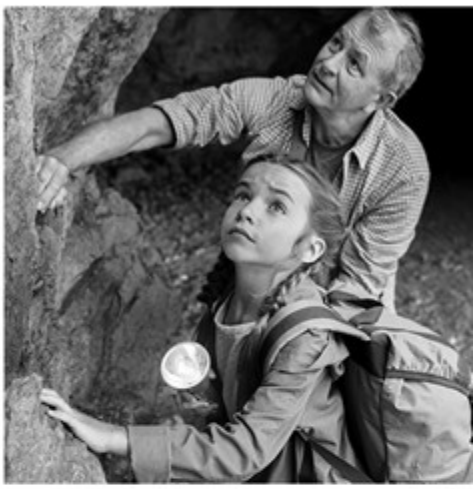
BlueCross BlueShield of Montana

MEMBER GUIDE



Blue Preferred Gold PPO[SM] 101

Blue Cross and Blue Shield of Montana,
a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company,
an Independent Licensee of the
Blue Cross and Blue Shield Association

SAMPLE SMALL GROUP

Effective January 1, 2024

MEDICAL BENEFITS

FOR CUSTOMER SERVICE
Call 1-800-447-7828

DENTAL BENEFITS

FOR CUSTOMER SERVICE
Call 1-888-788-4269

FOR PRIOR AUTHORIZATION
Call 1-855-313-8914 or Fax 1-866-589-8256 for Non-Behavioral Health
Call 1-855-313-8909 or Fax 1-855-649-9681 for Behavioral Health

FOR INPATIENT ADMISSIONS
Call 1-855-313-8914 or Fax 1-866-589-8256 for Non-Behavioral Health
Call 1-855-313-8909 or Fax 1-855-649-9681 for Behavioral Health

www.bcbsmt.com

- BCBSMT Provider Directory
- Wellness
- Customer Service
- Other Online Services and Information

BLUECARD® NATIONWIDE/WORLDWIDE COVERAGE PROGRAM
1-800-810-BLUE (2583) – http://provider.bcbs.com

FOR MEDICAL APPEALS
Send via fax:
Non-Behavioral Health: 1-866-589-8256
Behavioral Health: 1-855-649-9681
or
Mail to:
Blue Cross and Blue Shield of Montana
PO Box 4309
Helena, MT 59604-4309

FOR DENTAL APPEALS
Send to:
Blue Cross and Blue Shield of Montana
PO Box 6227
Helena, MT 59604-6227

MDLIVE®
1-888-684-4233

FOR PRESCRIPTION DRUG BENEFITS

Pharmacy Benefit Manager (PBM)

- Prime Therapeutics 1-855-258-8471
- For Prior Authorizations, fax: 1-877-243-6930

PBM Website www.myprime.com
Claim Forms www.myprime.com
Pharmacy Locator 1-866-325-5230
Specialty Care Pharmacy
(BCBSMT Specialty Network) 1-833-721-1619

- www.bcbsmt.com or www.myprime.com
- Prescriber Fax 1-888-302-1028

Mail-Order Services

- **Express Scripts** 1-833-715-0942
  PO Box 66577
  St. Louis, MO 63166-6577
- **Ridgeway Mail-Order Pharmacy** 1-800-630-3214
  2824 US Hwy 93 North
  Victor, MT 59875

Blue Cross and Blue Shield of Montana
3645 Alice Street
PO Box 4309
Helena, MT 59604-4309

FOR MEDICAL CLAIMS
Blue Cross and Blue Shield of Montana
PO Box 7982
Helena, MT 59604-7982

FOR DENTAL CLAIMS
Blue Cross and Blue Shield of Montana
PO Box 6227
Helena, MT 59604-6227

Certain terms in this Member Guide are defined in the Definitions section of this Member Guide. Defined terms are capitalized.

NO COVERAGE UNTIL DUES PAID

This Member Guide is being provided because the Member's employer has agreed to purchase health coverage from Blue Cross and Blue Shield of Montana. Coverage will not be effective, and the Member will not be entitled to Benefits, until and unless the employer pays the required dues.

MEMBER GUIDE

This Member Guide is a summary of the Benefits available under the Group Plan. Nothing in this Member Guide will alter any of the terms, conditions, limitations, or Exclusions of the Group Plan. If questions should arise, the provisions of the Group Plan will prevail. Please refer to the Group Plan on file with the Member's employer if there are any questions which aren't answered in the Member Guide or call the Member's Blue Cross and Blue Shield of Montana representative.

PRIVACY OF INSURANCE AND HEALTH CARE INFORMATION

It is the policy of Blue Cross and Blue Shield of Montana to protect the privacy of Members through appropriate use and handling of private information. Further, appropriate handling and security of private information may be mandated by state and/or federal law.

The Group and Beneficiary Member may receive a copy of Blue Cross and Blue Shield of Montana's "Notice of Privacy Practices," or other information about privacy practices, by calling the telephone number or writing to the address shown on the inside cover of this Member Guide.

MEMBER'S RIGHTS

When requested by the insured or the insured's agent, Montana law requires Blue Cross and Blue Shield of Montana to provide a summary of a Member's coverage for a specific health care service or Course of Treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or Hospital exceeds $500.

CONTINUITY OF CARE

If the Member's Participating Provider (professional) stops participating in the PPO Network, the Member may request continued treatment from that provider for a period of time after the provider stops participating, except for pregnancy, the continuity of care period is 90 days or until the next policy renewal date, whichever is longer. For pregnancy, the continuity of care period is through the postpartum period. For the Member to qualify for continuity of care, the provider must: 1. agree that the Member is in an active Course of Treatment as defined by ARM 6.6.5908; 2. agree to accept the same allowed amount as the provider would have accepted if the provider had remained a Participating Provider; and 3. agree not to seek payment from the Member of any amount for which the Member would not have been responsible if the provider had remained a Participating Provider. Continuity of care protections are only for an active Course of Treatment and are not required for Routine primary and preventive care.

MEMBER REWARDS - MEDICAL

Member Rewards is a free**,** voluntary program in which eligible Members can earn a percentage of the claim savings in the form of a cash reward by selecting quality, low-cost In-Network facilities for qualified elective, non-emergency medical services. Members can use the Provider Finder tool on BCBSMT's website at www.bcbsmt.com/find-care/providers-in-your-network/find-a-doctor-or-hospital to find a list of all eligible services/procedures and facility options. Shopping can also be conducted by calling Customer Service, who will shop for services/procedures and facilities on the Member's behalf.

When the Member chooses a rewards-eligible service/procedure, the Member will earn a portion of the savings in the form of a check mailed to the Member, usually within 60 days, after the claim is processed by BCBSMT. This reward is separate from and does not affect the Member's claim for a covered Benefit. To earn a reward, the Member must:

1. Have active coverage on the date the Member shops for a rewards-eligible service/procedure;
2. Have active coverage on the date the medical service/procedure is rendered; and
3. Complete the rewards-eligible service/procedure within thirteen calendar months of the date of shopping.

Incentive amounts and eligible services/procedures are subject to change; however, the maximum reward amount the Member may earn on any single procedure is $500. Any reward amounts received may be taxable.

The Member's provider may refer the Member to a facility or location to complete the Member's medical service/procedure that is not eligible for a reward. However, the Member must use a facility that is eligible for the program to receive a reward. If the Member's provider refers the Member to a facility that is not eligible for a reward under the program, Customer Service may be able to coordinate with the Member's provider to find an eligible facility or location, if one is available. Remember, all decisions on where to receive care are between the Member and the Member's provider.

Member Rewards is not a discount program and will not impact Benefits or claims processing. The Plan may discontinue this program upon 180 days' notice. To maintain eligibility for a reward, the Member must complete shopping for a rewards-eligible service/procedure prior to the program termination following such notice. All rewards earned under this program will be funded by BCBSMT, and subject to the provided provisions of this program and all other applicable articles of coverage including payment of Benefits, termination of coverage, and review of claim determinations. A referral or Prior Authorization may be required for the Member's service/procedure.

If the Member has questions about this program, call Customer Service or visit BCBSMT's website at www.bcbsmt.com.

MEMBER REWARDS - RX

Member Rewards Rx is a free, voluntary program in which eligible Members can earn a cash reward for choosing a cost-effective prescription alternative. Members use the Medication Finder feature located within the Provider Finder tool on BCBSMT's website at www.bcbsmt.com/find-care/providers-in-your-network/finda-a-doctor-or-hospital to shop for reward-eligible opportunities on prescribed medications.

When the Member chooses a reward-eligible medication, the Member will earn a reward in the form of a check mailed to the Member, usually within 60 days, after purchase of the medication. This reward is separate from, and does not affect, the Member's claim for coverage for a prescribed medication. To earn a reward, the Member must:

1. Have active coverage on the date the Member shops for a rewards-eligible prescribed medication; and
2. Have active coverage on the date the rewards-eligible prescribed medication is filled.

Reward eligibility is limited to the first fill of each rewards-eligible prescribed medication, after shopping. The reward amount the Member may earn on any reward-eligible medication is $100. Any reward amounts received are taxable.

The Member's provider may prescribe a medication that is not eligible for a reward. However, the Member must select a rewards-eligible medication to receive a reward. Remember, all decisions on prescribed medication use are between the Member and the Member's provider.

Member Rewards Rx is not a discount program and will not impact benefits or claims processing. The Plan may discontinue or change this program upon 180 days' notice. To maintain eligibility for a reward, the Member must complete the purchase of a rewards-eligible medication prior to the program termination, following such notice. All rewards earned under this program will be funded by BCBSMT, and are subject to the applicable provisions of this

program and all other applicable articles of coverage including payment of benefits, termination of coverage, and review of claim determinations.

If the Member has questions about this program, call customer service or visit BCBSMT's website at www.bcbsmt.com.

IDENTITY THEFT SERVICES

Blue Cross and Blue Shield of Montana (BCBSMT) offers, at no additional cost to the Member, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect the Member's information. These identity theft protection services are currently provided by BCBSMT's designated outside vendor and acceptance or declination of these services is optional to Member.

Members who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbsmt.com or telephonically by calling the toll-free telephone number on the Member's identification card. Services may automatically end when the person is no longer an eligible Member. In addition, services may change or be discontinued at any time and BCBSMT does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this Member Guide.

OVERPAYMENTS

If Blue Cross and Blue Shield of Montana pays for Covered Medical Expenses incurred by the Member and it is found that the payment was more than it should have been, or was made in error (overpayment), Blue Cross and Blue Shield of Montana has the right to obtain a refund of the overpayment from: (i) the person to, or for whom, such Covered Medical Expenses were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities or organizations, including, but not limited to, Participating Providers or Out-of-Network providers.

If no refund is received, Blue Cross and Blue Shield of Montana (in its capacity as insurer) has the right to deduct any refund for any overpayment due, up to an amount equal to the overpayment, from:

1. Any future payment made to any person or entity under this Member Guide, whether for the same or a different Member; or
2. Any future payment made to any person or entity under another Blue Cross and Blue Shield of Montana-administered program and/or Blue Cross and Blue Shield of Montana administered insured benefit program or policy; or
3. Any future payment made to any person or entity under another Blue Cross and Blue Shield of Montana-insured group plan or individual policy; or
4. Any future payment, or other payment, made to any person or entity; or
5. Any future payment owed to one or more Participating Providers or Out-of-Network providers.

Further, Blue Cross and Blue Shield of Montana has the right to reduce the Member's health plan's payment to a provider by the amount necessary to recover another Blue Cross and Blue Shield of Montana plan's or policy's overpayment to the same provider and to remit the recovered amount to the other health plan.

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SCHEDULE OF BENEFITS

Blue Preferred Gold PPO 101

Group Name:	SAMPLE GROUP NAME
Group Number:	123456
Effective Date:	January 1, 2024
Annual and Lifetime Plan Maximum:	None
Benefit Period:	Calendar Year

The Benefits are subject to the Benefit Period unless otherwise specified.

	In-Network	Out-of-Network
Deductible:		
Individual	$3,200	$6,200
Family	$9,600	$18,600
The In-Network and Out-of-Network Deductibles are separate amounts and one does not accumulate to the other.		
Any Copayments and/or Coinsurance do not accumulate to the Deductible.		
Coinsurance:	10%	50%
Out of Pocket Amount:		
Individual	$3,500	$10,500
Family	$10,500	$31,500
The In-Network and Out-of-Network Out of Pocket Amounts are separate amounts and one does not accumulate to the other. Charges in excess of the Allowable Fee do not accumulate to help meet the Out of Pocket Amount.		

Some Benefits may have payment limitations. Refer to the specific Benefit in this Schedule of Benefits for additional information. In addition:

- For Pediatric Dental Services provided by an Out-of-Network provider, Benefits will be provided as if such services were provided by an In-Network provider.
- For Emergency Services provided by an Out-of-Network provider, Benefits will be provided as if such services were provided by an In-Network provider. Nonemergency services for Mental Illness or Substance Use Disorder provided in an emergency setting will be paid the same as Emergency Services.
- Out-of-Network providers may bill the Member the difference between the Allowable Fee and the provider's charge, in addition to any applicable Deductible, Copayment and/or Coinsurance, even if Prior Authorization is obtained for the service, or if treatment is provided for Emergency Services or Pediatric Dental Services.

Term of Member Guide:	Monthly

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Accident		
Professional Provider Services	10%	50%
Facility Services	10%	50%
Acupuncture	10%	50%
Maximum Per Benefit Period – 12 Visits		
Ambulance	10%	10%
Autism Spectrum Disorders	10%	50%
Services, except medications/prescription drugs and Applied Behavior Analysis (ABA) services that are described in the Benefit section entitled Autism Spectrum Disorders are covered under medical Benefits.		
Medications/prescription drugs are covered under Prescription Drugs.		
Benefits for Autism Spectrum Disorders are not subject to any applicable Physical, Occupational or Speech Therapy visit maximum.		
Birthing Centers	10%	50%
Breast Examinations		
Preventive	Deductible, Copayment and/or Coinsurance Do Not Apply	50%*
Medical	After Deductible, Copayment and/or Coinsurance Do Not Apply	
*Deductible, Copayment and/or Coinsurance do not apply to the payment of the first $70 for preventive mammograms provided by an Out-of-Network provider.		
Chiropractic Services	10%	50%
Maximum Per Benefit Period for Chiropractic Manipulations – 10 Visits		
Convalescent Home Services	10%	50%
Maximum Per Benefit Period – 60 Days		
Diabetic Education Benefit		
The Deductible, Copayment and/or Coinsurance do not apply to the payment of the first $250. After the payment of $250, Deductible, Copayment and/or Coinsurance will apply.		
First $250	Deductible, Copayment and/or Coinsurance Do Not Apply	
After the first $250 in payment	10%	50%
Diagnostic Services		
Imaging Services		
Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET Scan)		
Professional Provider Services	10%	50%
Facility Services	10%	50%
All Other Covered Diagnostic Services		
Professional Provider Services	10%	50%
Facility Services	10%	50%
After Deductible, Copayment and/or Coinsurance do not apply to Diagnostic or Supplemental Breast Examinations. Please refer to the Breast Examination Benefit.		
Durable Medical Equipment		
Rental (up to Purchase Price), Purchase, Repair and Replacement of Durable Medical Equipment	10%	50%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Education Services		
Professional Provider Services	10%	50%
Facility Services	10%	50%
Emergency Room Care	10%*	10%*
*Nonemergency Mental Illness and Substance Use Disorder services provided by an In-Network provider or an Out-of-Network provider pay as Emergency Room Care.		
Emergency Room Care not related to an Emergency Medical Condition, accidental Injury, Mental Illness or Substance Use Disorder	10%	50%
Hearing Coverage for Dependent Children Under Age 19 Maximum one Amplification Device per ear every 3 years or as required by an audiologist.	10%	50%
Home Health Care Maximum Per Benefit Period – 180 Visits	10%	50%
Hospice Care		
Professional Provider Services	10%	50%
Facility Services	10%	50%
Hospital		
Professional Provider Services (when the professional provider is employed by the Hospital)		
Outpatient	10%	50%
Inpatient	10%	50%
Facility Services		
Outpatient	10%	50%
Inpatient	10%	50%
Maternity Services		
Professional Provider Services		
Outpatient	10%	50%
Inpatient	10%	50%
Facility Services		
Outpatient	10%	50%
Inpatient	10%	50%
Medical Supplies	10%	50%
Mental Health		
Professional Provider Services		
Outpatient	10%	50%
Inpatient	10%	50%
Facility Services		
Outpatient	10%	50%
Inpatient	10%	50%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Newborn Initial Care		
Professional Provider Services	10%	50%
Facility Services	10%	50%
Office Visit		
Primary Care Provider (PCP)	10%*	50%
Specialist	10%*	50%
*Deductible, Copayment and/or Coinsurance do not apply to In-Network Preventive Health Care services. Refer to the section entitled Preventive Health Care.		
Orthopedic Devices/Orthotic Devices	10%	50%
Other Facility Services – Inpatient and Outpatient	10%	50%
Pediatric Dental Care (for Members under 19 years of age)	30%	30%
Deductible and Coinsurance do not apply to fluoride treatments which are a Benefit for Members under age 19.		
Pediatric Orthodontic Services	30%	30%
Coverage limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria (e.g., severe, dysfunctional malocclusion) established by The Plan.		
Pediatric Vision Care (for Members under 19 years of age)		
Routine Exam	Deductible, Copayment and/or Coinsurance Do Not Apply	
Maximum Per Benefit Period – 1 Exam		
Frames and Lenses	10%	50%
Maximum Per Benefit Period – 1 Pair of Glasses or 1 Pair of Contact Lenses		
Physician Medical Services (Other than the Office Visit)	10%	50%
Prescription Drugs		
Refer to the last page of this Schedule of Benefits.		
Preventive Health Care		
Preventive Services	Deductible, Copayment and/or Coinsurance Do Not Apply	50%
Prostheses Benefit		
Rental (up to Purchase Price), Purchase, Repair and Replacement of Prosthetics	10%	50%
Rehabilitation Therapy		
Professional Provider Services		
Outpatient	10%	50%
Inpatient	10%	50%
Facility Services		
Outpatient	10%	50%
Inpatient	10%	50%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	IN-NETWORK COPAYMENT/ COINSURANCE	OUT-OF-NETWORK COPAYMENT/ COINSURANCE
Substance Use Disorder		
Professional Provider Services		
Outpatient	10%	50%
Inpatient	10%	50%
Facility Services		
Outpatient	10%	50%
Inpatient	10%	50%
Surgery Center Services – Outpatient		
Professional Provider Services	10%	50%
Facility Services	10%	50%
Telehealth		
Primary Care Provider (PCP)	10%	50%
Specialist	10%	50%
Therapies – Outpatient		
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy		
Professional Provider Services	10%	50%
Facility Services	10%	50%
Refer to the Autism Spectrum Disorders section for information on autism spectrum disorder therapies.		
Transplants		
Professional Provider Services		
Outpatient	10%	50%
Inpatient	10%	50%
Facility Services		
Outpatient	10%	50%
Inpatient	10%	50%
Urgent Care *Deductible, Copayment and/or Coinsurance do not apply to In-Network Preventive Health Care services. Refer to the section entitled Preventive Health Care.	10%*	10%
Virtual Visits – MDLIVE Providers Only	10%	Not a Benefit
Well-Child Care Services	Deductible, Copayment and/or Coinsurance Do Not Apply	50%, No Deductible

SCHEDULE OF BENEFITS, continued

PRESCRIPTION DRUG INFORMATION	DEDUCTIBLE	COPAYMENT/ COINSURANCE
Prescription Drugs (The Prescription Drugs Benefit utilizes a Drug List.) Any Deductible, Copayment and/or Coinsurance do not apply to certain contraceptive products. Refer to the Preventive Health Care Benefit. Any Deductible, Copayment and/or Coinsurance also do not apply to prescription smoking cessation products and over-the-counter smoking cessation aids/medications, for two 90-day treatment regimens.		
Deductible	Applies	
Retail Value Participating Pharmacy Prescriptions		
Copayments and/or Coinsurance for a 30-day supply are:		
Tier 1		10%
Tier 2		10%
Tier 3		20%
Tier 4		30%
Retail Participating Pharmacy Prescriptions		
Copayments and/or Coinsurance for a 30-day supply are:		
Tier 1		20%
Tier 2		20%
Tier 3		30%
Tier 4		40%
Retail Nonparticipating Pharmacy (Out-of-Network) Prescriptions		
Copayments and/or Coinsurance for a 30-day supply are:		
Tier 1		20%
Tier 2		20%
Tier 3		30%
Tier 4		40%
Mail Service Maintenance Prescriptions		
Copayments and/or Coinsurance for up to a 90-day supply are:		
Tier 1		10%
Tier 2		10%
Tier 3		20%
Tier 4		30%
Retail Value Participating Pharmacy Prescriptions		
Copayments and/or Coinsurance for up to a 90-day supply are:		
Tier 1		10%
Tier 2		10%
Tier 3		20%
Tier 4		30%
Specialty Medications purchased at participating Specialty Pharmacies in the Blue Cross and Blue Shield of Montana Specialty Network		
(30-day supply) Tier 5		40%
Tier 6		50%
A covered insulin drug, regardless of the amount or type that is prescribed, will not exceed a $25 Copayment for a 30-day supply.		
Preventive Medications	Does Not Apply	
In-Network Retail Value Participating Pharmacy and Retail Participating Pharmacy Prescriptions		
Copayments and/or Coinsurance for a 30-day supply are:		None
In-Network Retail Value Participating Pharmacy and Retail Participating Pharmacy Mail Service Maintenance Prescriptions		
Copayments and/or Coinsurance for up to a 90-day supply are:		None

Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

The Member must pay the difference between a Brand-Name Drug and the Generic Drug equivalent in addition to the Copayment and/or Coinsurance if the Member chooses a Brand-Name Drug when a Generic Drug equivalent is available. Please refer to Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefits section of this Member Guide for additional information.

Payment for Prescription Drug Products purchased at an Out-of-Network Pharmacy will be reduced by 50%, in addition to any Copayment and/or Coinsurance.

Deductible and Out of Pocket

- In-Network: In-Network Pharmacy claims apply to the In-Network Deductible (if applicable). Deductible (if applicable), Copayment and/or Coinsurance amounts paid at an In-Network Pharmacy would only apply to the In-Network Out of Pocket Amount.
- Out-of-Network: Pharmacy claims from an Out-of-Network Pharmacy apply to the Out-of-Network Deductible (if applicable). Deductible (if applicable), Copayment and/or Coinsurance amounts paid at an Out-of-Network Pharmacy would only apply to the Out-of-Network Out of Pocket Amount. Any amount the Member pays for the 50% Benefit reduction when prescription drugs are purchased at an Out-of-Network Pharmacy will not apply to any applicable Deductible and/or Out of Pocket Amounts.

PROVIDERS OF CARE FOR MEMBERS

The participation or nonparticipation of providers from whom a Member receives services, supplies, and medication impacts the amount The Plan will pay and the Member's responsibility for payment. Professional providers and facility providers are either In-Network or Out-of-Network providers. In-Network providers include Participating Providers and Preferred Provider Organization (PPO) providers. Out-of-Network providers are nonparticipating and non-PPO providers.

In-Network and Out-of-Network Professional Providers and Facility Providers

Professional providers include, but are not limited to, Physicians, doctors of osteopathy, Dentists, optometrists, podiatrists, audiologists, Advanced Practice Registered Nurses, physician assistants, naturopathic physicians, chiropractors, acupuncturists and physical therapists.

Facility providers include, but are not limited to, Hospitals, Rehabilitation Facilities, Home Health Agencies, Convalescent Homes, skilled nursing facilities, freestanding facilities for the treatment of Substance Use Disorder or Mental Illness, and freestanding surgical facilities (surgery center).

The Member may obtain a list of Participating Providers from Blue Cross and Blue Shield of Montana free of charge by contacting The Plan at the number listed on the inside cover of this Member Guide.

PPO Providers

Blue Cross and Blue Shield of Montana has a PPO Network of Hospitals and surgery centers in Montana that is utilized under this Benefit Plan. Outside of the state of Montana, there are also Blue Cross and/or Blue Shield PPO Hospitals and surgery centers nationwide. The Member receives the In-Network Benefit when utilizing the PPO Network or the nationwide Blue Cross and/or Blue Shield PPO Hospitals and surgery centers. If the Member obtains services or supplies from a non-PPO Network provider, the Out-of-Network Deductible, Coinsurance and Out of Pocket Amount will apply as indicated on the Schedule of Benefits.

The exceptions to the Benefit reduction are:

1. Emergency Services;
2. Nonemergency services for the treatment of Mental Illness and/or Substance Use Disorder provided in an emergency setting; and/or
3. Services that are unavailable within the PPO Network.

If a Member receives services from an out-of-state provider, then services must be provided by:

1. Blue Cross and/or Blue Shield PPO facility providers; and/or
2. Blue Cross and/or Blue Shield participating professional providers* or PPO professional providers.

*Some Blue Cross and/or Blue Shield Plans require services to be provided by a PPO professional provider for the Member to receive the highest level of Benefits. Contact The Plan for additional information on out-of-state services.

Emergency Services and services that are unavailable within the PPO Network will be covered as In-Network. **However, any nonparticipating provider or non-PPO provider can bill the Member for the difference between payment by Blue Cross and Blue Shield and provider charges plus Deductible, Copayment and/or Coinsurance even if Prior Authorization was obtained for such services.** The Member will be responsible for the balance of the nonparticipating provider's or non-PPO provider's charges after payment by Blue Cross and Blue Shield and payment by the Member of any Deductible, Copayment and/or Coinsurance.

Out of PPO Network Referrals

There may be circumstances under which the most appropriate treatment for the Member's condition is not available through the PPO Network. When this occurs, it is recommended that the Member's attending Physician contact The Plan for an out of PPO Network referral. If the referral is not approved, and the Member chooses to obtain services from a non-PPO Network provider, the Member will be responsible for the Out-of-Network Deductible and Coinsurance, in addition to any difference between the Blue Cross and Blue Shield of Montana Allowable Fee and the provider's billed charges.

If The Plan approves the referral, those services will process with the In-Network Deductible, Copayment and/or Coinsurance. However, any nonparticipating provider or non-PPO provider can bill the Member for the difference between payment by Blue Cross and Blue Shield and provider charges plus any Deductible, Copayment and/or Coinsurance even if The Plan approves the referral.

How Providers are Paid by The Plan and Member Responsibility

Payment by The Plan for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield of Montana provider network.

An **In-Network provider** agrees to accept payment of the Allowable Fee from Blue Cross and Blue Shield of Montana for Covered Medical Expenses, together with any Deductible, Copayment and/or Coinsurance from the Member, as payment in full. Generally, The Plan will pay the Allowable Fee for a Covered Medical Expense directly to the Participating Provider or PPO provider. In any event, The Plan may, in its discretion, make payment to the Member, the provider, the Member and provider jointly, or any person, firm, or corporation who paid for the services on the Member's behalf.

Out-of-Network providers do not have to accept Blue Cross and Blue Shield payment as payment in full. Payment to a nonparticipating provider or a non-PPO provider for Covered Medical Expenses is based on the Allowable Fee. The nonparticipating provider or a non-PPO provider can bill the Member for the difference between payment by Blue Cross and Blue Shield and provider charges plus Deductible, Copayment and/or Coinsurance. The Member will be responsible for the balance of the nonparticipating provider's or a non-PPO provider's charges after payment by Blue Cross and Blue Shield and payment of any Deductible, Copayment and/or Coinsurance.

How Providers are Paid by The Plan and Member Responsibility Outside of Montana

Payment by The Plan for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield provider network in the state where services are provided.

An **In-Network provider** agrees to accept payment of the Allowable Fee from Blue Cross and Blue Shield for Covered Medical Expenses, together with any Deductible, Copayment and/or Coinsurance from the Member, as payment in full. Generally, The Plan will pay the Allowable Fee for a Covered Medical Expense directly to the Participating Provider or PPO provider. In any event, The Plan may, in its discretion, make payment to the Member, the provider, the Member and provider jointly, or any person, firm, or corporation who paid for the services on the Member's behalf.

Out-of-Network providers do not have to accept Blue Cross and Blue Shield payment as payment in full. Payment to a nonparticipating provider or a non-PPO provider for Covered Medical Expenses is based on the Allowable Fee. The nonparticipating provider or a non-PPO provider can bill the Member for the difference between payment by Blue Cross and Blue Shield and provider charges plus Deductible, Copayment and/or Coinsurance. The Member will be responsible for the balance of the nonparticipating provider's or a non-PPO provider's charges after payment by Blue Cross and Blue Shield and payment of any Deductible, Copayment and/or Coinsurance.

Pretreatment Estimate of Dental Benefits and Treatment Plan

If the Member's Dentist recommends a Course of Treatment that will cost more than $300, the Dentist should prepare a claim form describing the planned treatment (called a "treatment plan"), copies of necessary x-rays, photographs and models and an estimate of the charges prior to beginning the Course of Treatment. The Plan will review the report and materials, taking into consideration any alternative adequate Course of Treatment, and will notify the Member and the Dentist of the estimated Benefits which will be provided under this Member Guide. This is not a guarantee of payment, but an estimate of the Benefits available for the proposed services to be rendered. The Plan's Pretreatment Estimates of Benefits are valid for 180 days, provided all eligibility and Member Guide requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, the Member is responsible for asking the Dentist to submit another request and treatment plan, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by The Plan.

For Prescription Drug Products, the Member will be responsible for paying the specific Copayment and/or Coinsurance as described in the Prescription Drugs section.

The Plan will not pay for any services, supplies or medications which are not a Covered Medical Expense, or for which a Benefit maximum has been met, regardless of whether provided by a Participating Provider or a nonparticipating provider. The Member will be responsible for all charges for such services, supplies, or medications.

MEMBERS RIGHTS AND RESPONSIBILITIES

A Member has the right to:

1. Receive information about The Plan, the quality assurance program, the Member's health Benefit Plan, the names of participating health care providers, and the Member's rights and responsibilities.
2. Be treated with respect and recognition of the Member's dignity and right to privacy.
3. Have a candid discussion of appropriate or Medically Necessary treatment options for the Member's condition, regardless of cost or Benefit coverage.
4. Participate with health care providers in decision-making regarding the Member's health care.
5. Voice complaints or appeals about the managed care organization, health care providers or the care provided.
6. Talk to the Member's health care provider and expect that the Member's records and conversations are kept confidential.
7. When requested by the insured or the insured's agent, Montana law requires Blue Cross and Blue Shield of Montana to provide a summary of a Member's coverage for a specific health care service or Course of Treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or Hospital exceeds $500.

A Member has the responsibility to:

1. Provide, to the extent possible, information that The Plan and health care providers need in order to care for the Member.
2. Follow the treatment plans and instruction for care the Member has agreed upon with the Member's health care providers.

OUT-OF-AREA SERVICES – THE BLUECARD PROGRAM

Out-of-Area Services

Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever a Member receives healthcare services outside of the Blue Cross and Blue Shield of Montana service area, the claims for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When a Member receives care outside of the Blue Cross and Blue Shield of Montana service area, the Member will receive care from one of two kinds of providers. Most providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. Blue Cross and Blue Shield of Montana explains below how we pay both kinds of providers.

1. **BlueCard® Program**

   Under the BlueCard® Program, when a Member receives Covered Medical Expenses within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Montana will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   For inpatient facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the provider, and the Member will be held harmless for the provider sanction.

When the Member receives Covered Medical Expenses outside the Blue Cross and Blue Shield of Montana service area and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Medical Expenses is calculated based on the lower of:

a. The billed covered charges for the Member's Covered Medical Expenses; or
b. The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Montana.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield of Montana uses for the Member's claim because they will not be applied after a claim has already been paid.

In some cases, Blue Cross and Blue Shield of Montana may, but is not required to, negotiate a payment with a nonparticipating healthcare provider on an exception basis.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, Blue Cross and Blue Shield of Montana will include any such surcharge, tax or other fee as part of the claim charge passed on to the Member.

2. Nonparticipating Healthcare Providers Outside of the Blue Cross and Blue Shield of Montana Service Area

a. Member Liability Calculation

When the Member incurs Covered Medical Expenses outside of the Blue Cross and Blue Shield of Montana service area for services provided by nonparticipating healthcare providers, the amount the Member pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the nonparticipating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the Covered Medical Expenses as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network Emergency Services.

b. Exceptions

In certain situations, Blue Cross and Blue Shield of Montana may use other payment bases, such as (i) the provider's billed charges for Covered Medical Expenses, (ii) the payment Blue Cross and Blue Shield of Montana would make if the Covered Medical Expenses had been obtained within the Blue Cross and Blue Shield of Montana service area, (iii) a special negotiated payment, or (iv) the lesser of any of the foregoing payment methods or the Allowable Fee determined for nonparticipating providers outside of Montana to pay for services provided by nonparticipating healthcare providers. In these situations, the Member may be liable for any difference between the amount that the nonparticipating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the Covered Medical Expenses as set forth in this paragraph.

3. Blue Cross Blue Shield Global Core

If the Member is outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, the Member may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Medical Expenses. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists the Member with accessing a network of inpatient, Outpatient and professional providers, the network is not served by a Host Blue. As such, when the Member receives care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin

Islands, the Member will typically have to pay the providers and submit the claims himself/herself to obtain reimbursement for these services.

If the Member needs medical assistance services (including locating a doctor or Hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter "BlueCard service area"), the Member should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

Benefits will not be provided for any services or supplies except for those provided for an Emergency Medical Condition and received through the Inter-Plan Arrangements, which includes the BlueCard Program.

a. Inpatient Services

In most cases, if the Member contacts the service center for assistance, Hospitals will not require the Member to pay for covered inpatient services, except for the cost-share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Member's claims to the service center to begin claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Medical Expenses.

The Member must contact Blue Cross and Blue Shield of Montana to obtain Prior Authorization to verify that inpatient services are for the treatment of an Emergency Medical Condition.

b. Outpatient Services

Outpatient Services are available for the treatment of an Emergency Medical Condition. Physicians, Urgent Care centers and other Outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require the Member to pay in full at the time of service. The Member must submit a claim to obtain reimbursement for Covered Medical Expenses.

c. Submitting a Blue Cross Blue Shield Global Core Claim

When the Member pays for Covered Medical Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, the Member should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the Member's claim. The claim form is available from Blue Cross and Blue Shield of Montana, the service center or online at www.bcbsglobalcore.com. If the Member needs assistance with the Member claim submission, the Member should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

COMPLAINTS AND GRIEVANCES

Complaints and Grievances

The Plan has established a Complaint and Grievance process. A complaint involves a communication from the Member expressing dissatisfaction about The Plan's services or lack of action or disagreement with The Plan's response. A grievance will typically involve a complaint about a provider or a provider's office and may include complaints about a provider's lack of availability or quality of care or services received from a provider's staff.

Most problems can be handled by calling Customer Service at the number appearing on the inside cover of this Member Guide. The Member may also file a written complaint or grievance with The Plan. The fax number, email address, and mailing address of The Plan appears on the inside cover of this Member Guide. Written complaints or grievances will be acknowledged within 3 days of receipt. The Member will be notified of The Plan's response within 60 days from receipt of the Member's written complaint or grievance.

APPEALS

Claims Procedures

Types of Claims

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

1. **Pre-Service Claims**

   A pre-service claim is any claim for a Benefit that, under the terms of this Member Guide, requires authorization or approval from The Plan or The Plan's subcontracted administrator prior to receiving the Benefit.

2. **Urgent Care Claims**

   An Urgent Care claim is any pre-service claim where a delay in the review and adjudication of the claim could seriously jeopardize the Member's life or health or ability to regain maximum function or subject the Member to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

3. **Post-Service Claims**

   A post-service claim is any claim for payment filed after a Benefit has been received and any other claim that is not a pre-service claim.

4. **Rescission Claims**

   A rescission of coverage is considered a special type of claim. A rescission is defined as any cancellation or discontinuation of coverage that has a retroactive effect and is based upon the Member's fraud or an intentional misrepresentation of a material fact. A cancellation or discontinuance of coverage that has a retroactive effect is not a rescission if and to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage, or to routine changes such as eligibility updates. A cancellation or discontinuance with a prospective effect only is not a rescission.

5. **Concurrent Care Claim**

   A Concurrent Care decision represents a decision of The Plan approving an ongoing course of medical treatment for the Member to be provided over a period of time or for a specific number of treatments. A Concurrent Care claim is any claim that relates to the ongoing course of medical or emergency treatment (and the basis of the approved Concurrent Care decision), such as a request by the Member for an extension of the number of treatments or the termination by The Plan of the previously approved time period for medical treatment.

Initial Claim Determination by Type of Claim

1. **Pre-Service Claim Determination and Notice**

   a. Notice of Determination

      Upon receipt of a pre-service claim, The Plan will provide timely notice of the initial claim determination once sufficient information is received to make an initial determination, but no later than 7 days after receiving the claim.

   b. Notice of Extension

      1. For reasons beyond the control of The Plan

         The Plan may extend the 7-day time period for an additional 7 days for reasons beyond The Plan's control. The Plan will notify the Member in writing of the circumstances requiring an extension and the date by which The Plan expects to render a decision.

      2. For receipt of information from the Member to decide the claim

         If the extension is necessary due to the Member's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the Member will be

given 45 days from receipt of the notice within which to provide the specified information. The Plan will notify the Member of the initial claim determination no later than 7 days after the earlier of the date The Plan receives the specific information requested or the due date for the requested information.

c. Notice of Improperly Submitted Claim

If a pre-service claim request was not properly submitted, The Plan will notify the Member about the improper submission as soon as practicable, but no later than 3 days after The Plan's receipt of the claim and will advise the Member of the proper procedures to be followed for filing a pre-service claim.

2. Urgent Care Claim Determination and Notice

a. Designation of Claim

Upon receipt of a pre-service claim, The Plan will make a determination if the claim involves Urgent Care. If a Physician with knowledge of the Member's medical condition determines the claim involves Urgent Care, The Plan will treat the claim as an Urgent Care claim.

b. Notice of Determination

If the claim is treated as an Urgent Care claim, The Plan will provide the Member with notice of the determination, either verbally or in writing, as soon as possible consistent with the Member's medical exigencies but no later than 72 hours from The Plan's receipt of the claim. If verbal notice is provided, The Plan will provide a written notice within 3 days after the date The Plan notified the Member.

c. Notice of Incomplete or Improperly Submitted Claim

If an Urgent Care claim is incomplete or was not properly submitted, The Plan will notify the Member about the incomplete or improper submission no later than 24 hours from The Plan's receipt of the claim. The Member will have at least 48 hours to provide the necessary information. The Plan will notify the Member of the initial claim determination no later than 48 hours after the earlier of the date The Plan receives the specific information requested or the due date for the requested information.

3. Post-Service Claim Determination and Notice

a. Notice of Determination

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

b. Notice of Extension

1. For reasons beyond the control of The Plan

The Plan may extend the 30-day timeframe for an additional 15-day period for reasons beyond The Plan's control. The Plan will notify the Member in writing of the circumstances requiring an extension and the date by which The Plan expects to render a decision in such case.

2. For receipt of information from the Member to decide the claim

If the extension is necessary due to the Member's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed. The Member will be given 45 days from receipt of the notice to provide the information. The Plan will notify the Member of the initial claim determination no later than 15 days after the earlier of the date The Plan receives the specific information requested, or the due date for the information.

4. Concurrent Care Determination and Time Frame for Decision and Notice

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

1. In response to the Member's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Member's claim involves Urgent Care, The Plan will review the claim and notify the Member of its determination no later than 24 hours from the date The Plan received the Member's claim, provided the Member's claim was filed at least 24 hours prior to the end of the approved time period or number of treatments.

2. If the Member's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Member's claim will be treated as and decided within the timeframes for an Urgent Care claim as described in the section entitled Initial Claim Determination by Type of Claim.
3. If the Member's claim did not involve Urgent Care, the time periods for deciding pre-service claims and post-service claims, as applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

Other than through a Plan amendment or termination, The Plan may not subsequently reduce or terminate an ongoing Course of Treatment for which the Member has received prior approval unless The Plan provides the Member with written notice of the reduction or termination and the scheduled date of its occurrence sufficiently in advance to allow the Member to appeal the determination and obtain a decision before the reduction or termination occurs.

5. Rescission of Coverage Determination and Notice of Intent to Rescind

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

a. The specific reason(s) for the rescission that show the fraud or intentional misrepresentation of a material fact;
b. The date when the notice period ends and the date to which coverage is to be retroactively rescinded;
c. A statement that the Member will have the right to appeal any final decision of The Plan to rescind coverage prior to or after the thirty (30) day period, and a description of The Plan's appeal procedures;
d. A reference to The Plan provision(s) on which the rescission is based; and/or
e. A statement that the Member is entitled to receive upon request and free of charge reasonable access to, and copies of all documents and records and other information relevant to the rescission.

Notice of an Adverse Benefit Determination

An "adverse benefit determination" is defined as a rescission or a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Benefit. If The Plan's determination constitutes an adverse benefit determination, the notice to the Member will include:

1. Information sufficient to identify the Benefit or claim involved, including, if applicable, the date of service, the health care provider, and the claim amount;
2. The reason(s) for the adverse benefit determination. If the adverse benefit determination is a rescission, the notice will include the basis for the fraud and/or intentional misrepresentation of a material fact;
3. A reference to the applicable Member Guide provision(s), including identification of any standard relied upon in The Plan to deny the claim (such as a Medical Necessity standard), on which the adverse benefit determination is based;
4. A description of The Plan's internal appeal and external review procedures (and for Urgent Care claims only, a description of the expedited review process applicable to such claims), a description of and contact information for a consumer appeal assistance program, and if applicable, a statement of the Member's right to file a civil action under Section 502(a) of ERISA;
5. If applicable, a description of any additional information necessary to complete the claim and why the information is necessary;
6. If applicable, a statement that any internal Medical Policy or guideline or other medical information relied upon in making the adverse benefit determination, and an explanation for the same, will be provided, upon request and free of charge;
7. If applicable, a statement that an explanation for any adverse benefit determination that is based on an experimental treatment or similar Exclusion or limitation or a Medical Necessity standard will be provided, upon request and free of charge;
8. If applicable, a statement that diagnosis and treatment codes will be provided, and their corresponding meanings, upon request and free of charge; and
9. A statement that reasonable access to and copies of all documents and records and other information relevant to the adverse benefit determination will be provided, upon request and free of charge.

How to File an Internal Appeal of an Adverse Benefit Determination

1. Time for Filing an Internal Appeal of an Adverse Benefit Determination

If the Member disagrees with an adverse benefit determination (including a rescission), the Member may appeal the determination within 180 days from receipt of the adverse benefit determination. With the exception of Urgent Care claims, The Member's appeal may be made verbally or in writing, should list the reasons why the Member does not agree with the adverse benefit determination, and must be sent to the address or fax number listed for appeals on the inside cover of this Member Guide. If the Member is appealing an Urgent Care claim, the Member may appeal the claim verbally by calling the telephone number listed for Urgent Care appeals on the inside cover of this Member Guide.

For additional assistance with an appeal, a Member may also contact the Commissioner of Securities and Insurance at: Montana Commissioner of Securities and Insurance, 840 Helena Ave., Helena, MT 59601 or call 1-800-332-6148 or 1-406-444-2040.

2. Access to Plan Documents

The Member may at any time during the filing period, receive reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination upon request and free of charge. Documents may be viewed at The Plan's office, at 3645 Alice Street, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m. Mountain Time, Monday through Friday, excluding holidays. The Member may also request that Blue Cross and Blue Shield of Montana mail copies of all documentation to the Member free of charge.

3. Submission of Information and Documents

The Member may present written evidence and testimony, including any new or additional records, documents or other information that are relevant to the claim for consideration by The Plan until a final determination of the Member's appeal has been made.

4. Consideration of Comments

The review of the claim on appeal will take into account all evidence, testimony, new and additional records, documents, or other information the Member submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial adverse benefit determination.

If The Plan considers, relies on or generates new or additional evidence in connection with its review of the Member's claim, The Plan will provide the Member with the new or additional evidence free of charge as soon as possible and with sufficient time to respond before a final determination is required to be provided by The Plan. If The Plan relies on a new or additional rationale in denying the Member's claim on review, The Plan will provide the Member with the new or additional rationale as soon as possible and with sufficient time to respond before a final determination is required to be provided by The Plan.

5. Scope of Review

The person who reviews and decides the Member's appeal will be a different individual than the person who decided the initial adverse benefit determination. The review on appeal will not give deference to the initial adverse benefit determination and will be made anew. The Plan will not make any decision regarding hiring, compensation, termination, promotion or other similar matters with respect to the individual selected to conduct the review on appeal based upon how the individual will decide the appeal.

6. Consultation with Medical Professionals

If the claim is, in whole or in part, based on medical judgment, The Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not have been involved in the initial adverse benefit determination. The Member may request information regarding the identity of any health care professional whose advice was obtained during the review of the Member's claim.

Time Period for Notifying Member of Final Internal Adverse Benefit Determination

The time period for deciding an appeal of an adverse benefit determination and notifying the Member of the final internal adverse benefit determination depends upon the type of claim. The chart below provides the time period in which The Plan will notify the Member of its final internal adverse benefit determination for each type of claim.

Type of Claim on Appeal	Time Period for Notification of Final Internal Adverse Benefit Determination
Urgent Care Claim	No later than 72 hours from the date The Plan received the Member's appeal, taking into account the medical exigency.
Pre-Service Claim	No later than 30 days from the date The Plan received the Member's appeal.
Post-Service Claim	No later than 60 days from the date The Plan received the Member's appeal.
Concurrent Care Claim	• If the Member's claim involved Urgent Care, no later than 72 hours from the date The Plan received the Member's appeal, taking into account the medical exigency. • If the Member's claim did not involve Urgent Care, the time period for deciding a pre-service (non-urgent care) claim or a post-service claim, as applicable, will govern.
Rescission Claim	No later than 60 days from the date The Plan received the Member's appeal.

Content of Notice of Final Internal Adverse Benefit Determination

If the decision on appeal upholds, in whole or in part, the initial adverse benefit determination, the final internal adverse benefit determination notice will include the following information:

1. Information sufficient to identify the claim involved in the appeal, including, as applicable, the date of service, the health care provider, and the claim amount;
2. The title and qualifying credentials of each health care professional participating in the appeal;
3. A statement from each health care professional participating in the appeal of their understanding of the basis for the Member's appeal;
4. The specific reason(s) for the final internal adverse benefit determination, including a discussion of the decision. If the final internal adverse benefit determination upholds a rescission, the notice will include the basis for the fraud or intentional misrepresentation of a material fact;
5. A reference to the applicable Member Guide provision(s), including identification of any standard relied upon in The Plan to deny the claim (such as a Medical Necessity standard), on which the final internal adverse benefit determination is based;
6. If applicable, a statement describing the Member's right to request an external review and the time limits for requesting an external review;
7. If applicable, a statement that any internal Medical Policy or guideline or medical information relied on in making the final internal adverse benefit determination will be provided, upon request and free of charge;
8. If applicable, an explanation of the scientific or clinical judgment for any final internal adverse benefit determination that is based on a Medical Necessity or an experimental treatment or similar Exclusion or limitation as applied to the Member's medical circumstances;
9. If applicable, a statement that diagnosis and treatment codes will be provided, with their corresponding meanings, upon request and free of charge;
10. A description of and contact information for a consumer appeal assistance program and a statement of the Member's right to file a civil action under Section 502(a) of ERISA; and
11. A statement that reasonable access to and copies of all documents and records and other information relevant to the final internal adverse benefit determination will be provided, upon request and free of charge.

External Review Procedures – In General

In most cases, and except as provided in the next two sections, the Member must follow and exhaust the internal appeals process outlined above before the Member may submit a request for external review. In addition, external review is limited to only those adverse benefit determinations that involve:

1. Rescissions of coverage; and

2. Medical judgment, including those adverse benefit determinations that are based on requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or adverse benefit determinations that certain treatments are experimental or investigational.

External review is not available for:

1. Adverse benefit determinations that are based on contractual or legal interpretations without any use of medical judgment; and
2. Adverse benefit determinations that are based on a failure to meet requirements for eligibility under a group health plan.

Standard External Review Procedures

There are two types of external review: a standard external review and an expedited external review. An expedited external review is generally based upon the seriousness of the Member's medical circumstances and entitles the Member to an expedited notice and decision-making process. The procedures for requesting standard (non-expedited) external reviews are discussed in this section. The procedures for requesting expedited external reviews are discussed in the next section.

External reviews (standard or expedited) of adverse benefit determinations or final internal adverse benefit determinations based upon a determination that certain treatments are experimental or investigational are discussed in separate sections, following the section entitled Expedited External Review Procedures, below.

1. Request for a Standard External Review

The Member must submit a written request to The Plan for a standard external review within 4 Months from the date the Member receives an adverse benefit determination or a final internal adverse benefit determination.

2. Preliminary Review

The Plan must complete a preliminary review within 5 business days from receipt of the Member's request for a standard external review to determine whether:

a. The Member is or was covered under The Plan when the health care item or service was requested or, in the case of a retrospective review, whether the Member was covered under The Plan when the health care item or service was provided;
b. The adverse benefit determination or final internal adverse benefit determination relates to the Member's failure to meet The Plan's eligibility requirements;
c. The Member has exhausted (or is not required to exhaust) The Plan's internal appeals process; and/or
d. The Member has provided all the information and forms required to process the external review.

Within 1 day after completing its review, The Plan will notify the Member in writing if the request is eligible for external review. If further information or materials are necessary to complete the review, the written notice will describe the information or materials and the Member will be given the remainder of the 4-Month period or 48 hours after receipt of the written notice, whichever is later, to provide the necessary information or materials. If the request is not eligible for external review, The Plan will outline the reasons for ineligibility in the notice, include a statement informing the Member or the Member's authorized representative of the right to appeal The Plan's determination to the Commissioner of Securities and Insurance and provide the Member with contact information for the U.S. Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)) and contact information for the Commissioner's office.

3. Assignment of an IRO

If the Member's request is eligible for external review, The Plan will within 1 business day assign the request for external review on a random basis or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved IROs compiled and maintained by the Montana Commissioner of Securities and Insurance to conduct the external review. In making the assignment, The Plan will consider whether an IRO is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination. The Plan will also take into account other circumstances, including conflict of interest concerns.

4. Initiation of External Review and Opportunity to Submit Additional Documents

Within 1 business day of assigning the IRO, The Plan will notify the Member or the Member's authorized representative in writing that The Plan has initiated an external review and that the Member or the Member's authorized representative may submit additional information to the IRO within 10 business days following the date of receipt of the notice for the IRO's consideration in its external review. The IRO may accept and consider additional information submitted after the 10 business days.

5. Plan Submission of Documents to the IRO

Within 5 business days after the date the IRO is assigned, The Plan must submit the documents and any information considered in making the benefits denial to the IRO. The Plan's failure to timely provide such documents and information will not constitute cause for delaying the external review. If The Plan fails to timely provide the documents and information, the IRO may terminate the external review and reverse the adverse benefit determination or final internal adverse benefit determination. If the IRO does so, it must notify the Member and The Plan within 1 business day after making the decision.

6. Reconsideration by Plan

On receiving any information submitted by the Member, the IRO must forward the information to The Plan within 1 business day. The Plan may then reconsider its adverse benefit determination or final internal adverse benefit determination. If The Plan decides to reverse its adverse benefit determination or final internal adverse benefit determination, The Plan must provide written notice to the Member and IRO within 1 business day after making the decision. On receiving The Plan's notice, the IRO must terminate its external review.

7. Standard of Review

In reaching its decision, the IRO will review the claim and will not be bound by any decisions or conclusions reached under The Plan's internal claims and appeals process. In addition to the documents and information timely received, and to the extent the information or documents are available, the IRO will consider the following in reaching a decision:

- **a.** The Member's medical records;
- **b.** The Member's treating provider(s)'s recommendations;
- **c.** Reports from appropriate health care professionals and other documents, opinions, and recommendations submitted by The Plan and the Member;
- **d.** The terms and conditions of The Plan, including specific coverage provisions, to ensure that the IRO's decision is not contrary to the terms and conditions of The Plan, unless the terms and conditions do not comply with applicable law;
- **e.** Appropriate practice guidelines, which must include applicable Evidence-Based Standards;
- **f.** Any applicable clinical review criteria developed and used by The Plan unless the criteria are inconsistent with the terms and conditions of The Plan or do not comply with applicable law;
- **g.** The applicable Medical Policies of The Plan; and/or
- **h.** The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider them appropriate.

8. Written Notice of the IRO's Final External Review Decision

The IRO will send written notification of its decision to the Member and to The Plan within 45 days after the IRO's receipt of the request for external review. The notice will include:

- **a.** A general description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;
- **b.** The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
- **c.** References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and Evidence-Based Standards;
- **d.** A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any Evidence-Based Standards relied on in making the decision;

e. A statement that the IRO's determination is binding, unless other remedies are available to The Plan or the Member under state or federal law;

f. A statement that judicial review may be available to the Member and The Plan; and

g. Contact information for a consumer appeal assistance program at the Commissioner of Securities and Insurance.

9. Compliance with IRO Decision

If the IRO reverses The Plan's adverse benefit determination or final internal adverse benefit determination, The Plan will immediately provide coverage or issue payment according to the written terms and Benefits of the Member Guide.

Expedited External Review Procedures

In general, the same rules that apply to standard external review apply to expedited external review, except that the timeframe for decisions and notifications is shorter.

1. Request for Expedited External Review

Under the following circumstances, the Member may request an expedited external review:

a. If the Member received an adverse benefit determination that denied the Member's claim and: 1. the Member filed a request for an internal Urgent Care appeal; and 2. the delay in completing the internal appeal process would seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function; or

b. Upon receipt of a final internal adverse benefit determination which involves: 1. a medical condition of the Member for which a delay in completing the standard external review would seriously jeopardize the Member's life or health or the Member's ability to regain maximum function; or 2. an admission, availability of care, a continued stay, or a health care item or service for which the Member received Emergency Services, but has not been discharged from a facility.

2. Preliminary Review

Upon receiving the Member's request for expedited external review, The Plan will immediately determine whether the request is eligible for external review, considering the same preliminary review requirements set forth in the Preliminary Review paragraph, Standard External Review Procedures section. After the preliminary review is complete, The Plan will immediately notify the Member or the Member's authorized representative in writing of its eligibility determination. If The Plan determines the Member's request is ineligible for review, the notice must include a statement informing the Member or the Member's authorized representative of the right to appeal The Plan's determination to the Commissioner of Securities and Insurance. The notice must also provide contact information for the Commissioner's office.

3. Assignment of an IRO

If a request is eligible for expedited external review, The Plan will assign an IRO pursuant to and in compliance with the independence and other selection requirements set forth in the Assignment of an IRO paragraph, Standard External Review Procedures section. The Plan will transmit all documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO in as expeditious of a manner as possible (including by phone, facsimile, or electronically).

4. Standard of Review

In reaching its decision, the IRO will review the claim and will not be bound by any decisions or conclusions reached under The Plan's internal claims and appeals process. In addition to the documents and information timely received, and to the extent the information or documents are available, the IRO will consider the same documents and information set forth in the Standard of Review paragraph, Standard External Review Procedures section.

5. Notice of Final External Review Decision

The IRO will provide the Member and The Plan with notice of its final external review decision as expeditiously as the Member's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO must provide written confirmation of its

decision to the Member and to The Plan within 48 hours after the date the IRO verbally conveyed the decision. The written notice will include:

- **a.** A description of the reason for the external review request, including information sufficient to identify the claim, and the reason for the prior denial;
- **b.** The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
- **c.** References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and Evidence-Based Standards;
- **d.** A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any Evidence-Based Standards relied on in making the decision;
- **e.** A statement that the IRO's determination is binding, unless other remedies are available to The Plan or the Member under state or federal law;
- **f.** A statement that judicial review may be available to the Member or The Plan; and
- **g.** Contact information for the appropriate consumer appeal assistance program at the Commissioner of Securities and Insurance.

6. Compliance with IRO Decision

If the IRO reverses The Plan's adverse benefit determination or final internal adverse benefit determination, The Plan will immediately approve coverage that was the subject of the adverse benefit determination or final internal adverse benefit determination according to the written terms and Benefits of the Member Guide.

7. Inapplicability of Expedited External Review

An expedited external review may not be provided for retrospective adverse benefit determinations or retrospective final internal adverse benefit determinations.

External Review Procedures – Experimental or Investigational

In most cases, and except as provided in the next two sections, the Member must follow and exhaust the internal appeals process outlined above before the Member or the Member's authorized representative may submit a request for external review. In addition, external review as outlined in the next two sections is limited to only those adverse benefit determinations or final internal adverse benefit determinations that certain treatments are experimental or investigational.

Standard External Review Procedures

There are two types of external review of adverse benefit determinations or final internal adverse benefit determinations that certain treatments are experimental or investigational: a standard external review and an expedited external review. An expedited external review is generally based upon the seriousness of the Member's medical circumstances and entitles the Member to an expedited notice and decision-making process. The procedures for requesting standard (non-expedited) external reviews are discussed in this section. The procedures for requesting expedited external reviews are discussed in the next section.

1. Request for a Standard External Review

The Member or the Member's authorized representative must submit a written request to The Plan for a standard external review within 4 Months from the date the Member or the Member's authorized representative receives an adverse benefit determination or a final internal adverse benefit determination.

2. Preliminary Review

Upon receipt of a request for standard external review, The Plan must complete a preliminary review within 5 business days to determine whether:

- **a.** The Member is or was covered under The Plan when the health care service or treatment was requested or, in the case of a retrospective review, whether the Member was covered under The Plan when the health care service or treatment was provided;
- **b.** The requested health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination: (i) is a covered Benefit under the Member's health plan except for The Plan's determination that the health care service or treatment is experimental or investigational for a particular medical condition; and (ii) is not explicitly listed as an excluded Benefit under the Member's health plan;

c. The Member's treating health care provider has certified that one of the following situations is applicable: (i) standard health care services or treatments have not been effective in improving the condition of the Member; (ii) standard health care services or treatments are not medically appropriate for the Member; or (iii) there is no available standard health care service or treatment covered by The Plan that is more beneficial than the requested health care service or treatment;

d. (i) The Member's treating health care provider has recommended a health care service or treatment that the Physician certifies, in writing, is likely to be more beneficial to the Member, in the Physician's opinion, than any available standard health care services or treatments; or (ii) a Physician who is licensed, board-certified, or eligible to take the examination to become board-certified and is qualified to practice in the area of medicine appropriate to treat the Member's condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the Member who is subject to the adverse benefit determination or final internal adverse benefit determination is likely to be more beneficial to the Member than any available standard health care services or treatments; and

e. The Member has exhausted The Plan's internal appeals process, or the Member is exempt from exhausting The Plan's internal appeals process.

Within 1 business day after completion of the preliminary review, The Plan will notify the Member or the Member's authorized representative in writing as to whether the request is complete, and the request is eligible for external review.

If the request is not complete, The Plan will inform the Member or the Member's authorized representative in writing and include in the notice the information or materials that are needed to make the request complete. If the request is not eligible for external review, The Plan will inform the Member or the Member's authorized representative in writing and include in the notice the reasons for the request's ineligibility. The notice of initial determination will include a statement informing the Member or the Member's authorized representative of the right to appeal the determination of ineligibility to the Commissioner of Securities and Insurance. The notice will also provide contact information for the Commissioner's office.

3. Assignment of an IRO

If the request is eligible for external review, The Plan will within 1 business day assign an IRO on a random basis or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved IROs compiled and maintained by the Commissioner of Securities and Insurance, to conduct the external review. In making the assignment, The Plan will consider whether an IRO is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination and will also take into account other circumstances, including conflict of interest concerns.

Within 1 business day of assigning the IRO, The Plan will notify the Member or the Member's authorized representative in writing that The Plan has initiated an external review and that the Member or the Member's authorized representative may submit additional information to the IRO within 10 business days following the date of receipt of the notice, for the IRO's consideration in its external review. The IRO may accept and consider additional information submitted after the 10 business days.

4. Plan Submission of Documents to the IRO

Within 5 business days after assigning an IRO, The Plan will provide to the assigned IRO any documents and information considered in making the adverse benefit determination or the final internal adverse benefit determination. Failure by The Plan to timely provide the documents and information may not delay the conduct of the external review. If The Plan fails to provide the documents and information within 5 business days, the assigned IRO may terminate the external review and decide to reverse the adverse benefit determination or final internal adverse benefit determination. Immediately upon making such a determination, the IRO will notify the Member or the Member's authorized representative and The Plan of its decision.

5. Reconsideration by The Plan

The IRO will forward any information submitted by Member or the Member's authorized representative to The Plan, within 1 business day of its receipt. The Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by The Plan may not delay or terminate the IRO's external review. The external review may be terminated only if The Plan decides, on completion of its reconsideration, to reverse its adverse benefit determination or final internal

adverse benefit determination and provide coverage for the requested health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination. The Plan will notify the Member or the Member's authorized representative and the IRO immediately in writing of its decision. The IRO will terminate the external review on receipt of the notice from The Plan.

6. Standard of Review

Within 1 business day after the receipt of the notice of assignment to conduct the external review, the assigned IRO will select a Clinical Peer, or multiple Clinical Peers if medically appropriate under the circumstances, to conduct the external review. In selecting Clinical Peers to conduct the external review, the assigned IRO will select Physicians or other health care providers who meet minimum statutorily prescribed qualifications and who, through clinical experience in the past 3 years, are experts in the treatment of the Member's condition and knowledgeable about the recommended or requested health care service or treatment. The choice of the Physicians or other health care providers to conduct the external review may not be made by the Member or the Member's authorized representative or The Plan.

Each Clinical Peer selected pursuant will review and consider all of the information and documents considered by The Plan in making the adverse benefit determination or the final internal Benefit determination and any other information submitted in writing by the Member or the Member's authorized representative.

Within 20 days after selection, each Clinical Peer will provide an opinion to the assigned IRO on whether the requested health care service or treatment should be covered. In reaching an opinion, Clinical Peers are not bound by any decisions or conclusions reached during The Plan's internal appeals process.

Each Clinical Peer's opinion will be in writing and include the following information:

- **a.** A description of the Member's medical condition;
- **b.** A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the requested health care service or treatment is more likely than not to be more beneficial to the Member than any available standard health care services or treatments and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
- **c.** A description and analysis of any Medical or Scientific Evidence considered in reaching the opinion;
- **d.** A description and analysis of any Evidence-Based Standard; and
- **e.** Information on whether the Clinical Peer's rationale for the opinion is based on the Member's medical records and/or the attending provider's or health care professional's recommendation.

7. Written Notice of the IRO's Final External Review Decision

Within 20 days after the date of receiving the opinion of each Clinical Peer, the IRO shall make a decision and provide written notice of the decision to the Member or the Member's authorized representative and to The Plan.

If a majority of the Clinical Peers respond that the recommended or requested health care service or treatment should be covered, the IRO shall make a decision to reverse The Plan's adverse benefit determination or final internal adverse benefit determination. If a majority of the Clinical Peers respond that the recommended or requested health care service or treatment should not be covered, the IRO shall make a decision to uphold The Plan's adverse benefit determination or final internal adverse benefit determination. If the Clinical Peers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the IRO shall obtain the opinion of an additional Clinical Peer. The additional Clinical Peer shall use the same information to reach an opinion as used by the Clinical Peers who have already submitted their opinions. The selection of the additional Clinical may not extend the time within which the assigned IRO is required to make a decision based on the opinions of the Clinical Peers.

The IRO will include in its written notice:

- **a.** A general description of the reason for the request for external review;
- **b.** The written opinion of each Clinical Peer, including the opinion of each Clinical Peer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
- **c.** The date on which the IRO was assigned to conduct the external review;

d. The date of the IRO's decision; and

e. The principal rationale for the IRO's decision.

8. Compliance with IRO Decision

If the IRO reverses The Plan's adverse benefit determination or final internal adverse benefit determination, The Plan shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse benefit determination or final internal adverse benefit determination.

Expedited External Review Procedures

In general, the same rules that apply to standard external review apply to expedited external review, except that requests for external review may be made differently and the timeframe for decisions and notifications is shorter.

1. Request for an Expedited External Review

The Member or the Member's authorized representative may make an oral or written request for an expedited external review of an adverse benefit determination or a final internal adverse benefit determination if the Member's treating health care provider certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

2. Preliminary Review

Upon receipt of a request for an expedited external review, The Plan must immediately complete a preliminary review to determine whether the request is eligible for external review, considering the same preliminary review requirements set forth in the Preliminary Review paragraph, Standard External Review Procedures section, above.

Immediately after completion of the preliminary review, The Plan will notify the Member or the Member's authorized representative in writing as to whether the request is complete, and the request is eligible for external review.

If the request is not complete, The Plan will inform the Member or the Member's authorized representative in writing and include in the notice the information or materials that are needed to make the request complete. If the request is not eligible for external review, The Plan will inform the Member or the Member's authorized representative in writing and include in the notice the reasons for the request's ineligibility. The notice of initial determination will include a statement informing the Member or the Member's authorized representative of the right to appeal the determination of ineligibility to the Commissioner of Securities and Insurance. The notice will also provide contact information for the Commissioner's office.

3. Assignment of an IRO

If the request is eligible for external review, The Plan will immediately assign an IRO on a random basis or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved IROs compiled and maintained by the Commissioner of Securities and Insurance, to conduct the external review. In making the assignment, The Plan will consider whether an IRO is qualified to conduct the particular expedited external review based on the nature of the health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination and will also take into account other circumstances, including conflict of interest concerns.

Within 1 business day after assignment of the IRO, The Plan will notify the Member or the Member's authorized representative, in writing, that The Plan has initiated an external review and that the Member or the Member's authorized representative may submit additional information to the IRO for the IRO's consideration in its external review.

4. Plan Submission of Documents to the IRO

Upon assigning an IRO, The Plan will provide any documents and information considered in making the adverse benefit determination or the final internal adverse benefit determination to the assigned IRO electronically, by telephone, by facsimile, or by any other available expeditious method. Failure by The Plan to provide the documents and information may not delay the conduct of the external review. If The Plan fails to provide the documents and information upon IRO assignment, the assigned IRO may terminate the external review and decide to reverse the adverse benefit determination or final internal adverse benefit determination. Immediately

upon making such a determination, the IRO will notify the Member or the Member's authorized representative and The Plan accordingly.

5. Standard of Review

Within 1 business day after the receipt of the notice of assignment to conduct the external review, the assigned IRO will select a Clinical Peer, or multiple Clinical Peers if medically appropriate under the circumstances, to conduct the external review. The assigned IRO will select Physicians or other health care providers using the same criteria as set forth in the Standard of Review paragraph in the Standard External Review Procedures, above. The choice of the Physicians or other health care providers to conduct the external review may not be made by the Member or the Member's authorized representative or The Plan.

Each Clinical Peer selected pursuant will review and consider all of the information and documents considered by The Plan in making the adverse benefit determination or the final internal Benefit determination and any other information submitted in writing by the Member or the Member's authorized representative.

Each Clinical Peer will provide an opinion to the assigned IRO as expeditiously and the Member's medical condition or circumstances require but no later than 5 calendar days after being selected as a Clinical Peer, on whether the requested health care service or treatment should be covered. If the Clinical Peer's opinion was initially made orally, the Clinical Peer shall provide the IRO written confirmation of the opinion within 48 hours after the opinion was initially made.

In reaching an opinion, Clinical Peers are not bound by any decisions or conclusions reached by The Plan. Each Clinical Peer's opinion may be rendered orally or in writing and will include the same information as set forth in the Standard of Review paragraph in the Standard External Review Procedures section, above.

6. Written Notice of the IRO's Final External Review Decision

Within 48 hours after the date of receiving the opinion of each Clinical Peer, the IRO shall make a decision based upon the recommendations of a majority of the Clinical Peers conducting the review and will provide oral or written notice of the decision to the Member or the Member's authorized representative and to The Plan. If the IRO's notice is provided orally, the IRO will provide written confirmation of the decision within 48 hours of the initial oral notice.

The IRO will include in its written notice:

- **a.** A general description of the reason for the request for external review;
- **b.** The written opinion of each Clinical Peer, including the opinion of each Clinical Peer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
- **c.** The date on which the IRO was assigned to conduct the external review;
- **d.** The date of the IRO's decision; and
- **e.** The principal rationale for the IRO's decision.

7. Compliance with IRO Decision

If the IRO reverses The Plan's adverse benefit determination or final internal adverse benefit determination, The Plan shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse benefit determination or final internal adverse benefit determination.

Deemed Exhaustion of Internal Appeal Process

1. The Member will be deemed to have exhausted the internal appeal process and may request external review or pursue any available remedies under state law or if applicable, a civil action under 502(a) of ERISA, if The Plan fails to comply with its claims and appeals procedures, except that claims and appeals procedures will not be deemed exhausted based on violations that are:

   - **a.** De minimis;
   - **b.** Non-prejudicial to the Member;
   - **c.** Attributable to good cause or matters beyond The Plan's control;
   - **d.** In the context of an ongoing, good faith exchange of information between the Member and The Plan; and
   - **e.** Not reflective of a pattern or practice of violations by The Plan.

2. Upon request of the Member, The Plan will provide an explanation of a violation within 10 days. The explanation will include a description of the basis for The Plan's assertion that the violation does not result in the deemed exhaustion of The Plan's internal claims and appeals procedures.
3. If the Member seeks external or judicial review based on deemed exhaustion of The Plan's internal claims and appeals procedures, and the external reviewer or court rejects the Member's request, The Plan will notify the Member within a reasonable period of time, not to exceed 10 days, of the Member's right to resubmit the Member's internal appeal. The timeframe for appealing the adverse benefit determination begins to run when the Member receives the notice of the right to resubmit the Member's internal appeal.

UTILIZATION MANAGEMENT

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, inpatient admission and length of stay is based on Blue Cross and Blue Shield of Montana Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services being rendered, during the course of care, or after care has been completed as a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity Review. If requested, services normally subject to a Post-Service Medical Necessity Review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Refer to the definition of Medically Necessary in the Definitions section of this Member Guide for additional information regarding any limitations and/or special conditions pertaining to the Member's Benefits.

Prior Authorization

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services described below for which the Member has obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

If Prior Authorization is required, the review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions of this Member Guide. The Plan recommends the Member confirm with the provider if Prior Authorization has been obtained.

To determine if a specific service or category requires Prior Authorization, visit the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.com for the required Prior Authorization list, which is updated when new services are added or when services are removed. The Member can also call Blue Cross and Blue Shield of Montana Customer Service at the number on the back of the Member's identification card.

Prior Authorization Responsibility

Participating Provider (In-Network) Prior Authorization

The Member's Participating Provider is responsible for obtaining Prior Authorization, in those circumstances where authorization may be required. If Prior Authorization is not obtained and the services are denied as not Medically Necessary, the Participating Provider will be held financially responsible and will not be able to bill the Member for the services.

For additional information about Prior Authorization for services outside of the Blue Cross and Blue Shield of Montana service area, see the section entitled, Out-of-Area Services – The BlueCard Program.

NOTE: Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the Prior Authorization requirements of The Plan. Unless a provider contracts directly with The Plan as a Participating Provider, the provider is not responsible for being aware of The Plan's Prior Authorization requirements, except as described in the section entitled Out-of-Area Services - The BlueCard® Program.

Nonparticipating Provider (Out-of-Network) Prior Authorization

If any provider outside of Montana (except for those contracting as Participating Providers directly with The Plan) or any nonparticipating provider recommends an admission or a service that requires Prior Authorization, the provider is

not obligated to obtain the Prior Authorization for the Member. In such cases, it is the Member's responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, the Member may be entirely responsible for the charges if the service is determined to not be Medically Necessary. If the services were determined to be Medically Necessary, Out-of-Network Benefits will apply. The provider may call on the Member's behalf, but it is the Member's responsibility to ensure that The Plan is called.

Inpatient Admissions

The Member's provider will need to obtain Prior Authorization from The Plan for an inpatient admission, if inpatient admissions are identified as needing a Prior Authorization. In the case of an elective inpatient admission, if services require an authorization it is recommended that the call for Prior Authorization should be made at least two working days before the Member is admitted. If the admission is due to an Emergency Medical Condition and obtaining Prior Authorization would delay Emergency Services, it is recommended that Prior Authorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

If Prior Authorization is not obtained for inpatient services and the services are denied as not Medically Necessary, the Participating Provider will be held financially responsible and will not be able to bill the Member for the services.

If the provider is not a network provider then the Member, the Member's provider, or the Member's authorized representative should obtain Prior Authorization by The Plan by calling the toll-free number shown on the back of the Member's identification card. The call should be made between 8:00 a.m. and 5:00 p.m., Mountain Time, on business days. After business hours or on weekends, please call the toll-free number listed on the back of the Member's identification card. The Member's call will be recorded and returned the next business day. A benefits management nurse will follow up with the Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if the Member uses an In-Network provider or In-Network specialty care provider. If the Member elects to use Out-of-Network providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not reasonably available from In-Network providers as defined by applicable law, and The Plan authorizes the Member's visit to an Out-of-Network provider to be covered at the In-Network Benefit level prior to the visit, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When Prior Authorization of an inpatient admission is obtained, a length of stay is assigned. The Member's provider may seek an extension for the additional days if the Member requires a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the Length of Stay/Service Review subsection of this Member Guide.

If The Plan determines that the Member's treatment does not require inpatient level of care, the Member and the Member's provider will be notified of that decision. If the Member proceeds with an inpatient stay without The Plan's approval, the Member may be responsible to pay the full cost of the services received.

If the Member, the Member's provider, or other appropriate party, as identified above, does not request Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Member Guide, the Member may be responsible for the full cost of the services.

For Behavioral Health Inpatient Hospital Admissions please see Contacting Behavioral Health section below.

Prior Authorization not Required for Maternity Care Unless Extension of Minimum Length of Stay Requested

The Plan is required to provide a minimum length of stay in a Hospital facility for the following:

Maternity Care

1. 48 hours following an uncomplicated vaginal delivery; or
2. 96 hours following an uncomplicated delivery by caesarean section.

The Member or the Member's provider will not be required to obtain Prior Authorization from The Plan for a length of stay less than 48 hours (or 96 hours) for Maternity Care. If the Member requires a longer stay, the Member, the Member's authorized representative, or the Member's provider must seek an extension for the additional days by obtaining Prior Authorization from The Plan.

Outpatient Service Prior Authorization Review

There may be general categories of covered Outpatient services that require Prior Authorization.

To determine if a specific service or category requires Prior Authorization, visit the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.com for the required Prior Authorization list, which is updated when new services are added or when services are removed. The Member can also call Customer Service at the number on the back of the Member's identification card.

For Behavioral Health Outpatient Service review please see Contacting Behavioral Health section below.

Prior Authorization Duration

A Prior Authorization is valid for at least three Months from the date the Member's provider receives approval from The Plan. Actual availability of Benefits is subject to eligibility and other terms, conditions and limitations and Exclusions of this Member Guide.

It is NOT necessary to obtain Prior Authorization for standard x-ray and lab services or Routine office visits.

If The Plan does not approve the Outpatient Service, the Member and the Member's provider will be notified of that decision. If the Member proceeds with the services without The Plan's approval, the Member may be responsible to pay the full cost of the services received.

If the Member, the Member's provider, or other appropriate party, as identified above, does not request Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Member Guide, the Member may be responsible for the full cost of the services.

Response to Prior Authorization Requests Involving Non-Urgent Care

Except in the case of a Prior Authorization request involving Urgent Care (see below), The Plan will provide a written response to the Member's Prior Authorization request no later than seven business days following the date The Plan receives the Member's request. This period may be extended one time for up to seven additional business days, if The Plan determines that additional time is necessary due to matters beyond our control.

If The Plan determines that additional time is necessary, The Plan will notify the Member in writing, prior to the expiration of the original seven business day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which The Plan expects to make the determination.

If an extension of time is necessary due to the need for additional information, The Plan will notify the Member of the specific information needed, and the Member will have 45 days from receipt of the notice to provide the additional information.

The Plan will provide a written response to the Member's request for Prior Authorization within seven business days following either the receipt of the additional information or, if the additional information is not received, the deadline for the receipt of the additional information. The procedure for appealing an adverse Prior Authorization determination is set forth in the section entitled Complaints and Grievances.

Response to Prior Authorization Requests Involving Urgent Care

A Prior Authorization request involving Urgent Care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Prior Authorization request.

In case of a Prior Authorization request involving Urgent Care, The Plan will respond to the Member no later than 48 hours after receipt of the request, unless the Member fails to provide sufficient information, in which case, the Member will be notified of the missing information within 24 hours of The Plan's receipt of the Urgent Care request and will have no less than 48 hours to provide the information. A response will be given as soon as possible (taking into account medical exigencies) but no later than 48 hours after the initial request, or, in the case where further information is requested, within 24 hours after the missing information is received or of the end of the period for the Member to provide the missing information.

NOTE: The Plan's response to the Member's Prior Authorization request involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Prior Authorization Required for Certain Prescription Drug Products and Other Medications

Prescription Drug Products, which are self-administered, process under the Prescription Drugs section of this Member Guide. There are other medications that are administered by a Covered Provider which process under the medical Benefits.

1. **Prescription Drugs – Covered Under the Prescription Drugs Benefit**

   Certain prescription drugs, which are self-administered, require Prior Authorization. Please refer to the Prescription Drugs section for complete information about the Prescription Drug Products that are subject to Prior Authorization, step therapy, and quantity limits, the process for requesting Prior Authorization, and related information.

2. **Other Medications – Covered Under Medical Benefits**

   Medications that are administered by a Covered Provider will process under the medical Benefits of this Member Guide. Certain medications administered by a Covered Provider require Prior Authorization. The medications that require Prior Authorization are subject to change by The Plan.

   In making determinations of coverage, The Plan may rely upon Pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in Montana, Medical Necessity, and Medical Policies. The Pharmacy policies and Medical Policies are located on The Plan website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.com.

   To determine which medications are subject to Prior Authorization, the Member or provider should refer to the list of medications which applies to the Member's Plan on The Plan website at www.bcbsmt.com or call the Customer Service toll-free number identified on the Member's identification card or The Plan website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.com.

General Provisions Applicable to All Required Prior Authorizations

1. **No Guarantee of Payment**

   Prior Authorization does not guarantee payment of Benefits by The Plan. Even if the service has been approved through Prior Authorization, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible for coverage as of the date of service or the Member's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Prior Authorization process may require additional documentation from the Member's health care provider or pharmacist. In addition to the written request for Prior Authorization, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by The Plan to make a determination of coverage pursuant to the terms and conditions of this Member Guide.

3. **Failure to Obtain Prior Authorization**

   If the Member, the Member's provider, or other appropriate party, as identified above, does not obtain Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Member Guide, the Member may be responsible for the full cost of the services.

Length of Stay/Service Review

Length of stay/Concurrent service review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions under this Member Guide.

Upon completion of the inpatient or emergency admission review, Blue Cross and Blue Shield of Montana will send a letter to the Member, the Member's provider, behavioral health practitioner and/or Hospital or facility with a determination on the approved length of service or length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient Care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the Appeal Procedure section of this Member Guide.

A length of stay/service review, also known as a concurrent Medical Necessity review, occurs when the Member, the Member's provider, or other authorized representative submits a request to The Plan for continued services. If the Member, the Member's provider or authorized representative requests to extend care beyond the approved time limit and it is a request involving Urgent Care or an ongoing Course of Treatment, The Plan will make a determination on the request as soon as possible but no later than 48 hours after it receives an urgent request, within 48 hours after it receives requested information (if the initial request is incomplete), or within seven business days after receipt of a non-urgent concurrent request.

Recommended Clinical Review

A Recommended Clinical Review is a Medical Necessity review for a covered service that occurs before services are completed and helps limit the situations where the Member may have to pay for a non-approved service. The Plan will review a Clinical Review request to determine if it meets approved Blue Cross and Blue Shield of Montana Medical Policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, the services will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/find-care/where-you-go-matters/utilization-management.com for the required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed, or call Customer Service at the number on the back of the Member's identification card. The Member or provider may request a Recommended Clinical Review.

Please coordinate with the provider to submit a written request for Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is not a guarantee of Benefits or payment of Benefits by The Plan. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Member Guide. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible for coverage as of the date of service or the Member's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from the Member's health care provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by The Plan to make a determination of coverage pursuant to the terms and conditions of this Member Guide.

Contacting Behavioral Health

The Member, the Member's provider, or authorized representative may contact The Plan for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of the Member's identification card and follow the prompts to the behavioral health unit. During regular business hours (7:00 a.m. and 5:00 p.m., Mountain Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 5:00 p.m., on weekends, and

on holidays, the same behavioral health line is answered by clinicians available for inpatient acute Recommended Clinical Reviews only. Requests for residential or Partial Hospitalization are reviewed during regular business hours.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Member eligibility, availability of Benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a post-service review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and Exclusions of this Member Guide. Post-Service Medical Necessity Review does not guarantee payment of Benefits by The Plan, for instance a Member may become ineligible for coverage as of the date of service or the Member's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Post-Service Medical Necessity Review process may require additional documentation from the Member's health care provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by The Plan to make a determination of coverage pursuant to the terms and conditions of this Member Guide.

Care Management

The goal of Care Management is to help the Member receive the most appropriate care that is also cost effective. If the Member has an ongoing medical condition or a catastrophic Illness, the Member should contact The Plan. If appropriate, a care manager will be assigned to work with the Member and the Member's providers to facilitate a treatment plan. Care Management includes Member education, referral coordination, utilization review and individual care planning. Involvement in Care Management does not guarantee payment by The Plan.

ELIGIBILITY AND ENROLLMENT

Who is Eligible

Employees

All employees of the Group are eligible if they are:

1. A member of the organization or employing unit, or a beneficiary of the trust to which this Member Guide is issued; and
2. Employed an average of 20-40 hours per week or more. The minimum number of work hours required to be eligible will be determined by the Group. The requirement will not be less than 20 hours or more than 40 hours. This includes a sole proprietor, partner, and independent contractor if these are included as an employee under the health Benefit Plan of the Small Employer; or
3. A variable hour employee, who works an average of 20-40 hours per week is subject to any probationary period required by the employer.

At the employer's discretion, seasonal employees may be eligible employees provided they are not designated as temporary and that they work the required number of hours per week. Officers of the employer group are subject to the same eligibility requirements as other employees, including working the required number of hours per week.

Persons working on a part-time, temporary and/or substitute basis are not eligible employees. Temporary basis means a definite period of time, not to exceed twelve Months, with no guarantee of employment on a permanent basis. A part-time basis means anything less than the hourly requirement of an eligible employee.

If an employee remains actively at work and the employee's hours have been reduced to less than that required by the Group, the employee may apply for the employer's or trustees' consent to remain a member of the Group for up to one year from the date of the reduction in work hours.

Retirees

Retirees are eligible for coverage if the:

1. Group offers retiree coverage; and
2. Eligibility guidelines for retiree coverage, established by the Group, are met.

Contact the Group Leader to determine if retiree coverage is available.

Applying for Coverage

An applicant may apply for coverage for himself/herself and/or any eligible Dependents (see below) by submitting the application(s) for medical insurance form, along with any exhibits, appendices, addenda and/or other required information ("application(s)") to Blue Cross and Blue Shield of Montana. The application(s) for coverage may or may not be accepted.

No eligibility rules or variations in premium will be imposed based on health status, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Applicants will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

Variation in the administration, processes or Benefits of this policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Enrollment

1. Initial Enrollment Period for Eligible Employees and Dependents

   Eligible employees and their Dependents must apply for membership within 30 days of the initial Effective Date of the Group if they are employed by the Group on that date. Eligible employees, who are not employed by the Group on the Group's initial Effective Date, and their Dependents, are eligible to apply for membership within 30 days following completion of the probationary waiting period shown on the group application.

   No such probationary waiting period may exceed 90 days unless permitted by applicable law. If records show that the Group has a probationary waiting period that exceeds 90 days, then the right is reserved to begin the Member's coverage on a date that is believed to be within the applicable allowed or required period. Regardless of whether that right is exercised, the Group is legally responsible for establishing and administering the probationary waiting period. If the Member has questions about the probationary waiting period, the Member should contact the plan administrator for the Group.

   Effective Date of Coverage

   a. If the probationary waiting period is less than 90 days, the Effective Date of coverage (for those who apply within the periods of eligibility) will be at 12:01 a.m. on the 1st or the 15th of the Month after completion of the probationary period, subject to the Group's anniversary date and meeting all eligibility and enrollment requirements;
   b. If the probationary waiting period is 90 days, the Effective Date of coverage (for those who apply within the periods of eligibility) will be at 12:01 a.m. on the 90th day of the probationary period, subject to the Group's anniversary date and meeting all eligibility and enrollment requirements; or
   c. If a variable hour employee, will be subject to the applicable measurement and look back periods established by the employer.

2. Annual Enrollment Period for Eligible Employees and Dependents

Employees and Family Members who do not apply within the initial period of eligibility may apply only during the Group's annual open enrollment period. The annual open enrollment period will be determined by the Group and Blue Cross and Blue Shield of Montana. Appropriate notice of the annual enrollment period will be provided to the employees.

Effective Date of Coverage

The Effective Date of coverage (for those who apply within the periods of eligibility) will be at 12:01 a.m. on the 1st or the 15th of the Month in which the person became eligible, subject to the Group's anniversary date and meeting all eligibility and enrollment requirements.

3. Special Enrollment for Loss of Coverage

Eligible Individuals

A special enrollment period may be available for the following eligible employees and/or Dependents:

a. Eligible employee

An eligible employee who is not currently enrolled and when enrollment was previously offered to the employee and declined, the employee was covered under another group health plan or had other health insurance coverage.

b. Dependent of Beneficiary Member

The Dependent of a Beneficiary Member who is not enrolled and when enrollment was previously offered and declined, the Dependent was covered under another group health plan or had other health insurance coverage.

c. Eligible employee and Dependent

An eligible employee and Dependent who are not enrolled and when enrollment was previously offered to the employee or Dependent and declined, the employee or Dependent was covered under another group health plan or had other health insurance coverage.

Conditions for Special Enrollment

a. When the employee declined enrollment for the employee or the Dependent, the employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment; and

1. The employee or Dependent had COBRA continuation coverage and the COBRA continuation coverage has expired; or

2. The employee or Dependent had other coverage that was not under a COBRA continuation provision and the other coverage has been terminated because of:

a. A loss of eligibility for the coverage. Loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the forgoing. However, loss of eligibility does not include a loss of coverage due to failure of the individual or the Beneficiary Member to pay premiums on a timely basis or termination of coverage for cause; or

b. Employer contributions towards the other coverage have been terminated; or

c. A situation in which the employee or Dependent incurs a claim that would meet or exceed a lifetime limit on non-essential benefits; or

d. A situation in which The Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

3. The employee or Dependent loses eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the employee or Dependent becomes eligible for financial assistance for group health coverage, under either the Children's Health Insurance Program or the Medicaid Program.

b. The employee must request enrollment (for the employee or the employee's Dependents) not later than 31 days after the exhaustion of the COBRA continuation coverage or termination of the other coverage because of loss of eligibility or termination of employer contributions.

c. The employee must request enrollment for the employee and or Dependent not later than 60 days after the date of termination of coverage under either the Children's Health Insurance Program or the Medicaid Program.

d. The employee must request enrollment for the employee or Dependent not later than 60 days after the date the employee or Dependent is determined to be eligible for financial assistance under the Children's Health Insurance Program or the Medicaid Program.

e. Enrollment during a special enrollment period is subject to all other applicable enrollment requirements of The Plan and the provisions of this Member Guide.

Effective Date of Enrollment

Enrollment due to loss of coverage will be effective not later than the first day of the first calendar Month beginning after the date the completed request for enrollment is received.

Special Enrollment for Marriage, Newborn, Adoption or Placement for Adoption

Application must be made for coverage within 30 days from the date of a special enrollment event or limited enrollment event. The Member must provide acceptable proof of a qualifying event with the application. Special enrollment qualifying events are discussed in detail below. The Plan will review this proof to verify the Member's eligibility for a special enrollment. Failure to provide acceptable proof of a qualifying event with the application will delay or prevent the processing of the application and enrollment in coverage. Please call the Customer Service number on the inside cover of this Member Guide for examples of acceptable proof for the following qualifying events.

Eligible Individuals

A special enrollment period may be available for the following individuals:

1. Eligible employee

An eligible employee who is not enrolled because of an election to not enroll during a previous enrollment period, and a person becomes a Dependent of the eligible employee through marriage, birth, or adoption or placement for adoption.

2. Spouse of a Beneficiary Member

An individual who becomes a Spouse of the Beneficiary Member.

3. Dependents

An individual who is a Dependent of a Beneficiary Member through marriage, adoption or placement for adoption, or an individual who is a Dependent of a Member through birth. A child placed for adoption will be eligible for coverage as of the date of adoption or placement for adoption and a child born to a Member will be eligible for coverage from and after the moment of birth subject to all the provisions of the section entitled Effective Date of Coverage.

Enrollment Period

The special enrollment period for Dependents under this section is for a period of 30 days and begins on the date of the marriage, birth, or adoption or placement for adoption. Enrollment during a special enrollment period is subject to all other applicable enrollment requirements of The Plan and provisions of this Member Guide.

Effective Date of Coverage

Enrollment will be effective as follows:

1. In the case of marriage, the date of marriage if the completed request for enrollment (application) is received by The Plan within 30 days after the date of marriage. If the application is received after 31 days of the date of marriage, the enrollee will be considered a Late Enrollee.

2. For a newborn born to a Member, the date of birth. Coverage will continue for 31 days. Coverage for the newborn will be provided only if the Beneficiary Member remains covered on the health plan during the 31-day

period. If the Beneficiary Member does not remain covered for 31 days, the newborn will only be covered for the amount of time (during the 31 days) that the Beneficiary Member is covered.

Coverage will continue for the child after the 31-day period if within the first 30 days of coverage, the Beneficiary Member:

a. Notifies The Plan to continue the coverage for the child; and
b. Pays the additional dues to continue coverage for the child.

Coverage will terminate after 31 days if The Plan is not notified to continue coverage.

3. In the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption. Children will be covered for a period of 31 days upon adoption or placement for adoption, including the date of placement, provided the Beneficiary Member remains covered under the Member Guide for those 31 days. If the Beneficiary Member does not remain covered for 31 days, the adopted child or the child placed for adoption will only be covered for the amount of time (during the 31 days) that the Beneficiary Member is covered.

Coverage will continue for the child after the 31-day period if within the first 30 days of coverage, the Beneficiary Member:

a. Notifies The Plan to continue the coverage for the child; and
b. Pays the additional dues to continue coverage for the child.

Coverage will terminate after 31 days if The Plan is not notified to continue coverage. In the event the placement is disrupted prior to legal adoption and the child is removed from placement, coverage shall cease upon the date the placement is disrupted.

Individuals enrolling during a special enrollment period are NOT Late Enrollees.

When Benefits Begin

The Member is entitled to the Benefits of this Member Guide beginning on the Member's Effective Date.

Renewal of Coverage for Family Members of Deceased Peace Officer, Game Warden, Firefighter or Volunteer Firefighter

The Member is a Spouse or Dependent of a peace officer, game warden, firefighter or volunteer firefighter who dies within the course and scope of employment while this Member Guide is in effect.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Beneficiary Members and Family Members can obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from Blue Cross and Blue Shield of Montana.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

1. The Family and Medical Leave Act of 1993 (FMLA) requires employers, who employ at least 50 workers within a 75-mile radius of the workplace, to provide eligible employees with up to 12 weeks of leave during any 12-Month period for any of the following reasons:

a. To care for a newborn child;
b. Because a child has been placed with the employee for adoption or foster care;
c. To care for a Spouse, child, or parent of the employee;
d. The employee's own serious health condition makes the employee unable to perform his or her job.

2. Eligible employees are those who have been employed by the employer for at least 12 Months and who have worked at least 1,250 hours for that employer during the previous 12-Month period.

3. The health Benefits of an employee and Dependents, if any, will be maintained during FMLA leave on the same terms and conditions as if the employee had not taken leave.
4. The health Benefits of an employee and Dependents, if any, may lapse at the employer's discretion during FMLA leave because the employee does not pay his or her share of the premiums in a timely manner or the employee does not elect health Benefits during the FMLA leave. Upon return from leave, the employee and Dependents, if any, will be reenrolled in the health Benefit Plan as if the coverage had not lapsed.
5. The employee's reenrollment in the health plan will be effective upon the date on which the employee returns to work.
6. An employee who takes FMLA leave and fails to pay any required premium contribution or fails to return from leave will be entitled to COBRA coverage for the maximum COBRA coverage period beginning when the FMLA coverage terminated.

TERMINATION OF COVERAGE

Termination When Employment Ceases or Family Member Status Changes

1. When Employment Ceases

   If the Effective Date of the Group Plan is the first day of the Month, membership, including that of any Family Members will terminate at the end of the Month in which the Member is no longer employed by the Group.

   If the Effective Date of the Group Plan is the fifteenth day of the Month, membership, including that of any Family Member, will terminate on the earlier of:

   a. The fifteenth day of the Month in which the Member is no longer employed by the Group; or
   b. The fifteenth day of the following Month.

2. Change of status for Medical Benefits

   Coverage for a Family Member will **terminate automatically** at midnight, Mountain Time, on the last day of the plan year in which a child reaches age 26. Coverage for a Spouse will terminate at midnight, Mountain Time, on the last day of the Month in which the Spouse's marriage to the Beneficiary Member is terminated.

3. Change of status for Pediatric Dental Benefits

   Coverage for a Family Member will **terminate automatically** at midnight, Mountain Time, on the last day of the Month in which a child reaches age 19 years of age.

Termination of Benefits

When the membership of a Beneficiary Member and/or Family Members is terminated for any reason listed in this section or any other section, Benefits will no longer be provided, and The Plan will not make payment for services provided to them after the date on which cancellation becomes effective.

However, if the Member is receiving Inpatient Care on the date coverage terminates, the Member will continue to receive the Benefits payable under this Member Guide:

1. For 30 days; or
2. Until the Member is discharged from the Inpatient Care facility, whichever occurs first.

Certificate of Creditable Coverage

Even though this health plan does not have a preexisting condition exclusion period, The Plan will issue a Certificate of Creditable Coverage to the Member, upon request, following termination of coverage.

CONTINUATION OF COVERAGE

COBRA

Certain employers maintaining group health coverage plans (whether insured or self-insured) must provide COBRA continuation coverage for qualified beneficiaries when group health coverage is lost. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). To lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before a qualifying event. A loss of coverage need not occur immediately after a qualifying event so long as the loss of coverage occurs before the end of the maximum COBRA coverage period. A qualified beneficiary is entitled to the coverage made available to similarly situated employees.

COBRA requires qualified beneficiaries or a representative acting on behalf of a qualified beneficiary to provide certain notices to the plan administrator (generally the employer), and requires the plan administrator to provide certain notices to qualified beneficiaries. The plan administrator is also the COBRA Administrator unless the plan administrator has designated another individual or entity to administer COBRA.

1. Small Employer Exception

Small employer plans are generally exempt from the COBRA regulations. A small employer plan, for the purposes of COBRA, is defined as an employer plan that normally employed fewer than 20 employees, including part-time employees, during the preceding calendar year. A group health plan that is a multi-employer plan (as defined in Internal Revenue Code (IRC)) is a small-employer plan if each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. Whether the plan is a multi-employer plan or not, the term employer includes all members of a controlled group.

A small employer employs fewer than 20 employees during a calendar year if it had fewer than 20 employees on at least 50 percent of its typical business days during that year. Only common-law employees are counted for purposes of the small employer exception; self-employed individuals, independent contractors (and their employees and independent contractors), and corporate directors are not counted.

2. Qualified Beneficiaries

Continuation of coverage is available to qualified beneficiaries. A qualified beneficiary is:

- **a.** Any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the Spouse of a covered employee, or the Dependent child of a covered employee; or
- **b.** Any child born to or placed for adoption with a covered employee during a period of COBRA continuation.

Individuals added to a qualified beneficiary's COBRA coverage (e.g., a new Spouse or person added as the result of a Special Enrollment event, etc.) do not become qualified beneficiaries in their own right, with the exception of 2.b. above.

Nonresidents - An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of IRC section 911(d)(2)) that constituted income from sources within the United States (within the meaning of IRC section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

3. Qualifying Events

A qualifying event is any of a set of specified events that occur while a group health plan is subject to COBRA and which causes a qualified beneficiary to lose coverage under the plan.

a. Employee

An employee will become a qualified beneficiary if the employee loses coverage under the plan because either one of the following qualifying events happen:

1. Employee’s hours of employment are reduced; or
2. Employment ends for any reason other than gross misconduct.

b. Spouse

The Spouse of an employee will become a qualified beneficiary if the Spouse loses coverage under the plan because any of the following qualifying events happen:

1. The employee dies;
2. The employee's hours of employment are reduced;
3. The employee's employment ends for any reason other than gross misconduct;
4. The employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. Divorce or legal separation from the employee.

c. Dependent Children

Dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happen:

1. The employee dies;
2. The employee's hours of employment are reduced;
3. The employee's employment ends for any reason other than gross misconduct;
4. The employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The employee becomes divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "Dependent child."

d. Retirees

If the plan provides retiree health coverage, a proceeding in bankruptcy under Title 11 of the United States Code can sometimes be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage for any retired employee covered under the plan, the covered retiree will become a qualified beneficiary with respect to the bankruptcy. The covered retiree's covered Spouse or surviving Spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

4. Period of Coverage

a. A qualified beneficiary may continue coverage for up to 18 Months when the employee loses coverage under the plan due to one of the following qualifying events:

1. A reduction in work hours; or
2. Voluntary or involuntary termination of employment for reasons other than gross misconduct.

b. A qualified beneficiary may continue coverage for up to 36 Months when the qualified beneficiary loses coverage under the plan due to one of the following qualifying events:

1. The employee's death;
2. Divorce or legal separation from the employee;
3. The covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act; or
4. A covered Dependent child ceases to be a Dependent child of the covered employee under the terms of the group health plan.

c. Bankruptcy

If the employer files Chapter 11 bankruptcy which results in loss of coverage (or substantial elimination of coverage within one year before or after bankruptcy is filed), a qualified beneficiary may continue coverage up to the following applicable periods:

1. Covered retiree: The maximum duration of the COBRA coverage is the lifetime of the retired covered employee.
2. Covered Spouse, surviving Spouse, or Dependent child of covered retiree: The maximum duration of the COBRA coverage ends the earlier of:

a. The date of death (of the Spouse, surviving Spouse or Dependent child); or
b. 36 Months after the death of the covered retiree.

5. Providing Notice of Qualifying Events

a. Responsibilities of Qualified Beneficiaries

1. General Notice Requirements

The qualified beneficiary or a representative of the qualified beneficiary must notify the administrator of the qualifying events listed below within 60 days after the latest of 1. the qualifying event; 2. the loss of coverage, or 3. the date that the qualified beneficiary receives information concerning COBRA coverage in a General Notice.

a. Divorce or legal separation;
b. Covered Dependent child ceases to be a Dependent child of a covered employee under terms of the plan; or
c. A second qualifying event. (See 5.a.2.).

Notification of a qualifying event must be timely mailed to the plan administrator (generally the Member's employer), or to the entity identified as the COBRA Administrator in the General COBRA Notice provided to the Member upon enrollment or when the Member's coverage is terminated**. Important Information: If notices are not received within the timeframes specified below, the qualified beneficiary will not be provided COBRA coverage.**

A single notice sent by or on behalf of the covered employee or any one of the qualified beneficiaries affected by the qualifying event satisfies the notice requirement for all qualified beneficiaries.

The following information should be included:

a. Name of covered employee;
b. Subscriber identification number;
c. Employee and qualified beneficiary names, address and telephone number (also note any different addresses for other qualified beneficiaries);
d. Employer/former employer;
e. Whether the event is a qualifying event; disability, or second qualifying event; and
f. Date of qualifying event.

Certain COBRA qualifying events have additional notice requirements which are explained in more detail below.

2. Second Qualifying Event

The qualified beneficiary or a representative of the qualified beneficiary must notify the administrator within 60 days of a second qualifying event. **Important Information: If notice is not received within the timeframes specified below, an extension of COBRA coverage will not be provided to the qualified beneficiary.**

The initial 18-Month COBRA coverage period may be extended for an additional 18 Months (for a total of 36 Months) for Spouses and Dependents who initially elected COBRA coverage if:

a. The first qualifying event is the employee's termination of employment or reduction in hours;
b. The second qualifying event occurs during the initial 18-Month COBRA coverage period;
c. The second qualifying event has a 36-Month maximum coverage period (see Period of Coverage 4.b.); and
d. The second qualifying event is one that would have caused loss of coverage in the absence of the first qualifying event.

If COBRA coverage was previously extended from 18 Months to 29 Months due to a Medicare disability determination, the maximum COBRA coverage period under a second qualifying event will be 36 Months.

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 Months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the Spouse and Dependent children will end 36 Months from the date the employee became entitled to Medicare as a result of turning 65 (but the covered employee's maximum coverage period will be 18 Months).

3. Disability Extension

A qualified beneficiary may be entitled to a disability extension of up to 11 additional Months. If a qualified beneficiary is entitled to the extension, which shall not extend the total period of continuation coverage beyond 29 Months, the extension applies to each qualified beneficiary who is not disabled, as well as to the disabled beneficiary, and it applies independently with respect to each of the qualified beneficiaries.

To qualify for a disability extension, the following requirements must be met:

a. The qualifying event must be a termination or reduction of hours of a covered employee's employment; and
b. The qualified beneficiary must have been determined under Title II or XVI of the Social Security Act (SSA) to be disabled at any time during the first 60 days of the COBRA continuation coverage.

Individuals who have been determined by SSA to be disabled prior to the occurrence of a qualifying event and the disability continues to exist at the time of the qualifying event, qualified beneficiaries are considered to meet the statutory requirements of being disabled within the first 60 days of COBRA coverage.

In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption.

The qualified beneficiary must provide a disability notice before the end of the first 18 Months of coverage.

The qualified beneficiary or a representative of the qualified beneficiary must also provide notice to the administrator within 30 days after the date of any final determination under the SSA that the qualified beneficiary is no longer disabled. Coverage will be terminated the later of 1. the first day of the Month that is more than 30 days after a final determination by SSA that the individual is no longer disabled; or 2. the end of the COBRA period that applies without regard to the disability extension.

b. Responsibilities of Plan Administrator

The plan administrator must notify the party responsible for administering COBRA within 30 days of the following events:

1. The employee's death;
2. The employee's termination (other than for gross misconduct);
3. Reduction in work hours of employment;
4. A proceeding in bankruptcy with respect to an employer from whose employment a covered employee retires; and
5. The covered employee becomes entitled to Medicare.

c. Responsibilities of the COBRA Administrator

The COBRA administrator must notify qualified beneficiaries of their right to COBRA coverage within 14 days after receiving notice of a qualifying event by providing qualified beneficiaries with a COBRA Election form.

If the plan administrator is the COBRA administrator, the plan administrator must notify qualified beneficiaries of their right to COBRA coverage within 44 days after receiving notice of a qualifying event.

6. Election of COBRA Coverage - Notice Requirements

After a qualified beneficiary or COBRA administrator has provided notice of a qualifying event, the qualified beneficiary will receive a COBRA Election form.

Each qualified beneficiary has an independent right to elect COBRA coverage. The qualified beneficiary or a representative of the qualified beneficiary must return the COBRA Election form to the administrator within 60 days from the date on the COBRA Election form. **Important Information: If the COBRA Election form is not returned within the 60-day timeframe, COBRA coverage will not be provided to any qualified beneficiaries.**

7. Trade Adjustment Assistance Eligible Employees

Employees who lost coverage as the result of a termination or a reduction of hours and who qualify for "trade adjustment assistance" ("TAA") under the Trade Act of 1974, as amended, are entitled to a second opportunity to elect COBRA coverage, if such coverage was not elected within the first 60 days after coverage is lost.

The second COBRA election period provisions are effective for individuals with respect to whom petitions for certification for trade adjustment assistance are filed on or after November 4, 2002. The second election period begins on the first day the employee began receiving TAA (or would have become eligible to begin receiving TAA but for exhaustion of unemployment compensation), but only if made within six Months after group health coverage is lost. Notice must be provided in accordance with "Responsibility of Qualified Beneficiary" above.

This coverage may continue for 18 Months from the date COBRA coverage begins. When the employee elects coverage, the election can include coverage for previously covered Dependents. Dependents are not qualified beneficiaries in their own right under this provision and therefore do not have an independent election.

8. Payment of Premium

The first premium payment must be made within 45 days of the date of the election of COBRA continuation coverage and must include payments retroactive to the date coverage would normally have terminated under this plan.

Subsequent payments must be made within 30 days after the first day of each coverage period. Payment is considered to be made on the date payment is sent to the employer or COBRA administrator. If the premium is not paid by the first day of the coverage period, a grace period of 30 days will be allowed for payment. The Member may instead request to be billed for continuation coverage for the following coverage periods: quarterly, semi-annually or annually.

9. Termination of Continued Coverage

- **a.** Coverage terminates the last day of the maximum required period under COBRA;
- **b.** Any of the following events will result in termination of coverage prior to expiration of the 18-Month, 29-Month, or 36-Month period:
  1. The first day on which timely payment is not made with respect to the qualified beneficiary;
  2. The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;
  3. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes covered under any other group health plan; or
  4. The date, after the date of the COBRA election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

10. Conversion Notice

During the 180 days preceding expiration of COBRA coverage, the qualified beneficiary will be notified of the options to enroll under a conversion health plan, if such an option exists.

11. Questions Concerning COBRA Coverage

For any questions concerning COBRA coverage, contact Blue Cross and Blue Shield of Montana (BCBSMT) at 1-800-447-7828.

12. Provide Notice of Address Changes

In order to protect all COBRA rights, Members must notify the administrator and Blue Cross and Blue Shield of Montana of any changes to the Member's or Family Member's addresses. A Member should also keep a copy of any notices for personal records.

Conversion Coverage

Montana law entitles certain persons to conversion coverage without evidence of insurability upon termination of their eligibility for group coverage or COBRA coverage. This coverage is at the option of the insured on any of the forms then customarily issued by Blue Cross and Blue Shield of Montana to individual policy holders, with the exception of those whose eligibility is determined by their affiliation other than by employment with a common entity.

1. Transfer upon change in employment status

   Conversion coverage is available if the Member has been covered under this Group Plan for at least three Months and is:

   - **a.** A Beneficiary Member or Family Member whose coverage ceased because of termination of membership in a group eligible for coverage under the Group Plan;
   - **b.** A Beneficiary Member or Family Member whose coverage ceased because of termination of employment of the Beneficiary Member;
   - **c.** A Beneficiary Member or Family Member whose coverage ceased because of discontinuance of the Beneficiary Member's employer's business; or
   - **d.** A Beneficiary Member or Family Member whose coverage terminated because of discontinuance of the coverage by the Beneficiary Member's employer where the employer does not provide for any other group disability insurance or plan.

2. Transfer upon change in Family Member status

   Conversion coverage is available following the termination of any continuation of coverage provisions of this Member Guide, for the following persons:

   - **a.** A Family Member of a Beneficiary Member who has died.
   - **b.** The Beneficiary Member's Spouse who enrolled as a Family Member and whose marriage ended because of divorce, annulment, or legal separation and the Beneficiary Member is still covered under the Group policy.
   - **c.** The Beneficiary Member's child who has been enrolled as a Family Member and coverage is terminated because the child reaches the age of 26 years.

3. Enrollment in conversion coverage

   The Member will be enrolled under the Blue Cross and Blue Shield of Montana conversion coverage program if the Member:

   - **a.** Meets the qualifications outlined in the conversion provision.
   - **b.** Applies to Blue Cross and Blue Shield of Montana and pay dues within 31 days after termination of group coverage.
   - **c.** Is not covered under another major medical disability policy or plan.

4. Benefits to Members Hospitalized on Date of Transfer to Conversion Coverage

   If the Member is receiving Inpatient Care on the date of transfer of membership to a Blue Cross and Blue Shield of Montana conversion coverage plan, the Member will continue to receive the Benefits payable under this Member Guide for 30 days from the date of transfer or until the Member is discharged from the Hospital, whichever occurs first.

   If the Member is receiving Inpatient Care on the date of transfer of membership from conversion coverage to another group health plan, Benefits will be subject to the limitations of the new health plan.

BENEFITS

The Plan will pay for the following Benefits provided by a Covered Provider based on the Allowable Fee and subject to any Deductible, Copayment and/or Coinsurance and other provisions, as applicable.

Please note that services must be determined to be Medically Necessary by The Plan in order to be covered. Coverage of Benefits is subject to Blue Cross and Blue Shield of Montana policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, Utilization Management, and clinical payment

and coding policies, which may be updated throughout the plan year. The policies and guidelines are resources utilized by Blue Cross and Blue Shield of Montana when making coverage determinations and lay out the procedure and/or criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Medical Expense or is not eligible for coverage as not Medically Necessary, Experimental/Investigational/Unproven, cosmetic, a convenience item, or a Member Guide Exclusion. The clinical payment and coding policies are intended to ensure the creation and submission of accurate documentation of the services performed and require all providers to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Under the clinical payment and coding policies, claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines. Provider claims are subject to the code edit protocols for services/procedures billed as well as to other applicable claim review which may include, but is not limited to, review of any terms of Benefit coverage, provider contract language, medical and medical management policies, utilization or clinical review or Utilization Management policies, medical records, clinical payment and coding policies as well as coding software logic, including but not limited to, lab management or other coding logic or edits.

Any line on the claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included as a Covered Medical Expense and will not be eligible for payment by The Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the provider rendering the item or service or submitting the claim is In-Network or Out-of-Network. The most up-to-date medical policies and clinical procedure and coding policies are available at www.bcbsmt.com or by contacting Customer Service at the number shown on the Member's identification card.

Accident

Services which are provided for bodily injuries resulting from an Accident.

Acupuncture

Services provided by a licensed acupuncturist to treat Illness or Injury.

The Schedule of Benefits describes payment limitations for these services.

Advanced Practice Registered Nurses and Physician Assistants-Certified

Services provided by an Advanced Practice Registered Nurse or a Physician Assistant-Certified who is licensed to practice medicine in the state where the services are provided and when payment would otherwise be made if the same services were provided by a Physician.

Ambulance

Licensed ground and air ambulance transport required for a Medically Necessary condition to the nearest appropriate site.

Anesthesia Services

Anesthesia services provided by a Physician (other than the attending Physician) or nurse anesthetist including the administration of spinal anesthesia and the injection or inhalation of a drug or other anesthetic agent.

The Plan will not pay for:

1. Hypnosis;
2. Local anesthesia or intravenous (IV) sedation that is considered to be an Inclusive Service/Procedure;
3. Anesthesia consultations before surgery that are considered to be Inclusive Services/Procedures because the Allowable Fee for the anesthesia performed during the surgery includes this anesthesia consultation; or
4. Anesthesia for Dental Services or extraction of teeth, except anesthesia provided at a Hospital in conjunction with dental treatment will be covered only when a nondental physical Illness or Injury exists which makes

Hospital care Medically Necessary to safeguard the Member's health. Dental Services and treatment are not a Benefit of this Member Guide, except as specifically included in the Dental Accident and Pediatric Dental Benefit.

Approved Clinical Trials

Routine Patient Costs provided in connection with an Approved Clinical Trial.

Autism Spectrum Disorders

Diagnosis and treatment of autistic disorder, Asperger's Disorder or Pervasive Developmental Disorder.

Covered services include:

1. Habilitative Care or Rehabilitative Care, including, but not limited to, professional, counseling and guidance services and treatment programs; Applied Behavior Analysis (ABA), also known as Lovaas Therapy; discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention;
2. Medications;
3. Psychiatric or psychological care; and
4. Therapeutic care provided by a speech-language pathologist, audiologist, occupational therapist or physical therapist.

Birthing Centers

Services for the delivery of a newborn provided at a birthing center.

Blood Transfusions

Blood transfusions, including the cost of blood, blood plasma, blood plasma expanders and packed cells. Storage charges for blood are paid when a Member has blood drawn and stored for the Member's own use for a planned surgery.

Breast Examinations (Preventive and Medical)

Mammography examinations

The minimum mammography examination recommendations are:

1. One baseline mammogram for women ages 35 through 39.
2. One mammogram every two years for women ages 40 through 49, or more frequently as recommended by a Physician.
3. One mammogram every year for women age 50 or older.

NOTE: Benefits will be provided for Medically Necessary Diagnostic and Supplemental Breast Examinations at no cost-share, after the Member has met the Deductible.

Chemotherapy

The use of drugs approved for use in humans by the U.S. Food and Drug Administration (FDA) and ordered by the Physician for the treatment of disease.

Chiropractic Services

Services of a licensed chiropractor.

The Schedule of Benefits describes payment limitations for these services.

Contraceptives

Services and supplies related to contraception, including but not limited to, oral contraceptives, contraceptive devices and injections, subject to the terms and limitations of the Member Guide.

Deductible and Coinsurance do not apply to contraceptives covered under the Preventive Health Care Benefit, whether provided during an office visit or through the Prescription Drugs Benefit.

NOTE: Prescriptions for a 12-Month supply of covered contraceptive drugs and devices may be renewed and refilled at least 60 days prior to the expiration of the prescription.

Convalescent Home Services

Services of a Convalescent Home as an alternative to Hospital Inpatient Care. The Plan will not pay for Custodial Care.

NOTE: The Plan will not pay for the services of a Convalescent Home if the Member remains inpatient at the Convalescent Home when a skilled level of care is not Medically Necessary.

Prior Authorization is required for Convalescent Home services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

The Schedule of Benefits describes payment limitations for these services.

Dental Accident Services

Dental Services provided by Physicians, Dentists, oral surgeons and/or any other provider are not covered under this Member Guide except that, Medically Necessary services for the initial repair or replacement of sound natural teeth which are damaged as a result of an Accident, are covered, except that orthodontics, dentofacial orthopedics, or related appliances are not covered, even if related to the Accident.

The Plan will not pay for services for the repair or replacement of teeth which are damaged as the result of biting and chewing. Damage to teeth as a result of biting and chewing will not be considered an Accident.

Diabetic Education

Outpatient self-management training and education services for the treatment of diabetes provided by a Covered Provider with expertise in diabetes.

NOTE: Benefits for outpatient diabetic self-management training and education are not subject to any visit limitations.

The Schedule of Benefits describes payment limitations for these services.

Diabetes Treatment (Office Visit)

Services and supplies for the treatment of diabetes provided during an office visit. For additional Benefits related to the treatment of diabetes, e.g., surgical services and medical supplies, refer to that specific Benefit.

Diagnostic Services

1. Diagnostic Imaging Procedures

   Diagnostic Imaging which includes Computerized Tomography Scan (CT Scan), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET Scan).

2. All Other Covered Diagnostic Services

   a. X-rays and Other Radiology. Some examples of other radiology include:

      1. Nuclear medicine;
      2. Ultrasound.

   b. Laboratory Tests. Some examples of laboratory tests include:

      1. Urinalysis;
      2. Blood tests;
      3. Throat cultures.

c. Diagnostic Testing. Tests to diagnose an Illness or Injury. Some examples of diagnostic testing include:
    1. Electroencephalograms (EEG);
    2. Electrocardiograms (EKG or ECG).

This Benefit does not include diagnostic services such as biopsies which are covered under the surgery Benefit.

Durable Medical Equipment

The appropriate type of equipment used for therapeutic purposes **where the Member resides**. Durable medical equipment, which requires a written prescription, must also be:

1. Able to withstand repeated use (consumables are not covered);
2. Primarily used to serve a medical purpose rather than for comfort or convenience; and
3. Generally not useful to a person who is not ill or injured.

The Plan will not pay for the following items:

1. Exercise equipment;
2. Car lifts or stair lifts;
3. Biofeedback equipment;
4. Self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition;
5. Air conditioners and air purifiers;
6. Whirlpool baths, hot tubs, or saunas;
7. Waterbeds;
8. Other equipment which is not always used for healing or curing;
9. Deluxe equipment. The Plan has the right to decide when deluxe equipment is required. However, upon such decision, payment for deluxe equipment will be based on the Allowable Fee for standard equipment;
10. Computer-assisted communication devices;
11. Durable medical equipment required primarily for use in athletic activities;
12. Replacement of lost or stolen durable medical equipment;
13. Repair to rental equipment; and
14. Duplicate equipment purchased primarily for Member convenience when the need for duplicate equipment is not medical in nature.

Education Services

Education services, other than diabetic education, that are related to a medical condition.

Emergency Room Care

1. Emergency room care for an accidental Injury.
2. Emergency room care for Emergency Services.
3. Emergency room care for the treatment of Mental Illness and/or Substance Use Disorder.

If the Member disagrees with The Plan's determination in processing Benefits as nonemergency services instead of Emergency Services, the Member may call The Plan at the number on the back of the Member’s identification card. Please see the section entitled How to File an Internal Appeal of an Adverse Benefit Determination in this document for specific information on the Member's right to seek and obtain a full and fair review of the claim.

Hearing Coverage for Dependent Children Under Age 19

Coverage is available for the Medically Necessary diagnosis and treatment of hearing loss for a covered Dependent under age 19, when prescribed, provided, or ordered by a licensed health care provider. One Amplification Device, with required accessories, are available for each ear, every three years, or as required by a licensed audiologist.

The Schedule of Benefits describes payment limitations for these services.

Home Health Care

The following services, when prescribed and supervised by the Member's attending Physician provided in the Member's home by a licensed Home Health Agency and which are part of the Member's treatment plan:

1. Nursing services;
2. Home Health Aide services;
3. Hospice services;
4. Physical Therapy;
5. Occupational Therapy;
6. Speech Therapy;
7. Medical social worker;
8. Medical supplies and equipment suitable for use in the home; and/or
9. Medically Necessary personal hygiene, grooming and dietary assistance.

The Plan will not pay for:

1. Maintenance or Custodial Care visits;
2. Domestic or housekeeping services;
3. "Meals-on-Wheels" or similar food arrangements;
4. Visits, services, medical equipment, or supplies not approved or included as part of the Member's treatment plan;
5. Services for the treatment of Mental Illness; and/or
6. Services provided in a nursing home or skilled nursing facility.

Prior Authorization is required for home health care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

The Schedule of Benefits describes payment limitations for these services.

Home Infusion Therapy Services

The preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Member by a Home Infusion Therapy Agency, including:

1. Education for the Member, the Member's caregiver, or a Family Member;
2. Pharmacy;
3. Supplies;
4. Equipment; and/or
5. Skilled nursing services when billed by a Home Infusion Therapy Agency.

NOTE: Skilled nursing services billed by a Licensed Home Health Agency will be covered under the home health care Benefit.

Home infusion therapy services must be ordered by a Physician and provided by a licensed Home Infusion Therapy Agency. A licensed Hospital, which provides home infusion therapy services, must have a Home Infusion Therapy Agency license or an endorsement to its Hospital facility license for home infusion therapy services.

Prior Authorization is required for home infusion therapy services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Hospice Care

A coordinated program of home care and Inpatient Care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill Member and the Member's Immediate Family. Benefits include:

1. Inpatient and Outpatient care;
2. Home care;
3. Nursing services - skilled and non-skilled;

4. Counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally ill Member; and/or
5. Instructions for care of the Member, counseling and other support services for the Member's Immediate Family.

The Plan will not pay for services that do not require skilled nursing care, including Custodial Care or care for the convenience of the patient or Family Member.

Prior Authorization is required for hospice care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Hospital Services - Facility and Professional

Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations

    a. Room and board, which includes special diets and nursing services.
    b. Intensive care and cardiac care units which include special equipment and concentrated nursing services provided by nurses who are Hospital employees.

2. Miscellaneous Hospital Services

    a. Laboratory procedures;
    b. Operating room, delivery room and recovery room;
    c. Anesthetic supplies;
    d. Surgical supplies;
    e. Oxygen and use of equipment for its administration;
    f. X-ray;
    g. Intravenous injections and setups for intravenous solutions;
    h. Special diets when Medically Necessary;
    i. Respiratory therapy, chemotherapy, radiation therapy and dialysis therapy;
    j. Physical Therapy, Speech Therapy and Occupational Therapy;
    k. Drugs and medicines which:

        1. Are approved for use in humans by the FDA; and
        2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
        3. Require a Physician's written prescription.

        Drugs and medicines which are used in off-label situations may be reviewed for Medical Necessity.

Inpatient Care services are subject to the following conditions:

1. Days of care

    a. The number of days of Inpatient Care provided is 365 days.
    b. In computing the number of Inpatient Care days available, days will be counted according to the standard midnight census procedure used in most Hospitals. The day a Member is admitted to a Hospital is counted, but the day a Member is discharged is not. If a Member is discharged on the day of admission, one day is counted.
    c. The day a Member enters a Hospital is the day of admission. The day a Member leaves a Hospital is the day of discharge.

2. The Member will be responsible to the Hospital for payment of its charges if the Member remains as an Inpatient Member when Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed reserved for a Member. No Benefits will be paid for Inpatient Care provided primarily for diagnostic or therapy services.

Prior Authorization is required for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Inpatient Care Medical Services Billed by a Professional Provider

Nonsurgical services by a Covered Provider, Concurrent Care and Consultation Services.

Medical services do not include surgical or maternity services. Inpatient Care medical services are covered only if the Member is eligible for Benefits under the Hospital Services, Inpatient Care Services section for the admission.

Medical care visits are limited to one visit per day per Covered Provider unless a Member's condition requires a Physician's constant attendance and treatment for a prolonged period of time.

Observation Beds/Rooms

Benefits will be made available for observation beds when Medically Necessary.

Outpatient Hospital Services

Use of the Hospital's facilities and equipment for surgery, respiratory therapy, chemotherapy, radiation therapy and dialysis therapy.

Inborn Errors of Metabolism

Treatment under the supervision of a Physician of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. Benefits include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

Infertility - Diagnosis and Treatment

The Plan will pay for:

The diagnosis and treatment of infertility, including:

1. Medically Necessary evaluation to determine cause of infertility;
2. Artificial insemination (AI) or intrauterine insemination (IUI); and/or
3. Medically Necessary reproductive procedures not related to in vitro fertilization.

The Plan will not pay for:

1. Prescription drugs used to treat infertility; and/or
2. Services, supplies, drugs, and devices related to in vitro fertilization.

Infusion Therapy Services – Outpatient

Some Outpatient infusion services for Routine maintenance drugs have been identified as capable of being administered outside of an Outpatient Hospital setting. The Out of Pocket Amount expenses may be lower when services are provided by a professional provider in an Infusion Suite, a home or an office, instead of a Hospital. Non-maintenance Outpatient infusion therapy services will be covered the same as any other Illness.

Maternity Services - Professional and Facility Covered Providers

1. Prenatal and postpartum care.
2. Delivery of one or more newborns.
3. Hospital Inpatient Care for conditions related directly to pregnancy. Inpatient Care following delivery will be covered for whatever length of time is Medically Necessary and will be at least 48 hours following a vaginal delivery and at least 96 hours following a delivery by cesarean section. The decision to shorten the length of stay of Inpatient Care to less than that stated in the preceding sentence must be made by the attending health care provider and the mother.

Under federal law, Benefits may not be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, under federal law, Covered Providers may not be required to obtain Prior Authorization from The Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

4. Payment for any maternity services by the professional provider is limited to the Allowable Fee for total maternity care, which includes delivery, prenatal and postpartum care.

Please refer also to the Newborn Initial Care section.

Medical Supplies

The following supplies for use outside of a Hospital:

1. Supplies for insulin pumps, syringes and related supplies for conditions such as diabetes;
2. Injection aids, visual reading and urine test strips, glucagon emergency kits for treatment of diabetes. One insulin pump for each warranty period is covered under the Durable Medical Equipment Benefit;
3. Sterile dressings for conditions such as cancer or burns;
4. Catheters;
5. Splints;
6. Colostomy bags and related supplies; and/or
7. Supplies for renal dialysis equipment or machines.

Medical supplies are covered only when:

1. Medically Necessary to treat a condition for which Benefits are payable; and
2. Prescribed by a Covered Provider.

Mental Health

Benefits provided for mental health are for the treatment of Mental Illness as defined in the section entitled Definitions.

Benefits include but are not limited to, Inpatient Care services, Outpatient services, including but not limited to Psychiatric Collaborative Care, rehabilitation services and medication for the treatment of Mental Illness.

Payment for mental health Benefits will be made as for any other Illness.

For purposes of this paragraph, the following definition will apply:

"Psychiatric Collaborative Care" means an evidence-based behavioral health service delivery method in which care:

1. Is delivered by a primary care team consisting of a primary care provider and a care manager who work in collaboration with a psychiatric consultant, including but not limited to a psychiatrist;
2. Is directed by the primary care team;
3. Includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate; and
4. Involves regular consultations between the psychiatric consultant and the primary care team to review the clinical status and care of patients and to make recommendations.

Outpatient Services

Care and treatment of Mental Illness if the Member is not an Inpatient Member and the care and treatment is provided by:

1. A Hospital;
2. A Physician or prescribed by a Physician;
3. A Mental Health Treatment Center;
4. A Substance Use Disorder Treatment Center;
5. A licensed psychologist;

6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. A licensed psychiatrist;
10. A licensed Advanced Practice Registered Nurse with a specialty in mental health;
11. A licensed Advanced Practice Registered Nurse with prescriptive authority and specializing in mental health;
12. A primary care team, in the case of Psychiatric Collaborative Care; or
13. Other Qualified Health Care Provider.

Outpatient Benefits are subject to the following conditions:

1. The services must be provided to diagnose and treat recognized Mental Illness; and
2. The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by Mental Illness.

The Plan will not pay for hypnotherapy or for services given by a staff member of a school or halfway house.

Inpatient Services

Care and treatment of Mental Illness, while the Member is an Inpatient Member, and which are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity residential services provided at a Residential Treatment Center are Benefits of this Member Guide.

Prior Authorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Partial Hospitalization

Care and treatment of Mental Illness, while the Partial Hospitalization services are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Prior Authorization is required for Partial Hospitalization. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Naturopathy

Services provided by a licensed naturopathic provider are covered if such services are a Benefit of this Member Guide.

Newborn Initial Care

1. The initial care of a newborn at birth provided by a Physician.
2. Nursery Care - Hospital nursery care of newborn infants.

Office Visit

Covered services provided in a Covered Provider’s office during a Professional Call and covered services provided in the home by a Covered Provider. Visits are limited to one visit per day per provider.

Oral Surgery

Benefits will be provided for the following:

1. Excision or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

2. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
3. Treatment of fractures of facial bone;
4. External incision and drainage of cellulitis (not including treatment of dental abscesses);
5. Incision of accessory sinuses, salivary glands or ducts;
6. Surgical removal of complete bony impacted teeth; and/or
7. Reduction of, dislocation of, or excision of, the temporomandibular joints.

Orthopedic Devices/Orthotic Devices

A supportive device for the body or a part of the body, head, neck or extremities, including but not limited to, leg, back, arm and neck braces. In addition, when Medically Necessary, Benefits will be provided for adjustments, repairs or replacement of the device because of a change in the Member's physical condition.

The Plan will not pay for foot orthotics defined as any in-shoe device designed to support the structural components of the foot during weight-bearing activities.

Pediatric Dental Care

Dental Benefits include coverage for the following Dental Services as long as these services are rendered by a Dentist or a Physician. When the term "Dentist" is used in this Member Guide, it will mean Dentist or Physician**.**

Diagnostic Evaluations

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

Periodic oral evaluation - Limited to 1 every 6 Months
Limited oral evaluation - problem focused
Comprehensive oral evaluation - Limited to 1 every 6 Months
Detailed and extensive oral evaluation - problem focused, by report
Comprehensive periodontal evaluation
Consultation (diagnostic service provided by Dentist or Physician other than practitioner providing treatment)

Benefits will not be provided for tests and oral pathology procedures, or for re-evaluations.

Preventive Services

Preventive services are performed to prevent dental disease. Dental Services include:

Prophylaxis - Adult - Limited to 1 every 6 Months
Prophylaxis - Child - Limited to 1 every 6 Months
Topical fluoride varnish - Less than age 19 - 2 in 12 Months
Topical application of fluoride (excluding prophylaxis) - Less than age 19 - 2 in 12 Months

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Periodontal maintenance combined with prophylaxes treatments (see "Non-Surgical Periodontic Services") are limited to four in a 12-Month period following completion of active periodontal therapy.

Diagnostic Radiographs

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

Intraoral - complete series (including bitewings) - 1 every 60 (sixty) Months
Intraoral - periapical first film
Intraoral - periapical - each additional film
Intraoral - occlusal film
Bitewing - single film - Adult - 1 set every calendar year / Children - 1 set every 6 Months
Bitewings - two films - Adult - 1 set every calendar year / Children - 1 set every 6 Months
Bitewings - four films - Adult - 1 set every calendar year / Children - 1 set every 6 Months
Vertical bitewings - 7 to 8 films - Adult - 1 set every calendar year / Children - 1 set every 6 Months

Panoramic film - 1 film every 60 (sixty) Months
Cephalometric x-ray
Oral / Facial Photographic Images
Interpretation of Diagnostic Image

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

Miscellaneous Preventive Services

Miscellaneous preventive services are other services performed to prevent dental disease and include:

Sealant - per tooth - unrestored permanent molars - Less than age 19 - 1 sealant per tooth every 36 Months
Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 Months
Space maintainer - fixed - unilateral - Limited to children under age 19
Space maintainer - fixed - bilateral - Limited to children under age 19
Space maintainer - removable - unilateral - Limited to children under age 19
Space maintainer - removable - bilateral - Limited to children under age 19
Re-cementation of space maintainer - Limited to children under age 19

Benefits are not available for nutritional, tobacco and oral hygiene counseling.

Basic Restorative Services

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Dental Services include:

Amalgam - one surface, primary or permanent
Amalgam - two surfaces, primary or permanent
Amalgam - three surfaces, primary or permanent
Amalgam - four or more surfaces, primary or permanent
Resin-based composite - one surface, anterior
Resin-based composite - two surfaces, anterior
Resin-based composite - three surfaces, anterior
Resin-based composite - four or more surfaces or involving incisal angle (anterior)

Benefits will not be provided for restorations placed within 12 Months of the initial placement by the same Dentist.

Non-Surgical Extractions

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Non-Surgical Periodontal Services

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

Periodontal scaling and root planing - four or more teeth per quadrant - Limited to 1 every 24 Months
Periodontal scaling and root planing - one to three teeth per quadrant - Limited to 1 every 24 Months
Scaling gingival inflammation - Limited to 1 every 6 Months combined with prophylaxis and periodontal maintenance
Full mouth debridement to enable comprehensive evaluation and diagnosis - Limited to 1 per lifetime
Periodontal maintenance - 4 in 12 Months combined with adult prophylaxis after the completion of active periodontal therapy
Collect - Apply Autologous Product - Limited to 1 in 36 Months

Adjunctive Services

Adjunctive general services include:

Palliative treatment of dental pain - minor procedure
Deep sedation/general anesthesia - first 30 minutes

Deep sedation/general anesthesia - each additional 15 minutes
Intravenous moderate (conscious) sedation/analgesia - first 30 minutes
Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes
Therapeutic drug injection, by report

Endodontic Services

Endodontics is the treatment of dental disease of the tooth pulp and includes:

Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and Benefits are not payable separately.
Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development. If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and Benefits are not payable separately.
Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when the Member discontinues treatment. - Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
Anterior root canal (excluding final restoration)
Bicuspid root canal (excluding final restoration)
Molar root canal (excluding final restoration)
Retreatment of previous root canal therapy - anterior
Retreatment of previous root canal therapy - bicuspid
Retreatment of previous root canal therapy - molar
Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
Apicoectomy/periradicular surgery - anterior
Apicoectomy/periradicular surgery - bicuspid (first root)
Apicoectomy/periradicular surgery - molar (first root)
Apicoectomy/periradicular surgery (each additional root)
Root amputation - per root
Hemisection (including any root removal) - not including root canal therapy

Oral Surgery Services

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
Removal of impacted tooth - soft tissue
Removal of impacted tooth - partially bony
Removal of impacted tooth - completely bony
Removal of impacted tooth - completely bony with unusual surgical complications
Surgical removal of residual tooth roots (cutting procedure)
Coronectomy - intentional partial tooth removal
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
Surgical access of an unerupted tooth
Alveoloplasty in conjunction with extractions - per quadrant
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
Alveoloplasty not in conjunction with extractions - per quadrant

Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
Removal of exostosis
Incision and drainage of abscess - intraoral soft tissue
Suture of recent small wounds up to 5 cm
Bone replacement graft for ridge preservation - per site
Excision of pericoronal gingiva

Surgical Periodontal Services

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

Gingivectomy or gingivoplasty - four or more teeth - Limited to 1 every 36 Months
Gingivectomy or gingivoplasty - one to three teeth
Gingivectomy or gingivoplasty - with restorative procedures, per tooth – Limited to 1 every 36 Months
Gingival flap procedure, four or more teeth - Limited to 1 every 36 Months
Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant - Limited to 1 every 36 Months
Clinical crown lengthening hard tissue
Osseous surgery (including flap entry and closure) four or more contiguous teeth or bounded teeth spaces per quadrant - Limited to 1 every 36 Months
Osseous surgery (including flap entry and closure) one to three contiguous teeth or bounded teeth spaces per quadrant - Limited to 1 every 36 Months
Bone replacement graft - first site in quadrant - Limited to 1 every 36 Months
Pedicle soft tissue graft procedure
Subepithelial connective tissue graft procedures (including donor site surgery)
Soft tissue allograft - Limited to 1 every 36 Months
Free soft tissue graft - 1st tooth
Free soft tissue graft - additional teeth
Treatment of complications (post-surgical) unusual circumstances, by report

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

Major Restorative Services

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

Detailed and extensive oral evaluation - problem focused, by report
Inlay - metallic - one surface - An alternate benefit will be provided
Inlay - metallic - two surfaces - An alternate benefit will be provided
Inlay - metallic - three surfaces - An alternate benefit will be provided
Onlay - metallic - two surfaces - Limited to 1 per tooth every 60 Months
Onlay - metallic - three surfaces - Limited to 1 per tooth every 60 Months
Onlay - metallic - four or more surfaces - Limited to 1 per tooth every 60 Months
Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 Months
Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 Months
Crown - porcelain fused to predominately base metal - Limited to 1 per tooth every 60 Months
Crown - porcelain fused to noble metal - Limited to 1 per tooth every 60 Months
Crown - 3/4 cast high noble metal - Limited to 1 per tooth every 60 Months
Crown - 3/4 cast predominately base metal - Limited to 1 per tooth every 60 Months
Crown - 3/4 porcelain/ceramic - Limited to 1 per tooth every 60 Months
Crown - full cast high noble metal - Limited to 1 per tooth every 60 Months
Crown - full cast predominately base metal - Limited to 1 per tooth every 60 Months
Crown - full cast noble metal - Limited to 1 per tooth every 60 Months
Crown - titanium - Limited to 1 per tooth every 60 Months
Post and core - Limited to 1 per tooth every 60 Months
Protective Restoration
Inlay Repair
Onlay Repair

Veneer Repair
Resin infiltration/smooth surface - Limited to 1 every 36 Months

Benefits will not be provided for the replacement of a lost, missing or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

Benefits will not be provided for services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

Benefits will not be provided for services to restore occlusion on incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 Months whether placement was provided under this Member Guide or under any prior dental coverage, even if the original crown was stainless steel.

Prosthodontic Services

Prosthodontics involve procedures necessary for providing artificial replacements for missing natural teeth and includes:

Adjust complete denture - maxillary
Adjust complete denture - mandibular
Adjust partial denture - maxillary
Adjust partial denture - mandibular
Repair broken complete denture base
Replace missing or broken teeth - complete denture (each tooth)
Repair resin denture base
Repair cast framework
Repair or replace broken clasp
Replace broken teeth - per tooth
Add tooth to existing partial denture
Add clasp to existing partial denture
Rebase complete maxillary partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Rebase maxillary partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Rebase mandibular partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline complete maxillary denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline complete mandibular denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline maxillary partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline mandibular partial denture - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-Month period 6 Months after initial installation
Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-Month period 6 Months after initial installation
Complete denture - maxillary - Limited to 1 every 60 Months
Complete denture - mandibular - Limited to 1 every 60 Months
Immediate denture - maxillary - Limited to 1 every 60 Months
Immediate denture - mandibular - Limited to 1 every 60 Months
Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 Months
Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 Months
Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 Months
Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 Months
Removable unilateral partial denture-one piece cast metal (including clast and teeth) - Limited to 1 every 60 Months

An implant is a covered procedure only if determined to be a Dental Necessity. Claim review is conducted by The Plan who reviews the clinical documentation submitted by the treating Dentist. If The Plan determines an arch can be restored with a standard prosthesis or restoration, no Benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate Benefit provision of The Plan (see “Alternate Care”).

Endosteal Implant - 1 every 60 Months
Surgical Placement of Interim Body - 1 every 60 Months
Eposteal Implant - 1 every 60 Months
Transosteal Implant, including hardware - 1 every 60 Months
Implant supported complete denture
Implant supported partial denture
Connecting Bar - implant or abutment supported - 1 every 60 Months
Prefabricated Abutment - 1 every 60 Months
Custom Abutment - 1 every 60 Months
Abutment supported porcelain ceramic crown - 1 every 60 Months
Abutment supported porcelain fused to high noble metal - 1 every 60 Months
Abutment supported porcelain fused to predominately base metal crowns - 1 every 60 Months
Abutment supported porcelain fused to noble metal crown - 1 every 60 Months
Abutment supported cast high noble metal crown - 1 every 60 Months
Abutment supported cast predominately base metal crown - 1 every 60 Months
Abutment supported cast noble metal crown - 1 every 60 Months
Implant supported porcelain/ceramic crown - 1 every 60 Months
Implant supported porcelain fused to high metal crown - 1 every 60 Months
Implant supported metal crown - 1 every 60 Months
Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 Months
Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 Months
Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 Months
Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 Months
Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 Months
Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 Months
Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 Months
Implant supported retainer for ceramic fixed partial denture - 1 every 60 Months
Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 Months
Implant supported retainer for cast metal fixed partial denture - 1 every 60 Months
Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 Months
Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 Months
Implant Maintenance Procedures - 1 every 60 Months
Scaling and debridement implant - 1 every 60 Months
Repair Implant Prosthesis - 1 every 60 Months
Replacement of Semi-Precision or Precision Attachment - 1 every 60 Months
Repair Implant Abutment - 1 every 60 Months
Implant Removal - 1 every 60 Months
Debridement periimplant defect, covered if implants are covered - Limited to 1 every 60 Months
Debridement and osseous periimplant defect, covered if implants are covered - Limited to 1 every 60 Months
Bone graft implant periimplant defect, covered if implants are covered
Bone graft implant replacement, covered if implants are covered
Implant Index - 1 every 60 Months
Pontic - cast high noble metal - Limited to 1 every 60 Months
Pontic - cast predominately base metal - Limited to 1 every 60 Months
Pontic - cast noble metal - Limited to 1 every 60 Months
Pontic - titanium - Limited to 1 every 60 Months
Pontic - porcelain fused to high noble metal - Limited to 1 every 60 Months
Pontic - porcelain fused to predominately base metal - Limited to 1 every 60 Months

Pontic - porcelain fused to noble metal - Limited to 1 every 60 Months
Pontic - porcelain/ceramic - Limited to 1 every 60 Months
Inlay/onlay - porcelain/ceramic - Limited to 1 every 60 Months
Inlay - metallic - two surfaces - Limited to 1 every 60 Months
Inlay - metallic - three or more surfaces - Limited to 1 every 60 Months
Onlay - metallic - three surfaces - 1 every 60 Months
Onlay - metallic - four or more surfaces - 1 every 60 Months
Retainer - cast metal for resin bonded fixed prosthesis - 1 every 60 Months
Retainer - porcelain/ceramic for resin bonded fixed prosthesis - 1 every 60 Months
Resin retainer - for resin bonded fixed prosthesis - 1 every 60 Months
Crown - porcelain/ceramic - 1 every 60 Months
Crown - porcelain fused to high noble metal - 1 every 60 Months
Crown - porcelain fused to predominately base metal - 1 every 60 Months
Crown - porcelain fused to noble metal - 1 every 60 Months
Crown - 3/4 cast high noble metal - 1 every 60 Months
Crown - 3/4 cast predominately base metal - 1 every 60 Months
Crown - 3/4 cast noble metal - 1 every 60 Months
Crown - 3/4 porcelain/ceramic - 1 every 60 Months
Crown - full cast high noble metal - 1 every 60 Months
Crown - full cast predominately base metal - 1 every 60 Months
Crown - full cast noble metal - 1 every 60 Months
Occlusal guard, by report - 1 in 12 Months for patients 13 and older
Repair/reline occlusal guard - 1 every 24 Months for patients 13 and older
Occlusal guard adjustment - 1 every 24 Months for patients 13 and older
Tissue conditioning (maxillary)
Tissue conditioning (mandibular)

NOTE: Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

NOTE: Implant retained crowns, bridges, and dentures are subject to the alternate Benefit provision of The Plan (see “Alternate Care”).

Endosteal, eposteal, and transosteal implants – one every 60 Months only if determined to be a Dental Necessity.

Benefits will not be provided for the following Prosthodontic Services:

1. Treatment to replace teeth which were missing prior to the Effective Date.
2. Congenitally missing teeth.
3. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

Miscellaneous Restorative and Prosthodontic Services

Other restorative and prosthodontics services include:

Diagnostic Models
Re-cement inlay
Re-cement or re-bond indirectly fabricated or prefabricated post and core
Re-cement crown
Prefabricated porcelain crown - primary - Limited to 1 every 60 Months
Prefabricated stainless steel crown - primary tooth - Under age 15 - Limited to 1 per tooth in 60 Months
Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 Months
Core buildup, including any pins - Limited to 1 per tooth every 60 Months
Pin retention - per tooth, in addition to restoration
Prefabricated post and core, in addition to crown - Limited to 1 per tooth every 60 Months
Crown repair, by report
Re-cement fixed partial denture
Fixed partial denture repair, by report

Medically Necessary Orthodontic Services

Benefits for Medically Necessary orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth. Coverage for orthodontic services is shown on the Schedule of Benefits. Covered services include:

Limited orthodontic treatment of the primary dentition
Limited orthodontic treatment of the transitional dentition
Limited orthodontic treatment of the adolescent dentition
Limited orthodontic treatment of the adult dentition
Interceptive orthodontic treatment of the primary dentition
Interceptive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the adolescent dentition
Comprehensive orthodontic treatment of the adult dentition
Removable appliance therapy
Fixed appliance therapy
Pre-orthodontic treatment visit
Periodic orthodontic treatment visit (as part of Member Guide)
Orthodontic retention (removal of appliances, construction and placement of retainer(s)

NOTE: Benefits for codes D0330, D0340, D0350, and D0470 will be applied to the lifetime orthodontia maximum when performed as part of orthodontia treatment.

Special Provisions Regarding Orthodontic Services:

Pediatric Orthodontic Services – Coverage is limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria established by The Plan (e.g., severe, dysfunctional malocclusion).

Benefits for Medically Necessary orthodontic services are limited to Members who meet the Policy criteria related to a medical condition including but are not limited to:

1. Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services.
2. Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services.
3. Skeletal anomaly involving maxillary and/or mandibular structures.

Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

1. Orthodontic treatment is started on the date the bands or appliances are inserted. Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the Benefit Period maximum for orthodontic services.
2. If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
3. If the Member's coverage is terminated prior to the completion of the orthodontic treatment plan, the Member is responsible for the remaining balance of treatment costs.
4. Recementation of an orthodontic appliance by the same provider who placed the appliance and/or who is responsible for the ongoing care of the Member is not covered.
5. Benefits are not available for replacement or repair of an orthodontic appliance.
6. For services in progress on the Effective Date, Benefits will be reduced based on the Benefits paid prior to this coverage beginning.

Important Information About the Member's Dental Benefits

Dental Procedures Which Are Not Dentally Necessary

Please note that in order to provide dental care Benefits at a reasonable cost, this Member Guide provides Benefits only for those covered Dental Services and eligible dental treatment that are determined by The Plan to be Dentally Necessary.

No Benefits will be provided for procedures which are not Dentally Necessary. Dentally Necessary generally means that a specific procedure provided to the Member is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to the Member, as determined by The Plan.

The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Dentally Necessary.

Care by More Than One Dentist

If the Member changes Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if the Member had stayed with the same Dentist until treatment was completed. There will be no duplication of Benefits.

Non-Compliance with Prescribed Care

Any additional treatment and resulting liability which is caused by the lack of a Member's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Member.

The Plan will not pay for:

1. Services and treatment not prescribed by or under the direct supervision of a Dentist, except in those states where dental hygienists are permitted to practice without supervision by a Dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
2. Services and treatment which are experimental or investigational;
3. Services and treatment which are for any Illness or bodily Injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This Exclusion applies whether or not the Member claim the benefits or compensation;
4. Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA Hospital or similar person or group;
5. Services and treatment performed prior to the Member's Effective Date of coverage;
6. Services and treatment incurred after the termination date of the Member's coverage unless otherwise indicated;
7. Services and treatment which are not Dentally Necessary or which do not meet generally accepted standards of dental practice;
8. Services and treatment resulting from the Member's failure to comply with professionally prescribed treatment;
9. Any charges for failure to keep a scheduled appointment;
10. Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
11. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
12. Any loss for which a contributing cause was the commission of a felony or serious illegal act, or an attempt to commit a felony or an attempt to commit a serious illegal act, for which the Member has been found guilty in a court of competent jurisdiction or to which the Member has plead guilty or no contest. This Exclusion does not apply to the extent the Member suffers a loss as a victim of domestic violence;
13. Office infection control charges;
14. Charges for copies of the Member's records, charts or x-rays, or any costs associated with forwarding/mailing copies of the Member's records, charts or x-rays;
15. State or territorial taxes on Dental Services performed;
16. Those submitted by a Dentist, which is for the same services performed on the same date for the same Member by another Dentist;
17. Those provided free of charge by any governmental unit, except where this Exclusion is prohibited by law;
18. Those for which the Member would have no obligation to pay in the absence of this or any similar coverage;
19. Those which are for specialized procedures and techniques;
20. Those performed by a Dentist who is compensated by a facility for similar covered services performed for Members;
21. Duplicate, provisional and temporary devices, appliances, and services;
22. Plaque control programs, oral hygiene instruction, and dietary instructions;

23. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
24. Gold foil restorations;
25. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
26. Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
27. Hospital costs or any additional fees that the Dentist or Hospital charges for treatment at the Hospital (Inpatient or Outpatient);
28. Charges by the provider for completing dental forms;
29. Adjustment of a denture or bridgework which is made within 6 Months after installation by the same Dentist who installed it;
30. Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
31. Cone Beam Imaging and Cone Beam MRI procedures;
32. Sealants for teeth other than permanent molars;
33. Precision attachments, personalization, precious metal bases and other specialized techniques;
34. Replacement of dentures that have been lost, stolen or misplaced;
35. Orthodontic care for Dependent children age 19 and over;
36. Repair of damaged orthodontic appliances;
37. Replacement of lost or missing appliances;
38. Fabrication of athletic mouth guard;
39. Internal and external bleaching;
40. Nitrous oxide;
41. Oral sedation;
42. Topical medicament center;
43. Orthodontic care for a Member or Spouse covered under the Standard Plan Option;
44. Bone grafts when done in connection with extractions, apicoectomies or non-covered/non-eligible implants;
45. When two or more services are submitted, and the services are considered part of the same service to one another The Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by The Plan;
46. When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), The Plan will pay for the service that represents the final treatment as determined by The Plan;
47. Amounts which are in excess of the Allowable Fee, as determined by The Plan.

Pediatric Vision Care

The following services only may be provided by a licensed ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician to Members under 19 years of age:

1. One Routine vision exam per Benefit Period; and/or
2. One pair of glasses (frames and lenses) or one pair of contacts per Benefit Period.

The Plan will not pay for any vision service, treatment or materials not specifically listed above.

Physician Medical Services

Medical services by a Covered Provider for:

1. Inpatient Hospital Physician visits;
2. Convalescent Home facility Physician visits; and/or
3. Surgical facility Physician services.

The Plan will not pay for pre- or postsurgical visits that are considered to be Inclusive Services/Procedures that are included in the payment for the surgery.

This Benefit does not include services provided in the home or the Covered Provider's office.

Postmastectomy Care and Reconstructive Breast Surgery

Postmastectomy Care

Medically Necessary Inpatient Care for the period of time determined by the attending Physician and the Member, following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

Prior Authorization is required for Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Reconstructive Breast Surgery

1. All stages of Reconstructive Breast Surgery after a mastectomy including, but not limited to:
   - **a.** All stages of reconstruction of the breast on which a mastectomy has been performed;
   - **b.** Surgery and reconstruction of the other breast to establish a symmetrical appearance;
   - **c.** Chemotherapy; and/or
   - **d.** Prostheses and physical complications of all stages of a mastectomy and breast reconstruction, including lymphedemas.

   Coverage described in 1.a. through 1.d. will be provided in a manner determined in consultation with the attending Physician and the patient.
2. Breast prostheses as the result of a mastectomy.

For specific Benefits related to postmastectomy care, refer to that specific Benefit, e.g., surgical services and Hospital services.

Prescription Drugs

Refer to the Prescription Drugs section in the Schedule of Benefits for specific information on the application of any Deductible, Copayment and/or Coinsurance.

The Prescription Drugs Benefit is for Prescription Drug Products which are self-administered. This Benefit does not include medications which are administered by a Covered Provider. If a medication is administered by a Covered Provider, the claim will process under the Member's medical Benefits. **Please refer to the Utilization Management section for complete information about the medications that are subject to the Member's medical Benefits, the process for requesting Prior Authorization for medications subject to the Member's medical Benefits, and related information.**

Subject to the terms, conditions, and limitations of this Member Guide, The Plan will pay for Prescription Drug Products, which:

1. Are approved for use in humans by the FDA; and
2. Require a Physician's written prescription; and
3. Are dispensed under federal or state law pursuant to a prescription order or refill.

Prescription Drug Products which are used in off-label situations may be reviewed for Medical Necessity.

Drug Lists

Drugs listed on the Drug List are selected by The Plan based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or Affiliated with Blue Cross and Blue Shield of Montana. The committee considers existing drugs approved by the FDA, as well as those newly FDA approved for inclusion on the Drug List. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost, and how it compares with drugs currently on the Drug List.

Positive changes (e.g., adding drugs to the Drug List, drugs moving to a lower payment tier) occur quarterly after review by the Committee. Changes to the Drug List that could have an adverse financial impact to the Member (e.g., drug Exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or Prior Authorization) occur annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the Drug List may occur more frequently.

The Drug List and any modifications will be made available to the Member. By accessing the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists or calling the Customer Service toll-free number on the Member's identification card, the Member will be able to determine the Drug List that applies to the Member's Plan and whether a particular drug is on the Drug List.

The Member, or the Member's prescribing health care provider, can ask for a Drug List exception if the Member's drug is not on the Drug List. To request this exception, the Member or the Member's prescriber, can call the number on the back of the Member's identification card to ask for a review. Blue Cross and Blue Shield of Montana will notify the Member or the Member's prescriber of its decision with respect to the request within 72 hours after the request is received.

If the Member has a health condition that may jeopardize their life, health or keep the Member from regaining function, or the Member's current drug therapy uses a non-covered drug, the Member's prescriber, may be able to ask for an expedited review process by marking the review as an urgent request. Blue Cross and Blue Shield of Montana will notify the Member or the Member's prescriber, of the coverage decision within 24 hours after they receive the request for an expedited review.

If the coverage request is denied, Blue Cross and Blue Shield of Montana will let the Member and the Member's prescriber, know why it was denied and offer the Member a covered alternative drug (if applicable). If the Member's exception is denied, the Member may appeal the decision according to the appeals process the Member will receive with the denial determination. The Member should call the number on the back of the Member's identification card if the Member has any questions.

Covered Prescription Drug Products

The following Prescription Drugs Products, obtained from a Participating Pharmacy, either retail or mail-order, or a retail nonparticipating Pharmacy, are covered:

1. Legend drugs - drugs requiring written prescriptions and dispensed by a licensed pharmacist for treatment of an Illness or Injury;
2. One prescription oral agent for controlling blood sugar levels for each class of drug approved by the FDA;
3. Insulin with a prescription;
4. Disposable insulin needles/syringes;
5. Test strips;
6. Lancets;
7. Oral contraceptives, contraceptive devices or injections prescribed by a Physician; and
8. Smoking cessation products and over-the-counter smoking cessation aids/medications with a written prescription, as required by the Affordable Care Act. Tobacco counseling is available under the Preventive Health Care Benefit.

The Schedule of Benefits lists any Deductible, Copayment and/or Coinsurance that the Member is responsible for and payment limitations for these Prescription Drug Products.

Non-Covered Prescription Drug Products

The Plan will not pay for:

1. Drugs/products which are not included on the Drug List, unless specifically covered elsewhere in this Member Guide and/or such coverage is required in accordance with applicable law or regulatory guidance;
2. Non-FDA approved Drugs;
3. Compounded Drugs;
4. Drugs, that the use or intended use of which would be illegal, abusive, not Medically Necessary, or otherwise improper such as anabolic steroids;
5. Any drug used for the purpose of weight loss;
6. Fluoride supplements, except as required by the Affordable Care Act for children under age 6;

7. Devices, technologies, and/or Durable Medical Equipment of any type (even though such devices may require a prescription order), such as, but not limited to, therapeutic devices, artificial appliance, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections);
8. Over-the-counter drugs that do not require a prescription, except over-the-counter smoking cessation aids with a written prescription;
9. Prescription for which there is an exact over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined;
10. Prescription Drug Products for cosmetic purposes, including the treatment of hair loss (e.g., Minoxidil, Rogaine);
11. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those otherwise covered under this section;
12. Prescription Drug Products used for erectile dysfunction;
13. Prescription Drug Products used for the treatment of infertility;
14. Insulin pumps and glucose meters. Insulin pumps and glucose meters are covered under the Durable Medical Equipment Benefit. Insulin pump supplies are covered under the Medical Supplies Benefit;
15. Drugs or items labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Member is charged for the item;
16. Biological sera, blood, or blood plasma;
17. Prescription Drug Products which are to be taken by or administered to the Member, in whole or in part, while the Member is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility's charge;
18. Any Prescription Drug Product refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;
19. Replacement prescription drugs or Prescription Drug Products due to loss, theft or spoilage;
20. Prescription Drug Products obtained from a Pharmacy located outside the United States for consumption within the United States;
21. Prescription Drug Products provided by a mail-order Pharmacy that is not approved by The Plan;
22. Non-sedating antihistamines;
23. Brand-Name Proton Pump Inhibitors (PPIs);
24. Prescription Drug Products determined by The Plan to have inferior efficacy or significant safety issues;
25. Administration or injection of any drugs;
26. Repackagers, Institutional Packs, Clinic Packs, or other custom packaging;
27. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary), including, but not limited to, preservatives, solvents, ointment bases, flavoring, coloring, diluting, emulsifying and suspending agents;
28. Bulk powders;
29. Surgical supplies (e.g., Amvisc, Cellugel, Duovisc, Hyalgan, Provisc, Supartz, Synvisc, Viscoat);
30. Drugs which do not by law require a Prescription from a provider or health care practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies); and drugs or covered devices for which no valid Prescription is obtained;
31. Vitamins (except those vitamins which by law require a Prescription and for which there is no non–prescription alternative);
32. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select vaccinations administered through certain Value and Participating Pharmacies are an exception to this Exclusion;
33. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Member Guide;

    NOTE: This exception does not apply to dietary formula necessary for the treatment of Inborn Errors of Metabolism.

34. Drugs used or intended to be used in the treatment of a condition, sickness, disease, Injury, or bodily malfunction which is not covered under the Member Guide, or for which Benefits have been exhausted;
35. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Member's identification card;
36. Benefits will not be provided for any self-administered drugs dispensed by a Physician;
37. Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, The Plan may limit Benefits to only certain therapeutic equivalents/therapeutic alternatives. If the Member does not choose the therapeutic equivalents/therapeutic alternatives that are covered under the Prescription Drug Program, the drug purchased will not be covered under any Benefit level;
38. Experimental/Investigational/Unproven status of a drug or device is determined by Blue Cross and Blue Shield of Montana taking into consideration a variety of factors, including demonstration of efficacy in peer reviewed literature. With respect to FDA approval, if FDA approval is not obtained, the drug will be considered Experimental/Investigational/Unproven, but if FDA approval is obtained, while this will be considered by Blue Cross and Blue Shield of Montana in making its determination of Experimental/Investigational/Unproven status, such approval will not be determinative;
39. Certain drug classes where there are over-the-counter alternatives available;
40. Diagnostic agents (except for diabetic testing supplies or test strips);
41. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines; and
42. New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

Vaccinations Obtained Through Select Participating Pharmacies

Vaccinations are available through select Participating Pharmacies that have contracted with Blue Cross and Blue Shield of Montana. To obtain a current list of Participating Pharmacies and a list of covered vaccines, the Member can call the Customer Service toll-free number identified on the Member's identification card or access www.bcbsmt.com and click on "Member Services". Then click on the "Prescription Drug Plan Information" and select "Pharmacy Program." The Member should present the Member's identification card to the pharmacist at the time services are received. The pharmacist will inform the Member of any applicable Copayment and/or Coinsurance.

Each select Participating Pharmacy that has contracted with Blue Cross and Blue Shield of Montana to provide this service may have age, scheduling, or other requirements that will apply, so the Member should contact the Participating Pharmacy in advance. Childhood immunizations subject to state regulations are not available under this Pharmacy Benefit but are covered under the medical Benefits of the health plan.

Controlled Substances Limitation

If it is determined that a Member may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any Benefit for additional drugs may be subject to review to assess whether Medically Necessary or appropriate and restrictions may include but not be limited to a certain provider and/or Pharmacy and/or quantities and/or day's supply for the prescribing and dispensing of the controlled substance medication. Additional Copayments and/or Coinsurance may apply.

Purchase and Payment of Prescription Drug Products

Prescription Drug Products may be obtained using a retail Pharmacy or a mail-order Pharmacy approved by The Plan. To use a mail-order Pharmacy, the Member must send an order form with the prescription to the address listed on the mail-order service form and pay any required Deductible, Copayment and/or Coinsurance. The address of each mail-order Pharmacy approved by The Plan is listed on the inside cover of this Member Guide.

Available Prescription Drug Products include Brand-Name Drugs and Generic Drugs. If a Generic Drug equivalent becomes available during the period of coverage for this policy, it may be added to the Drug List maintained by and available to the Member on the Blue Cross and Blue Shield of Montana website and the Pharmacy Benefit Manager's website. Refer to the inside cover of this Member Guide for information on Blue Cross and Blue Shield of Montana's Pharmacy Benefit Manager. The availability of a Generic Drug may allow the Member to obtain a drug at a potentially lower out of pocket cost. The factors that determine the costs to a Member include the terms of the coverage and the Drug List in effect as of the date of the prescription and the Pharmacy service date, as well as the use of a Participating Pharmacy or nonparticipating Pharmacy. In addition to any Deductible, Copayment and/or Coinsurance, if the Member chooses a Brand-Name Drug for which a Generic Drug equivalent is available, the

Member is required to pay the difference between the cost of the Brand-Name Drug and the Generic Drug equivalent.

Exceptions to this provision may be allowed for certain preventive medications (including prescription contraceptive medications) if the Member's health care provider submits a request to The Plan indicating that the Generic Drug would be medically inappropriate, along with supporting documentation. If The Plan grants the exception request, any difference between the cost of the Brand-Name Drug and the Generic Drug equivalent will be waived.

The difference in the cost between a Generic Drug equivalent and a Brand-Name Drug may not be required if there is a medical reason (e.g., adverse event) the Member would need to take the Brand-Name Drug and certain criteria are met. The Member's provider can submit a request to waive the difference in cost between the Brand-Name Drug and the Generic Drug equivalent. In order for this request to be reviewed, the Member's provider must submit a MedWatch form to the FDA to notify the FDA of the issues experienced by the Member with the Generic Drug equivalent. The Member's provider must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment and/or Coinsurance will still apply. For additional information, contact Customer Service at the number on the back of the Member's identification card or visit the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com.

If drugs or Prescription Drug Products are purchased at a Value Participating Pharmacy, a Participating Pharmacy or a mail-order Pharmacy approved by The Plan, and the Member presents the Member's identification card at the time of purchase, the Member must pay any required Deductible, Copayment and/or Coinsurance. The Deductible, Copayment and/or Coinsurance apply to the In-Network Deductible and In-Network Out of Pocket Amount.

If a covered prescription drug was paid for using a drug manufacturer's coupon or copayment card, the coupon or copayment card amount will not apply to The Plan Deductible or Out of Pocket Amount.

If the Member uses a Participating Pharmacy to fill a prescription but elects to submit the claim directly to The Plan's Pharmacy Benefit Manager, instead of having the Participating Pharmacy submit the claim, the Member will be reimbursed for the prescription drug based on the amount that would have been paid to the Participating Pharmacy, less any Deductible, Copayment and/or Coinsurance.

If drugs or Prescription Drug Products are purchased at a nonparticipating Pharmacy, the Member must pay for the prescription at the time of dispensing and then file a prescription drug claim form with The Plan's Pharmacy Benefit Manager for reimbursement. Any Deductible, Copayment and/or Coinsurance apply to any applicable Out-of-Network Deductible and Out-of-Network Out of Pocket Amount. The Member will be reimbursed for the prescription drug at 50% of the amount that would have been paid to a Participating Pharmacy, less any applicable Out-of-Network Deductible, Copayment and/or Coinsurance and any additional charge for the difference between the cost of the Brand-Name Drug and the Generic Drug equivalent. The 50% Benefit reduction does not apply to any Out of Pocket Amounts.

Please refer to Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefits section of this Member Guide for additional information.

How Member Payment is Determined

Prescription Drug Products are separated into Tiers. Generally, each drug is placed into one of six drug Tiers.

- Tier 1 Generic Drugs (preferred) – includes mostly Preferred Generic Drugs and may contain some Brand-Name Drugs.
- Tier 2 Generic Drugs (non-preferred) – includes mostly Non-Preferred Generic Drugs and may contain some Brand-Name Drugs.
- Tier 3 brand drugs (preferred) – includes mostly Preferred Brand-Name Drugs and may contain some Generic Drugs.
- Tier 4 brand drugs (non-preferred) – includes mostly Non-Preferred Brand-Name Drugs and may contain some Generic Drugs.
- Tier 5 specialty drugs (preferred) – includes mostly Preferred Specialty Medications and may contain some Generic Drugs.
- Tier 6 specialty drugs (non-preferred) – includes mostly Non-Preferred Specialty Medications and may contain some Generic Drugs.

To determine the Tier in which a drug is included, access the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists or call the number on the back of the Member's identification card. Benefits will be provided as shown on the Schedule of Benefits.

Prescription Drug Products Subject to Prior Authorization, Step Therapy or Dispensing Limits

1. Prescription Drug Products subject to Prior Authorization require prior approval from The Plan's Pharmacy Benefit Manager before they can qualify for coverage under The Plan. If the Member does not obtain Prior Authorization before a Prescription Drug Product is dispensed, the Member may pay for the prescription and then pursue authorization of the drug from The Plan's Pharmacy Benefit Manager. If the authorization is approved by The Plan's Pharmacy Benefit Manager, the Member should then submit a claim for the prescription drug on a prescription claim form to The Plan's Pharmacy Benefit Manager for reimbursement.
2. Prior Authorization does not guarantee payment of the Prescription Drug Product by The Plan. Even if the prescription drug has been approved through Prior Authorization, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible as of the date the drug is dispensed, or the Member's Benefits may have changed as of the date the drug is dispensed.
3. The step therapy program requires that the Member has a prescription history for a prerequisite medication before The Plan will cover a targeted drug. If the Member and their provider decide that a prerequisite drug is not right for the Member or is not as good in treating Member's condition, the provider should submit a Prior Authorization request for coverage of the other drug.
4. A dispensing limit is a limitation on the number or amount of a Prescription Drug Product covered within a certain time period and quantity of covered medication per prescription. Dispensing limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, appropriate utilization, and to avoid misuse/abuse of the medication. A prescription written for a quantity in excess of the established limit will require a clinical review before Benefits are available.

Certain Prescription Drug Products, such as those used to treat rheumatoid arthritis, growth hormone deficiency, or hepatitis C, may be subject to Prior Authorization, step therapy, or dispensing limits. The Prescription Drug Products included in these programs are subject to change, and medications for other conditions may be added to the program.

If the Member's provider is prescribing a Prescription Drug Product subject to Prior Authorization, step therapy, or dispensing limits, the provider should fax the request for Prior Authorization to The Plan's Pharmacy Benefit Manager at the fax number listed on the inside cover of this Member Guide. The Member and provider will be notified of The Plan's Pharmacy Benefit Manager's determination. If the request is denied, the decisions may be appealed according to the appeals process provided with the denial determination.

In making determinations of coverage, The Plan's Pharmacy Benefit Manager may rely upon Pharmacy policies developed through consideration of peer reviewed medical literature, FDA approvals, accepted standards of medical practice in Montana, Pharmacy Benefit Manager evaluations, Medical Necessity, and Medical Policies. The Pharmacy policies and Medical Policies are located on The Plan website at www.bcbsmt.com.

To find out more about Prior Authorization/step therapy/dispensing limits or to determine which Prescription Drug Products are subject to Prior Authorization, step therapy or dispensing limits, the Member or provider should refer to the Drug List which applies to the Member's Plan at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists or www.myprime.com or call the Customer Service toll-free number identified on the Member's identification card.

Prescription Eye Drop Refills

Refills for prescription eye drops to treat a chronic eye disease or condition will be refilled if 1. the original prescription order states that additional quantities of the eye drops are needed; 2. the refill does not exceed the total quantity of dosage units authorized by the prescribing Member's provider on the original prescription order, including refills; and 3. an amount of time has passed in which the insured should have used 70% of the dosage unit of the drug according to the prescriber's instructions; or:

- Not earlier than the 21st day after the date a prescription order for a 30-day supply is dispensed; or
- Not earlier than the 42nd day after the date a prescription order for a 60-day supply is dispensed; or
- Not earlier than the 63rd day after the date a prescription order for a 90-day supply is dispensed.

Multi-Category Split Fill Program

If this is the Member's first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if the Member has not filled one of these medications within 120 days, the Member may only be eligible for a partial fill (14 - 15-day supply) of the medication for up to the first 3 Months of therapy. The partial fill is designed to determine how the medication is working therapeutically for the Member. Any applicable Copayment and/or Coinsurance may be adjusted to align with the quantity of pills dispensed. If the medication is working and the Member's provider would like to continue on this medication, the Member may be eligible to receive up to a 30-day supply after completing up to 3 Months of the partial supply. Call the number on the back of the Member's identification card for any questions or for a list of drugs that are included in this program, or visit the website at https://www.bcbsmt.com/rx-drugs/pharmacy/pharmacy-programs.

Specialty Medications

1. Specialty Medications are generally prescribed for individuals with complex medical conditions such as multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These medications also have one or more of the following characteristics:
   - **a.** Injected or infused, but some may be taken by mouth;
   - **b.** Unique storage or shipment requirements;
   - **c.** Additional education and support required from a health care professional; and/or
   - **d.** Usually not stocked at retail Pharmacies.
2. For the highest level of Benefits, Specialty Medications must be acquired through The Plan's contracted Specialty Pharmacies listed on the inside cover of this Member Guide. A list of covered Specialty Medications may be found on The Plan website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. Registration and other applicable forms are also located on the website.

Preventive Health Care

Covered preventive services include, but are not limited to:

1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's (USPSTF) current recommendations (additional information is provided by accessing http://www.uspreventiveservicestaskforce.org); and
2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention (CDC); and
3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;

   In addition to the screening services recommended under the HRSA Guidelines, the following services are included:

   - **a.** Lactation Services

     Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. In addition, Benefits are provided for the purchase of manual or electric breast pumps or the rental of Hospital-grade pumps. The purchase of an electric breast pump is limited to one electric breast pump per Benefit Period.

   - **b.** Contraceptives

     FDA approved contraceptive methods, including certain contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity; and
4. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to or after November 2009.
5. Current recommendations of the United States Preventive Service Task Force regarding obesity screening and counseling.

The preventive services listed above may change as USPSTF, CDC and HRSA guidelines are modified and any such changes will be implemented by Blue Cross and Blue Shield of Montana in the quantities and at the times required by applicable law.

Examples of Preventive Health Care services as defined under federal law include, but are not limited to, colonoscopies, immunizations and vaccinations. Examples of other Preventive Health Care services include, but are not limited to, physical examinations and annual In Home Health Assessment. Any services that are billed as a diagnostic service, will be covered under regular medical Benefits.

Drugs (including both prescription and over-the-counter) that fall within a category of the current “A” or “B” recommendations of the United States Preventive Services Task Force and that are listed on the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the ACA Preventive Services Drug List that are obtained from a nonparticipating Pharmacy, may be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximums.

HDHP-HSA Preventive Drug Program

In addition to the Preventive Health Care services listed above, Benefits include coverage for certain Outpatient prescription drugs, that are covered under the HDHP-HSA Preventive Drug Program, when prescribed by a Qualified Health Care Provider. To determine which drugs or drug categories are covered under the HDHP-HSA Preventive Drug Program, the Qualified Health Care Provider should access the Blue Cross and Blue Shield website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists or call the Customer Service toll-free number on the identification card. The listing of a drug on the HDHP-HSA Preventive Drug Program list does not guarantee coverage. Drugs and drug categories are subject to change.

Benefits for Outpatient prescription drugs covered under the HDHP-HSA Preventive Drug Program will be provided at 100% of the eligible charge and will not be subject to any Deductible, Copayment and/or Coinsurance when obtained from a Value Participating Pharmacy or a Participating Pharmacy when prescribed for preventive purposes.

Benefits for Outpatient prescription drugs covered under the HDHP-HSA Preventive Drug Program will be provided at 50% of the eligible charge when received from a nonparticipating Pharmacy. The Deductible will not apply.

These drugs could also at times be prescribed for treatment purposes. If the Qualified Health Care Provider has prescribed a listed drug for treatment purposes (and not preventive purposes) then it will be subject to any applicable Deductible, Copayment and/or Coinsurance.

NOTE: For more information on drugs covered under the Prescription Drug Benefit, refer to the Prescription Drugs section of this Member Guide.

For more detailed information on all covered services, contact Customer Service.

Prostheses

The appropriate devices used to replace a body part missing because of an Accident, Injury, or Illness.

When placement of a prosthesis is part of a surgical procedure, it will be paid under Surgical Services.

Payment for deluxe prosthetics will be based on the Allowable Fee for a standard prosthesis.

The Plan will not pay for the following items:

1. Computer-assisted communication devices;
2. Replacement of lost or stolen prosthesis.

NOTE: The prosthesis will not be considered a replacement if the prosthesis no longer meets the medical needs of the Member due to physical changes or a deteriorating medical condition.

Radiation Therapy

The use of x-ray, radium, or radioactive isotopes ordered by the attending Physician and performed by a Covered Provider for the treatment of disease.

Rehabilitation – Facility and Professional

Rehabilitation Therapy and other covered services, as outlined in this Rehabilitation section, billed by a Rehabilitation Facility provider or a professional provider for services provided to a Member.

The Plan will not pay when the primary reason for Rehabilitation is any one of the following:

1. Custodial Care;
2. Diagnostic admissions;
3. Maintenance, nonmedical self-help, or vocational educational therapy;
4. Social or cultural rehabilitation;
5. Learning and developmental disabilities; and
6. Visual, speech, or auditory disorders because of learning and developmental disabilities or psychoneurotic and psychotic conditions.

Benefits will not be provided under this Rehabilitation section for treatment of Substance Use Disorder or Mental Illness as defined in the Substance Use Disorder and Mental Health sections.

Benefits will be provided for services, supplies and other items that are within the scope of the rehabilitation Benefit described in this Rehabilitation section only as provided in and subject to the terms, conditions and limitations applicable to this Rehabilitation section and other applicable terms, conditions and limitations of this Member Guide. Other Benefit sections of this Member Guide, such as but not limited to Hospital Services, do not include Benefits for any services, supplies or items that are within the scope of the rehabilitation Benefit as outlined in this section.

Rehabilitation Facility Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations: Room and Board, which includes but is not limited to dietary and general, medical and rehabilitation nursing services.
2. Miscellaneous Rehabilitation Facility Services (whether or not such services are Rehabilitation Therapy or are general, medical or other services provided by the Rehabilitation Facility during the Member's admission), including but not limited to:
    a. Rehabilitation Therapy services and supplies, including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy;
    b. Laboratory procedures;
    c. Diagnostic testing;
    d. Pulmonary services and supplies, including but not limited to oxygen and use of equipment for its administration;
    e. X-rays and other radiology;
    f. Intravenous injections and setups for intravenous solutions;
    g. Special diets when Medically Necessary;
    h. Operating room, recovery room;
    i. Anesthetic and surgical supplies;
    j. Drugs and medicines which:
        1. Are approved for use in humans by the FDA; and
        2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
        3. Require a Physician's written prescription.

        Drugs and medicines which are used in off-label situations may be reviewed for Medical Necessity.
3. Rehabilitation Facility Inpatient Care Services do not include services, supplies or items for any period during which the Member is absent from the Rehabilitation Facility for purposes not related to rehabilitation, including but not limited to intervening inpatient admissions to an acute care Hospital.

Prior Authorization is required for Rehabilitation Facility Inpatient Care. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Rehabilitation Facility Inpatient Care is subject to the following conditions:

1. The Member will be responsible to the Rehabilitation Facility for payment of the Facility's charges if the Member remains as an Inpatient Member when Rehabilitation Facility Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed reserved for a Member.
2. The term Rehabilitation Facility does not include:
   a. A Hospital when a Member is admitted to a general medical, surgical or specialty floor or unit (other than a rehabilitation unit) for acute Hospital care, even though rehabilitation services are or may be provided as a part of acute care;
   b. A nursing home;
   c. A rest home;
   d. Hospice;
   e. A skilled nursing facility;
   f. A Convalescent Home;
   g. A place for care and treatment of Substance Use Disorder;
   h. A place for treatment of Mental Illness; and/or
   i. A long-term, chronic-care institution or facility providing the type of care listed above.

Rehabilitation Facility Inpatient Care Services Billed by a Professional Provider

All professional services provided by a Covered Provider who is a physiatrist or other Physician directing the Member's Rehabilitation Therapy. Such professional services include care planning and review, patient visits and examinations, consultation with other Physicians, nurses or staff, and all other professional services provided with respect to the Member. Professional services provided by other Covered Providers (i.e., who are not the Physician directing the Member's Rehabilitation Therapy) are not included in the rehabilitation Benefit but are included to the extent provided in and subject to the terms, conditions and limitations of other Member Guide Benefits (e.g., Physician Medical Services).

Outpatient Rehabilitation

Rehabilitation Therapy provided on an Outpatient basis by a facility or professional provider.

Routine Foot Care

Benefits for Medically Necessary Routine foot care, when obtained from a Covered Provider.

Substance Use Disorder

Benefits for Substance Use Disorder will be paid as any other Illness.

Outpatient Services

Care and treatment for Substance Use Disorder, when the Member is not an Inpatient Member, and provided in or by:

1. A Hospital;
2. A Mental Health Treatment Center;
3. A Substance Use Disorder Treatment Center;
4. A Physician or prescribed by a Physician;
5. A licensed psychologist;
6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. A licensed psychiatrist; or
10. Other Qualified Health Care Provider.

Outpatient services are subject to the following conditions:

1. The services must be provided to diagnose and treat recognized Substance Use Disorder; and

2. The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Substance Use Disorder.

The Plan will not pay for hypnotherapy or for services given by a staff member of a school or halfway house.

Inpatient Care Services

Care and treatment of Substance Use Disorder, while the Member is an Inpatient Member, and which are provided in or by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity services provided at a Residential Treatment Center are Benefits of this Member Guide.

Prior Authorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Partial Hospitalization

Care and treatment of Substance Use Disorder, while the Partial Hospitalization services are provided by:

1. A Hospital;
2. A Freestanding Inpatient Facility; or
3. A Qualified Health Care Provider.

Prior Authorization is required for Partial Hospitalization services. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Surgical Services

Surgical Services Billed by a Professional Provider

Services by a professional provider for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery. The charge for a surgical suite outside of the Hospital is included in the Allowable Fee for the surgery.

Surgical Services Billed by an Outpatient Surgical Facility or Freestanding Surgery Centers

Services of a surgical facility or a freestanding surgery center licensed, or certified for Medicare, by the state in which it is located and have an effective peer review program to ensure quality and appropriate patient care. The surgical procedure performed in a surgical facility or a freestanding surgery center is recognized as a procedure which can be safely and effectively performed in an Outpatient setting.

The Plan will allow Benefits for a Recovery Care Bed when Medically Necessary and provided for less than 24 hours. Payment will not exceed the semiprivate room rate that would be billed for an inpatient stay.

Surgical Services Billed by a Hospital (Inpatient and Outpatient)

Services of a Hospital for surgical procedures and the care of fractures and dislocations performed in an Outpatient or inpatient setting, including the usual care before and after surgery.

Telehealth

Medically Necessary Telehealth services are covered when provided by a Covered Provider.

Therapies for Down Syndrome

Benefits will be provided for the diagnosis and treatment of Down syndrome for a covered child under 19 years of age. Covered services include:

1. Habilitative Care or Rehabilitative Care that is prescribed, provided, or ordered by a licensed Physician, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child.

Habilitative Care and Rehabilitative Care includes Medically Necessary interactive therapies derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention.

2. Medically Necessary therapeutic care that is provided by a licensed speech-language pathologist a physical therapist or an occupational therapist. Visit limits do not apply.

When treatment is expected to require extended services, Blue Cross and Blue Shield of Montana may request that the treating Physician provide a treatment plan based on evidence-based screening criteria. The treatment plan will consist of the diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. Blue Cross and Blue Shield of Montana may request that the treatment plan be updated every 6 Months.

Therapies - Outpatient

Services provided for Physical Therapy, Speech Therapy, cardiac therapy and Occupational Therapy, not including Rehabilitation Therapy.

Transplants

For certain transplants, Blue Cross and Blue Shield of Montana contracts with a number of Centers of Excellence that provide transplant services. Blue Cross and Blue Shield of Montana highly recommends use of the Centers of Excellence because of the quality of the outcomes at these facilities. Members being considered for a transplant procedure are encouraged to contact Blue Cross and Blue Shield of Montana Customer Service to discuss the possible benefits of utilizing the Centers of Excellence.

Transplant services include:

1. Organ procurement including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ and transportation of the donor or donor organ to the location of the transplant operation;
2. Donor services including the pre-operative services, transplant related diagnostic lab and x-ray services, and the transplant surgery hospitalization. Transplant related services are covered for up to six Months after the transplant;
3. Hospital Inpatient Care services;
4. Surgical services;
5. Anesthesia;
6. Professional provider and diagnostic Outpatient services; and/or
7. Licensed ambulance travel or commercial air travel for the Member receiving the treatment to the nearest Hospital with appropriate facilities.

Payment by The Plan is subject to the following conditions:

1. When both the transplant recipient and donor are Members, both will receive Benefits;
2. When the transplant recipient is a Member and the donor is not, both will receive Benefits to the extent that benefits for the donor are not provided under other hospitalization coverage; and
3. When the transplant recipient is not a Member and the donor is, the donor will receive Benefits to the extent that benefits are not provided to the donor by hospitalization coverage of the recipient.

The Plan will not pay for:

1. Experimental/Investigational/Unproven procedures;
2. Transplants of a nonhuman organ or artificial organ implant; or
3. Donor searches.

Prior Authorization is required for transplants. Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements.

Virtual Visits

Benefits for services provided by consultation with a licensed provider participating in the MDLIVE program through interactive video via an online portal or mobile application. Virtual Visits provide access to providers who can provide

diagnosis and treatment of nonemergency medical, Mental Illness and Substance Use Disorder conditions in situations that may be handled without a traditional office visit, Urgent Care visit or emergency room care.

For an MDLIVE provider, call the telephone number listed on the inside cover of this Member Guide.

Well-Child Care

Well-child care provided by a Physician or a health care professional supervised by a Physician.

Benefits shall include coverage for:

1. Histories;
2. Physical examinations;
3. Developmental assessments;
4. Anticipatory guidance;
5. Laboratory tests; and/or
6. Preventive immunizations.

COORDINATION OF BENEFITS WITH OTHER INSURANCE

The Coordination of Benefits (COB) provision applies when a Member has health care coverage under more than one plan. “Plan” is defined below.

The order in which each plan will make payment for Covered Medical Expenses is governed by the order of benefit determination rules. The plan that pays first is called the primary plan. The primary plan must pay Covered Medical Expenses in accordance with its Member Guide terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce payment for Covered Medical Expenses so that payment by all plans does not exceed 100% of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

Plan

Any of the following that provide benefits, or services, for medical or dental care or treatment include:

1. Group and nongroup health insurance contracts;
2. Health Maintenance Organization (HMO) contracts;
3. Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured);
4. Medical care components of long-term care contracts, such as skilled nursing care; and
5. Medicare or any other federal governmental plan, as permitted by law.

The term plan does not include:

1. Hospital indemnity coverage or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified Accident coverage;
4. Limited benefit health coverage, if determined by the commissioner to be "excepted benefits" as defined in 33-22-140, MCA;
5. School Accident type coverage;
6. Benefits for non-medical components of long-term care policies; or
7. Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

Each Member Guide for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan

In a COB provision, “this plan” means that part of the Member Guide providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other plans. Any other part of the Member Guide providing health care benefits is separate from this plan. A Member Guide may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules

The rules that determine whether this plan is a primary plan, or secondary plan, when the person has health care coverage under more than one plan.

1. When this plan is primary, it determines payment for Covered Medical Expenses first before those of any other plan without considering any other plan's benefits.
2. When this plan is secondary, it determines its Benefits after those of another plan and may reduce payment for Covered Medical Expenses so that payment by all plans does not exceed 100% of the total allowable expense.

Allowable Expense

A Covered Medical Expense, including Deductibles, Copayment and/or Coinsurance, that is covered at least in part by any plan covering the Member. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an allowable expense, unless one of the plans provides coverage for private Hospital room expenses.
2. If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
3. If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
4. If a Member is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the primary plan because a Member has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan

A plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent

The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a Member is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan; and
2. Except as provided below, a plan that does not contain a COB provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits, and provides that this supplementary coverage, shall be excess to any other parts of the plan provided by the Group. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.

3. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

4. Each plan determines its order of benefits using the first of the following rules that apply.

Non-Dependent or Dependent

The plan that covers the person as an employee or retiree is the primary plan and the plan that covers the employee or retiree as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee or retiree is the secondary plan and the other plan is the primary plan.

Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan, the order of benefits is determined as follows:

1. **Dependent Child - Parents are married or are living together**

   a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
   b. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

2. **Dependent Child - Parents are divorced or separated or not living together**

   a. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
   b. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above shall determine the order of benefits;
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above shall determine the order of benefits; or
   d. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      1. The plan covering the custodial parent;
      2. The plan covering the Spouse of the custodial parent;
      3. The plan covering the non-custodial parent;
      4. The plan covering the Spouse of the non-custodial parent.

3. **Dependent Child Covered Under More than One Plan of Individuals Who Are Not the Parents of the Child**

   The provisions of 1. or 2. above shall determine the order of benefits as if those individuals were the parents of the child.

4. Active Employee or Retired or Laid-off Employee

The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, (or is a Dependent of such employee) is the primary plan. The plan covering that same person as a retired or laid-off employee (and the Dependent of such employee) is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the section Non-Dependent or Dependent can determine the order of benefits.

5. COBRA or State Continuation Coverage

If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee or retiree or covering the person as a Dependent of an employee or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the section Non-Dependent or Dependent can determine the order of benefits.

6. Longer or Shorter Length of Coverage

The plan that covered the person as an employee or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of This Plan

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Plan and other plans. Blue Cross and Blue Shield of Montana may obtain the facts and information it needs from or provide such facts and information to other organizations or persons for the purpose of applying these COB rules and determining Benefits payable under this Plan and other plans covering the Member claiming Benefits. Blue Cross and Blue Shield of Montana need not inform, or get the consent of, any person to obtain such information. Each Member claiming Benefits under this Plan must provide Blue Cross and Blue Shield of Montana any facts it needs to apply those rules and determine Benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Blue Cross and Blue Shield of Montana may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under this plan. Blue Cross and Blue Shield of Montana will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means the reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Blue Cross and Blue Shield of Montana is more than it should have paid under this COB provision, it may recover the excess from one or more of the Members it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION WITH MEDICARE AND PROPERTY AND CASUALTY INSURANCE AS APPLICABLE

Coordination With Medicare

The Plan will coordinate Benefits with Medicare according to the federal Medicare secondary payor laws and regulations (“MSP rules”). This means that The Plan and/or Medicare may adjust payment so that the combined payments by The Plan and Medicare will be no more than the charge for the Benefits received by the Member. The Plan will never pay more than it would pay if the Member was not covered by Medicare.

1. For Working Aged

Medicare pays secondary to The Plan for Benefits for Beneficiary Members and their Spouses who are Members, covered by employers with 20 or more employees, who qualify for age-based Medicare as a result of attaining age 65 and older and who are covered by virtue of the Beneficiary Member’s current employment status.

Medicare will be the primary for a Member that refuses coverage under this Group Plan.

Medicare will pay primary to The Plan for the working aged Members covered by employers with fewer than 20 employees, including a multi-employer association if the Member is covered by an employer within the multi-employer association with fewer than 20 employees.

2. For Disabled Members under Age 65

Medicare pays secondary to The Plan for Benefits for Members under age 65, covered by employers with 100 or more employees, who qualify for disability-based Medicare and are covered by virtue of a Beneficiary Member’s current employment status.

Medicare pays primary to The Plan for disabled Members under age 65 covered by employers with fewer than 100 employees.

3. For End-Stage Renal Disease

Medicare pays secondary to The Plan for Benefits for Members who qualify for Medicare as a result of end-stage renal disease (“ESRD”), regardless of employer size, and are entitled to Benefits payable under this Group Plan, for the first 30 Months that a particular Member qualifies for Medicare as a result of ESRD. After the 30 Month period, Medicare will pay primary to The Plan.

Special Coordination of Benefits rules apply if a Member is entitled to Medicare based on ESRD and Medicare based on either age or disability.

- **a.** If The Plan is required to pay before Medicare under 1 or 2 above for a Member before the Member qualifies for Medicare based on ESRD, The Plan will continue to pay primary to Medicare after the Member becomes covered under Medicare based on ESRD but only for the 30 Month period above, after which Medicare will pay primary to The Plan.
- **b.** If The Plan is required to pay primary to Medicare based on ESRD and the Member that qualifies for Medicare based on ESRD above later becomes entitled to age-based or disability-based Medicare during the 30 Month period, Medicare will pay second to The Plan for the duration of the 30 Month period, after which Medicare will pay primary to The Plan. If the Member qualifies for age-based or disability-based Medicare after the 30 Month period, Medicare will pay primary to The Plan.

c. Medicare continues to be primary to The Plan after an aged or disabled Member becomes eligible for Medicare based on ESRD if:

1. The Member is already entitled to Medicare on the basis of age or disability when the Member becomes eligible for Medicare based on ESRD; and
2. The Group has fewer than 20 employees in the case of age-based Medicare or fewer than 100 employees in the case of disability-based Medicare.

4. For Retired Persons

Medicare is primary to The Plan for Beneficiary Members age 65 if the Beneficiary Member is a qualified individual age 65 and over and retired.

Medicare is primary to The Plan for Beneficiary Member's Spouse who is also a Member and who is a qualified individual if both the Beneficiary Member and the Member Spouse are age 65 and over and retired.

5. Current Employment Status

Under the MSP rules, a Member has current employment status if the Member is:

a. Actively working as an employee; or
b. Not actively working but is receiving disability benefits from an employer but only for a period of up to 6 Months; or
c. Not actively working but retains employment rights in the industry (including but not limited to a Member who is temporarily laid off or on sick leave, teachers and other seasonal workers), has not been terminated by an employer, is not receiving disability benefits from an employer for more than 6 Months, is not receiving Social Security disability benefits and has group health coverage under this Group Plan that is not COBRA coverage.

Other Insurance

If a property or casualty insurer pays for services provided to the Member and coordination of benefits is not applicable, The Plan will credit the Member's Deductible, Copayment and/or Coinsurance, as applicable, if the Member notifies The Plan of the payment, within 12 Months of the date of service.

EXCLUSIONS AND LIMITATIONS

All Benefits provided under this Member Guide are subject to the Exclusions and limitations in this section and as stated under the Benefit section. **The Plan will not pay for:**

1. All services, supplies, drugs and devices which are provided to treat any Illness or Injury arising out of employment when the Member's employer has elected or is required by law to obtain coverage for Illness or Injury under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This Exclusion applies to all services and supplies provided to treat such Illness or Injury even though:

a. Coverage under the government legislation provides benefits for only a portion of the services incurred;
b. The employer has failed to obtain such coverage required by law;
c. The Member waives his or her rights to such coverage or benefits;
d. The Member fails to file a claim within the filing period allowed by law for such benefits;
e. The Member fails to comply with any other provision of the law to obtain such coverage or benefits; or
f. The Member was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

This Exclusion will not apply if the Member is permitted by statute not to be covered and the Member elects not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws.

This Exclusion will not apply if the Member's employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws or employer's liability acts of any state, country, or the United States.

2. Services, supplies, drugs and devices which the Member is entitled to receive or does receive from TRICARE, the Veteran's Administration (VA), but not Medicaid. This Exclusion is not intended to exclude Covered Medical Expenses from coverage if a Member is a resident of a Montana state institution when services are provided.

   NOTE: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Member. When such a circumstance occurs, the Member will receive an explanation of Benefits.

3. Services, supplies, drugs and devices to treat any Injury or Illness resulting from war, declared or undeclared, insurrection, rebellion, or armed invasion.

4. Any loss for which a contributing cause was the commission of a felony or serious illegal act, or an attempt to commit a felony or an attempt to commit a serious illegal act, for which the Member has been found guilty in a court of competent jurisdiction or to which the Member has plead guilty or no contest. This Exclusion does not apply to the extent the Member suffers a loss as a victim of domestic violence.

5. Services for which a Member is not legally required to pay or charges that are made only because Benefits are available under this Member Guide.

6. Services, supplies, drugs and devices provided to the Member before the Member's Effective Date or after the Member's coverage terminates.

7. Nonsurgical treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction, anterior or internal dislocations, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances.

8. Orthodontics.

9. All Dental Services, including but not limited to ridge augmentation and vestibuloplasty, whether performed by Physicians, Dentists, oral surgeons and/or any other provider, except for services provided as the result of a Dental Accident and for services covered under the Pediatric Dental Care Benefit.

10. Vision services, including but not limited to prescription, fitting or provision of eyeglasses or contact lenses and Lasik Surgery, except for services covered under the Pediatric Vision Care Benefit. In addition, vision services may be covered for specific conditions in Medical Policy.

11. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging, or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

12. Hearing aids, except as otherwise provided under this Member Guide, and Medically Necessary cochlear implants may also be covered per Medical Policy.

13. Cosmetic services or complications resulting therefrom, except when covered services are provided to correct a condition resulting from an Accident, a condition resulting from an Injury or to treat a congenital anomaly, as applicable in Medical Policy.

14. For travel by a Member or provider.

15. Any related services to a non-covered service except for Routine Patient Costs for Members in an Approved Clinical Trial. Related services are:

    a. Services in preparation for the non-covered service;
    b. Services in connection with providing the non-covered service;
    c. Hospitalization required to perform the non-covered service; or
    d. Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

16. Any service or procedure which is determined by The Plan to be an Inclusive Service/Procedure.

17. Any services, supplies, drugs and devices which are:

- **a.** Experimental/Investigational/Unproven services, except for any services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial;
- **b.** Not accepted standard medical practice. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice;
- **c.** Not a Covered Medical Expense;
- **d.** Not Medically Necessary; or
- **e.** Not covered under applicable Medical Policy.

18. Any services, supplies, drugs and devices considered to be Experimental/Investigational/Unproven and which are provided during a Phase I or II clinical trial, or the experimental or research arm of a Phase III clinical trial, except for any services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial. This includes services, supplies, drugs and devices under study to determine the maximum tolerated dosage(s), toxicity, safety, or efficacy as compared with standard treatment, or for the diagnosis of the condition in question.

19. Transplants of a nonhuman organ or artificial organ implant.

20. Private duty nursing.

21. Abortions, except in the case of rape or incest, or for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed.

22. Reversal of an elective sterilization.

23. Services, supplies, drugs and devices related to in vitro fertilization.

24. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

25. Foot orthotics.

26. Services, supplies, drugs and devices related to treatment for psychological or psychogenic sexual dysfunctions.

27. Services, supplies, drugs and devices relating to any of the following treatments or related procedures:

- **a.** Homeopathy;
- **b.** Hypnotherapy;
- **c.** Rolfing;
- **d.** Holistic medicine;
- **e.** Religious counseling; or
- **f.** Self-help programs.

28. Services provided by a massage therapist.

29. Sanitarium care, Custodial Care, rest cures, or convalescent care to help the Member with daily living tasks. Examples include but are not limited to, help in:

- **a.** Walking;
- **b.** Getting in and out of bed;
- **c.** Bathing;
- **d.** Dressing;
- **e.** Feeding;
- **f.** Using the toilet;
- **g.** Preparing special diets; or
- **h.** Supervision of medication which is usually self-administered and does not require the continuous attention of medical personnel.

No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, or extended care facility for the types of care outlined in this Exclusion.

30. Over-the-counter food supplements, formulas, and/or Medical Foods, regardless of how administered except when used for Inborn Errors of Metabolism.

31. Services, supplies, drugs and devices for the surgical treatment of any degree of obesity, whether provided for weight control or any medical condition.

32. Services, supplies, drugs and devices for weight reduction or weight control. This Exclusion does not include intensive behavioral dietary counseling when services are provided by a Physician, physician assistant or nurse practitioner.

33. Charges associated with health clubs, weight loss clubs or clinics.

34. Services, supplies, drugs and devices for the treatment of Illness, Injury and/or complications resulting from services that are not Covered Medical Expenses, except for any services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial.

35. Tutoring services.

36. Any services, supplies, drugs and devices not provided in or by a Covered Provider.

37. Services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature.

38. Deluxe medical equipment including, but not limited to, durable medical equipment, prosthetics and communication devices except as included in the Durable Medical Equipment Benefit and the Prosthetic Benefit in the section entitled Benefits.

39. Services or supplies for:

- **a.** Intersegmental traction;
- **b.** All types of home traction devices and equipment;
- **c.** Vertebral axial decompression sessions;
- **d.** Surface Electromyography (EMG); the measurement of muscle electrical activity with electrodes placed on the skin over the muscle;
- **e.** Spinal manipulation under anesthesia;
- **f.** Muscle testing through computerized kinesiology machines; or
- **g.** Balance testing through computerized dynamic posturography sensory organization test.

40. All services, supplies, drugs and devices provided to treat any Illness or Injury arising out of employment as an athlete by or on a team or sports club engaged in any contact sport that includes significant physical contact between the athletes involved, including but not limited to football, hockey, roller derby, rugby, lacrosse, wrestling and boxing, where the Member's employer is not required by law to obtain coverage for Illness or Injury under state or federal workers' compensation, occupational disease or similar laws.

41. Testing of:

- **a.** Blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood;
- **b.** Urine for measurement of collagen cross links;
- **c.** Cervicovaginal fluid for amniotic fluid protein; or
- **d.** Allergen specific IgG measurement.

42. Applied Behavior Analysis (ABA) services, except as specifically included in this Member Guide under Autism Spectrum Disorders.

43. Services, supplies, drugs and devices provided outside of the United States, except if such services are provided as the result of an Emergency Medical Condition.

44. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

45. Nonemergency care services or supplies provided outside of the United States.

46. Services, supplies, drugs and devices which are not listed as a Benefit as described in this Member Guide.

CLAIMS

How to Obtain Payment for Covered Expenses for Benefits

1. If a Member obtains Benefits from a Participating Provider, the Participating Provider will submit claims to The Plan for the Member. If a Member obtains Benefits from a nonparticipating provider, the Member may be required to submit all claims to The Plan. All claims for services must be submitted on or before December 31 of the calendar year following the year in which services were received. All claims must provide enough information about the services for The Plan to determine whether or not they are a Covered Medical Expense. Submission of such information is required before payment will be made. In certain instances, Blue Cross and Blue Shield of Montana may require that additional documents or information including, but not limited to, Accident reports, medical records, and information about other insurance coverage, claims, payments and settlements, be submitted within the timeframe requested for the additional documentation before payment will be made.

   However, claims for prescription drugs purchased from a nonparticipating Pharmacy must be submitted within one year from the date of purchase.

2. If a Member purchases drugs or Prescription Drug Products at a Value Participating Pharmacy, a Participating Pharmacy, an Extended Supply Pharmacy or a mail-order Pharmacy approved by The Plan, and the Member's identification card is presented at the time of purchase, the Member must pay for the Prescription Drug Product and the Participating Pharmacy will submit a claim for the cost of the covered prescription drug or Prescription Drug Product to The Plan's Pharmacy Benefit Manager. The Member's responsibility for the cost of the covered drug or Prescription Drug Product will then accumulate to the Member's In-Network Deductible and In-Network Out of Pocket Amount. Once the Deductible, if applicable, is met, the Member will only be required to pay the appropriate Copayment and/or Coinsurance if the amount can be determined by the Pharmacy at the time of purchase.

   If a Member purchases drugs or Prescription Drug Products at a nonparticipating Pharmacy, the Member must pay for the prescription at the time of dispensing and then within one year of the date of purchase submit a claim for the prescription drug on a form to The Plan's Pharmacy Benefit Manager for reimbursement. The Member's Deductible, Copayment and/or Coinsurance for the covered drug or Prescription Drug Product will then accumulate to the Out-of-Network Deductible and the Out-of-Network Out of Pocket Amount. The 50% Benefit reduction for prescription drugs purchased at an Out-of-Network Pharmacy does not apply to any applicable Out-of-Network Deductible and/or Out of Pocket Amount. The Member will be reimbursed for the prescription drug at 50% of the amount that would have been paid to a Participating Pharmacy, less any Out-of-Network Deductible, Copayment and/or Coinsurance.

   Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

3. Claims must be submitted to the address listed on the inside cover of this Member Guide, on the claim form. Contact the Customer Service number on the back of the Member's identification card for information on how to submit a claim.

Prescription Drug Claims - Filling Prescriptions at a Retail Pharmacy

Outpatient prescription drugs are available through the Prime Therapeutics Prescription Drugs Benefit. Prime Therapeutics is the Pharmacy Benefit Manager.

1. Go to a Prime Therapeutics Value Participating Pharmacy or a Participating Pharmacy that accepts Member identification cards. To find out if a Pharmacy takes part in the program, ask the pharmacist. To find a Prime Therapeutics Value Participating Pharmacy or a Participating Pharmacy nearest the Member, check the list on the website www.bcbsmt.com or call the Pharmacy locator at the telephone number on the inside cover of this document.
2. Present the prescription and the Member's identification card to the pharmacist.

3. Make sure that the pharmacist has complete and correct information about the Member for whom the prescription is written, including sex and date of birth.
4. When the Member receives a prescription, he or she should sign the Pharmacy log and pay his or her share of the cost.
5. If a Member purchases prescription drugs from a Participating Pharmacy or mail-service Pharmacy approved by The Plan, the Member must pay for the Prescription Drug Product and the Pharmacy will submit the prescription drug claims to the Pharmacy Benefit Manager.
6. The Member must pay the difference between a Brand-Name Drug and the Generic Drug equivalent if the Member purchases a Brand-Name Drug when a Generic Drug equivalent is available.
7. The Plan makes use of a Drug List, which is a list of covered prescription drugs for dispensing to Members as appropriate.
8. For prescriptions filled at a Pharmacy that is not part of the network, the Member will need to pay the entire cost of the prescription at the time the prescription is filled and dispensed and submit a paper claim to the Pharmacy Benefit Manager for reimbursement. The Member will be reimbursed for the prescription drug at 50% of the amount that would have been paid to a Participating Pharmacy less any Out-of-Network Deductible, Copayment and/or Coinsurance. The Member will not receive the preferred pricing.
9. Prescriptions filled at Hospital Pharmacies are not eligible for reimbursement unless they are listed as a network Pharmacy.

Pharmacy Benefit Manager claim forms are available by calling The Plan at the telephone number on the inside cover of this document.

Mail-Service Pharmacy

The Member may obtain maintenance prescriptions through the mail. Maintenance prescriptions are those that the Member expects to continue using for an extended period of time and for which a prescription can be written for up to a 90-day supply. Coverage for costly prescriptions should be verified prior to ordering. Specific Benefits are outlined in the Prescription Drugs section in this document.

To obtain a mail service claim form, call The Plan at the telephone number on the inside cover of this document.

To order a prescription:

1. Complete all sections and sign the Mail-Service order form.
2. Enclose the following:
   a. The original prescription written for up to a 90-day supply;
   b. The Member's current Pharmacy telephone number, prescription numbers to be transferred; and
   c. The Member's telephone number.
3. Mail the form to the mail service Pharmacy at the address listed on the form.

REBATES AND PREMIUM ABATEMENTS

Rebate: In the event federal or state law requires The Plan to rebate a portion of annual premiums (dues) paid, The Plan will provide any rebate as required or allowed by such federal or state law.

Abatement: The Plan may from time to time determine to abate (all or some of) the premium (dues) due under this Member Guide for particular period(s). Any abatement of premium (dues) by The Plan represents a determination by The Plan not to collect premium (dues) for the applicable period(s) and does not represent a reduction in the rates under the Member Guide. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).

Administrative: The Policyholder hereby gives The Plan assurances that Policyholder is obligated to, and will, pay or credit such rebates or abatements to its Beneficiary Members to the extent and in the manner required by applicable law. The Policyholder shall provide The Plan with any information, records and documentation that The Plan may require or request with regard to the subject matter of this section in a time, form and manner specified by The Plan.

The Plan will rely upon such information, records and documentation as accurate and complete.

The Plan makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of the Policyholder and any Beneficiary Member or former Beneficiary Member (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws and regulations. The Policyholder shall assure appropriate notification to federal and state tax agencies and that any payment to the Beneficiary Members and former Beneficiary Members (if applicable) will be accompanied by appropriate federal and state documentation, e.g., Form 1099 or W-2. The Policyholder agrees to indemnify and hold The Plan harmless against any and all claims, demands, costs, fines, losses, interest, settlements, judgments, damages, penalties, taxes, expenses (including reasonable attorneys' fees) or other liabilities resulting from the Policyholder's failure to carry out its responsibilities or obligations as set forth in this Member Guide.

GENERAL PROVISIONS

Modification of Group Plan

The Plan may make administrative changes or changes in dues, terms or Benefits in the Group Plan by giving written notice to the Group at least 60 days in advance of the Effective Date of the changes. Dues may not be increased more than once during a 12-Month period, except as allowed by Montana law.

No change in the Group Plan will be valid unless in writing and signed by the President of Blue Cross and Blue Shield of Montana. No other agent or representative or employee of The Plan may change any part of this Member Guide.

Clerical Errors

No clerical error on the part of The Plan shall operate to defeat any of the rights, privileges, or Benefits of any Member covered under the Group Plan. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits will be made. Clerical errors shall not prevent administration of the Group Plan in strict accordance with its terms.

Notices Under Contract

Any notice required by the Group Contract may be given by United States mail, postage paid. Notice to the Beneficiary Member will be mailed to the address appearing on the records of The Plan. Notice to The Plan must be sent to Blue Cross and Blue Shield of Montana at the address listed on the inside cover of this Member Guide. Any time periods included in a notice shall be measured from the date the notice was mailed.

A Beneficiary Member or Family Member may reasonably request, in writing, that any communication of the Member's health information be sent to an alternate address or by alternative means should disclosure of any of the Member's health information endanger the Member.

Contract Not Transferable by the Member

No person, other than the Beneficiary Member or a Family Member listed on the subscriber application for membership and accepted by The Plan, is entitled to Benefits under the Group Contract. The Contract is not transferable to any other person.

Rescission of Member Guide

This Member Guide is subject to rescission if the Member commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, concerning a Member's health, claims history, or current receipt of health care services. Blue Cross and Blue Shield of Montana will provide at least 30 days advance written notice to the subscriber before coverage may be rescinded.

Validity of Contract

If any part, term, or provision of the Group Contract is held by the courts to be illegal or in conflict with or not in compliance with any applicable law of the state of Montana or the United States, the Group Contract shall not be rendered invalid but shall be construed and applied in accordance with such provisions as would have applied had the Contract been in conformance with applicable law and the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the Contract did not contain the particular part, term, or provision held to be invalid.

Waiver

The waiver by The Plan of any breach of any provision of the Group Plan will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure of The Plan to exercise any right hereunder will not operate as a waiver of such right. All rights and remedies provided herein are cumulative.

Payment by The Plan

Payment under the Group Contract is not assignable by the Member to any third party. Payment made by The Plan shall satisfy any further obligation of The Plan.

Conformity with Montana Statutes

The provisions of this Member Guide conform to the minimum requirements of Montana law and have control over any conflicting statutes of any state in which the insured resides or may receive health services on or after the Effective Date of the Group Plan.

Forms for Proof of Loss

The Plan shall furnish, upon written request of a Member claiming to have a loss under the Group Plan, forms of Proof of Loss for completion by the Member. The Plan shall not, by reason of either the requirement to furnish such forms or the requirement for completion and submission of such forms by the Member, have any responsibility for the completion or submission of such form or the manner of any such completion, attempted completion, submission or attempted submission, of the form.

Time of Payment of Claims

The Plan will pay or deny a claim within 30 days after receipt of a Proof of Loss unless The Plan makes a reasonable request for additional information or documents in order to evaluate the claim. If The Plan makes a reasonable request for additional information or documents, The Plan shall pay or deny the claim within 60 days of receiving the Proof of Loss unless The Plan has notified the Member, the Member's authorized representative, or the claimant of the reasons for failure to pay the claim in full or unless The Plan has a reasonable belief that insurance fraud has been committed and The Plan has reported the possible insurance fraud to the Commissioner of Insurance. This section does not eliminate a Plan's right to conduct a thorough investigation of all the facts necessary to determine payment of a claim.

If The Plan fails to comply with this section and The Plan is liable for payment of the claim, The Plan shall pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after The Plan's receipt of the Proof of Loss or 60 days after receipt of the Proof of Loss if The Plan made a reasonable request for information or documents. Interest payments must be made to the person who receives the claims payment. Interest is payable under this subsection only if the amount of interest due on a claim exceeds $5.

Members Rights

Members have only those rights as specifically provided in the Group Plan. In addition, when requested by the insured or the insured's agent, Montana law requires Blue Cross and Blue Shield of Montana to provide a summary of a Member's coverage for a specific health care service or Course of Treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or Hospital exceeds $500.

Alternate Care

The Plan may make payment for services which are not listed as a Benefit of the Group Plan in order to provide quality care at a lesser cost. Such payments will be made only upon mutual agreement by the Member and The Plan.

Alternate Dental Benefits

In all cases in which there is more than one Course of Treatment possible, the Benefit will be based upon the most efficient Course of Treatment, as determined by The Plan.

If the Member and Dentist or Physician decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for Dental Services rather than standard procedures, the Benefits provided will be limited to the Benefit for the standard procedures for Dental Services, as determined by The Plan.

Benefit Maximums

Once The Plan pays the maximum amount for a specific Benefit, no further payment will be made for that specific condition under any other provisions of the Member Guide.

Pilot Programs

The Plan reserves the right to develop and enter into pilot programs under which health care services not normally covered under the Group Plan will be paid. The existence of a pilot program does not guarantee any Member the right to participate in the pilot program or that the pilot program will be permanent. A pilot program is an initial small-scale implementation that is used to prove the variability of a project idea. This could involve either the exploration of a novel new approach or idea or the application of a standard approach new to the organization. It enables an organization to manage the risk of a new idea and identify any deficiencies before substantial resources are committed. BCBSMT will submit and obtain approval from the Commissioner of Securities and Insurance for any pilot program prior to its offering to Members.

Fees

The Plan reserves the right to charge the Member a reasonable fee for providing information or documents to the Member which were previously provided in writing to the Member. Fees may be charged for the costs of copying labor, supplies and postage. Fees will not be charged for searching for and retrieving the requested information.

Subrogation

1. To the extent that Benefits have been provided or paid under the Group Plan, The Plan may be entitled to subrogation against a judgment or recovery received by a Member from a third party found liable for a wrongful act or omission that caused the Injury requiring payment for Benefits.
2. The Member will take no action through settlement or otherwise which prejudices the rights and interest of The Plan under the Group Plan.
3. If the Member intends to institute an action for damages against a third party, the Member will give The Plan reasonable notice of intention to institute the action. Reasonable notice will include information reasonably calculated to inform The Plan of facts giving rise to the third-party action.
4. The Member may request that The Plan pay a proportional share of the reasonable costs of the third-party action, including attorney fees. If The Plan elects not to participate in the cost of the action, The Plan waives 50 percent of its subrogation interest.
5. The right of subrogation may not be enforced until the Member has been completely compensated for the injuries.

Statements are Representations

All statements and descriptions in any application shall be considered representations and not warranties. In the absence of fraud, any misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the Member Guide unless:

1. Fraudulent;

2. Material either to the acceptance of the risk or to the hazard assumed by The Plan; or
3. The Plan in good faith would not have issued the Member Guide, would not have issued the Member Guide in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to The Plan as required either by the application for the Member Guide or otherwise. No statement made for the purpose of effecting coverage shall avoid such coverage or reduce Benefits unless contained in a written instrument signed by the Member, a copy of which has been furnished to such Member.

When the Member Moves Out of State

If the Member moves to an area served by another Blue Cross or Blue Shield plan, the Member's coverage will be transferred to the plan serving the new address. The new plan must offer coverage that is in compliance with the conversion laws of that state. This coverage is that which is normally provided to Members who leave a Group and apply for new coverage as individuals. Although subject to the conversion laws of that state, such coverage is usually provided without a medical examination or health statement. If the Member accepts the conversion coverage, the new plan will credit the Member for the length of time of enrollment with Blue Cross and Blue Shield of Montana toward any of its own waiting periods. Any physical or mental conditions covered by The Plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage. The premium rate and benefits available from the new plan may vary significantly from those offered by The Plan.

The new plan may also offer other types of coverage that are outside of the transfer program. This coverage may require a medical examination or health statement to exclude coverage for preexisting conditions and may not apply time enrolled in Blue Cross and Blue Shield of Montana to waiting periods.

Right to Audit

The Plan reserves the right to audit a Group's employment records to determine whether all employees of the Group are eligible. The Plan further reserves the right to correspond directly with employees to obtain affidavits certifying such eligibility.

Independent Relationship

Participating Providers furnishing care to a Member do so as independent contractors with The Plan; however, the choice of a provider is solely the Member's. Under the laws of Montana, The Plan cannot be licensed to practice medicine or surgery and The Plan does not assume to do so. The relationship between a provider and a patient is personal, private, and confidential. The Plan is not responsible for the negligence, wrongful acts, or omissions of any providers, or provider's employees providing services, or Member receiving services. The Plan is not liable for services or facilities which are not available to a Member for any reason.

Blue Cross and Blue Shield of Montana as an Independent Plan

The Group, on behalf of itself and its employees, hereby expressly acknowledges its understanding that the Group Contract constitutes a contract solely between the Group and The Plan, that The Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting The Plan to use the Blue Cross and Blue Shield Service Mark in the state of Montana, and that The Plan is not contracting as the agent of the Association. The Group further acknowledges and agrees that it has not entered into the Group Contract based upon representations by any person other than The Plan and that no person, entity, or organization other than The Plan shall be held accountable or liable to the Group for any of The Plan's obligations to the Group created under the Group Contract. This paragraph shall not create any additional obligations whatsoever on the part of The Plan other than those obligations created under other provisions of the Group Contract.

Federal Balance Billing and Other Protections

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Montana law, if there is a conflict between the terms of this **Federal Balance Billing and Other Protections** section and the terms in the rest of this Member Guide, the terms of this section will apply. However, definitions set forth in the **Federal No Surprises Act Definitions** provision of this section are for purposes of covered services under this section only.

- **Continuity of Care**

  If the Member is under the care of an In-Network provider as defined in this Member Guide, who ceases participating in The Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), the Member may be able to continue coverage for that provider's covered services at the In-Network Benefit level if one of the following conditions is met:

  1. The Member is undergoing a Course of Treatment for a serious and complex condition;
  2. The Member is undergoing institutional or Inpatient Care;
  3. The Member is scheduled to undergo nonelective surgery from the provider (including receipt of postoperative care from such provider or facility with respect to such surgery);
  4. The Member is pregnant or undergoing a Course of Treatment for their pregnancy; or
  5. The Member is, or was, determined to be terminally ill.

  A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if the Member is currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), or (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

  Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies the Member of the provider's termination, or any longer period provided by state law. If the Member is in the second or third trimester of pregnancy when the provider's termination takes effect, continuity of coverage may be extended through the postpartum period. The Member has the right to appeal any decision made for a request for benefits under this provision, as explained in the **Appeals** section of this Member Guide.

- **Federal No Surprises Act Definitions**

  The definitions below apply only to this **Federal Balance Billing and Other Protections** section. To the extent the same terms are also defined in the **Definitions** section in this Member Guide, those terms will apply only to their use in the Member Guide, or this **Federal Balance Billing and Other Protections** section, respectively.

  "Air Ambulance Services" means, for purposes of this section only, medical transport by helicopter or airplane for patients.

  "Emergency Medical Condition" means, for purposes of this section only, a medical condition, including a mental health condition or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

  "Emergency Services" means, for purposes of this section only:

  1. A medical screening examination performed in the emergency department of a hospital or a freestanding emergency department;
  2. Further medical examination or treatment the Member receives at a Hospital, regardless of the department of the Hospital, or a freestanding emergency department to evaluate and treat an Emergency Medical Condition until the Member's condition is stabilized; and
  3. Covered services the Member receives from a Non-Participating Provider during the same visit after the Member's Emergency Medical Condition has stabilized unless:
     a. The Member's Non-Participating Provider determines the Member can travel by non-medical or nonemergency transport;
     b. The Member's Non-Participating Provider has provided the Member with a notice to consent form for balance billing of services; and
     c. The Member has provided informed consent for additional post stabilization care and services.

  "Non-Participating Provider" means, for purposes of this section only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with BCBSMT for furnishing such item or service under The Plan.

"Non-Participating Emergency Facility" means, for purposes of this section only, with respect to a covered item or service, an emergency department of a Hospital or an independent freestanding emergency department that does not have a direct or indirect contractual relationship with BCBSMT for furnishing such item or service under The Plan.

"Participating Provider" means, for purposes of this section only, with respect to a covered service, a facility, Physician or other health care provider who has a contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Member) for furnishing such item or service under The Plan, regardless of whether the provider is considered a preferred or In-Network provider for purposes of In-Network or Out-of-Network Benefits under The Plan.

"Participating Facility" means, for purposes of this section only, with respect to covered service, a Hospital, Hospital outpatient department, critical access Hospital, ambulatory surgical center or any other facility as otherwise required by law, that has a direct or indirect contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Member) for furnishing such item or service under The Plan, regardless of whether the provider is considered a preferred or In-Network provider for purposes of In-Network or Out-of-Network Benefits under The Plan.

"Qualifying Payment Amount" means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

"visit" includes, for purposes of this section only, covered items and services provided as part of nonemergency services furnished by a Non-Participating Provider, regardless of whether the Non-Participating Provider is present at a Participating Facility when furnishing the covered items or services.

- **Federal No Surprises Act Surprise Billing Protections**

  The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below:

  1. Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
  2. Covered nonemergency services performed by a Non-Participating Provider at a Participating Facility (unless the Member gives written consent and gives up balance billing protections).
  3. Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

- **Claims Payments**

  For Included Services, The Plan will send an initial payment or notice of denial of payment directly to the provider.

- **Cost-Sharing**

  For nonemergency services performed by Non-Participating Providers during the Member's visit at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate the Member's cost-share requirements, including Deductibles, Copayments, and/or Coinsurance.

  For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate the Member's cost-share requirements, including Deductibles, Copayments, and/or Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

  For Included Services, these cost-share requirements will be counted toward the Member's In-Network Deductible and/or Out of Pocket Amount, if any.

- **Federal No Surprises Act Prohibition of Balance Billing**

  The Member is protected from balance billing on Included Services as set forth below.

If the Member receives Emergency Services from a Non-Participating Provider or Non-Participating Emergency Facility, the most the Non-Participating Provider or Non-Participating Emergency Facility may bill the Member is the In-Network cost-share. The Member cannot be balance billed for these Emergency Services unless the Member gives written consent for services once their Emergency Medical Condition has stabilized, and gives up their protections not to be balanced billed for services received after they are in a stable condition.

When the Member receives covered nonemergency services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill the Member is The Plan's In-Network cost-share requirements. When the Member receives emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, or other items and services as otherwise required by law at a Participating Facility, or if the Member receives services from a Non-Participating Provider if there is no Participating Provider who can furnish such service at that Participating Facility, Non-Participating Providers can't balance bill the Member and may not ask the Member to give up their protections not to be balance billed. If the Member receives other services at Participating Facilities, Non-Participating Providers can't balance bill the Member unless they give written consent and give up their protections.

If The Plan includes Air Ambulance Services as a covered service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill the Member is the In-Network cost-share. The Member cannot be balance billed for these Air Ambulance Services.

STATEMENT OF ERISA RIGHTS

Statement of ERISA Rights

NOTE: Any reference in this section to the plan means the Member's group medical benefits plan. The plan administrator is the Member's employer. Plan and plan administrator do not refer to Blue Cross and Blue Shield of Montana in the statement of ERISA rights.

1. As a participant in a group medical benefits plan, the Member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:
   - **a.** Examine without charge, at the plan administrator's office and at other specified locations such as work sites, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
   - **b.** Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
   - **c.** Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.
2. In addition to creating rights for plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the plan. These persons, called fiduciaries, have a duty to do so prudently and in the interest of the Member and other Plan participants and beneficiaries.
3. No one, including the Member's employer or any other person, may fire the Member or otherwise discriminate against the Member to prevent the Member from obtaining a welfare benefit or exercising the Member's rights under ERISA.
4. If the Member's claim for a welfare Benefit is denied in whole or part, the Member must receive a written explanation of the reason for the denial. The Member has the right to have the plan administration review and reconsider the Member's claim.
5. Under ERISA there are steps the Member can take to enforce the above rights. For instance, if the Member requests materials from the plan and does not receive them within 30 days, the Member may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to $110 per day until the Member receives the materials unless the materials were not sent because of reasons beyond the control of the administrator.
6. If the Member has a claim for Benefits which is denied or ignored, in whole or in part, the Member may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting the Member rights, the Member may seek assistance from the U.S. Department of Labor, or the Member may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If the Member is successful, the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order the Member to pay these costs and fees; for example, if it finds the Member's claim is frivolous.

7. If the Member has any questions about this statement or the Member's rights under ERISA, the Member should contact the plan administrator or the nearest office of the Employee Benefits Security Administration of the U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

DEFINITIONS

This section defines certain words used throughout this Member Guide. These words are capitalized whenever they are used as defined.

ACCIDENT

An unexpected traumatic incident or unusual strain which is:

1. Identified by time and place of occurrence;
2. Identifiable by part of the body affected; and
3. Caused by a specific event on a single day.

Some examples include:

1. Fracture or dislocation.
2. Sprain or strain.
3. Abrasion, laceration.
4. Contusion.
5. Embedded foreign body.
6. Burns.
7. Concussion.

ADVANCED PRACTICE REGISTERED NURSE

Nurses who have additional professional education beyond the basic nursing degree required of a registered nurse and are considered Advanced Practice Registered Nurses by applicable state law. Advanced Practice Registered Nurses include nurse practitioners, nurse-midwives, nurse-anesthetists and clinical nurse specialists.

AFFILIATE/AFFILIATED

Any entity or person who directly or indirectly through one or more intermediaries controls, is controlled by, or under common control with a specified entity or person.

ALLOWABLE FEE

The Allowable Fee is based on, but not limited to, the following:

1. Medicare RBRVS based is a system established by Medicare to pay Physicians for a "work unit." The RBRVS value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers' billed charge; or
2. Diagnosis-related group (DRG) methodology is a system used to classify Hospital cases into one of approximately 500 to 900 groups that are expected to have similar Hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of Hospital resources for the given DRG regardless of the actual Hospital resources used. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating provider under the DRG system can be considerably less than the nonparticipating providers' billed charge; or
3. Billed charge is the amount billed by the provider; or

4. Case rate methodology is an all-inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the case rate system can be considerably less than the nonparticipating providers' billed charge; or
5. Per diem methodology is an all-inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the per diem system can be considerably less than the nonparticipating providers' billed charge; or
6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating provider under the flat fee per category of service system can be considerably less than the nonparticipating providers' billed charge; or
7. Flat fee per unit of service fixed payment amount for a unit of service. For instance, a unit of service could be the amount of "work units" customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the flat fee per unit system can be considerably less than the nonparticipating providers' billed charge; or
8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or
9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or
10. The amount negotiated with the Pharmacy Benefit Manager or manufacturer or the actual price for prescription or drugs; or
11. The American Society of Anesthesiologists' Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a "work unit." The payment value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the system can be considerably less than the nonparticipating providers' billed charge.
12. For nonparticipating providers in Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by The Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for nonparticipating providers will represent an average contract rate for Participating Providers adjusted by a predetermined factor established by The Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. Blue Cross and Blue Shield of Montana will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by nonparticipating providers which may also alter the Allowable Fee for a particular service. In the event The Plan does not have any claim edits or rules, The Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

    Any change to the Medicare reimbursement amount will be implemented by The Plan within 90 days after the Effective Date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

13. For nonparticipating providers outside Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee (i) for professional providers is based on publicly available data and historic reimbursement to providers for the same or similar professional services, adjusted for geographic differences where applicable, or (ii) for Hospital or other facility providers is based on publicly available data reflecting the approximate cost that Hospitals or other facilities have incurred historically to provide the same or similar service, adjusted for geographic differences where applicable, plus a margin factor for the Hospital or facility.

In the event the nonparticipating Allowable Fee does not equate to the nonparticipating provider's billed charges, the Member will be responsible for the difference, along with any applicable Deductible, Copayment, and/or

Coinsurance amount. This difference may be considerable. To find out an estimate of The Plan's nonparticipating Allowable Fee for a particular service, Members may call the Customer Service number shown on the back of the Member's identification card.

Montana law requires Blue Cross and Blue Shield of Montana to provide a summary of a Member's coverage for a specific health care service or Course of Treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or Hospital exceeds $500.

ALLOWABLE FEE (Dental Services)

The amount determined by The Plan as the maximum amount eligible for payment of Benefits. A participating Dentist agrees to accept payment of the Allowable Fee from The Plan for covered Dental Services, together with any Deductible, Copayment and/or Coinsurance for the Member, as payment in full. Nonparticipating Dentists do not have to accept The Plan's payment as payment in full and can bill the Member for the difference between payment by The Plan and provide charges plus Deductible, Copayment and/or Coinsurance. The Member will be responsible for the balance of the nonparticipating Dentist's charges after payment by The Plan and payment of any Deductible, Copayment and/or Coinsurance.

AMPLIFICATION DEVICE

A hearing device, hearing aid, or a wearable, non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold, batteries, and cords.

APPLIED BEHAVIOR ANALYSIS (ABA) – (ALSO KNOWN AS LOVAAS THERAPY)

Medically Necessary interactive therapies or treatment derived from evidence-based research. The goal of ABA is to improve socially significant behaviors to a meaningful degree, including:

1. Increase desired behaviors or social interaction skills;
2. Teach new functional life, communication, or social, skills;
3. Maintain desired behaviors, such as teaching self-control and self-monitoring procedures;
4. Appropriate transfer of behavior from one situation or response to another;
5. Restrict or narrow conditions under which interfering behaviors occur;
6. Reduce interfering behaviors such as self-injury.

ABA therapy and treatment includes Pivotal Response Training, Intensive Intervention Programs, and Early Intensive Behavioral Intervention, and the terms are often used interchangeably. The ABA Benefit also includes Discrete Trial Training, a single cycle of behaviorally based instruction routine that is a companion treatment with ABA.

Services must be provided by an appropriately certified provider.

APPROVED CLINICAL TRIAL

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition. The trial must be:

1. Conducted under an investigational new drug application reviewed by the FDA;
2. Exempt from an investigational new drug application; or
3. Approved or funded by:
    a. The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
    b. A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
    c. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
    d. The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and provide unbiased scientific review by individuals who have no interest in the outcome of the review.

BENEFICIARY MEMBER

A person in the employer Group who has applied for, been accepted as a Member, and maintains membership in The Plan under the terms of this Member Guide.

BENEFIT

Services, supplies and medications that are provided to a Member and covered under this Member Guide as a Covered Medical Expense or Dental Service.

BENEFIT PERIOD

For the Member Guide - Is the period of time shown in the Schedule of Benefits.

For the Member - Is the same as for the Member Guide except if the Member's Effective Date is after the Effective Date of the Member Guide, the Benefit Period begins on the Member's Effective Date and ends on the same date the Member Guide Benefit Period ends. Thus, the Member's Benefit Period may be less than 12 Months.

BEST EVIDENCE

Means evidence based on:

1. Randomized Clinical Trials;
2. A Cohort Study or Case-Control Study, if Randomized Clinical Trials are not available;
3. A Case Series, if Randomized Clinical Trials, Cohort Studies or Case-Control Studies are unavailable; and/or
4. An Expert Opinion, if Randomized Clinical Trials, Cohort Studies, Case-Control Studies or Case Series are unavailable.

BLUE CROSS AND BLUE SHIELD OF MONTANA SPECIALTY NETWORK

Specialty Pharmacy providers who have entered into an agreement with The Plan or a third party on behalf of The Plan to provide Specialty Medications to Members and which have agreed to accept specified reimbursement rates.

BRAND-NAME DRUG

A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand-Name Drug. There may also be situations where a drug's classification changes from generic to Brand-Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to payment obligations from generic to Brand-Name.

CARE MANAGEMENT

A process that assesses and evaluates options and services required to meet the Member's health care needs. Care Management may involve a team of health care professionals, including Covered Providers, The Plan and other resources to work with the Member to promote quality, cost-effective care.

CASE-CONTROL STUDY

A retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

CASE SERIES

An evaluation of a series of patients with a particular outcome, without the use of a control group.

CLINICAL PEER

A Physician or other health care provider who:

1. Holds a nonrestricted license in a state of the United States; and
2. Is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

COHORT STUDY

A prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

COINSURANCE

The percentage of the Allowable Fee payable by the Member for Covered Medical Expenses or Dental Services. The applicable Coinsurance for In-Network Covered Medical Expenses or Dental Services and Out-of-Network Covered Medical Expenses or Dental Services is stated in the Schedule of Benefits.

COMPOUNDED DRUGS

Drugs or inert ingredients that have been measured and mixed by a pharmacist to produce a unique formulation because commercial products either do not exist or do not exist in the prescribed dosage, size, or form.

CONCURRENT CARE

Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or

Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Member's condition requires the skills of separate Physicians.

CONSULTATION SERVICES

Services of a consulting Physician requested by the attending Physician. These services include discussion with the attending Physician and a written report by the consultant based on an examination of the Member.

CONTRACT

This Group Contract, the group application and any amendments, endorsements, riders, or modifications to the Contract made to it by The Plan. The Group Contract is issued to the employer.

CONVALESCENT HOME

An institution, or distinct part thereof, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is:

1. A skilled nursing facility;
2. An extended care facility;
3. An extended care unit; or
4. A transitional care unit.

A Convalescent Home is primarily engaged in providing continuous nursing care by or under the direction and supervision of a registered nurse for sick or injured persons during the convalescent stage of their Illness or Injuries and is not, other than incidentally, a rest home or home for Custodial Care, or for the aged.

NOTE: A Convalescent Home shall not include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and treatment of Mental Illness or Substance Use Disorder.

COPAYMENT

The specific dollar amount payable by the Member for Covered Medical Expenses. The applicable Copayments are stated in the Schedule of Benefits.

COURSE OF TREATMENT

Any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERED MEDICAL EXPENSE

Expenses incurred for Medically Necessary services, supplies and medications that are based on the Allowable Fee and:

1. Covered under the Group Plan;
2. In accordance with Medical Policy; and
3. Provided to the Member by and/or ordered by a Covered Provider for the diagnosis or treatment of an active Illness or Injury or in providing maternity care.

In order to be considered a Covered Medical Expense, the Member must be charged for such services, supplies and medications.

COVERED PROVIDER

A participating or nonparticipating provider which has been recognized by Blue Cross and Blue Shield of Montana as a provider of services for Benefits described in this Member Guide. A provider may, because of the

limited scope of practice, be covered only for certain services provided. To determine if a provider is covered, The Plan looks to the nature of the services rendered, the extent of licensure and The Plan's recognition of the provider.

Covered Providers include professional providers and facility providers including Physicians, doctors of osteopathy, Dentists, optometrists, podiatrists, audiologists, nurse specialists, naturopathic physicians, Advanced Practice Registered Nurses, physician assistants, chiropractors, psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, acupuncturists, physical therapists, speech-language pathologists, licensed addiction counselors, Hospitals and Freestanding Surgical Facilities.

CREDITABLE COVERAGE

Coverage that the Member had for medical Benefits under any of the following plans, programs and coverages:

1. A group health plan.
2. Health insurance coverage.
3. Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1935c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4 (Medicare).
4. Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s (Medicaid).
5. Title 10, chapter 55, United States Code (TRICARE).
6. A medical care program of the Indian Health Service or of a tribal organization.
7. A health plan offered under Title 5, chapter 89, of the United States Code (Federal Employee Health Benefits Program).
8. A public health plan.
9. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).
10. A high risk pool in any state.

Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits.

CUSTODIAL CARE

Any service, primarily for personal comfort or convenience, that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the Member's condition. Custodial Care services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable nonprofessional personnel, are to assist with Routine medical needs (e.g., simple care and dressings, administration of Routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

DEDUCTIBLE

The dollar amount each Member must pay for In-Network Covered Medical Expenses or Dental Services and Out-of-Network Covered Medical Expenses or Dental Services incurred during the Benefit Period before The Plan will make payment for any Covered Medical Expense or Dental Services to which the Deductible applies. The In-Network and Out-of-Network Deductibles are separate, and one does not accumulate to the other.

Only the Allowable Fee for Covered Medical Expenses or Dental Services is applied to the Deductible. Thus, Copayment and/or Coinsurance, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Member's responsibility.

If two or more Members covered under the same Family Membership satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Member of the Family Membership.

If a Member is in the Hospital on the last day of the Member's Benefit Period and continuously confined through the first day of the next Benefit Period, only one In-Network or Out-of-Network Deductible will be applied to that Hospital stay (facility charges only). If the Member satisfied the Member's Deductible prior to that Hospital stay, no Deductible will be applied to that stay.

DENTAL PROVIDER

A Dental Provider may be participating or nonparticipating. A participating Dental Provider is a provider who has a contract with Blue Cross and Blue Shield of Montana. These providers agree to accept payment directly from Blue Cross and Blue Shield of Montana for covered dental Benefits. This payment, together with the Member's

Deductible and Coinsurance described in the Schedule of Benefits, is accepted as payment in full. The Member may obtain a list of participating Dental Providers from Blue Cross and Blue Shield of Montana upon request.

If a Member receives services from a nonparticipating Dental Provider, the Member is responsible for the balance of the nonparticipating provider's bill after payment by Blue Cross and Blue Shield of Montana.

DENTAL SERVICES

Dental Services for which allowances are provided in this Member Guide.

DENTALLY NECESSARY/DENTAL NECESSITY

Those services, supplies, or appliances covered under The Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or Injury; and
2. Provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. Not primarily for the convenience of the Member or his Dentist; and
4. The most economical supplies, appliances, or levels of Dental Service that are appropriate for the safe and effective treatment of the Member.

DENTIST

A person licensed to practice dentistry in the state where the service is provided.

DENTURIST

A person licensed as a Denturist in the state where the service is provided.

DEPENDENT

1. The Beneficiary Member's Spouse;
2. The Beneficiary Member's unmarried or married child up to age 26, including an eligible foster child;
3. Children for whom the Beneficiary Member becomes legally responsible by reason of placement for adoption, as defined in Montana law; or
4. An unmarried child of the Beneficiary Member who is 26 years of age or older and disabled.

For purposes of this Member Guide the unmarried child will be considered disabled if the child:

1. Was covered under this Member Guide before age 26;
2. Cannot support himself/herself because of intellectual disability or physical disability; and
3. Is legally dependent on the Beneficiary Member for support.

Proof of those qualifications must be supplied to The Plan within 31 days following the child's 26th birthday. Although there is no limiting age for disabled children, The Plan reserves the right to require periodic certification from the Beneficiary Member of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child's 26th birthday.

DIAGNOSTIC BREAST EXAMINATION

A Medically Necessary and clinically appropriate examination of the breast, including diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

DRUG LIST

A list of all drugs that may be covered under the Prescription Drugs section of this Member Guide. A current list is available on the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. Contact a Customer Service representative at the telephone number shown on the back of the Member's identification card for more information.

EFFECTIVE DATE

For a Member - the Effective Date of a Member's coverage means the date the Member:

1. Has met the requirements of The Plan stated in this Member Guide; and
2. Is shown on the records of The Plan to be eligible to receive Benefits.

For the Member Guide - the Effective Date of the Member Guide is the date shown on the face of this Member Guide.

For any endorsement, rider, or amendment - the Effective Date is the date shown on the Member Guide unless otherwise shown on the endorsement, rider and amendment.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another Hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn fetus.

EMERGENCY SERVICES

Health care items or services furnished or required to evaluate and treat an Emergency Medical Condition.

ERISA

The Employee Retirement Income Security Act of 1974, as amended and all regulations applicable thereto.

EVIDENCE-BASED STANDARD

The conscientious, explicit, and judicious use of the current Best Evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

EXCLUSION

A provision which states that The Plan has no obligation under this Member Guide to make payment.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device, biological product or medical treatment or procedure is Experimental, Investigational and/or Unproven if **The Plan determines** that:

1. The drug, device, biological product or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product or medical treatment or procedure is furnished; or
2. The drug, device, biological product or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials, or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
3. The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Approval by a governmental or regulatory agency will be taken into consideration in assessing the Experimental/Investigational/Unproven status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

EXPERT OPINION

A belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

FAMILY MEMBER

A Dependent who has been accepted as a Member of The Plan and enrolled by a Beneficiary Member.

FAMILY MEMBERSHIP

The family unit including the Beneficiary Member and all Family Members who have been accepted as Members of The Plan.

FREESTANDING INPATIENT FACILITY

For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorder in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment Center. Services include medical evaluation and health supervision; Substance Use Disorder education; organized individual, group and family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up program after discharge.

For treatment of Mental Illness, it means a facility licensed by the state and specializing in the treatment of Mental Illness.

GENERIC DRUG

A drug that has the same active ingredient as a Brand-Name Drug and is allowed to be produced after the Brand-Name Drug's patent has expired. In determining the brand or generic classification for covered drugs, Blue Cross and Blue Shield of Montana uses the generic/brand status assigned by a nationally recognized provider of drug product database information. Not all drugs identified as a "generic" by the drug product database, manufacturer, Pharmacy or Physician may process as a Generic Drug. Generic Drugs are listed on the Drug List which is available on the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. The Member may also contact Customer Service for more information.

GROUP

The organization, employer, or trust to which the Contract has been issued and includes the Beneficiary Members and their Family Members.

GROUP PLAN

The Contract between Blue Cross and Blue Shield of Montana and the Group.

HABILITATIVE CARE

Coverage will be provided for Habilitative Care services when the Member requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Other services for people with disabilities.

These services may be provided in a variety of inpatient and/or Outpatient settings as prescribed by a Physician.

HOME HEALTH AGENCY

An agency licensed by the state which provides home health care to Members in the Member's home.

HOME HEALTH AIDE

A nonprofessional worker who has been trained for home care of the sick and is employed by a Home Health Agency.

HOME INFUSION THERAPY AGENCY

A health care provider that provides home infusion therapy services.

HOSPITAL

A facility providing, by or under the supervision of licensed Physicians, services for medical diagnosis, treatment, rehabilitation and care of injured, disabled, or sick individuals. A Hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week and provides 24-hour nursing care by licensed registered nurses. Hospital does not include the following, even if such facilities are associated with a Hospital:

1. A nursing home;
2. A rest home;
3. A Convalescent Home; and/or
4. A long-term, chronic-care institution or facility providing the type of care listed above.

ILLNESS

An alteration in the body or any of its organs or parts which interrupts or disturbs the performance of a vital function, thereby causing or threatening pain or weakness.

IN HOME HEALTH ASSESSMENT

Covered services may include, but are not limited to, health history, blood pressure and blood sugar level screening. The assessment is designed to provide the Member with information regarding their health that can be discussed with the Member's health care provider, and is not a substitute for diagnosis, management and treatment by the Member's health care provider.

IN-NETWORK

Providers who are:

1. Participating Blue Cross and Blue Shield of Montana Professional Providers;
2. Participating Blue Cross and Blue Shield of Montana Facility Providers, except for Hospitals and surgery centers;

3. PPO Hospitals and surgery centers; or
4. Blue Cross and/or Blue Shield PPO providers outside of Montana.

INCLUSIVE SERVICES/PROCEDURES

A portion of a service or procedure which is necessary for completion of the service or procedure or a service or procedure which is already described or considered to be part of another service or procedure.

INFUSION SUITE

An alternative to Hospital and clinic-based infusion settings where Specialty Medications can be infused.

INJURY

Physical damage to an individual's body, caused directly and independent of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

INPATIENT CARE

Care provided to a Member who has been admitted to a facility as a registered bed patient and who is receiving services, supplies and medications under the direction of a Covered Provider with staff privileges at that facility. Examples of facilities to which a Member might be admitted include:

1. Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent Homes;
5. Freestanding Inpatient Facilities.

INPATIENT MEMBER

A Member who has been admitted to a facility as a registered bed patient for Inpatient Care.

LATE ENROLLEE

An eligible employee or Dependent, other than a special enrollee under Montana law, who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 30 days. However, an eligible employee or Dependent is not considered a Late Enrollee if a court has ordered that coverage be provided for a Spouse, minor, or Dependent child under a covered employee's health Benefit Plan and a request for enrollment is made within 30 days after issuance of the court order.

LIFE-THREATENING CONDITION

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MEDICAL FOODS

Nutritional substances in any form that are:

1. Formulated to be consumed or administered enterally under supervision of a Physician;
2. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;
3. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
4. Essential to optimize growth, health, and metabolic homeostasis.

MEDICAL OR SCIENTIFIC EVIDENCE

Evidence found in the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's library of medicine for indexing in Index Medicus and Excerpta Medica, published by the Reed Elsevier group;

3. Medical journals recognized by the Secretary of Health and Human Services under 42 U.S.C. 1395x(t)(2)(B) of the federal Social Security Act;
4. The following standard reference compendia:
   a. The American Hospital Formulary Service Drug Information;
   b. Drug Facts and Comparisons;
   c. The American Dental Association Guide to Dental Therapeutics; and
   d. The United States Pharmacopeia;
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
   a. The federal Agency for Healthcare Research and Quality;
   b. The National Institutes of Health;
   c. The National Cancer Institute;
   d. The National Academy of Sciences;
   e. The Centers for Medicare and Medicaid Services;
   f. The FDA; and
   g. Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6. Any other Medical or Scientific Evidence that is comparable to the sources listed in subsection 4 or 5.

MEDICAL POLICY

The policy of The Plan which is used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

MEDICALLY NECESSARY (FOR AUTISM, ASPERGER'S DISORDER AND PERVASIVE DEVELOPMENTAL DISORDER)

Any care, treatment, intervention, service, or item that is prescribed, provided or ordered by a Physician or psychologist and that will or is reasonably expected to:

1. Prevent the onset of an Illness, condition, Injury, or disability;
2. Reduce or improve the physical, mental, or developmental effects of an Illness, condition, or Injury, or disability; or
3. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

MEDICALLY NECESSARY (FOR DOWN SYNDROME)

Any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician licensed in this state and that will or is reasonably expected to:

1. Reduce or improve the physical, mental, or developmental effects of Down syndrome; or
2. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and

3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a Covered Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Member receives the services, supplies, or medications and a claim is submitted to The Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MEMBER

Both the Beneficiary Member and Family Members.

MEMBER GUIDE

The summary of Benefits issued to a Member that describes the Benefits available under the Group Plan.

MEMBER'S IMMEDIATE FAMILY

The Member's Spouse and children or parents and siblings who are caring for the hospice patient in that family.

MENTAL HEALTH TREATMENT CENTER

A treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider. The facility must be:

1. Licensed as a Mental Health Treatment Center by the state;
2. Funded or eligible for funding under federal or state law; or
3. Affiliated with a Hospital under a contractual agreement with an established system for patient referral.

MENTAL ILLNESS

A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

1. Present distress or a painful symptom;
2. A disability or impairment in one or more areas of functioning; or
3. A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

Mental Illness does not include:

1. Developmental disorders;
2. Speech disorders;
3. Psychoactive Substance Use Disorders;
4. Eating disorders (except for bulimia and anorexia nervosa); or
5. Impulse control disorders (except for intermittent explosive disorder and trichotillomania).

MONTH

For the purposes of this Member Guide, a Month has 30 days even if the actual calendar Month is longer or shorter.

MULTIDISCIPLINARY TEAM

A group of health service providers who are either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. Members of the Multidisciplinary Team may include, but are not limited to, a licensed psychologist, licensed speech therapist, registered physical therapist, or licensed occupational therapist.

NON-PREFERRED BRAND-NAME DRUG

A Brand-Name Drug that is identified on the Drug List as a Non-Preferred Brand-Name Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

NON-PREFERRED GENERIC DRUG

A Generic Drug that is identified on the Drug List as a Non-Preferred Generic Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

NON-PREFERRED SPECIALTY MEDICATION

A Specialty Medication, which may be a Generic or Brand-Name Drug, that is identified on the Drug List as a Non-Preferred Specialty Medication. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

OCCUPATIONAL THERAPY

Therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of speech tasks or goal-directed activities designed to improve the functional performance of an individual.

ORTHOPEDIC DEVICES

Rigid or semirigid supportive devices which restrict or eliminate motion of a weak or diseased body part. Orthopedic Devices are limited to braces, corsets and trusses.

OUT-OF-NETWORK

Providers who are:

1. Nonparticipating professional providers;
2. Nonparticipating facility providers;
3. Non-PPO Network Hospitals and surgery centers; or
4. Blue Cross and Blue Shield of Montana Participating Hospitals and surgery centers that are not in the PPO Network.

OUT OF POCKET AMOUNT

For the Member:

The total amount of applicable In-Network Deductible, Copayment and/or Coinsurance, and the applicable Out-of-Network Deductible, Copayment and/or Coinsurance each Member must pay for Covered Medical Expenses and Dental Services incurred during the Benefit Period. Once the Member has satisfied the applicable Out of Pocket Amount, the Member will not be required to pay the Member's applicable Deductible, Copayment and/or Coinsurance for Covered Medical Expenses and Dental Services for the remainder of that Benefit Period. The Out of Pocket Amount for the Member is listed in the Schedule of Benefits. The In-Network and Out-of-Network Out of Pocket Amounts are separate, and one does not accumulate to the other.

If a Member is in the Hospital on the last day of the Member's Benefit Period and continuously confined through the first day of the next Benefit Period, the applicable Deductible, Copayment and/or Coinsurance for the entire Hospital stay (facility charges only) will only apply to the applicable Out of Pocket Amount of the Benefit Period in which the inpatient stay began. If the Member satisfied the Out of Pocket Amount prior to that Hospital stay, no applicable Deductible, Copayment and/or Coinsurance will be applied to that stay.

Non-covered services, the nonparticipating Pharmacy 50% Benefit reduction, and amounts over the allowed amount billed by a nonparticipating provider do not accumulate to the Out of Pocket Amount and are the Member's responsibility.

For the Family:

The total amount of applicable In-Network Deductible, Copayment and/or Coinsurance, and the applicable Out-of-Network Deductible, Copayment and/or Coinsurance for Covered Medical Expenses and Dental Services a Family Membership must pay for services incurred during that Benefit Period. Once the applicable Deductible, Copayment and/or Coinsurance paid by the Member during the Benefit Period for two or more Family Members covered under the same Family Membership total the applicable Out of Pocket Amount for the family, the Members covered under the same Family Membership will not be required to pay the applicable Deductible, Copayment and/or Coinsurance for Covered Medical Expenses and Dental Services the remainder of that Benefit Period. The Out of Pocket Amount for the family is listed on the Schedule of Benefits. The In-Network and Out-of-Network Out of Pocket Amounts are separate, and one does not accumulate to the other. For family

coverage when only two Members are enrolled, the two Members each must meet their Individual Out of Pocket Amounts only.

Non-covered services, the nonparticipating Pharmacy 50% Benefit reduction, and amounts over the allowed amount billed by a nonparticipating provider do not accumulate to the Out of Pocket Amount and are the Member's responsibility.

OUTPATIENT

Services or supplies provided to the Member by a Covered Provider while the Member is not an Inpatient Member.

PARTIAL HOSPITALIZATION

A time-limited ambulatory (Outpatient) program offering active treatment which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

A Partial Hospitalization program should offer four to eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA FACILITY PROVIDER

A facility which has a contract with Blue Cross and Blue Shield of Montana and may include, but are not limited to, Hospitals, Home Health Agencies, Convalescent Homes, skilled nursing facilities, Freestanding Inpatient Facilities and freestanding surgical facilities. Please read the section entitled Providers of Care for Members.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA PROFESSIONAL PROVIDER

A provider who has a contract with Blue Cross and Blue Shield of Montana and may include, but are not limited to, Physicians, physician assistants, nurse specialists, Dentists, podiatrists, speech therapists, physical therapists and occupational therapists. Please read the section entitled Providers of Care for Members.

PARTICIPATING PHARMACY

A Pharmacy which has entered into an agreement with The Plan or a third party on behalf of The Plan to provide Prescription Drug Products to Members and has agreed to accept specified reimbursement rates. Participating Pharmacies may be Value Participating Pharmacies or Participating Pharmacies.

PARTICIPATING PROVIDER

A Participating Blue Cross and Blue Shield of Montana Professional Provider or a Participating Blue Cross and Blue Shield of Montana Facility Provider.

PHARMACY

A state and federally licensed establishment that is physically separate and apart from any provider's office, and where legend drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he or she practices.

PHARMACY BENEFIT MANAGER

The company with whom The Plan has entered into an agreement for the processing of prescription drug claims.

PHYSICAL THERAPY

Treatment of disease or Injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and pain relief.

PHYSICIAN

A person licensed to practice medicine in the state where the service is provided.

PLAN - THE PLAN

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

PPO - A PREFERRED PROVIDER ORGANIZATION

A provider or group of providers which have contracted with The Plan to provide services to Members covered under PPO Benefit Contracts.

PPO NETWORK

A provider or group of providers which have a PPO contract with Blue Cross Blue Shield of Montana. The Member may obtain a list of PPO providers from Blue Cross Blue Shield of Montana upon request.

PREFERRED BRAND-NAME DRUG

A Brand-Name Drug that is identified on the Drug List as a Preferred Brand-Name Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PREFERRED GENERIC DRUG

A Generic Drug that is identified on the Drug List as a Preferred Generic Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PREFERRED SPECIALTY MEDICATION

A Specialty Medication, which may be a Generic or Brand-Name Drug, that is identified on the Drug List as a Preferred Specialty Medication. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at https://www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PRESCRIPTION DRUG PRODUCT

A medication, product or device approved by the FDA.

PRIOR AUTHORIZATION

The process that determines in advance the Medical Necessity or Experimental/Investigational/Unproven nature of certain care and services under the Member Guide. Prior Authorization is used to inform the Member whether or not a proposed service, medication, supply, or on-going treatment is Medically Necessary and is a Covered Medical Expense of the Member Guide.

Prior Authorization does not guarantee that the care and services a Member receives are eligible for Benefits under the Member Guide. At the time the Member's claims are submitted, they will be reviewed in accordance with the terms of the Member Guide.

PROFESSIONAL CALL

An interview between the Member and the professional provider in attendance. The professional provider must examine the Member and when appropriate provide or prescribe medical treatment. "Professional Call" does not include telephone calls or any other communication where the Member is not examined by the professional provider, except as included in the Benefit sections entitled Telehealth and Virtual Visits.

PROOF OF LOSS

The documentation accepted by Blue Cross and Blue Shield of Montana upon which payment of Benefits is made.

QUALIFIED HEALTH CARE PROVIDER

A person licensed as a Physician, audiologist, psychologist, social worker, clinical professional counselor, marriage and family therapist, or addiction counselor or another appropriate licensed health care practitioner.

QUALIFIED INDIVIDUAL (FOR AN APPROVED CLINICAL TRIAL)

An individual with group health coverage or group or individual health insurance coverage who is eligible to participate in an Approved Clinical Trial according to the trial protocol for the treatment of cancer or other Life-Threatening Condition because:

1. The referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate; or
2. The individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

RANDOMIZED CLINICAL TRIAL

A controlled, prospective study of patients who have been assigned at random to an experimental group or a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention. The term includes a study of the groups for variables and anticipated outcomes over time.

RECOMMENDED CLINICAL REVIEW

An optional voluntary review of a provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to determine whether the procedure, treatment or test meets approved Blue Cross and Blue Shield of Montana Medical Policy guidelines and Medical Necessity requirements.

RECONSTRUCTIVE BREAST SURGERY

Surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

RECOVERY CARE BED

A bed occupied in an Outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATION FACILITY

A facility, or a designated unit of a facility, licensed, certified or accredited to provide Rehabilitation Therapy including:

1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or a facility associated or co-located with a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital; and/or
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Member, regardless of the category of facility licensure.

REHABILITATION THERAPY

A specialized, intense and comprehensive program of therapies and treatment services (including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy) provided by a Multidisciplinary Team for treatment of an Injury or physical deficit. A Rehabilitation Therapy program is:

1. Provided by a Rehabilitation Facility in an Inpatient Care or Outpatient setting;
2. Provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;
3. Designed to restore the patient's maximum function and independence; and
4. Medically Necessary to improve or restore bodily function and the Member must continue to show measurable progress.

REHABILITATIVE CARE

Coverage will be provided for Rehabilitative Care services when the Member requires help to keep, recover or improve skills and functioning for daily living that have been lost or impaired because the Member was sick, hurt or disabled. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Psychiatric rehabilitation.

These services may be provided in a variety of inpatient and/or Outpatient settings as prescribed by a Physician.

RESIDENTIAL TREATMENT CENTER

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and on-site nursing care and supervision for at least one shift a day with on call availability for other shifts for patients with Mental Illness and/or Substance Use Disorders. Blue Cross and Blue Shield of Montana requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located and/or accredited by a national organization that is recognized by Blue Cross and Blue Shield of Montana as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

ROUTINE

Examinations or services provided when there is no objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any Injury or Illness.

ROUTINE PATIENT COSTS

All items and services covered by a group health plan or a plan of individual or group health insurance coverage when the items or services are typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. The term does not include:

1. An investigational item, device, or service that is part of the trial;
2. An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis.

SMALL EMPLOYER

A person, firm, corporation, partnership, or bona fide association that:

1. Is actively engaged in business; and
2. With respect to a calendar year and a plan year, employed at least 1 but not more than 50 Eligible Employees during the preceding calendar year and employed at least two employees on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer must be based on the average number of employees reasonably expected to be employed by the employer in the current calendar year.

In determining the number of eligible employees, companies are considered one employer if they are:

1. Affiliated companies;
2. Eligible to file a combined tax return for purposes of state taxation; or
3. Members of a bona fide association.

SPECIALTY MEDICATIONS

Specialty Medications are used to treat complex medical conditions and are typically given by injection but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail Pharmacies. Some conditions such as hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with Specialty Medications.

SPECIALTY PHARMACY

A Pharmacy which has entered into an agreement with The Plan or a third party on behalf of The Plan to provide Specialty Medications to Members and which has agreed to accept specified reimbursement rates.

SPEECH THERAPY

The treatment of communication impairment and swallowing disorders.

SPOUSE

The opposite sex or the same sex person to whom the Beneficiary Member is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

SUBSTANCE USE DISORDER

The uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a licensed addiction counselor or other appropriate medical practitioner.

SUBSTANCE USE DISORDER TREATMENT CENTER

A treatment facility that provides a program for the treatment of Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider licensed by the state. The facility must also be licensed or approved as a Substance Use Disorder Treatment Center by the department of health and human services or must be licensed or approved by the state where the facility is located.

SUPPLEMENTAL BREAST EXAMINATION

A Medically Necessary and appropriate examination of the breast, including breast magnetic resonance imaging or breast ultrasound, that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person's risk of breast cancer.

TELEHEALTH

The use of audio, video, or another telecommunications technology or media, including audio-only communication that is:

1. Used by a health care provider or health care facility to deliver health care services; and
2. Delivered over a secure connection that complies with state and federal law.

Telehealth does not include delivery of health care services by means of facsimile machine or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

URGENT CARE

Urgent Care services are considered treatment in any setting that, if delayed, could seriously jeopardize the Member's life and health or ability to regain maximum function or would subject the Member, in the opinion of a health care provider with knowledge of the Member's medical condition, to severe pain that cannot be adequately managed without the service or treatment.

VALUE PARTICIPATING PHARMACY

A Participating Pharmacy which has a written agreement with Blue Cross and Blue Shield of Montana to provide pharmaceutical services to the Member or an entity chosen by Blue Cross and Blue Shield of Montana to administer its prescription drug program that has been designated as a Value Participating Pharmacy.

VIRTUAL VISIT

Consultation with a licensed provider through interactive video, or other communication technology allowed by applicable law, via online portal or mobile application.

BlueCross BlueShield of Montana

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601		

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Montana

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

Notice That Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of Benefits under this group health plan coverage no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to reenroll in the plan. Individuals have 30 days beginning with the start of the plan year to request enrollment.

Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26

Children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of Dependent coverage for children ended before attainment of age 26 are eligible to enroll in this group health coverage, regardless of student status, financial dependency or marital status. Individuals may request enrollment for such children for 30 days beginning with the start of the plan year.

For additional information regarding these notices, contact:

Blue Cross and Blue Shield of Montana
3645 Alice Street
P.O. Box 4309
Helena, MT 59604-4309
1-800-447-7828

bcbsmt.com

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