

Enclosed is MUST Plan Amendment #5 effective January 1, 2008. The terms of this Amendment become effective with respect to each Member Groups effective date or next annual renewal date concurrent with or after January 1, 2008. Also included is Amendment #6 effective July 1, 2008.

Please review them carefully and store them with your current Schedule of Medical Benefits and your MUST Summary Plan Description.

<i><b>AMENDMENT SUMMARY</b></i>
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**Amendment #5**

**Change to Dependent Eligibility-** Language has been amended to comply with Montana Law-Senate Bill-419 redefining dependent eligibility for health benefit purposes (see the MUST website at [www.mustbenefits.org](http://www.mustbenefits.org) “Hot Topics”, for additional information).

**Amendment #6**

**First Dollar Benefit** - First dollar coverage is increased in the Basic Plan from \$250 to \$300 per Benefit Period.

**Preventive Care Benefit (3 years and older)** – The benefit has been increased from \$250 to \$300 per Benefit Period in all plans.

**Mammogram Benefit** – The benefit has been increased from \$200 to \$250 per Benefit Period in all plans.

**Colonoscopy Screening Benefit** – The benefit has been increased from \$750 to \$1000 in all plans for the initial screening colonoscopy.

**Pharmacy Benefit** – The \$50 pharmacy deductible is now included in the \$1500 out-of-pocket maximum for prescription drug plans A and B.

**Family Status Enrollment Changes** – Language added recognizing divorce, legal separation and death as Special Enrollment events.

**Dependent Termination** – Language added to clarify that termination of an adult dependent occurs on the last day of the month.

**Travel Benefit** –A new travel benefit of up to \$600 per trip is added for reimbursement of travel expenses for medically necessary services that cannot be obtained in Montana. The benefit requires authorization from APS Healthcare, pays at 100%, deductible applies on the HSA plan only. (A Travel Request form can be found on the MUST website at [www.mustbenefits.org](http://www.mustbenefits.org) Forms & Publications page).

**Morbid Obesity Exclusions** - Change to exclusion #3, stating that surgery for morbid obesity excluded, except as specifically covered under the new “Bariatric Surgery Benefit”.

**Bariatric Surgery Benefit** – Bariatric surgery benefit and criteria added to the plan, treatment and services must be prior authorized as medically necessary or will not be covered. Prior authorization review and mandatory case management provided by APS Healthcare.

**AMENDMENT #5**  
TO THE  
SUMMARY PLAN DESCRIPTION  
FOR  
MONTANA UNIFIED SCHOOL TRUST (MUST)

Effective January 1, 2008, Montana Unified School Trust (the Plan) is amended as follows:

Effective January 1, 2008, the terms of this Amendment will become effective with respect to each Member Group commencing on the Member Group's effective date or next annual renewal date concurrent with or after January 1, 2008.

Within the “**ELIGIBILITY PROVISIONS**” section, “DEPENDENT ELIGIBILITY”, as amended, is deleted and replaced as follows:

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant has been assigned by the Employer, and who is either:

1. The Participant's legal spouse of the opposite sex, according to the marriage laws of the state where the marriage was first solemnized or established.

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

2. The Participant's Adult Dependent provided all of the following “Required Eligibility Conditions” are met:
  - A. The Participant and Adult Dependent are both eighteen (18) years of age or older and each has the capacity to enter into a contract: and
  - B. The Participant and Adult Dependent has had joint ownership or joint tenancy of a residence together for at least the most recent twelve (12) consecutive months, and the jointly-owned or jointly-leased residence has served as the primary placed residence for each of them during the same period; and
  - C. The Adult Dependent does not meet the MUST eligibility requirements of a spouse or a Dependent child; and
  - D. The Adult Dependent does not have a parental relationship with the Participant; and
  - E. The Adult Dependent is not related to the Participant by blood or marriage; and
  - F. The Adult Dependent has a financially-interdependent relationship with the Participant as evidenced by at least three (3) of the following:
    - 1) Joint ownership or lease of a motor vehicle;
    - 2) At least one joint liability such as a loan or credit card;
    - 3) Mutually-granted powers of attorney or mutually-granted health care powers of attorney;
    - 4) Designation of each other as primary beneficiary in wills, life insurance policies, or retirement annuities.

3. *The Participant's or Adult Dependent's unmarried Dependent child who meets all of the following "Required Eligibility Conditions":*
- A. *Is a natural child; step-child; legally adopted child; a child who has been Placed with the Participant for adoption and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and*
  - B. *Is less than twenty-five (25) years of age. This requirement is waived if the Participant's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time; and*
  - C. *Is not an employee eligible for coverage under a group health plan offered by the Dependent child's employer for which the child's premium contribution amount is greater than the premium amount for coverage as a Dependent under this Plan.*
  - D. *Is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage;*
  - E. *Is not entitled to benefits under Medicare or Medicaid.*

Dependents on active military duty for more than thirty-one (31) consecutive days are not eligible.

Within the "**EFFECTIVE DATE OF COVERAGE**" section, "DEPENDENT COVERAGE", as amended, is deleted and replaced as follows:

DEPENDENT COVERAGE

Each Participant who requests Dependent Coverage on the Plan's enrollment form will become covered for Dependent Coverage as follows:

1. On the Participant's effective date of coverage, if application for Dependent Coverage is made on the Plan's enrollment form before the last day of the Waiting Period imposed on Employees by this Plan. This subsection applies only to Dependents who are eligible on the Participant's effective date of coverage. Enrollment under this subsection will not be considered Late Enrollment.
2. In the event a Dependent is acquired after the Participant's effective date of coverage as a result of a legal guardianship or in the event that a Participant is required to provide coverage as a result of a valid court order, or if the Dependent is acquired as a result of operation of law, Dependent Coverage will begin on the first day of the month following the Plan's receipt of an enrollment form and copy of said court order, if applicable. Enrollment under this subsection will not be considered Late Enrollment.

Within the “**TERMINATION OF COVERAGE**” section, items 9, 10, 11 and 14, as amended, are deleted and 13 is renumbered as item 9. Deleted items 9, 10, 11 and 14 are written as follows:

9. On September 30<sup>th</sup> for any year that the Dependent does not return as a Full-time Student for the Fall term or is not enrolled as a Full-time Student during the immediately preceding Spring term;
10. On January 31<sup>st</sup> for any year that the Dependent does not return as a Full-time Student for the Spring term, provided the Dependent was enrolled as a Full-time Student during the immediately preceding Fall term;
11. On the last day of the month in which the Dependent ceases to be a Full-time Volunteer, unless an otherwise eligible dependent who ceases to be a Full-time Volunteer, enrolls as a Full-Time Student, for the next semester or quarter immediately following loss of Full-Time Volunteer status;
14. On the last day of the month in which the Plan receives that the Dependent ceases to be financially dependent (at least 50%) upon the Participant.

Within the “**GENERAL DEFINITIONS**” section, the following definitions are deleted in their entirety:

“Full-Time Student” means a person who is currently enrolled in and regularly attending an accredited secondary school, college, university or technical school as a Full-Time Student as that term is defined by such school’s admission and attendance policy regarding Full-Time Student status.

“Full-Time Volunteer” means a person who is currently enrolled as an unpaid volunteer worker in a full-time service project sponsored by an organized religion, non-profit corporation or public agency for a period of time expected to last for ninety (90) days or more.

**AMENDMENT #6**

TO THE  
SUMMARY PLAN DESCRIPTION  
FOR  
MONTANA UNIFIED SCHOOL TRUST (MUST)

Effective July 1, 2008, Montana Unified School Trust (the Plan) is amended as follows:

Within the “**MEDICAL PLAN COVERAGE OPTIONS**”, “**BASIC MEDICAL COST SHARING**” is replaced as follows:

<p><b>BASIC MEDICAL COST SHARING</b> The Benefit Period is a twelve-month period as follows:</p> <p>For July Renewals the Benefit Period commences on <b>JULY 1<sup>ST</sup></b> and ends on <b>JUNE 30<sup>TH</sup></b> of each year For September Renewals the Benefit Period commences on <b>SEPTEMBER 1<sup>ST</sup></b> and ends on <b>AUGUST 31<sup>ST</sup></b> of each year <b>BEGINNING JULY 1, 2005</b>, Member Groups who change their renewal from July to September, the Benefit Period will commence on July 1<sup>st</sup> of the year in which the change occurs and end on August 31<sup>st</sup> of the following year. Thereinafter, the Benefit Period will commence on September 1<sup>st</sup> and end on August 31<sup>st</sup> of each year.</p>			
First Dollar Benefit* (Before Deductible)	Deductible per Covered Person / Family per Benefit Period (After First Dollar Benefit)	Benefit Percentage	Out-of-Pocket Maximum per Benefit Period**
\$300	Waived	100%	N/A
N/A	\$2000 / \$4000	70%	\$4000 / \$8000
<p>*Eligible Expenses that would otherwise be subject to the Deductible and/or Out-of-Pocket Maximum are payable at 100% under the First Dollar Benefit up to a maximum of \$300 per Benefit Period. Once the first \$300 of Eligible Expenses has been exhausted during the same Benefit Period, any remaining Eligible Expenses are subject to the Deductible and/or Out-of-Pocket Maximum. After satisfaction of the Deductible, any remaining Eligible Expenses are payable at the Benefit Percentage stated above. The amount payable by the Plan will not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Medical Benefits, for any reason. **<b>Out-of-Pocket Maximum includes amounts applied toward the Deductible and charges for Eligible Expenses in excess of the Benefit Percentage.</b></p> <p><b>Eligible Expenses which do not apply toward the Out-of-Pocket Maximum or for which the Benefit Percentage remains the same after satisfaction of the Out-of-Pocket Maximum are specifically stated under Limited Medical Benefits.</b></p>			

Within the “**BASIC MEDICAL SCHEDULE OF BENEFITS**”, “**FIRST DOLLAR BENEFIT**” (Before Deductible) is replaced as follows:

<b>BASIC MEDICAL PLAN OPTION LIMITED MEDICAL BENEFITS</b>
<b><u>FIRST DOLLAR BENEFIT</u> (Before Deductible)</b>
*Eligible Expenses that would otherwise be subject to the Deductible and/or Out-of-Pocket Maximum are payable at 100% under the First Dollar Benefit up to a maximum of \$300 per Benefit Period. Once the first \$300 of Eligible Expenses has been exhausted during the same Benefit Period, any remaining Eligible Expenses are subject to the Deductible and/or Out-of-Pocket Maximum. After satisfaction of the Deductible, any remaining Eligible Expenses are payable at the Benefit Percentage stated below. The amount payable by the Plan will not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Medical Benefits, for any reason.

Within the “**BASIC, COMPREHENSIVE AND REVISED, MEDICAL SCHEDULE OF BENEFITS**”, “**PREVENTIVE CARE**”, as amended, is deleted and replaced as follows:

<b>BASIC, COMPREHENSIVE AND REVISED MEDICAL PLANS LIMITED MEDICAL BENEFITS</b>	<b>Benefit Period Benefit Limitations</b>
<b><u>PREVENTIVE CARE (3 years of age or older)</u></b>	
<b>Physician Charges and Diagnostic Screening Tests</b>	
Deductible Waived, Benefit Percentage ..... 100%	
Maximum Benefit per Benefit Period.....	\$300
<b>Mammogram, once per Benefit Period</b>	
Deductible Waived, Benefit Percentage ..... 100%	
Maximum Benefit per Benefit Period.....	\$250
<b>Pap Test (Pathology only, excluding office visit charges), once per Benefit Period</b>	
Deductible Waived, Benefit Percentage ..... 100%	
Maximum Payable up to UCR	
<b>Fecal Occult Blood Test, limited to one per Benefit Period for 50 years or older</b>	
Deductible Waived, Benefit Percentage ..... 100%	
<b>Flexible Sigmoidoscopy, limited to one every 5 Benefit Periods for 50 years or older</b>	
Deductible Waived, Benefit Percentage ..... 100%	
<b>Colonoscopy (including facility and physician services), limited to one every 10 Benefit Periods for 50 years or older</b>	
First \$1,000 of charges, Deductible Waived, Benefit Percentage.... 100%	
Charges exceeding \$1,000, Deductible Applies, Benefit PercentageApplie	
<b>Colorectal Cancer testing performed more frequently or earlier than 50 years, regardless of diagnosis</b>	
Deductible Applies, Benefit Percentage ..... Applies	

BASIC, COMPREHENSIVE AND REVISED MEDICAL PLANS LIMITED MEDICAL BENEFITS	Benefit Period Benefit Limitations
<b>Immunizations (3 years of age or older)</b> Deductible Waived, Benefit Percentage ..... Applies	
<p><b>IMMUNIZATIONS OBTAINED THROUGH PROVIDERS OTHER THAN ANY COUNTY HEALTH DEPARTMENT APPLY TOWARD THE ROUTINE CARE LIMITATIONS AND MAXIMUMS.</b></p> <p><b>IMMUNIZATIONS OBTAINED AT ANY COUNTY HEALTH DEPARTMENT DO NOT APPLY TOWARD THE WELL-CHILD OR PREVENTIVE CARE LIMITATIONS AND MAXIMUMS AND ARE PAYABLE AT 100%, DEDUCTIBLE WAIVED.</b></p>	

Within the **HSA COMPATIBLE (HDHP) SCHEDULE OF BENEFITS**, “PREVENTIVE CARE”, as amended, are deleted and replaced as follows:

<b>HSA COMPATIBLE MEDICAL PLAN LIMITED MEDICAL BENEFITS</b>	
<p><b><u>PREVENTIVE CARE</u> (3 years of age or older)</b></p>	
<p><b>Physician Charges and Diagnostic Screening Tests</b></p>	
Deductible Waived, Benefit Percentage .....	100%
Maximum Benefit per Benefit Period / <b>\$300</b>	
<p><b>Mammogram, once per Benefit Period</b></p>	
Deductible Waived, Benefit Percentage .....	100%
Maximum Benefit per Benefit Period / <b>\$250</b>	
<p><b>Pap Test (pathology only, excluding office visit charges), once per Benefit Period</b></p>	
Deductible Waived, Benefit Percentage .....	100%
Maximum Payable up to UCR	
<p><b>Fecal Occult Blood Test, limited to one per Benefit Period for 50 years or older</b></p>	
Deductible Waived, Benefit Percentage .....	100%
<p><b>Flexible Sigmoidoscopy, limited to one every 5 Benefit Periods for 50 years or older</b></p>	
Deductible Waived, Benefit Percentage .....	100%
<p><b>Colonoscopy (including facility and physician services), limited to one every 10 Benefit Periods for 50 years or older</b></p>	
First <b>\$1,000</b> of charges, Deductible Waived, Benefit Percentage.....	100%
Charges exceeding <b>\$1,000</b> , Deductible Applies, Benefit Percentage .....	Applies
<p><b>Colorectal Cancer testing performed more frequently or earlier than 50 years, regardless of diagnosis</b></p>	
Deductible Applies, Benefit Percentage .....	Applies
<p><b>Immunizations (3 years of age or older)</b></p>	
Deductible Waived, Benefit Percentage .....	Applies

HSA COMPATIBLE MEDICAL PLAN LIMITED MEDICAL BENEFITS
<p><b>IMMUNIZATIONS OBTAINED THROUGH PROVIDERS OTHER THAN ANY COUNTY HEALTH DEPARTMENT APPLY TOWARD THE ROUTINE CARE LIMITATIONS AND MAXIMUMS.</b></p> <p><b>IMMUNIZATIONS OBTAINED AT ANY COUNTY HEALTH DEPARTMENT DO NOT APPLY TOWARD THE WELL-CHILD OR PREVENTIVE CARE LIMITATIONS AND MAXIMUMS AND ARE PAYABLE AT 100%, DEDUCTIBLE WAIVED.</b></p>

Within the “**BASIC, COMPREHENSIVE AND REVISED MEDICAL SCHEDULE OF BENEFITS**”, “TRAVEL BENEFIT” is added following “REHABILITATION/CARDIAC THERAPY” as follows:

BASIC, COMPREHENSIVE AND REVISED MEDICAL PLANS LIMITED MEDICAL BENEFITS	Benefit Period Benefit Limitations
<p><b><u>TRAVEL BENEFIT</u></b>  <i>Further details of this benefit described in the Medical Benefits section</i>  <i>Deductible Waived, Benefit Percentage.....100%</i></p>	<p>\$600 per trip</p>
<p><b>REIMBURSEMENT UNDER THIS BENEFIT REQUIRES PRE-AUTHORIZATION. CONTACT APS HEALTHCARE TO OBTAIN OUT-OF-STATE TRAVEL PREAUTHORIZATION REQUEST FORM OR ACCESS FORM ONLINE AT MUST WEBSITE.</b></p>	

Within the “**HSA MEDICAL SCHEDULE OF BENEFITS**”, “TRAVEL BENEFIT” is added following “REHABILITATION/CARDIAC THERAPY” as follows:

HSA MEDICAL PLAN LIMITED MEDICAL BENEFITS
<p><b><u>TRAVEL BENEFIT</u></b>  <i>Further details of this benefit described in the Medical Benefits section</i>  <i>Deductible..... Applies</i>  <i>Benefit Percentage.....100%</i>  <i>Maximum Benefit.....\$600 per trip</i></p>
<p><b>REIMBURSEMENT UNDER THIS BENEFIT REQUIRES PRE-AUTHORIZATION. CONTACT APS HEALTHCARE TO OBTAIN OUT-OF-STATE TRAVEL PREAUTHORIZATION REQUEST FORM OR ACCESS FORM ONLINE AT MUST WEBSITE.</b></p>

Within the “**COMPREHENSIVE MEDICAL SCHEDULE OF BENEFITS**” and “**REVISED MEDICAL SCHEDULE OF BENEFITS**”, the shaded part only of the “**PHARMACY BENEFIT**” is replaced as follows:

<b>PHARMACY BENEFIT</b>	
Specific information regarding Coverage, Service Options, Limitations and Exclusions are specifically stated under the Pharmacy Benefit section of this Plan. Copayments do not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum. <b>The Pharmacy Benefit Manager (PBM) will provide separate information for details regarding Network pharmacies and Preferred Brand prescriptions upon enrollment for coverage under this Plan. The Prescription Drug Deductible and Pharmacy Out-of-Pocket Maximum applies only to pharmacy charges eligible under the Pharmacy Benefit.</b>	
<b>If the doctor authorizes a generic drug and the Participant requests a Preferred or Non-Preferred Brand, the Participant must pay the difference as well as the Copayment amount.</b>	
<b>Plans A &amp; B:</b>	
Prescription Drug Deductible Per Covered Person per Benefit Period.....	\$50*
Pharmacy Out-of-Pocket Maximum Per Covered Person per Benefit Period .....	\$1,500*
<i>*Includes Prescription Drug Deductible</i>	
<b>Plan C:</b>	
Prescription Drug Deductible per Covered Person per Benefit Period.....	\$100
Pharmacy Out-of-Pocket Maximum .....	N/A
The Pharmacy Out-of-Pocket Maximum <i>includes amounts applied toward the Prescription Drug Deductible and cumulative Copayments</i> per Benefit Period. After satisfaction of the Pharmacy Out-of-Pocket Maximum per Benefit Period, Copayments will be waived for the remainder of the benefit Period for Retail and Mail Order prescriptions.	

Within the **EFFECTIVE DATE OF COVERAGE** section, FAMILY STATUS ENROLLMENT CHANGE is added following “**SPECIAL ENROLLMENT PERIOD**”:

**FAMILY STATUS ENROLLMENT CHANGES**

*In addition to Special Enrollment, a Participant may enroll eligible Dependents or change Plan Options as a result of a family status change due to divorce or legal separation of the Employee or death of the Employee’s spouse. Coverage will become effective on the first day of the month following the family status change, provided the request for such coverage is made verbally or in writing within thirty (30) days of the family status change and application for such coverage is made on the Plan’s enrollment form within sixty (60) days of the family status change.*

Within the “**TERMINATION OF COVERAGE**” section, under “DEPENDENT TERMINATION”, as amended, which states the following:

**Each Covered Person, whether Participant or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continued Coverage after Termination.**

Coverage for a Dependent will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

Item number 13, renumbered as #9, is replaced as follows:

9. *On the last day of the month* the Participant and Adult Dependent terminate their Adult Dependent relationship as evidenced by a signed Notification of Change in or Termination of Adult Dependent Relationship.

Within the “**MEDICAL BENEFITS**” section, “TRAVEL BENEFIT” is added following “REHABILITATION/CARDIAC THERAPY” as follows:

#### TRAVEL BENEFIT

Charges are payable as specifically stated in the Schedule of Medical Benefits. **Coverage under this benefit includes reimbursement for travel expenses for the sole purpose of receiving Medically Necessary treatment or services that cannot be obtained within the state of Montana** as determined by the APS Healthcare. Coverage is based upon information required from the Participant and patient’s treating Physician provided on the Out-of-State Travel Preauthorization Request Form. To receive Medically Necessary specialized health services, the following incurred charges are payable. **Reimbursement under this benefit requires authorization from APS Healthcare.**

The cost of transportation by round trip coach airfare, trainfare, busfare or the IRS reimbursement rate for medical travel by automobile (as determined by APS Healthcare) for the Covered Person will be provided to and from the site where treatment will be rendered. Transportation charges for a companion to accompany a Covered Member who is over 18 years of age may be covered if certified by the physician and approved by APS Healthcare. Submission of the travel receipts for airfare, trainfare or busfare is required for reimbursement. Total reimbursement for travel costs under this subsection shall not exceed \$600.00 for the Covered Person and \$600.00 for a medically necessary companion per authorized trip.

Within the “**MEDICAL BENEFITS**”, under “Morbid Obesity Exclusions”, item 3 is replaced as follows:

3. Charges incurred for gastric bypass, stomach stapling, gastroplasty and similar surgical procedures regardless of the diagnosis, *except as specifically covered under the “Bariatric Surgery Benefit”*.

Within the “**MEDICAL BENEFITS**”, “**BARIATRIC SURGERY BENEFIT**” is added following “Morbidity Exclusions” as follows:

### **BARIATRIC SURGERY BENEFIT**

Charges are payable as specifically stated in the Schedule of Medical Benefits. Coverage is limited to the following bariatric surgeries for the treatment of Morbid Obesity as defined by this section:

- Laparoscopic Gastric Banding (Lap Banding Procedure)
- Gastric Bypass (Roux-en-Y)

The definition of “Morbid Obesity” for surgical intervention means a condition of persistent and uncontrollable weight gain and is defined as a body mass index (BMI) of 35 to 39 with at least two co-morbid conditions (conditions listed under Selection Criteria) or a BMI of 40 with or without accompanying co-morbid conditions. BMI is calculated by dividing a person’s weight (in kilograms) by his/her height squared (in meters).

**Treatment must be Prior Authorized as Medically Necessary by APS Healthcare. If Prior Authorization is not obtained or charges are found not to be Medically Necessary, charges in connection with or related to bariatric surgery will not be covered. Specialized case management by a registered nurse will be mandatory for Covered Persons who are considering bariatric surgery to assist them with prior-authorization of services. For Covered Person’s who meet medical necessity for bariatric surgery, the case manager will continue to collaborate with the participant and their provider(s) in the pre-operative and post-operative phase.**

**APS Healthcare Case Management phone number: 1-866-598-3974, option #3**

Adjustment to the Lap Band is considered medically necessary. The adjustment is usually performed in the physician’s office. Performance of the procedure in an outpatient surgery setting requires documentation of medical necessity as well as X-rays, including a before and after barium swallow.

Covered services for bariatric surgery for Morbid Obesity as well as any complications that might result from approved bariatric surgery are considered medically necessary only when **all** of the selection criteria 1-5 are met.

### **Selection criteria:**

1. Presence of morbid obesity that has persisted for at least 3 years is defined as a body mass index (BMI) of 35 to 39 with at least two co-morbid conditions as listed or a BMI of 40 with or without accompanying co-morbid conditions which must be documented by a Physician. Co-morbid conditions include:
  - a. Clinically significant obstructive sleep apnea
  - b. Obesity Hypoventilation Syndrome
  - c. Obesity related Cardiomyopathy
  - d. Insulin dependent or oral medication dependent diabetes
  - e. Mechanical Arthropathy
  - f. Gastroesophageal reflux disorder (GERD)
  - g. Hypertension
  - h. Medically refractory hypertension (blood pressure greater than 140 mmHg. Systolic and/or 90 mmHg diastolic despite optimal medical management)
  - i. Coronary artery disease
  - j. Dyslipidemia

2. Covered Person has completed growth (18 years of age or documentation of completion of bone growth);
3. Covered Person attempted weight loss in the past without successful long-term weight reduction, which must be documented;
4. Covered Person must meet *either* the physician-supervised nutrition and exercise program *or* the multidisciplinary surgical preparatory regimen described below:
  - a. *Physician-supervised nutrition and exercise program:* Documentation\* that the Covered Person has participated in a physician-supervised nutrition and exercise program including dietician/nutritionist consultation, low calorie diet, increased physical activity, behavioral modification and this is documented in the medical record. A physician supervised multidisciplinary program for the purpose of meeting this standard must meet **all** of the following criteria:
    - i. The program must be supervised and monitored by the physician;
    - ii. The nutrition and exercise program(s) must be for a cumulative total of 6 months or longer in duration and occur within 1 (one) year prior to surgery, with participation in one program for at least 6 (six) consecutive months. (Prior authorization may be made prior to completion of nutrition and exercise program as long as a consecutive 6 (six) month's participation in a multidisciplinary program(s) will be completed prior to the date of surgery).
    - iii. Covered Person's participation in a physician-supervised nutrition and exercise program must be documented in the medical records by an attending physician who supervised the Covered Person's participation.

The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. The Covered Person must lose 10% of their starting body weight prior to surgery.

*\*A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the physician's contemporaneous assessment of the patient's progress throughout the course of the nutrition and exercise program. For Covered Persons who participate in a medically supervised nutrition and exercise program (e.g., Medifast, Optifast), records documenting the Covered Person's participation and progress may substitute for physician medical records.*

- b. *Multidisciplinary surgical preparatory regimen:* Immediately prior to the time of surgery, the prescribing physician must document\*\* that the Covered Person participated in an organized multidisciplinary surgical preparatory regimen of at least 3 consecutive months meeting **all** of the criteria below. The regimen is necessary in order to improve surgical outcomes, reduce the potential for surgical complications, and to establish the Covered Person's ability to comply with post-operative medical care and dietary restrictions. Multidisciplinary surgical preparatory regimen must include:

- i. Consultation with a licensed dietician or nutritionist.
- ii. Participation in a reduced-calorie diet program supervised by a licensed dietician or nutritionist;
- iii. Loss of 10% of their starting body weight prior to surgery
- iv. A physical activity assessment prior to surgery, supervised by a licensed exercise therapist or other licensed qualified professional
- v. Participation in a behavior modification program supervised by a licensed qualified professional
- vi. Attendance at all of the pre-surgery and postoperative surgery appointments and support group meetings

*\*\*Documentation is required in the medical record of the Covered Person's attendance and participation in the multidisciplinary surgical preparatory regimen and post-operative support group meetings; and*

*A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation must include medical records of the physician's initial assessment of the Covered Person, and the physician's assessment of the Covered Person's progress at the completion of the multidisciplinary surgical preparatory regimen.*

- 5. For both criterion a and b, the Covered Person must have a documented psychological evaluation by a licensed mental health professional that addresses the following:
  - a. Absence of problems related to alcohol or substance abuse (other than nicotine/caffeine) for at least one year
  - b. Absence of major psychotic or severe psychiatric disturbances (schizophrenia, borderline personality disorder, suicidal ideation, severe depression)
  - c. Absence of compulsive or obsessive-compulsive disorder
  - d. Absence of an active binge eating disorder
  - e. Absence of severe mental retardation
  - f. Absence of unrealistic expectations for weight loss and lack of knowledge about surgery; *and*
  - g. An assessment of the patient's likelihood to comply with long-term post-operative requirements.

*Note: The presence of depression due to obesity is not normally considered a contraindication to obesity surgery.*

### **Exclusions**

The following charges incurred for weight reduction, weight loss, the treatment of obesity, and the treatment of Morbid Obesity are excluded:

1. Vitamins, food supplementation, commercial or franchise diet programs, exercise and educational programs (See Morbid Obesity Eligible Expenses Section for medical coverage guidelines for morbid obesity).
2. Any incurred expenses for which all of the conditions of the bariatric surgery benefit of this Plan have not been met.
3. Revision of bariatric surgery is not medically necessary for a stretched stomach pouch (formed by a previous gastric restrictive procedure) due to the patient overeating.
4. A second bariatric surgical procedure, whether or not the first procedure was performed while covered under this Plan.
5. Surgical procedures except for Roux-en-Y Gastric Bypass Surgery and the Lap-Banding surgical procedure.
6. Complications resulting from any type of bariatric surgery that was performed while the Covered Person was covered under another plan.

*Prophylactic cholecystectomy is considered inclusive of the bariatric surgery.*