan description
- B** Billing group number
- C** Benefit Period
- D** Balance from previous Benefit Period
- E** Payments received
- F** Payment receipt date
- G** Adjustments to current/past month's premiums
- H** Total number of employees on plan for month
- I** Total month's premium*
- J** Total adjustments
- K** Adjusted premium amount
- L** Total payments made
- M** Yearly cumulative balance as of date noted
- N** Balance due

*Matches total from Premium Statement for this month

Pharmacy Benefit Management Program

Charges for prescription drugs are payable as specifically stated in the Schedule of Medical Benefits. Prescription drug charges are payable only through the Pharmacy Benefit Management (PBM) program, which is sponsored in conjunction with and is an integral part of the MUST plan. Caremark is the Pharmacy Benefit Manager for MUST. For more information, visit the Caremark Web site at www.caremark.com.

Coverage

In plans that include prescription drug coverage, the coverage will include only those drugs requiring a prescription written by a licensed physician and those that are medically necessary for the treatment of an illness or injury or that are otherwise specifically listed as covered.

Service Options

The following service options are available for obtaining prescriptions under the Pharmacy Benefit.

- **PBM Network Prescriptions.** Available only through a retail pharmacy that is part of the PBM (Caremark) Network. The pharmacy will bill MUST directly for that part of the prescription cost that exceeds the co-payment. (The co-payment amount must be paid to pharmacy at time of purchase.) The Prescription Identification Card is required for this option.
- **Member-Submit Prescriptions.** Available only if 1) the Prescription Identification Card cannot be used because a pharmacy is not part of the PBM Network or 2) the Prescription Identification Card is not used at a PBM pharmacy. Prescriptions must be paid for at the point-of-purchase and the prescription drug receipt must be submitted to the Pharmacy Benefit Manager (PBM), along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription drug less the applicable co-payment per prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a network prescription.
- **Mail-Order Prescriptions.** Available only through licensed pharmacies that are part of the PBM Network that fills prescriptions and delivers them to covered persons via the United States Postal Service, United Parcel Service, or other delivery service. The pharmacy will bill MUST directly for prescription costs that exceed the co-payment.

Step Therapy

In Step Therapy, the plan will require the use of certain generic drugs before a brand-name drug is tried. These generics, which have been rigorously tested and approved by the U.S. Food & Drug Administration (FDA), allow the member to begin or continue treatment with safe, effective, and less-expensive drugs.

On or after July 1, 2011 the first time the member submits a prescription that is on the Step Therapy list, the pharmacist will tell him/her that there is a message in the computer indicating that MUST uses Step Therapy. This means that, if the member would rather not pay the cost difference between the brand-name drug and the generic drug (plus the co-insurance), the doctor will need to write a new prescription for a drug that is on the list.

Drug Options

- **Generic.** Those drugs and supplies listed in the most current edition of the Physician's Desk Reference or by

the PBM Program as generic drugs.

- **Preferred Brand.** Non-generic drugs and supplies listed as Preferred Brand by the PBM Program as stated in a written list (updated periodically) that is provided to covered members.
- **Non-Preferred Brand.** Copyrighted or patented brand name drugs (non-generic) that are not recognized or listed as Preferred Brand drugs or supplies by the PBM Program.

Quantity, Limits, and Co-payments

Thirty-day prescriptions may be filled at any PBM (Caremark) Network pharmacy. Supply is limited to 30 days for Member Submit and PBM Network prescriptions, unless the provider has written a prescription for a 90-day supply.

The participant is responsible for paying the established co-payment amount, which varies depending upon the drug option (generic, preferred brand, or non-preferred brand) and depending upon whether the member group has elected the Standard or Enhanced Pharmacy Benefit Plan. The co-payment tiers are outlined in the Benefit Summary and Summary Plan Description.

The participant can usually save money with 90-day prescriptions for maintenance drugs. The retail discount may be greater and the co-payment lower than if three 30-day prescriptions were filled. To fill a 90-day prescription, the participant can either use one of the mail-order services available to MUST or visit a pharmacy that has agreed to accept the mail-order co-payment level. Call Caremark customer service (800-895-0690) to locate a pharmacy that can fill a 90-day prescription.

Mail-Order Outlets

- Caremark (800-895-0690)
- Ridgeway Pharmacy, Stevensville, MT (800-630-3214)

Many other pharmacies participate in the 90-day network for MUST participants. This list changes frequently, so the member should ask his/her pharmacist if he/she belongs to the MUST 90-day prescription network.

First Choice Health Medical Management

MUST and First Choice Health (FCH) are committed to managing available resources to best support the health and well being of MUST employees and their dependents. Information about the various services and contacts are listed below.

Maternity Management

This Maternity Management resource is available to MUST members and their dependents. The Maternity Management program is provided through First Choice Health and in partnership with UMR. The program is a telephone-based educational program designed to complement the prenatal care eligible women receive from their maternity healthcare team. As you know, sometimes women have a number of questions about their pregnancy and would like information in addition to what has been provided during their prenatal office visits. The Maternity Management program nurses provide members with educational information and resources. Nurses utilize the American College of Obstetricians & Gynecologists [ACOG] clinical guidelines and have a background in obstetrics. Once enrolled, and with a mother's permission, the nurse will notify the obstetrician of enrollment in the program. Expectant women who enroll will receive one-on-one phone calls from a nurse and free educational materials.

- Low-risk cases are contacted by the nurse each trimester and are encouraged to call their Maternity Management nurse with questions.
- High-risk cases are monitored more closely by URAC-accredited maternity case-management nurses. Frequency of calls is based on an individual's clinical indications.

The toll-free number for the Maternity Management Program is 800-756-7751.

Case Management

The FCH Case Management team assists MUST members and their families to understand and navigate the complex healthcare environment. Our nurses' and behavioral health counselors' services are free, voluntary, and confidential. The case manager works with the member over the telephone to identify needs and create a plan; is an advocate to obtain the most appropriate and cost-effective care; helps participants understand their diagnoses and make decision regarding healthcare following the recommendations of healthcare providers; and provides support and resources for participants and their families.

To access case management

- The plan member, eligible dependents, care providers, or benefit-plan administrator may contact FCH's Case-Management Department by phone to request service.
- An intake coordinator will take some initial information and forward your request to a case manager.
- A case manager will contact the member to discuss his/her needs and concerns, and to review how case management might help.

Case-management services include

- **Medical case manager.** Members work with a registered nurse.
- **Behavioral-health case manager.** Members work with a licensed counselor.
- **Weight management (bariatric surgery).** Members work with a registered nurse.

The toll-free number for FCH case management service is 800-808-0450.

Inpatient Hospital Admission Certification

Whenever an inpatient hospital admission is necessary, MUST encourages the plan member to contact FCH medical management as soon as possible for certification of the stay. FCH clinical staff work with the patient and his/her physician to ensure his/her health needs are met. Throughout the stay, FCH medical management stays in contact with coordinators at the hospital and monitors the member's progress. FCH clinical staff are available to answer questions the participant may have while in the hospital and can also help with discharge planning needs and follow-up details. If a member is planning a hospitalization or has been hospitalized for an emergency, hospital personnel or the participant should call FCH medical management and give the clinical staff the following information:

- The member's name, identification number, address, and telephone number
- The patient's name
- The physician's name and telephone number
- The hospital's name and telephone number.

Specific outpatient hospital procedures, hospital observations room stays (admit under 24 hours), and free-standing surgical center admission do not need to be called and/or certified. Please refer to the standard pre-certification list, available online at www.mustbenefits.org/publications.

For inpatient hospital certification, the toll-free number is 877-714-5557.

For mental health/chemical-dependency certification, the toll-free number is 800-640-7682.

Privacy

At MUST, we are absolutely committed to protecting our members' privacy. Because MUST and its contractors respect your right to healthcare confidentiality, members can expect the highest privacy standards in all matters. For a complete copy of MUST's privacy policy, see the Summary Plan Description.

First Choice Health Numbers

Maternity Program

800-756-7751

Case Management

800-808-0450

Inpatient Hospital Certification

800-714-5557

Mental Health/Chemical Dependency Certification

800-640-7682

Alere Health Management

Program Description

MUST offers members access to a confidential health management program called Alere. It is a confidential educational support program designed to help MUST participants follow their doctors' treatment plans and manage chronic health conditions.

A participant may qualify for the program if they have one of the following conditions:

- Adult and Pediatric Asthma
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Diabetes
- Heart Failure
- Peptic Ulcer Disease

Alere participants will have the full support of a registered nurse, available via a toll-free phone line, 24 hours a day, seven days a week. They will be able to schedule convenient phone appointments with an Alere nurse, ask questions about their condition, and receive information to help understand and manage their condition effectively.

Getting Started

Participants are identified for the program by AccordantCare based on prescription and health-claims data. An Alere representative will contact the participant to personally welcome him/her to the program and answer any questions he/she may have. If participants would like to know more about the program they can contact Alere at 877-912-5373, Monday through Friday, 7a.m. to 10 p.m. to speak with a representative. Participants who need telecommunication device (TDD) assistance should call 800-231-4403.

Privacy

At MUST, we are absolutely committed to protecting our members' privacy. Because MUST and its contractors respect your right to healthcare confidentiality, members can expect the highest privacy standards in all matters. For a complete copy of MUST's privacy policy, see the Summary Plan Description.

Alere Numbers

Toll-free
1-877-912-5373

Toll-free TDD
800-231-4403

Healthy Futures Wellness Program

Program Description

Healthy Futures is a confidential, convenient, and pro-active wellness program that gives MUST members information needed to ensure good health for years to come. MUST-insured school districts are on a rotating schedule so that every member group has the opportunity to participate in the program once every three years. Participating members should expect to complete the following steps:

1. **Health Risk Assessment (HRA).** This is a questionnaire members fill out about their lifestyle and current health. A report is compiled by a third-party health-screening vendor.
2. **Health-screening.** This portion requires that members attend an event in their area staged by a health-screening vendor. Health professionals check members' blood pressure, body-fat percentage, pulse, and blood-oxygen levels. They also run a basic blood panel, which includes
 - a Complete Metabolic Panel (glucose-levels, etc.).
 - a Lipid Panel (cholesterol, triglycerides, etc.).
 - a Complete Blood Count.

Privacy

At MUST, we are absolutely committed to protecting our members' privacy. Because MUST and its contractors respect your right to healthcare confidentiality, members can expect the highest privacy standards in all matters. For a complete copy of MUST's privacy policy, see the Summary Plan Description.

Contact

For more information about Healthy Futures, or to discuss details of a scheduled Healthy Futures event, contact MUST at 800-845-7283.

Life, AD&D, and Dependent Life Insurance

Life and AD&D Insurance Options for Active Employees

(For Life and AD&D Insurance Options for Retirees, see *Retiree Eligibility and Benefit*, pg. 14)

Montana Unified School Trust (MUST) provides Basic Life and Accidental Death and Dismemberment (AD&D) Insurance to active employees enrolled in medical coverage. There is no cost to the member group for this basic coverage.

MUST also makes available two Additional Life and AD&D Insurance plans to active employees. Member groups determine whether to make either or both of these coverage options available to their employees. Under Option 1, the member group elects a set amount of coverage for employees and pays for the coverage. This coverage is billed to the member group by MUST. Under Option 2, employees may choose the amount of coverage that they want and pay for it themselves. This coverage is billed to the member group by the life/AD&D insurance company. The monthly premium to be deducted from the employee's pay for Option 2 coverage is determined using an age-banded scale.

If the enrollment form is received more than 30 days after a member initially becomes eligible for the coverage, a medical-history statement and approval from The Standard will be required before coverage is provided.

Basic Life and AD&D

Active employees enrolled in MUST medical plans will automatically be covered for \$10,000 Basic Life and AD&D insurance.

Basic Life and AD&D	
Amount of coverage	\$10,000 Life and AD&D
Cost per member per month	None. Coverage automatic when participant enrolls in health plan
New enrollees	Designate beneficiary/beneficiaries on Enrollment Form
Beneficiary change	Designate new beneficiary/beneficiaries on Change Form

Option 1: Employer-Paid Additional Life and AD&D

This option and the amount of coverage are elected by the member group. Amounts are elected in multiples of \$10,000 up to a maximum based on district size (see below).

Employer-Paid Additional Life and AD&D	
Amount of coverage	Multiples of \$10,000 up to issue amounts listed below
Fewer than 10 participants	\$100,000 maximum
10 or more participants	\$150,000 maximum
Cost per member per month	Based on standardized monthly rate per \$10,000 of insurance
Dependent life insurance	Spouse and eligible children covered for \$5,000 each with a standardized monthly rate regardless of the number of children
Enrollment	Use Employee Life Enrollment Form
Administration setup	Designate beneficiary/beneficiaries on Employee Life Enrollment Form

Employer-Paid Additional Life and AD&D	
Billing procedure	MUST bills the member group monthly
Effective date of coverage	Same as medical coverage †

Option 2: Employee-Paid Additional Life and AD&D

The member group may elect to make additional life insurance available to participants, to be paid by the employee (or the employer may elect to pay a portion). Coverage can be elected in multiples of \$10,000. Limitations on the coverage amount and guaranteed issue amount are shown below.

Employee-Paid Additional Life and AD&D	
Amount of coverage	Multiples of \$10,000 up to 4 times annual salary (not to exceed \$500,000)
Guaranteed issue amount	
Fewer than 10 participants	\$30,000 without submitting Medical History Statement
10 or more participants	\$50,000 without submitting Medical History Statement
Cost per member per month	Costs are based on an age-banded scale
Dependent life insurance	Spouse and eligible children covered for \$5,000 each; standardized monthly rate regardless of number of dependents
Enrollment	Complete Employee Life Enrollment Form
Administration setup	Formulated Excel spreadsheet provided to clerk
Billing procedure	Life/AD&D insurance company bills the district each month.*
Effective date of coverage	For participants who enrolled on time and who are requesting up to the guaranteed issue amount, the effective date is the same as for medical coverage. For late entrants and participants requesting amounts above the guaranteed issue amount, the effective date is the first of the month following notification of approval.†

Life Insurance Claims

To file a life insurance claim for a covered participant, contact MUST Customer Service at 800-845-7283. A staff member will verify the participant’s eligibility for life insurance and request proof of death.

* Option 2 Employee-paid Additional Life and AD&D is billed directly by the life/AD&D insurance company, not by MUST. The district will use the formulated Excel spreadsheet to enter all employees who have chosen Option 2 and their coverages. The spreadsheet will calculate the total cost automatically to determine the payroll deduction for each employee.

— Each month the district will add or delete enrollees on the worksheet and mail the form with their bill directly to Standard Insurance Company, 10 N. Post Street, Suite 309, Spokane, WA 99201 or e-mail to ddavenpo@standard.com. After Standard has received the district’s worksheet, they will issue a bill.

† Medical History Statements are required for late entrants and for persons electing an amount of coverage that exceeds the guaranteed issue amount. Send Medical History Statements to the address shown on the form.

— Coverage will not become effective until Standard Insurance Company has reviewed the Medical History Statements and approved coverage. They will notify the district in writing if the applicant is approved.

Life Insurance Underwriting Rules

- An employee cannot receive life insurance coverage as both a participant and a dependent.
- Only one Dependent Life election is allowed. If the district offers both Employer-paid dependent life (Option 1) and Employee-paid dependent life (Option 2), the participant may elect dependent life under only one of these options.
- Election of Dependent Life covers all eligible dependents. There is no need to name the dependents individually on the application. If a claim is ever filed for payment of the dependent’s life insurance benefit, eligibility will be determined at that time.

Long-Term Disability (LTD) Insurance

Basic LTD Insurance

Montana Unified School Trust (MUST) provides a Basic LTD benefit for eligible, active employees enrolled in the medical plan – at no cost to the member group. LTD insurance pays a benefit in the event that the employee is disabled and cannot work because of illness or injury. The Basic LTD Plan pays 50% of the pre-disability monthly income (up to the maximum monthly benefit) after a 180-day waiting period.

Enhanced LTD Options

Member groups may enhance this LTD coverage for employees by electing one of the optional plans shown below.

	Basic LTD	LTD Option 1	LTD Option 2
Monthly benefit	50% of insured predisability earnings, reduced by deductible income from other sources	60% of insured predisability earnings, reduced by deductible income from other sources	60% of insured predisability earnings, reduced by deductible income from other sources
Maximum monthly benefit	\$5,000	\$6,000	\$6,000
Benefit waiting period	180 days	180 days	90 days
Maximum benefit period	To age 65	To age 65	To age 65
Rate per member	Provided by MUST	\$1.96 per month	\$5.60 per month
Billing procedure	N/A	Life/AD&D insurance company bills district monthly	Life/AD&D insurance company bills district monthly

LTD Claims

To file a long-term disability claim for a covered participant, contact MUST Customer Service at 800-845-7283 or find a copy on our Web site at www.mustbenefits.org/forms/life-and-ltd.

HIPAA Privacy and Security

MSSF and other entities directly involved in administering the MUST plan benefits may view participants' health information in the course of determining eligibility and administering benefits. To do this, staff members must comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA (Health Insurance Portability and Accountability Act of 1996) as stated in 45 CFR Parts 160, 162 and 164, as periodically amended. HIPAA limits the ways in which protected health information is collected, stored, used, and shared.

About Protected Health Information (PHI)

Under HIPAA privacy provisions, Protected Health Information (PHI) is any health information – including demographic information – collected from an individual that

- Is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual; and
 - That identifies the individual; or
 - With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

This information cannot be used or disclosed without the covered person's written permission except in certain specified circumstances stated in the HIPAA privacy regulations.

Consent to Share Information

Plan participants may access health information (such as medical claims) for themselves and for their dependents under age 18. Members 18 and older may need to sign a HIPAA Authorization Form to release their information to another person unless that person is involved in the participant's care or payment for care.

List of Forms, Publications, and Internet Resources

Forms

This handbook notes many forms, but not all. Below is a list of the most commonly used forms, with the most commonly used forms at the top. You may obtain copies of these and other forms at www.mustbenefits.org/forms. You may also call the MUST Administration office at 800-845-7283 for copies.

- Enrollment Form
- Life Insurance Enrollment Form
- Multiple Coverage Inquiry
- Basic Plan Acknowledgment Form
- High Deductible Health Plan Acknowledgment Form
- Declaration of Adult Dependent Form
- Change Form
- HIPAA Authorization Form (to release confidential information)
- Benefit Election Form (during Open Enrollment only)
- Pharmacy Reimbursement Form
- Medical History Statement
- Termination Form

Publications

Summary Plan Description and Schedules of Medical Benefits

To access the Summary Plan Description and Schedules of Medical Benefits, the member must simply visit www.mustbenefits.org and click on the First Choice Health button on the bottom left. Members must register with the secure Web portal to access these full plan documents. The information contained therein supersedes all other plan description.

To access the less detailed Benefit Summary, visit www.mustbenefits.org and click on the *Publications* tab on the left. This is a good general introduction to the benefit packages available through MUST.

Other

- Annual Reports
- The MUST Read newsletter
- Prior-authorization list
- Various brochures for specific programs and offerings

Internet Resources

- MUST Information: www.mustbenefits.org
- U.S. Treasury Department Web site for Health Savings Accounts: www.treasury.gov/offices/public-affairs/hsa/
- Wells Fargo Web site for MUST participants with Health Savings Accounts: www.wfhbs.com
- Pharmacy Benefit Manager (PBM) Web site: www.caremark.com

Questions and Answers

Below you will find commonly asked questions and answers. Others are available on the MUST Web site. As always, if you have a question that Q&A forums do not cover, simply call MUST customer service at 1-800-845-7283.

Dependents

Can I drop my dependents at any time?

Yes, you can drop your dependents at any time but MUST coverage is for the entire month. Terminations are only effective on the last day of the month.

Can I add my family members back on at any time?

No, they can only be added during a special enrollment period or open enrollment and we may impose an 18-month pre-existing-condition exclusion period for age 19 and older.

Can I continue to cover my ex-spouse or spouse from whom I am legally separated?

No. Ex-spouses and legally separated spouses are ineligible for coverage.

Pharmacy

How do I submit my RX for secondary coverage?

Fill out the Caremark Claim Reimbursement form.

Can I drop only the prescription drug part of my plan?

No. Prescription drug benefits are integrated with MUST health plans.

Special Enrollment

Is a pay increase a qualifying event for coverage?

If the participant was eligible for coverage before the pay increase, the answer is no. If the participant was ineligible for coverage before the pay increase but is eligible now, then the answer is yes.

Is pregnancy a qualifying event for coverage?

No. Pregnancy does not by itself create a special enrollment opportunity. However, the birth of the baby is a special-enrollment qualifying event. Also note that a baby born to a current MUST participant is automatically covered for the first 31 days. This does not apply if a participant's dependent child has a baby.

My spouse's company increased insurance premiums. Can we drop his coverage and enroll with MUST?

No. A premium increase does not qualify as a special enrollment event. The loss of other coverage has to be involuntary to meet the standard for a qualifying event. However, you can enroll during Open Enrollment.

Retirement

What happens to the life insurance on the employee when he/she retires?

He/she can continue the policy on a self-pay basis with the Standard.

Retired member is to be a Board Member. What forms need to be submitted?

A new enrollment form and new life enrollment form.

Do members really have to send proof of retirement to MUST?

Yes. We need to be able to determine eligibility.

I was covered as a retiree under my former school district's plan, but dropped the plan. Can I re-enroll?

No. A retiree who drops MUST coverage may not re-enroll at a later time.

If retirees drop MUST coverage, can they re-enroll later under a special-enrollment qualifying event?

No. Retirees who drop MUST coverage cannot re-enroll.

Medicare

How will my medical claims be paid if I choose not to enroll in Medicare Part B?

We strongly encourage all retired Medicare-eligible participants to enroll in Medicare Part B. However, if the retired participant is eligible for Medicare Part B and elects not to enroll, MUST will simply pay eligible claims as a secondary payer.

If my Medicare coverage is primary, why did MUST pay more on my claim than Medicare?

Being “primary” simply indicates which coverage pays first. After Medicare has paid its portion of a claim, it is possible that the MUST plan would pay more toward that particular service than Medicare.

Other

Why is it important for a school official to review the Enrollment Form for completeness?

Incomplete forms cause delays. An incomplete form may have to be returned to the participant for completion, which means payment of claims may be delayed and a participant may have problems filling prescriptions because his/her record is inactive.

How does one receive the travel benefit?

A member must have a prior authorization in place in order to submit travel expenses for reimbursement.

Can we make an employee effective later than 1st of the month following date of hire?

An explanation is required for the Enrollment Supervisor to consider this request.

What is the Social Security Administration’s definition of disability?

The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment that makes you unable to do your past relevant work or any other substantial gainful work.

My wife, who wasn’t previously covered under my plan, is pregnant. Can she enroll and will the plan cover her claims?

She can enroll but only during the next Open Enrollment period. Claims incurred on or after her effective date will be covered according to plan benefits. Pregnancy is never considered a pre-existing condition; however, it does not create special enrollment rights.

If a husband and wife are both active employees, do they have to enroll separately in MUST to receive the \$10,000 basic life insurance and basic LTD coverage?

No. The married employees can fill out one green MUST Enrollment Form as employee and spouse, then partially complete a second Enrollment Form for the spouse only, as follows:

- The spouse should complete only Sections 1 and 5, and the Health Coverage Waiver section on the back of the Enrollment Form.
- Write “LIFE ONLY” prominently on the front of the Enrollment Form (such as across the Dependent area in Section 3).

This ensures that life-insurance beneficiary information is on file for the employee who enrolled in MUST as a spouse.

Does the above procedure also apply to retirees?

No. Only active employees are eligible for the Basic Life and LTD coverage.