AcademicBlue℠

Montana University System (MUSSIP) Student Health Insurance Plan 2020-2021

Underwritten by:
Blue Cross and Blue Shield of Montana (BCBSMT)

Please read the brochure to understand your coverage.
Please see "Important Notice" on the final page of this document.

Account Medical Number: 058188

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Introduction

The Montana University System Student Insurance Plan (MUSSIP) is pleased to offer the AcademicBlue Student Health Insurance Plan, underwritten by Blue Cross and Blue Shield of Montana. This brochure explains your health care benefits, including what health care services are covered and how to use the benefits. This insurance Plan protects Insured students and their covered Dependents on or off campus for weekends, holidays, summer vacations, at home or while traveling 24 hours per day for the Policy year. This Plan meets the requirements of the Affordable Care Act. The actuarial value of this plan meets or exceeds a "Gold" metal level of coverage. This policy will always pay benefits in accordance with any applicable federal and state insurance law(s).

Please keep these three fundamental Plan features in mind as you learn about this Policy:

- **This student health insurance Plan is a Preferred Provider Organization (PPO) Plan.** You should seek treatment from the BCBSMT (PPO) Network, which consists of hospitals, doctors, ancillary, and other health care providers who have contracted with BCBSMT for the purpose of delivering covered health care services at negotiated prices so you can maximize your benefits under this Plan. A list of Network Providers can be found online at **bsbcmt.com** or by calling (855) 267-0214. Using BCBSMT providers may save you money.

- **Participating in an insurance Plan does not mean all of your health care costs are paid in full by the insurance company.** There are several areas for which you could be responsible for payment, including, but not limited to, a Deductible, a Copayment or Coinsurance and medical costs for services excluded by the Plan.

- **It is your responsibility to familiarize yourself with this Plan.** Exclusions and limitations are applied to the coverage as a means of cost containment (Please see the “Exclusions and Limitations” section for more details). To make this coverage work for you, it is helpful to be informed and proactive. Check the covered benefits in this brochure before your procedure whenever possible. Know the specifics and communicate them to your health care provider. **We are here to help.**

Please Note: We have capitalized certain terms that have specific, detailed meanings, which are important to help you understand your Policy. Please review the meaning of the capitalized terms in the "Definitions" section.

Privacy Notice

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 brochure.

Eligibility/How to Enroll

Who Is Eligible

1. All students are eligible if they are:
    a. A fee-paying student attending credit courses at a participating campus; and
    b. A student enrolled for six credit hours or more at all campuses. A student enrolled for less than six credit hours is not eligible to enroll in the Student Health Plan unless certain criteria are met. Please contact your campus insurance representative.
2. Participation Requirements
    a. All students enrolled for six credit hours or more are required to carry health insurance coverage. Students can enroll for coverage when they register on-line for classes.
3. The Student Health Plan fee will be assessed each Fall and Spring semester at registration.
    a. Enrollment in the Student Health Plan is required for all International Students (residing within the United States), at all campuses regardless of the number of credit hours, unless proof of other coverage in the United States is submitted to the campus.
4. The Student Health Plan fee will be assessed each Fall and Spring semester at registration.
    a. Waiver of coverage must be made no later than the 15th class day of the semester, Fall and Spring. Only students with other coverage will be allowed to waive coverage.

Enrollment/Waiver Process

The Effective Date of coverage (for those who apply within the periods of eligibility) will be the date assigned by the Group. A specific period of time is allowed at the beginning of each semester for enrolling in The Plan or waiving coverage. For the Fall and Spring semesters, the enrollment/waiver period begins on the first day of scheduled classes each semester and ends 15 class days later.

Effective Date of Coverage

1. For the Student
   a. The effective date of coverage for eligible students shall be the first day of the applicable coverage period
   b. If a student becomes eligible after the beginning of the applicable coverage period, the student's effective date will be the first day of the applicable coverage period after the required premium is paid

2. For Newborn Children
   For a newborn born to a Member, the date of birth. Coverage will continue for 31 days only. 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.

3. For Adoption or Placement for Adoption.
   In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption. 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. Coverage will continue for 31 days only. Coverage for the child 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 child will only be covered for the amount of time (during the 31 days) that the Beneficiary Member is covered.

Qualifying Events

Eligible students will not be allowed to enroll in The Plan after the applicable enrollment/waiver period unless proof is furnished that the student became ineligible for coverage under another group insurance plan during the 31 days immediately preceding the date of the request for late enrollment. The coverage will be for the entire semester.

Conditions for Special Enrollment for Loss of Eligibility

1. When the student declined enrollment for the student, the student stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment; and
   a. The student had COBRA continuation coverage and the COBRA continuation coverage has expired; or

   b. The student had other coverage that was not under a COBRA continuation provision and the other coverage has been terminated because of:

      i. A loss of eligibility for the coverage. Loss of eligibility for coverage includes loss 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

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

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

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

2. The student must request enrollment 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.

3. The student must request enrollment not later than 60 days after the date of termination of coverage under either the Children's Health Insurance Program or the Medicaid Program.

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

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

EFFECTIVE DATE OF ENROLLMENT

Enrollment due to loss of eligibility will be the first day of the applicable semester.

WHEN BENEFITS BEGIN

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

CHANGE OF STATUS

Change of Status forms should be completed and returned to The Plan for:

1. Name changes; or

2. Address changes.

Effective Dates and Termination

The Policy on file at the school becomes effective at 12:00 a.m. Mountain time at the University's address on the later of the following dates:

1. The effective date of the Policy
2. The date premium is received by the Company or its authorized representative.

Termination When No Longer Eligible For Coverage

When No Longer Eligible for Coverage your membership will terminate on the earlier of:

1. The last day of the period for which payment has been made; or
2. The date the university is no longer participating in the Student Health Plan; or
3. The date of the entry into military service, except for temporary duty of thirty (30) days or less.

In the event the covered student withdraws from the university within the 100 percent refund period, the following action may take place:

If an unexpected illness or accident forces the student to drop classes, and there was intent by the individual to finish the course of study during the coverage period, he/she may be covered for the remainder of the coverage period. (In this case, the Director of the Student Health Center would make the decision on whether a medical release is in order.) Students who intend to pursue this option should contact the Health Center within the 100 percent refund period.

Coverage period notice: Coverage Periods are established by the University and subject to change from one Policy year to the next.

Extension of Benefits After Termination

When the membership of a Beneficiary Member 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, except in the following instances:

If the Member is receiving Inpatient Care at a health care facility on the day coverage terminates, the Benefits of this Brochure shall be provided:

1. Until the maximum amount of Benefits has been paid.
2. Until the inpatient stay ends.
3. Until the end of a 90-day period from the day coverage terminates.
4. Until the Member becomes covered without limitation as to the condition for which the Member is receiving Inpatient Care under any other group coverage.
5. Or whichever occurs first.

Coordination of Benefits

Under a Coordination of Benefits (COB) provision, the Plan that pays first is called the Primary Plan. The Secondary Plan typically makes up the difference between the Primary Plan's benefit and the Covered Expenses. When one Plan does not have a COB provision, that Plan is always considered the Primary Plan, and always pays first. You may still be responsible for applicable Deductible, Copayments and Coinsurance amounts.

Additional Covered Expenses

The Policy will always pay benefits in accordance with any applicable federal and state insurance law(s).

Schedule of Benefits

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 PPO providers. Out-of-Network providers are nonparticipating and non-PPO providers.

Professional providers include, but are not limited to, Physicians, doctors of osteopathy, dentists, optometrists, podiatrists, Advanced Practice Registered Nurses, physician assistants, naturopathic physicians, chiropractors 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 Chemical Dependency or Mental Illness and freestanding surgical facilities (surgery center).

Blue Cross and Blue Shield of Montana also has a PPO Network of Hospitals and surgery centers in Montana. Outside of the state of Montana, there are also Blue Cross and/or Blue Shield PPO Hospitals and surgery centers nationwide.

After the Deductible is satisfied, benefits will be paid based on the selected provider. Benefits will be paid at 80 percent of the Allowable Fee for services rendered by In-Network and PPO providers, unless otherwise specified in the Brochure. Services obtained from Out-of-Network providers will be paid at 60 percent of the Allowable Fee, unless otherwise specified in the Brochure. Benefits will be paid up to the maximum for each service as specified below, regardless of the provider selected.

AT PHARMACIES CONTRACTING WITH THE PRIME THERAPEUTICS NETWORK: You must go to a pharmacy contracting with the Prime Therapeutics Network in order to access this program. Present your insurance ID card to the pharmacy to identify yourself as a participant in this Plan. Eligibility status will be online at the pharmacy. You can locate a participating pharmacy by calling **(800) 423-1973**; you also can locate one online at bcbsmt.com.

Maximum Benefit		Unlimited
Deductible (Per Policy Year)	In-Network and PPO Provider	Out-of-Network Provider
	$500 Student	$1,000 Student
Out-Of-Pocket Amount (Per Policy Year)	$6,850 Student	$13,700 Student

OUT-OF-POCKET AMOUNT

The Deductible, Copayment and Coinsurance apply to the Out-of-Pocket Amount. Some Benefits have specific Benefit Period maximums. Even if the Out of Pocket Amount is met, Benefits will not be paid for services after the maximum Benefit is paid. These specific Benefit maximums are listed in this Brochure.

The Out of Pocket Amount does not apply to charges in excess of the Allowable Fee. This means that charges in excess of the Allowable Fee do not accumulate to help meet the Out of Pocket Amount.

The relationship between Blue Cross and Blue Shield of Montana (BCBSMT) and Contracting Pharmacies is that of Independent Contractors, contracted through a related company, Prime Therapeutics, LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSMT, as well as several other independent Blue Cross Plans, has an ownership interest in Prime Therapeutics.

Deductible applies unless otherwise noted

Inpatient	In-Network Provider	Out-of-Network Provider
Hospital Expenses: Includes daily semi-private room rate; intensive care; general nursing care provided by the hospital; hospital miscellaneous expenses such as the cost of the operating room, laboratory tests, X-ray examinations, pre-admission testing, anesthesia, drugs (excluding take-home drugs) or medicines, physical therapy, therapeutic services and supplies.	**80%** of Allowable Fee	**60%** of Allowable Fee
Surgical Expense: When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full Allowable Fee for that procedure.	**80%** of Allowable Fee	**60%** of Allowable Fee
Assistant Surgeon	**80%** of Allowable Fee	**60%** of Allowable Fee
Anesthetist	**80%** of Allowable Fee	**60%** of Allowable Fee
Doctor's Office Visits	**80%** of Allowable Fee	**60%** of Allowable Fee
Routine Well-Baby Care	**80%** of Allowable Fee	**60%** of Allowable Fee
Mental Illness/Substance Use Disorder	Paid as any other covered Illness	

Outpatient	In-Network Provider	Out-of-Network Provider
Surgical Expenses: When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure.	**80%** of Allowable Fee	**60%** of Allowable Fee
Day Surgery Miscellaneous: Related to scheduled surgery performed in a hospital, including the cost of the operating room, laboratory tests, X-ray examinations, professional fees, anesthesia, drugs or medicines and supplies.	**80%** of Allowable Fee	**60%** of Allowable Fee
Assistant Surgeon	**80%** of Allowable Fee	**60%** of Allowable Fee

Outpatient	In-Network Provider	Out-of-Network Provider
Anesthetist	**80%** of Allowable Fee	**60%** of Allowable Fee
Doctor Office Visit/Consultation: **Doctor Copayment Amount:** For office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians. **Specialty Copayment Amount:** For office visit/consultation when services rendered by a Specialty Care Provider refer to the Medical/Surgical Expenses section for more information.	**100%** of Allowable Fee after **$20** Copayment per visit **$40** Copayment per visit	**60%** of Allowable Fee
Therapy Services: Includes, but not limited to, physical, occupational, cardiac and speech therapy.	**80%** of Allowable Fee	**60%** of Allowable Fee
Chiropractic Care	10 max visit each plan year maximum	
Radiation Therapy and Chemotherapy: Includes dialysis and respiratory therapy.	**80%** of Allowable Fee	**60%** of Allowable Fee
Emergency Care and Accidental Injury		
Facility Services: (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply).	**80%** of Allowable Fee after **$100** Copayment (Deductible waived)	
Physician Services	**80%** of Allowable Fee	
Non-Emergency Care		
Facility Services: (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply).	**80%** of Allowable Fee after **$100** Copayment (Deductible waived)	**60%** of Allowable Fee
Physician Services	**80%** of Allowable Fee	**60%** of Allowable Fee

Urgent Care Services	**80%** of Allowable Fee after **$40** Copayment (Deductible waived)	**60%** of Allowable Fee
Hi-Tech Radiology-Cat Scan, Pet Scan, MRI (reading/professional component included)	**100%** of Allowable Fee after **$100** Copayment (Deductible waived)	**60%** of Allowable Fee
Tests and Procedures: Diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits **(including diagnostic lab tests and x-rays).**	**80%** of Allowable Fee	**60%** of Allowable Fee
Mental Illness/ Chemical Dependency	Paid as any other covered Illness	
Extended Care Expenses	**In-Network Provider**	**Out-of-Network Provider**
Extended Care Expenses: All services must be pre-authorized.	**80%** of Allowable Fee	**60%** of Allowable Fee
Home Health Care	Limited to 180 visit maximum each plan year	
Skilled Nursing	Limited to 60 day maximum each plan year	
Hospice Care	No Plan Year Visit Maximums	
Private Duty Nursing	$10,000 maximum each plan year	
Other	**In-Network Provider**	**Out-of-Network Provider**
Ground and Air Ambulance Services	**80%** of Allowable Fee	**80%** of Allowable Fee
Virtual Visits (through MD Live*)	**$20** Copayment per visit (Deductible waived)	**60%** of Allowable Fee
Durable Medical Equipment: When prescribed by a Doctor and a written prescription accompanies the claim when submitted.	**80%** of Allowable Fee	**60%** of Allowable Fee
Maternity/Complications of Pregnancy	**80%** of Allowable Fee	**60%** of Allowable Fee
Dental: Made necessary by Injury to sound, natural teeth only.	**80%** of Allowable Fee	**60%** of Allowable Fee

*MDLIVE is a separate company that operates and administers the virtual visits program for Blue Cross and Blue Shield of Montana. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without written permission.

Other	In-Network Provider	Out-of-Network Provider
Pediatric Vision, up to age 19	Please see policy for benefit details	
Pediatric Routine Dental Care, up to age 19: See benefit flier for details.	**80%** of Allowable Fee	**80%** of Allowable Fee
Pediatric Basic and Major Dental, up to age 19: See benefit flier for details.	**50%** of Allowable Fee	**50%** of Allowable Fee
Pediatric Medically Necessary Orthodontia, up to age 19: See benefit flier for details.	**50%** of Allowable Fee	**50%** of Allowable Fee
Autism Spectrum Disorders: Applied Behavior Analysis (ABA) services are only covered for Members under 19 years of age.	**80%** of Allowable Fee	**60%** of Allowable Fee
Organ and Tissue Transplant Services: The transplant must meet the criteria established by BCBSMT for assessing and performing organ or tissue transplants as set forth in BCBSMT's written medical policies.	**80%** of Allowable Fee	**60%** of Allowable Fee

Other	In-Network Provider	Out-of-Network Provider
Preventive Care Services, includes but are not limited to: a. An annual routine physical exam, annual pap smear, annual mammogram screening, prostate screening, colorectal screening and immunizations. b. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"); c. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"); d. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, child(ren), and adolescents; and e. With respect to women, such additional preventive care and screenings, not described in item "a" above, as provided for in comprehensive guidelines supported by the HRSA. Preventive care services as mandated by state and federal law. Please refer to the Policy or call Blue Cross and Blue Shield of Montana for more information at **(855) 267-0214**.	**100%** of Allowable Fee (Deductible waived)	**100%** of Allowable Fee

Pharmacy Benefits	In-Network Provider	Out-of-Network Provider
Retail Pharmacy: (Deductible waived) Benefits include diabetic supplies. Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available at three (3) times the Copayment. Copayment amounts will apply to Out-of-Pocket Amount.	*At pharmacies contracting with Prime Therapeutics Network:* **100%** of Allowable Fee after a	When the Member obtains prescription drugs from an Out-of-Network pharmacy (other than a Network pharmacy): Benefits will be provided at **60%** of the amount the Member would have received had he/she obtained drugs from a Network pharmacy minus the Copayment.
Generic Drug	**$15** Copayment	**$15** Copayment
Preferred Brand-name Drug	**$30** Copayment*	**$30** Copayment*
Non-Preferred Brand-name Drug	**$50** Copayment*	**$50** Copayment*

*Copayment plus the cost difference between the Brand Name Drug or supplies per prescription for which there is a Generic Drug or supply available.

Preauthorization Notification

Preauthorization is recommended for any Inpatient admission, including admissions to a Hospital, Chemical Dependency Treatment Center, Mental Illness Treatment Center, Chemical Dependency or psychiatric residential treatment facility, intensive Outpatient programs, Outpatient surgery, or other medical procedures or services as soon as the provider recommends or schedules services to allow The Plan to begin working with the Member on Preauthorization. The Member or provider should notify The Plan's Preauthorization Department by calling the number shown on the Member's Identification Card before receiving treatment. It is NOT necessary to preauthorize standard x-ray and lab services or Routine office visits. If the Member does not request Preauthorization, The Plan will conduct a retrospective review after the claims have been submitted. It is determined that services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the health insurance plan, the Member will be responsible for the full cost of the services. Please refer to your school's student health policy for complete details on specific preauthorization requirements for services and benefits.

The relationship between Blue Cross and Blue Shield of Montana (BCBSMT) and Contracting Pharmacies is that of Independent Contractors, contracted through a related company, Prime Therapeutics, LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSMT, as well as several other independent Blue Cross Plans, has an ownership interest in Prime Therapeutics.

Definitions

ACCIDENT
An unexpected traumatic incident or unusual strain which is:

- Identified by time and place of occurrence;
- Identifiable by part of the body affected; and
- Caused by a specific event on a single day.

Some examples include:

- Fracture or dislocation
- Sprain or strain
- Abrasion, laceration
- Contusion
- Embedded foreign body
- Burns
- 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.

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 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 (DRGs) 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 nonparticipating providers 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.

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 nonparticipating providers 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.

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 Copayment, Coinsurance and Deductible 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 their 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.

BENEFICIARY MEMBER
The student who has applied for, been accepted as a Member, and maintains membership in The Plan under the terms of this Brochure **BENEFIT.**

Services, supplies and medications that are provided to a Member and covered under this Brochure as a Covered Medical Expense.

BENEFIT MANAGEMENT
A program designed to involve the Member, Covered Providers and The Plan's professional staff in assisting with the management of the Member's health care while maintaining the quality of care.

CHEMICAL DEPENDENCY
Alcoholism or drug addiction.

CHEMICAL DEPENDENCY TREATMENT CENTER
A treatment facility that provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician or addiction counselor licensed by the state. The facility must also be licensed or approved as a Chemical Dependency Treatment Center by the department of health and human services or must be licensed or approved by the state where the facility is located.

COINSURANCE
The percentage of the Allowable Fee payable by the Member for Covered Medical Expenses. The applicable

Coinsurance for In-Network Covered Medical Expenses and Out-of-Network Covered Medical Expenses is stated in the Schedule of Benefits.

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:

- A skilled nursing facility;
- An extended care facility;
- An extended care unit; or
- 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 Chemical Dependency.

COPAYMENT
A fixed dollar amount that the Member must pay before benefits are payable under the Group plan.

COVERED MEDICAL EXPENSE
Expenses incurred for Medically Necessary services, supplies and medications that are based on the Allowable Fee and:

- Covered under the Group Plan;
- In accordance with Medical Policy; and
- 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, nurse specialists, naturopathic physician, Advanced Practice Registered Nurses, physician assistants, Hospitals and Freestanding Surgical Facilities.

DEDUCTIBLE
The amount listed in the Schedule of Benefits, which you must pay for Covered Medical Expenses before The Plan

will make payment. The Deductible will apply to Covered Medical Expenses for services provided to each Member each school semester.

EMERGENCY CARE
Health care services provided in a hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, Sickness or Injury is of such a nature that failure to get immediate care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

EFFECTIVE DATE
For a Member - the Effective Date of a Member's coverage means the date the Member:

- Has met the requirements of The Plan to be eligible to receive Benefits.

EXCLUSION
A provision which states that The Plan has no obligation under this Contract to make payment.

EXPERT OPINION
A belief or an interpretation by specialist with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

GENERIC
A medication that is comparable to brand/reference listed drug product, has the same active ingredient(s), is expected to have the same clinical effect, and is available by multiple manufacturers.

GROUP
The organization to which the Contract has been issued and includes the Beneficiary Members. For the purposes of this Brochure the Group is the Montana University System Student Insurance Plan.

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.

ILLNESS
An alteration in the body or any of its organs or parts which interrupts or disturbs the performance of a vital function, hereby causing or threatening pain or weakness.

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
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.

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:

- Hospitals;
- Transitional care units;
- Skilled nursing facilities;
- Convalescent homes;
- Freestanding inpatient facilities.

INVESTIGATIONAL/EXPERIMENTAL SERVICE

1. A surgical or medical procedure, supply, device, or drug which at the time provided, or sought to be provided, is determined by The Plan to fall into one or more of the following categories:
2. Has not received the required final approval to market from appropriate government bodies;
3. Is one about which the peer - reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
4. Is not demonstrated to be as beneficial as established alternatives;
5. Has not been demonstrated to improve the net health outcomes;
6. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting; or
7. Is not the standard practice or procedure utilized by practicing physicians in treating other patients with the same or similar condition.

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:

- Final approval from the appropriate governmental regulatory agencies;
- Scientific studies showing conclusive evidence of improved net health outcome; and
- In accordance with any established standards of good medical practice.

MEDICALLY NECESSARY
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.

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.

MEMBER
The Beneficiary Member.

MEMBER BROCHURE

The summary of Benefits issued to a Member that describes the Benefits available under the Group Plan.

MENTAL ILLNESS
A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

- Present distress or a painful symptom;
- A disability or impairment in one or more areas of functioning; or
- 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:

- Developmental disorders;
- Speech disorders;
- Psychoactive substance use disorders;
- Eating disorders (except for bulimia and anorexia nervosa);
- Impulse control disorders (except for intermittent explosive disorder and trichotillomania); or
- Severe Mental Illness

ORTHOPEDIC DEVICES
Rigid or semi rigid 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 PROVIDER
Providers who are:

1. Non-participating professional providers;
2. Non-participating facility providers;
3. Non-PPO Network Hospitals and surgery centers; and
4. Blue Cross and Blue Shield of Montana Participating Hospitals and surgery centers that are not in the PPO Network.

OUTPATIENT
Services or supplies provided to the Member by a Covered Provider while the Member is not an Inpatient Member.

OUT-OF-POCKET AMOUNT
For the Member:
The total amount of Deductible, Coinsurance and Copayment a Member must pay for Covered Medical Expenses incurred during the Benefit Period. Once the Member has satisfied the Out of Pocket Amount, the Member will not be required to pay that Member's Deductible, Coinsurance or Copayment for Covered Medical Expenses for the remainder of that Benefit Period. The Out of Pocket Amount for the Member is listed in the Schedule of Benefits.

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, Deductible and Coinsurance for the entire stay will only apply to the 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 Deductible or Coinsurance will be applied to that stay.

Non-covered services and amounts billed by a nonparticipating provider do not accumulate to the Out of Pocket Amount and are the Member's responsibility.

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 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.

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. Payment to a non-PPO Network provider is subject to the non-PPO Network provider reduction shown in the Schedule of Benefits and the Special Provisions section of this document.

PRESCRIPTION DRUG PRODUCT
A medication, product or device approved by the Food and Drug Administration.

PRIOR AUTHORIZATION
A process 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 this Group Plan.

QUALIFYING INTERCOLLEGIATE SPORT
Means a sport: a.) which has been accorded varsity status by the Institution as an NCAA or NAIA sport; and (b.) which is administered by such Institution's department of intercollegiate athletics; and (c.) for which the eligibility of the participating student athlete is reviewed and certified in accordance with NCAA or NAIA legislation, rules, or regulations; and (d.) which entitles qualified participants to receive the Institution's official awards.

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.

ILLNESS
An alteration in the body or any of its organs or parts which interrupt's or disturbs the performance of a vital function, thereby causing or threatening pain or weakness.

Specialty Pharmacy
A pharmacy which has entered into an agreement with The Plan to provide Specialty Pharmaceuticals to Members and which has agreed to accept specified reimbursement rates.

Virtual Visits means services provided for the treatment of non-emergency medical and behavioral health conditions as described under the Policy.

WE, OUR, US
Means Blue Cross and Blue Shield of Montana or its authorized agent.

Exclusions and Limitations

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.
    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 TRICARE, the Veteran's Administration (VA), and Indian Health Services 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 Benefits 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 commission by the Member of a felony, or attempt to commit a felony. This exclusion does not apply if the loss is related to being 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.

6. Professional or courtesy discounts.

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

8. 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.

9. Orthodontics.

10. 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.

11. 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.

12. Hearing aids, except that Medically Necessary cochlear implants may be covered per Medical Policy.

13. Services except when 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 service or procedure which is determined by The Plan to be an Inclusive Service/Procedure.

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

    a. Investigational/Experimental 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.

    e. Not covered under applicable Medical Policy.

17. Any services, supplies, drugs and devices considered to be Investigational/Experimental Services 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, efficacy or efficacy as compared with standard treatment, or for the diagnosis of the condition in question

18. Outpatient prescription drugs for which Benefits are provided under this prescription program.

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

20. Reversal sterilization.

21. Services, supplies, drugs and devices for the treatment of infertility.

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

23. Routine foot care for Members without co-morbidities, except Routine foot care is covered if a Member has co-morbidities such as diabetes.

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

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

26. 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. Marriage counseling.
    f. Religious counseling.
    g. Self-help programs.
    h. Stress management.
    i. Biofeedback.
    j. Massage therapy.

27. 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.

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.

28. Vitamins, except that vitamins may be covered in Medical Policy.

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

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

31. 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.

32. Charges associated with health clubs, weight loss clubs or clinics.

33. Services, supplies, drugs and devices for the treatment of Illness, Injury and/or complications resulting from services that are not Covered Medical Expenses.

34. Tutoring services.

35. Any services, supplies, drugs and devices not provided in or by a Covered Provider.

36. Services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature.

37. 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” of the Group Contract.

38. Services, supplies, drugs and devices not provided in a student health center or by a Covered Provider.

39. Services, supplies, drugs and devices provided normally without charge by the Health Center on the campus, or by any person employed or retained by the Member’s Health Center, or services provided by the student medical fee.

40. Applied Behavior Analysis (ABA) services, except as specifically included in this Brochure.

41. Services, supplies, drugs and devices which are not listed as a Benefit as described in this Brochure.

Academic Emergency Services*

To ensure immediate access to assistance if you experience a crisis while traveling over 100 miles from home, or outside your home country, Academic HealthPlans has included Academic Emergency Services (AES) benefits in your Student Health Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis, no matter how large or small. For more details, go to **bcbsmt.com.**

BlueCard®

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 referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area Blue Cross and Blue Shield of Montana serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Blue Cross and Blue Shield of Montana for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Contract are described generally below.

Typically, Members, when accessing care outside the geographic area Blue Cross and Blue Shield of Montana serves, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. Blue Cross and Blue Shield of Montana payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when Members incur Covered Medical Expenses within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Montana will remain responsible to the Group for fulfilling Blue Cross and Blue Shield of Montana contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Member liability on claims for Covered Medical Expenses processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to Blue Cross and Blue Shield of Montana by the Host Blue.

**Academic Emergency Services and AD&D coverage are underwritten by 4 Ever Life International Limited and administered by Worldwide Insurance Services, LLC, separate and independent companies from Academic HealthPlans.*

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to Blue Cross and Blue Shield of Montana by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

a. An actual price. An actual price is a negotiated payment without any other increases or decreases, or

b. An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

c. An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to Blue Cross and Blue Shield of Montana is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

In some instances, federal law or the laws of a small number of states may require a Host Blue either (i) to use a basis for determining Member liability for Covered Medical Expenses that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should either federal law or the law of the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Blue Cross and Blue Shield of Montana would then calculate Member liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. Recovery amounts determined in these ways will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Non-Participating Healthcare Providers Outside of the Blue Cross and Blue Shield of Montana Service Area

a. Member Liability Calculation

When Members incur Covered Medical Expenses outside of the Blue Cross and Blue Shield of Montana service area for services provided by non-participating healthcare providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations,

the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

b. Exceptions.

In some exception cases, Blue Cross and Blue Shield of Montana may pay claims from non-participating healthcare providers outside of the Blue Cross and Blue Shield of Montana service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a participating provider, as determined by Blue Cross and Blue Shield of Montana or by applicable state law. In other exception cases, Blue Cross and Blue Shield of Montana may pay such a claim based on the payment Blue Cross and Blue Shield of Montana would make if Blue Cross and Blue Shield of Montana were paying a non-participating provider inside of the Blue Cross and Blue Shield of Montana service area, as described elsewhere in this Contract, where the Host Blue's corresponding payment would be more than Blue Cross and Blue Shield of Montana's in-service area non-participating provider payment or we may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core 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, can arrange a physician appointment or hospitalization, if necessary.

For additional information regarding the BlueCard® Program or Blue Cross and Blue Shield Global Core, refer to your policy located at **bcbsmt.com.**

Summary of Benefits and Coverage

The Affordable Care Act requires all health insurers to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a description of the benefits and health coverage offered by a particular health plan. The SBC is intended to provide clear, consistent descriptions that may make it easier for people to understand their health insurance coverage.

The items in the SBC just represent an overview of coverage; they are not an exhaustive list of what is covered or excluded. The full terms of coverage are located in The Group Contract or Member Guide. To obtain an SBC, please go to **bcbsmt.com.**

BCBSMT Online Resources

BCBSMT members have online access to claims status, Explanations of Benefits, ID cards, Network Providers, correspondence and coverage information by logging in to **Blue Access for Members℠ (BAM)**. Visit **bcbsmt.com** and click on the "Log in" tab. Follow the simple, onscreen directions to establish an online account in minutes.

BAM has been enhanced to include BAM Mobile, a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Email Preferences and making the change there.

Claims Procedure

In the event of Injury or Illness, the student should:

1. Report to the Student Health Center, if available, for treatment, or, when not in school, to his/her doctor or hospital. Students should go to a participating doctor or hospital for treatment if possible.

   IN AN EMERGENCY, REPORT DIRECTLY TO THE NEAREST EMERGENCY ROOM FOR TREATMENT.

2. Mail to the address below all prescription drug receipts (for providers outside of those contracting with Prime Therapeutics), medical and hospital bills, along with patient's name and Insured student's name, address, Social Security Number and name of the University under which the student is Insured.

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. All claims must be submitted within 12 months of the date of service.

The Plan is underwritten by:

BCBSMT

Submit all claims or inquiries to:

Blue Cross and Blue Shield of Montana
P.O. Box 7982
Helena, MT 59604-7982
BCBSMT Customer Service **(855) 267-0214**

Please keep this Brochure as a general summary of your health insurance. The Group Contract on file at the

University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. The Group Contract is the contract and will govern and control the payment of benefits. **See the Group Contract on file with your school for more information.**

Important Notices

This information provides a brief description of the important features of the insurance Plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued in the state in which the Policy was delivered. Complete details may be found in the Policy on file at your school's office. The Policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.

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.

See the Policy on file with your school for more information.

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	Email:	CivilRightsCoordinator@hcsc.net

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 मे 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.