BLUE PREFERRED SILVER PPO 022

SAMPLE SMALL GROUP

Effective January 1, 2016

BlueCross BlueShield of Montana

MEDICAL BENEFITS

FOR CUSTOMER SERVICE
Call 1-800-447-7828

DENTAL BENEFITS

FOR CUSTOMER SERVICE
Call 1-800-866-739-4090

FOR PREAUTHORIZATION
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
- Other Online Services and Information

BLUECARD® NATIONWIDE/WORLD WIDE 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

FOR PRESCRIPTION DRUG BENEFITS

Pharmacy Benefit Manager (PBM)

- Prime Therapeutics 1-800-423-1973
- For preauthorizations, fax: 1-877-243-6930

PBM Website www.myprime.com
Claim Forms 1-866-325-5230
Pharmacy Locator 1-866-325-5230
Specialty Care Pharmacy (Prime Therapeutics Specialty Pharmacy LLC) 1-877-627-MEDS (6337)

- www.primetherapeutics.com/specialty
- Prescriber Fax 1-877-828-3939

Mail Order Services

- **PrimeMail** 1-866-325-5230
  PO Box 27836
  Albuquerque, NM 87125-7836
- **Ridgeway Mail-Order Pharmacy** 1-800-630-3214
  2824 US Hwy 93 North
  Victor, MT 59875

Blue Cross and Blue Shield of Montana
560 North Park Avenue
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

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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 to you because your employer has agreed to purchase health coverage from Blue Cross and Blue Shield of Montana. Your coverage will not be effective, and you will not be entitled to Benefits, until and unless your 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 your employer if you have any questions which aren't answered in the Member Guide or call your 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.

MEMBERS 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.

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SCHEDULE OF BENEFITS

Blue Preferred Silver PPO 022

Group Name:	SAMPLE SMALL GROUP
Group Number:	SS022O
Effective Date:	January 1, 2016
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	$3,500	$7,000
Family	$7,000	$14,000
The In-Network and Out-of-Network Deductibles are separate amounts and one does not accumulate to the other.		
Coinsurance:	None	None
Out of Pocket Amount:		
Individual	$3,500	$7,000
Family	$7,000	$14,000
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 Emergency Services provided by an Out-of-Network Provider, Benefits will be provided as if such services were provided by an In-Network provider.
- Out-of-Network providers may bill the Member the difference between the Allowable Fee and the provider's charge, in addition to any Deductible even if Preauthorization is obtained for the service or treatment is provided for Emergency Services.

Term of Member Guide:	Monthly

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION **Deductible applies to all services unless noted otherwise.**	**IN-NETWORK COINSURANCE/ COPAYMENT**	**OUT-OF-NETWORK COINSURANCE/ COPAYMENT**
Accident		
Professional Provider Services	None	None
Facility Services	None	None
Acupuncture	None	None
Maximum Per Benefit Period – 12 Visits		
Ambulance	None	None
Autism Spectrum Disorders		
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 the Prescription Drug Pharmacy Integrated Benefit.		
ABA services are only covered for Members under 19 years of age	None	None
Birthing Centers	None	None
Chemical Dependency Treatment		
Professional Provider Services	None	None
Facility Services	None	None
Chiropractic Services	None	None
Maximum Benefit Per Benefit Period for Chiropractic Manipulations – 10 Visits		
Convalescent Home Services	None	None
Maximum Per Benefit Period – 60 Days		
Diabetic Education Benefit		
The Deductible does not apply to the payment of the first $250. After the payment of $250, Deductible will apply.		
First $250	Deductible Does Not Apply	
After the first $250 in payment	None	None
Diagnostic Services		
Diagnostic Imaging Services		
Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET Scan)		
Professional Provider Services	None	None
Facility Services	None	None
All Other Covered Diagnostic Services		
Professional Provider Services	None	None
Facility Services	None	None
Durable Medical Equipment		
Rental (up to Purchase Price), Purchase and Repair and Replacement of Durable Medical Equipment	None	None

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION **Deductible applies to all services unless noted otherwise.**	**IN-NETWORK COINSURANCE/ COPAYMENT**	**OUT-OF-NETWORK COINSURANCE/ COPAYMENT**
Education Services		
Professional Provider Services	None	None
Facility Services	None	None
Emergency Room Care	None	None
Home Health Care	None	None
Maximum Per Benefit Period – 180 Visits		
Hospice Care	None	None
Hospital		
Professional Services (when the Professional Provider is employed by the Hospital)		
Outpatient	None	None
Inpatient	None	None
Facility Services		
Outpatient	None	None
Inpatient	None	None
Mammograms		
Routine	Deductible Does Not Apply	None*
Medical	None	None
*Deductible does not apply to the payment of the first $70 for Routine mammograms provided by an Out-of-Network provider.		
Maternity Services		
Professional Provider Services	None	None
Facility Services	None	None
Medical Supplies	None	None
Mental Illness		
Professional Provider Services	None	None
Facility Services	None	None
Newborn Initial Care		
Professional Provider Services	None	None
Facility Services	None	None
Office Visit	None*	None
*Deductible does not apply to Preventive Health Care services. Refer to the section entitled Preventive Health Care.		
Orthopedic Devices/Orthotic Devices	None	None
Other Facility Services – Inpatient and Outpatient	None	None

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION **Deductible applies to all services unless noted otherwise.**	**IN-NETWORK COINSURANCE/ COPAYMENT**	**OUT-OF-NETWORK COINSURANCE/ COPAYMENT**
Pediatric Dental Care (For Members under 19 years of age)	None	None
Deductible and Coinsurance do not apply to fluoride treatments which are a Benefit for Members under age 19.		
Pediatric Orthodontic Services	None	None
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 Does Not Apply	
Maximum Per Benefit Period – 1 Exam		
Frames and Lenses	None	None
Maximum Per Benefit Period – 1 Pair of Glasses or 2 Boxes of Contact Lenses		
Physician Medical Services (Other than the Office Visit)	None	None
Prescription Drug Pharmacy Integrated Benefit (The Prescription Drug Pharmacy Integrated Benefit utilizes a Drug List.) Deductible does not apply to certain contraceptive products. Refer to the Preventive Health Care Benefit. Deductible also does not apply to smoking cessation products and over-the-counter aids/medications, for two 90-day treatment regimens.		
Retail Pharmacy Prescriptions – 30-day supply	None	None
Mail Service Maintenance Prescriptions – 90-day supply	None	None
Retail Pharmacy – 90-day supply (only available at a Value Participating Pharmacy)	None	None
The Member must pay the difference between a Brand-Name drug and the Generic equivalent if the Member chooses a Brand-Name drug when a Generic drug is available. Payments for Prescription Drug Products purchased at a Non-Participating Pharmacy will be reduced by 50%.		
Specialty Pharmaceuticals, when purchased at a Non-Participating Specialty Pharmacy, are not covered.		
Preventive Health Care		
Routine Services	Deductible Does Not Apply	None
Prostheses Benefit		
Rental (up to Purchase Price), Purchase and Repair and Replacement of Prosthetics	None	None

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION **Deductible applies to all services unless noted otherwise.**	**IN-NETWORK COINSURANCE/ COPAYMENT**	**OUT-OF-NETWORK COINSURANCE/ COPAYMENT**
Rehabilitation Therapy		
Professional Services		
Outpatient	None	None
Inpatient	None	None
Facility Services		
Outpatient	None	None
Inpatient	None	None
Severe Mental Illness		
Professional Provider Services	None	None
Facility Services	None	None
Surgery Center Services - Outpatient		
Professional Provider Services	None	None
Facility Services	None	None
Therapies – Outpatient		
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy		
Professional Provider Services	None	None
Facility Services	None	None
Transplants		
Professional Services		
Outpatient	None	None
Inpatient	None	None
Facility Services		
Outpatient	None	None
Inpatient	None	None
Urgent Care	None*	None
*Deductible does not apply to Preventive Health Care services Refer to the section entitled Preventive Health Care.		
Well-Child Care Services	Deductible Does Not Apply	None, No Deductible

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, Advanced Practice Registered Nurses, physician assistants, naturopathic physicians, 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 Chemical Dependency 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.

The exceptions to the Benefit reduction are:

- Emergency Services;
- 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:

- Blue Cross and/or Blue Shield PPO facility providers; and/or
- 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 Benefit. 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, Coinsurance and/or Copayment even if Preauthorization 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, Coinsurance and/or Copayment.

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 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 and 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 Deductible, Coinsurance and/or Copayment 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, Coinsurance and/or Copayment 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, Coinsurance and/or Copayment. 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, Coinsurance and/or Copayment.

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 of Montana provider network in the state where serves 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, Coinsurance and/or Copayment 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, Coinsurance and/or Copayment. 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, Coinsurance and/or Copayment.

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.

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 explain 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.

   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:

   - The billed covered charges for the Member's Covered Medical Expenses; or
   - 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.

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. **Non-Participating 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 non-participating healthcare providers, the amount the 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 liable 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 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 Covered Medical Expenses, the payment Blue Cross and Blue Shield of Montana would make if the healthcare services had been obtained within the Blue Cross and Blue Shield of Montana service area, or a special negotiated payment to determine the amount Blue Cross and Blue Shield of Montana will pay for services provided by non-participating healthcare providers. In these situations, the Member may be liable 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 Medical Expenses as set forth in this paragraph.

3. BlueCard Worldwide® Program

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 BlueCard Worldwide® Program when accessing Covered Medical Expenses. The BlueCard Worldwide Program 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 BlueCard Worldwide Program 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 receive 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 BlueCard Worldwide 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.

- **Inpatient Services**

  In most cases, if the Member contacts the BlueCard Worldwide 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 BlueCard Worldwide 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 preauthorization to verify that Inpatient Services are for the treatment of an Emergency Medical Condition.

- **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.

- **Submitting a BlueCard Worldwide 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 BlueCard Worldwide International claim form and send the claim form the provider's itemized bill(s) to the BlueCard Worldwide 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 BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If the Member needs assistance with the Member claim submission, the Member should call the BlueCard Worldwide 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 10 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 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. 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 15 days after receiving the claim.

   b. Notice of Extension

      1. For reasons beyond the control of The Plan

         The Plan may extend the 15-day time period for an additional 15 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 15 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 5 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;
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.

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 560 North Park Avenue, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m., 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.

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 during the appeal process.

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 and will not be a subordinate of the person who made 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 (nor have been a subordinate of any person previously consulted). 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.

Type of Claim on Appeal	Time Period for Notification of Final Internal Adverse Benefit Determination
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 his/her/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;
   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 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, in writing, or the Member's authorized representative, 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;
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.

PREAUTHORIZATION

The Plan has designated certain covered services which require Preauthorization in order for the Member to receive the maximum Benefits possible under this Member Guide.

The Member is responsible for satisfying the requirements for Preauthorization. This means that the Member must request Preauthorization or assure that the Member's Physician, provider of services, the Member's authorized representative, or a Family Member complies with the requirements below. If the Member utilizes a Network Provider for covered services, that provider may request Preauthorization for the services. However, it is the Member's responsibility to assure that the services are preauthorized before receiving care.

To request Preauthorization, the Member or his/her Physician must call the Preauthorization number shown on the Member's Identification Card **before** receiving treatment. The Plan will assist in coordination of the Member's care so that his/her treatment is received in the most appropriate setting for his/her condition and that the Member receives the highest level of Benefits under this Member Guide.

Preauthorization does not guarantee that the care and services a Member receives are eligible for Benefits under the Member Guide. In addition, a nonparticipating provider or non-PPO provider can bill the Member for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus Deductible, Coinsurance and/or Copayment even if the service is an Emergency Service or the if the service has been Preauthorized.

Preauthorization Process for Inpatient Services

For an Inpatient facility stay, the Member must request Preauthorization from The Plan **before** the Member's scheduled admission. The Plan will consult with the Member's Physician, Hospital, or other facility to determine if Inpatient level of care is required for the Member's illness or injury. The Plan may decide that the treatment the Member needs could be provided just as effectively in a different setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office).

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 does not request Preauthorization, the claim will be denied on the basis of no Preauthorization. The Member may appeal the denial of the claim as outlined in the section entitled "Appeals." If it is determined that the 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 Member Guide, the Member may be responsible for the full cost of the services.

Unscheduled Inpatient admissions, such as admissions for Emergency Medical Conditions and maternity care should be preauthorized within two days after the admission.

Preauthorization Process for Mental Illness, Severe Mental Illness and Chemical Dependency Services

All Inpatient and partial hospitalization services related to treatment of Mental Illness, Severe Mental Illness and Chemical Dependency must be Preauthorized by The Plan. Preauthorization is also required for the following Outpatient Services and must be submitted no later than 15 business days before the service is provided:

- Electroconvulsive therapy;
- Intensive Outpatient Treatment;
- Neuropsychological testing;
- Psychological testing;
- Repetitive Transcranial Magnetic Stimulation.

Preauthorization is not required for therapy visits to a Physician or other professional Provider licensed to perform covered services under this Member Guide. However, all services are subject to the provisions in the section entitled Concurrent Review.

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

If the Member does not request Preauthorization, 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 or 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.

Preauthorization Process for Other Outpatient Services

In addition to the Preauthorization requirements outlined above, The Plan also requires Preauthorization, which must be submitted no later than 15 business days before the service is provided, for certain Outpatient services, including:

- Dialysis treatment - Out-of-Network;
- High-cost injections, including but not limited to IVIG, Avastin, Rituxan, and Remicade injections.
- Home Health Care;
- Home Hemodialysis;
- Home Infusion Therapy;
- Hospice Services;
- Molecular Genetic Testing;
- Outpatient elective surgery - Out-of-Network;
- Transplant Evaluations

For additional information on Preauthorization, the Member or the Provider may call the Customer Service number on the Member's identification card.

It is NOT necessary to preauthorize 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 does not request Preauthorization, the claim will be denied on the basis of no Preauthorization. The Member may appeal the denial of the claim as outlined in the section entitled "Appeals." If it is determined that the 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 Member Guide, the Member may be responsible for the full cost of the services.

The Benefits section of this Member Guide details the services which are subject to Preauthorization.

Preauthorization Request Involving Non-Urgent Care

Except in the case of a Preauthorization Request Involving Urgent Care (see below), The Plan will provide a written response to the Member's Preauthorization request no later than 15 days following the date we receive the Member's request. This period may be extended one time for up to 15 additional days, if we determine 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 15-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 Preauthorization within 15 days following receipt of the additional information. The procedure for appealing an adverse Preauthorization determination is set forth in the section entitled Complaints and Grievances.

Preauthorization Request Involving Urgent Care

A Preauthorization 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 Preauthorization request.

In case of a Preauthorization Request Involving Urgent Care, The Plan will respond to the Member no later than 72 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 and will have no less than 48 hours to provide the information. A Benefit determination will be made as soon as possible (taking into account medical exigencies) but no later than 72 hours after the initial request, or within 48 hours after the missing information is received (if the initial request is incomplete).

NOTE: The Plan's response to the Member's Preauthorization 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.

Preauthorization Request Involving Emergency Care

If the Member is admitted to the Hospital for Emergency Care and there is not time to obtain Preauthorization, the Member's Provider must notify The Plan within two working days following the Member's emergency admission.

Preauthorization Required For Certain Prescription Drug Products and Other Medications

Prescription Drug Products, which are self-administered, process under the Prescription Drug Program Benefit 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 Drug Program Benefit**

   Certain prescription drugs, which are self-administered, require Preauthorization. Please refer to the Prescription Drug Program section for complete information about the Prescription Drug Products that are subject to Preauthorization, step therapy, and quantity limits, the process for requesting Preauthorization, 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 Preauthorization. The medications that require Preauthorization are subject to change by The Plan.

   For any medication that is subject to Preauthorization, the Member or provider should fax the request for Preauthorization to the Blue Cross and Blue Shield of Montana Medical Review Preauthorization Department at 1-866-589-8256. The Member or provider may also submit a written request for Preauthorization. Preauthorization forms are located on The Plan website at www.bcbsmt.com, and may be printed directly from the website. The Plan will notify the Member and provider of the Preauthorization determination.

   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.

   To determine which medications are subject to Preauthorization, 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.

General Provisions Applicable to All Required Preauthorizations

1. **No Guarantee of Payment**

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

2. **Request for Additional Information**

   The Preauthorization process may require additional documentation from the Member's health care provider or pharmacist. In addition to the written request for Preauthorization, 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 Preauthorization**

   For Services Other Than For Mental Illness, Severe Mental Illness and Chemical Dependency

   If the Member does not obtain Preauthorization, the claim will be denied on the basis of no Preauthorization. The Member may appeal the denial of the claim as outlined in the section entitled "Appeals." If it is determined that the 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 Member Guide, the Member may be responsible for the full cost of the services.

   For Mental Illness, Severe Mental Illness and Chemical Dependency Services

   If the Member does not obtain Preauthorization, 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 or 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.

Any treatment the Member receives which is not a covered service under this Member Guide, or is not determined to be Medically Necessary, or is not performed in the appropriate setting will be excluded from the Member's Benefits. This applies even if Preauthorization approval was requested or received.

Concurrent Review

Whenever it is determined by The Plan, that Inpatient care or an ongoing course of treatment may no longer meet medical necessity criteria or is considered Experimental/Investigational/Unproven (EIU), the Member, Member's Provider or the Member's authorized representative may submit a request to The Plan for continued services. If the Member, the Member's Provider or the Member's authorized representative requests to extend care beyond the approved time limit and it is a Request Involving Urgent Care, The Plan will make a determination on the request/appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

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.

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 your Group Leader to determine if retiree coverage is available.

Applying for Coverage

An Applicant may apply for coverage in 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.

   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; or
   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 91st day after completion of the probationary period, subject to the Group’s anniversary date and meeting all eligibility and enrollment requirements.

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 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, Birth, 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.

Eligible Individuals

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

a. 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.

b. Spouse of a Beneficiary Member.

An individual who becomes a Spouse of the Beneficiary Member or a Spouse of the Beneficiary Member and a child becomes a Dependent of the Beneficiary Member through birth, adoption or placement for adoption.

In the case of marriage, only the Spouse or the Spouse's children can be added at that time, not any additional children in the family who were not enrolled when previously eligible.

c. 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 the moment of birth subject to all the provisions of the section entitled Effective Date of Coverage.

In the case of birth or adoption of a child, only the newborn or newly adopted child can be added to the coverage at that time, not a Spouse or any other children who were not enrolled when previously eligible.

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:

a. 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.

b. 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 those 30 days, the Beneficiary Member:

   1. Notifies The Plan to continue the coverage for the child; or
   2. 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.

c. 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 those 30 days, the Beneficiary Member:

   1. Notifies The Plan to continue the coverage for the child; or
   2. 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.

When Benefits Begin

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMSCO)

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 Group notifies us that 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 Group Notifies The Plan that 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 Standard Time, on the last day of the Month in which a child reaches age 26 years. Coverage for a Spouse will terminate at midnight, Mountain Standard 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 Standard 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 your employer), or to the entity identified as the COBRA Administrator in the General COBRA Notice provided to you upon enrollment or when your 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 in the Hospital 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 in the Hospital 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 the Deductible, Coinsurance and other provisions, as applicable.

Benefits outlined in this section are subject to the Plan's Medical Policy, any specific exclusions identified for that specific Benefit and to the exclusions and limitations outlined in the Exclusions and Limitations section.

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 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.

Note: Applied Behavior Analysis (ABA), also known as Lovaas Therapy, is only available for Members under age 19.

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.

Chemical Dependency

Benefits for Chemical Dependency will be paid as any other Illness.

Outpatient Services

Care and treatment for Chemical Dependency when the Member is not an Inpatient Member and provided by:

1. a Hospital;
2. a Mental Health Treatment Center;
3. a Chemical Dependency Treatment Center;
4. a Physician or prescribed by a Physician;
5. a psychologist;
6. a licensed social worker;
7. a licensed professional counselor;
8. an addiction counselor licensed by the state; or
9. a licensed psychiatrist.

Outpatient services are subject to the following conditions:

1. the services must be provided to diagnose and treat recognized Chemical Dependency;
2. the treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Chemical Dependency; and
3. no Benefits will be provided for marriage counseling, hypnotherapy, or for services given by a staff member of a school or halfway house.

Inpatient Care Services

Care and treatment of Chemical Dependency, 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 Physician.

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 Group Plan.

Preauthorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Preauthorization.

Partial Hospitalization

Care and treatment of Chemical Dependency, while the Partial Hospitalization services are provided by:

1. a Hospital;
2. a Freestanding Inpatient Facility; or
3. a Physician.

Preauthorization is required for Partial Hospitalization services. Please refer to the section entitled Preauthorization.

Chemotherapy

The use of drugs approved for use in humans by the U.S. Food and Drug Administration 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. Oral contraceptives are paid as described in the Preventive Health Care section or under the Prescription Drug Pharmacy Integrated Benefit section.

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 Drug Pharmacy Integrated Benefit. For additional information, access www.bcbsmt.com and click on the Members tab and select Pharmacy.

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.

Preauthorization is required for Convalescent Home services. Please refer to the section entitled Preauthorization.

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 of teeth which are damaged as the result of biting and chewing.

Diabetic Education

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

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:

      - Nuclear medicine
      - Ultrasound

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

- Urinalysis
- Blood tests
- Throat cultures

c. Diagnostic Testing. Tests to diagnose an Illness or Injury. Some examples of diagnostic testing include:

- Electroencephalograms (EEG)
- 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.

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.
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 mental or nervous conditions.
6. Services provided in a nursing home or skilled nursing facility.

Preauthorization is required for home health care. Please refer to the section entitled Preauthorization.

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.
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.

Preauthorization is required for home infusion therapy services. Please refer to the section entitled Preauthorization.

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
5. Instructions for care of the Member, counseling and other support services for the Member's Immediate Family.

Preauthorization is required for hospice care. Please refer to the section entitled Preauthorization.

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, 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, dialysis therapy.
    j. Physical Therapy, Speech Therapy and Occupational Therapy.
    k. Drugs and medicines which:

        1. Are approved for use in humans by the U.S. Food and Drug Administration; 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.

Preauthorization is required for Inpatient Care. Please refer to the section entitled Preauthorization.

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.

3. Preauthorization is required for Inpatient Care. Please refer to the section entitled Preauthorization.

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

Payment will be made 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.

Mammograms (Routine 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.

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 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 Preauthorization 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.
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.
2. Prescribed by a Covered Provider.

Mental Illness

Benefits for Mental Illness will be paid as any other Illness.

Outpatient Services

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

1. a Hospital;
2. a Physician or prescribed by a Physician;
3. a Mental Health Treatment Center;
4. a Chemical Dependency Treatment Center;
5. a psychologist;
6. a licensed social worker;
7. a licensed professional counselor;
8. a licensed addiction counselor; or
9. a licensed psychiatrist.

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 the Mental Illness.

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

Inpatient Care 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 Physician.

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 Group Plan.

Preauthorization is required for Inpatient Care services and Residential Treatment Center services. Please refer to the section entitled Preauthorization.

Partial Hospitalization

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

1. a Hospital;
2. a Freestanding Inpatient Facility; or
3. a Physician.

Preauthorization is required for Partial Hospitalization. Please refer to the section entitled Preauthorization.

Naturopathy

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

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 Visits

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:

- Excision or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses)
- Treatment of fractures of facial bone
- External incision and drainage of cellulitis (not including treatment of dental abscesses)
- Incision of accessory sinuses, salivary glands or ducts
- Surgical removal of complete bony impacted teeth
- 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:

D0120 Periodic oral evaluation - Limited to 1 every 6 months
D0140 Limited oral evaluation - problem focused
D0150 Comprehensive oral evaluation - Limited to 1 every 6 months
D0160 Detailed and extensive oral evaluation - problem focused, by report
D0180 Comprehensive periodontal evaluation
D9310 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:

D1120 Prophylaxis - Child - Limited to 1 every 6 months
D1203 Topical application of fluoride (excluding prophylaxis) - child - Limited to 2 every 12 months
D1204 Topical application of fluoride (excluding prophylaxis) - Age 15 to 19 - 2 every 12 months
D1206 Topical fluoride varnish - Less than age 19 - 2 in 12 months

Diagnostic Radiographs

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

D0210 Intraoral - complete series (including bitewings) 1 every 60 (sixty) months
D0220 Intraoral - periapical first film
D0230 Intraoral - periapical - each additional film
D0240 Intraoral - occlusal film
D0270 Bitewing - single film Adult - 1 set every calendar year / Children - 1 set every 6 months
D0272 Bitewings - two films - Adult - 1 set every calendar year / Children - 1 set every 6 months
D0274 Bitewings - four films Adult - 1 set every calendar year / Children - 1 set every 6 months
D0277 Vertical bitewings - 7 to 8 films - Adult - 1 set every calendar year / Children - 1 set every 6 months
D0330 Panoramic film - 1 film every 60 (sixty) months
D0340 Cephalometric x-ray
D0350 Oral / Facial Photographic Images

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:

D1351 Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months
D1352 Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months.
D1510 Space maintainer - fixed - unilateral - Limited to children under age 19
D1515 Space maintainer - fixed - bilateral - Limited to children under age 19
D1520 Space maintainer - removable - unilateral - Limited to children under age 19
D1525 Space maintainer - removable - bilateral - Limited to children under age 19
D1550 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:

D2140 Amalgam - one surface, primary or permanent
D2150 Amalgam - two surfaces, primary or permanent
D2160 Amalgam - three surfaces, primary or permanent
D2161 Amalgam - four or more surfaces, primary or permanent
D2330 Resin-based composite - one surface, anterior
D2331 Resin-based composite - two surfaces, anterior
D2332 Resin-based composite - three surfaces, anterior
D2335 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:

D7140 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:

D4341 Periodontal scaling and root planning-four or more teeth per quadrant - Limited to 1 every 24 months
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant - Limited to 1 every 24 months
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - Limited to 1 per lifetime
D4910 Periodontal maintenance - 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy

Benefits will not be provided for chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.

Adjunctive Services

Adjunctive general services include:

D9110 Palliative treatment of dental pain - minor procedure
D9220 Deep sedation/general anesthesia - first 30 minutes
D9221 Deep sedation/general anesthesia - each additional 15 minutes
D9241 Intravenous conscious sedation/analgesia - first 30 minutes
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes
D9610 Therapeutic drug injection, by report

Benefits will not be provided for local anesthesia, nitrous oxide analgesia, therapeutic parenteral drugs, or other drugs or medicaments and/or their application.

Endodontic Services

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

D3220 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.
D3222 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.
D3230 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.
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue 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.
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
D3410 Apicoectomy/periradicular surgery - anterior
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
D3425 Apicoectomy/periradicular surgery - molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3450 Root amputation - per root
D3920 Hemisection (including any root removal) - not including root canal therapy

Pulpal debridement is considered part of endodontic therapy when performed by the same Dental Provider and not associated with a definitive emergency visit.

Benefits will not be provided for the following “Endodontic Services”:

- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal.

- Endodontic therapy if the Member discontinues endodontic treatment.

Oral Surgery Services

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

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth - partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva
D9930 Treatment of complications (post-surgical) unusual circumstances, by report

Benefits will not be provided for the following Oral Surgery procedures:

- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.

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:

D4210 Gingivectomy or gingivoplasty - four or more teeth - Limited to 1 every 36 months
D4211 Gingivectomy or gingivoplasty - one to three teeth
D4240 Gingival flap procedure, four or more teeth - Limited to 1 every 36 months
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant - Limited to 1 every 36 months
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure (including donor site surgery)
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - Limited to 1 per lifetime

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:

D2510 Inlay - metallic - one surface - An alternate benefit will be provided
D2520 Inlay - metallic - two surfaces - An alternate benefit will be provided

D2530 Inlay - metallic - three surfaces - An alternate benefit will be provided
D2542 Onlay - metallic - two surfaces - Limited to 1 per tooth every 60 months
D2543 Onlay - metallic - three surfaces - Limited to 1 per tooth every 60 months
D2544 Onlay - metallic - four or more surfaces - Limited to 1 per tooth every 60 months
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
D2751 Crown - porcelain fused to predominately base metal - Limited to 1 per tooth every 60 months
D2752 Crown - porcelain fused to noble metal - Limited to 1 per tooth every 60 months
D2780 Crown - 3/4 cast high noble metal - Limited to 1 per tooth every 60 months
D2781 Crown - 3/4 cast predominately base metal - Limited to 1 per tooth every 60 months
D2783 Crown - 3/4 porcelain/ceramic - Limited to 1 per tooth every 60 months
D2790 Crown - full cast high noble metal - Limited to 1 per tooth every 60 months
D2791 Crown - full cast predominately base metal - Limited to 1 per tooth every 60 months
D2792 Crown - full cast noble metal - Limited to 1 per tooth every 60 months
D2794 Crown - titanium - Limited to 1 per tooth every 60 months
D2940 Protective Restoration

Benefits will be provided for the replacement of a lost or defective crown. However, Benefits will not be provided for the restoration of occlusion or 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. Crowns placed over implants will be covered.

Prosthodontic Services

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

D5110 Complete denture - maxillary - Limited to 1 every 60 months
D5120 Complete denture - mandibular - Limited to 1 every 60 months
D5130 Immediate denture - maxillary - Limited to 1 every 60 months
D5140 Immediate denture - mandibular - Limited to 1 every 60 months
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 months
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 months
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 months
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 months
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) - Limited to 1 every 60 months
D5410 Adjust complete denture - maxillary
D5411 Adjust complete denture - mandibular
D5421 Adjust partial denture - maxillary
D5422 Adjust partial denture - mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth - complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5740 Reline maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation

D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation

D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.

D5850 Tissue conditioning (maxillary)

D5851 Tissue conditioning (mandibular)

Note: 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.

D6010 Endosteal Implant - 1 every 60 months

D6012 Surgical Placement of Interim Implant Body - 1 every 60 months

D6040 Eposteal Implant - 1 every 60 months

D6050 Transosteal Implant, Including Hardware - 1 every 60 months

D6053 Implant supported complete denture

D6054 Implant supported partial denture

D6055 Connecting Bar - implant or abutment supported - 1 every 60 months

D6056 Prefabricated Abutment - 1 every 60 months

D6058 Abutment supported porcelain ceramic crown - 1 every 60 months

D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 months

D6060 Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months

D6061 Abutment supported porcelain fused to noble metal crown - 1 every 60 months

D6062 Abutment supported cast high noble metal crown - 1 every 60 months

D6063 Abutment supported cast predominately base metal crown - 1 every 60 months

D6064 Abutment supported cast noble metal crown - 1 every 60 months

D6065 Implant supported porcelain/ceramic crown - 1 every 60 months

D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months

D6067 Implant supported metal crown - 1 every 60 months

D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months

D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months

D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months

D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months

D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months

D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months

D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months

D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months

D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months

D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months

D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months

D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months

D6080 Implant Maintenance Procedures -1 every 60 months

D6090 Repair Implant Prosthesis - 1 every 60 months

D6091 Replacement of Semi-Precision or Precision Attachment - 1 every 60 months

D6095 Repair Implant Abutment - 1 every 60 months

D6100 Implant Removal - 1 every 60 months

D6190 Implant Index - 1 every 60 months
D6210 Pontic - cast high noble metal - Limited to 1 every 60 months
D6211 Pontic - cast predominately base metal - Limited to 1 every 60 months
D6212 Pontic - cast noble metal - Limited to 1 every 60 months
D6214 Pontic - titanium - Limited to 1 every 60 months
D6240 Pontic - porcelain fused to high noble metal - Limited to 1 every 60 months
D6241 Pontic - porcelain fused to predominately base metal - Limited to 1 every 60 months
D6242 Pontic - porcelain fused to noble metal - Limited to 1 every 60 months
D6245 Pontic - porcelain/ceramic - Limited to 1 every 60 months
D6519 Inlay/onlay - porcelain/ceramic - Limited to 1 every 60 months
D6520 Inlay - metallic - two surfaces - Limited to 1 every 60 months
D6530 Inlay - metallic - three or more surfaces - Limited to 1 every 60 months
D6543 Onlay - metallic - three surfaces - 1 every 60 months
D6544 Onlay - metallic - four or more surfaces - 1 every 60 months
D6545 Retainer - cast metal for resin bonded fixed prosthesis - 1 every 60 months
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis - 1 every 60 months
D6740 Crown - porcelain/ceramic - 1 every 60 months
D6750 Crown - porcelain fused to high noble metal - 1 every 60 months
D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months
D6752 Crown - porcelain fused to noble metal - 1 every 60 months
D6780 Crown - 3/4 cast high noble metal - 1 every 60 months
D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months
D6782 Crown - 3/4 cast noble metal - 1 every 60 months
D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months
D6790 Crown - full cast high noble metal - 1 every 60 months
D6791 Crown - full cast predominately base metal - 1 every 60 months
D6792 Crown - full cast noble metal - 1 every 60 months
D6973 Core buildup for retainer, including any pins - 1 every 60 months
D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older

Prosthetics placed over implants will be covered.

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

Benefits will not be provided for the following Prosthodontic Services:

- Treatment to replace teeth which were missing prior to the Effective Date, except those teeth missing due to congenital malformation.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

Miscellaneous Restorative and Prosthodontic Services

Other restorative and prosthodontics services include:

D0470 Diagnostic Models
D2910 Re-cement inlay
D2920 Re-cement crown
D2930 Prefabricated stainless steel crown - primary tooth - Under age 15 - Limited to 1 per tooth in 60 months
D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
D2950 Core buildup, including any pins- Limited to 1 per tooth every 60 months
D2951 Pin retention - per tooth, in addition to restoration
D2954 Prefabricated post and core, in addition to crown- Limited to 1 per tooth every 60 months
D2980 Crown repair, by report
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report

Orthodontic Services

Orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening)

of the teeth for Members. Coverage for orthodontic services is shown on the Schedule of Benefits. Covered services include:

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit
D8670 Periodic orthodontic treatment visit (as part of contract)
D8680 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.
- Orthodontic services are paid over the Course of Treatment, up to the maximum Benefit Period orthodontic Benefit. Benefits cease when the Member is no longer covered, whether or not the entire Benefit has been paid out.
- 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.
- If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
- 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.
- 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.
- Benefits are not available for replacement or repair of an orthodontic appliance.
- 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

1. 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.

2. 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.

3. 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 or supplies not specifically listed as a Dental Service, or when they are related to a non-covered service.
2. Amounts which are in excess of the Allowable Fee, as determined by The Plan.
3. Dental Services for treatment of congenital or developmental malformation, except as included in the pediatric orthodontic Benefit.
4. Services performed for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve aesthetics.
5. Dental Services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders or to increase vertical dimension.
6. Dental Services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in the mouth is not considered an accidental injury.
7. Services or supplies that do not meet accepted standards of dental practice.
8. Hospital and ancillary charges.
9. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
10. Services or supplies received from someone other than a Dentist or Denturist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
11. Services or supplies received for behavior management or consultation purposes.
12. Charges for nutritional, tobacco or oral hygiene counseling.
13. Charges for local, state or territorial taxes on Dental Services or procedures.
14. Charges for the administration of infection control procedures as required by local, state or federal mandates.
15. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
16. Orthodontic services, except Pediatric Orthodontic Services are covered when Medically Necessary.
17. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
18. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
19. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
20. Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
21. Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to the Member's Effective Date under this Member Guide; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after the Member's Effective Date.
22. Any services, treatments or supplies included as Dental Services under other hospital, medical and/or surgical coverage.
23. Case presentations or detailed and extensive treatment planning when billed for separately.

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.
2. One pair of glasses (frames and lenses) or two boxes of contacts per Benefit Period.

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

Postmastectomy Care and Reconstructive Breast Surgery

Postmastectomy Care

Inpatient Care for the period of time determined by the Attending Physician, in consultation with the Member, to be Medically Necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

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.
   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 Drug Pharmacy Integrated Benefit

The Prescription Drug Pharmacy Integrated 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 Preauthorization section for complete information about the medications that are subject to the Member's medical Benefits, the process for requesting Preauthorization 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 U.S. Food and Drug Administration; 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

Covered drugs 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 which are employed by or affiliated with Blue Cross and Blue Shield of Montana. The committee considers drugs regulated by the FDA for inclusion on the Drug List. 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. The committee considers drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to the Drug List can be made from time to time.

The Plan may offer multiple Drug Lists. By accessing www.bcbsmt.com or www.myprime.com or calling the Customer Service toll-free number on the Member's identification card, the Member or provider can 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 (also known as a formulary). To request this exception, the Member or the Member's prescriber, can call the number on the back of the Member's ID card to ask for a review. If the Member has a health condition that may jeopardize his/her life, health or keep the Member from regaining function, or the Member's current drug therapy uses a non-covered drug, the Member or the Member's prescriber, may be able to ask for an

expedited review process. Blue Cross and Blue Shield of Montana will the Member or the Member's prescriber, know 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 ID 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 United States food and drug administration.
3. Insulin on prescription.
4. Disposable insulin needles/syringes.
5. Test strips.
6. Lancets.
7. Oral contraceptives, contraceptive devices, implantables or injections prescribed by a Physician.
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 the payment limitations for these Prescription Drug Products.

Non-Covered Prescription Drug Products

The Plan will not pay for:

1. Nonlegend drugs other than insulin.
2. Compounded medications.
3. Anabolic Steroids.
4. Any drug used for the purpose of weight loss.
5. Fluoride supplements, except as required by the Affordable Care Act for children under age 6.
6. Over-the-counter drugs that do not require a prescription, except over-the-counter smoking cessation aids with a written prescription.
7. Prescription Drug Products for cosmetic purposes, including the treatment of alopecia (hair loss) (e.g., Minoxidil, Rogaine).
8. Prescription drugs for which there is an exact over-the-counter equivalent.
9. 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.
10. Drugs used for erectile dysfunction.
11. Drugs used for the treatment of infertility.
12. Insulin pumps and glucose meters. Insulin pumps and glucose meters are covered under the Durable Medical Equipment Benefit.
13. Drugs or items labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Member is charged for the item.
14. Biological sera, blood, or blood plasma.
15. 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.
16. 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.
17. Replacement prescription drugs or Prescription Drug Products due to loss, theft or spoilage .

18. Prescription products obtained from a pharmacy located outside the United States for consumption within the United States.
19. Prescription Drug Products provided by a mail-order pharmacy that is not approved by The Plan.
20. Repackaged medications.
21. Non-sedating antihistamines.
22. Brand-Name Proton Pump Inhibitors (PPIs).
23. Drugs determined by The Plan to have inferior efficacy or significant safety issues.

Controlled Substances Limitation

If The Plan determines that a Member may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any Benefits for additional drugs may be subject to a review for Medical Necessity, appropriateness and other restrictions.

Purchase and Payment of Prescription Drug Products

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

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 ID card at the time of purchase, the Member must pay for the Prescription Drug Product and the Participating Pharmacy will submit a claim for the Prescription Drug Product to The Plan's Pharmacy Benefit Manager. The cost of the covered drug or Prescription Drug Product will then accumulate to the Member's Deductible and Out-of-Pocket Amount. Once the Deductible is met, the Member will only be required to pay the appropriate Coinsurance if the amount can be determined by the pharmacy at the time of purchase.

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 the Member's Deductible and Coinsurance.

If drugs or Prescription Drug Products are purchased at a nonparticipating outpatient pharmacy, the Member must pay for the prescription at the time of dispensing and then submit a claim for the prescription drug on a prescription claim form with The Plan's 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 the Member's Deductible and Coinsurance.

Prescription Drug Products Subject to Preauthorization, Step Therapy or Quantity Limits

1. Prescription Drug Products subject to Preauthorization 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 Preauthorization 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. Preauthorization does not guarantee payment of the Prescription Drug Product by The Plan. Even if the prescription drug has been preauthorized, 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. A step therapy program is designed to help the Member use the lowest cost product(s) within a drug class. Drugs subject to step therapy are widely considered equivalent to other products within the class by both physicians and pharmacists. In order to obtain a medication within a step therapy program, the member must fail a first line drug. In general, first line products are usually generic medications. In some cases, a pharmacy policy will allow the step therapy to be waived. The pharmacy policies are located on The Plan website at www.bcbsmt.com.
4. A quantity limit is a limitation on the number or amount of a Prescription Drug Product covered within a certain time period. Quantity limits are established to ensure that prescribed quantities are consistent with clinical dosing

guidelines, to control for billing errors by pharmacies, to encourage dose consolidation, 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 Preauthorization before Benefits are available.

Certain Prescription Drug Products, such as those used to treat rheumatoid arthritis, growth hormone deficiency, hepatitis C, or more serious forms of anemia, hypertension, and epilepsy, are subject to Preauthorization, step therapy, or quantity limits. The Prescription Drug Products included in the prescription drug program 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 Preauthorization, step therapy, or quantity limits, the provider should fax the request for Preauthorization to The Plan's Pharmacy Benefit Administrator 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 Administrator's determination.

In making determinations of coverage, The Plan's Pharmacy Benefit Administrator 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 Preauthorization/step therapy/quantity limits or to determine which Prescription Drug Products are subject to Preauthorization, step therapy or quantity limits, the Member or provider should refer to the Drug List which applies to the Member's Plan at www.bcbsmt.com or www.myprime.com or call the Customer Service toll-free number identified on the Member's identification card.

Specialty Medications

1. Specialty Medications are generally prescribed for individuals with complex or ongoing medical conditions such as multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These high cost 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
   d. Usually not stocked at retail pharmacies

2. Specialty Medications must be acquired through The Plan's contracted Specialty Pharmacy listed on the inside cover of this Member Guide. A list of covered Specialty Medications may be found on The Plan website at www.bcbsmt.com. 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 current recommendations (additional information is provided by accessing http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm); and

2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention; 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, The Plan will reimburse the Member the actual cost for the purchase of a manual or electric breast pump. The Member may purchase a maximum of two electric breast pumps per

year or rent Hospital-grade pumps. For additional information, access www.bcbsmt.com, then click on Member Services. Under Member Services, click on “Advantages of Membership” and select “New Mothers.”

b. Contraceptives

Food and Drug Administration approved contraceptive methods, including certain contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity. For additional information, access www.bcbsmt.com and click on the Members tab and select Pharmacy; 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.

Examples of Preventive Health Care services include, but are not limited to, physical examinations, colonoscopies, immunizations and vaccinations.

For more detailed information on all covered services, contact Customer Service or access www.bcbsmt.com.

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 Chemical Dependency or Mental Illness as defined in the Chemical Dependency and Mental Illness 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 benefit 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

    a. 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 U.S. Food and Drug Administration; 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.

Preauthorization is required for Rehabilitation Facility Inpatient Care. Please refer to the section entitled Preauthorization.

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 Chemical Dependency;
    h. A place for treatment of Mental Illness;
    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 contract benefits (e.g., Physician Medical Services).

Outpatient Rehabilitation

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

Severe Mental Illness

Benefits include but are not limited to:

1. Inpatient Care services, Outpatient services, rehabilitation services and medication for the treatment of Severe Mental Illness;
2. Services provided by a licensed Physician, licensed Advanced Practice Registered Nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed Physician; and
3. Services provided by a licensed Advanced Practice Registered Nurse with prescriptive authority and specializing in mental health.

Benefits for Severe Mental Illness will be paid as any other Illness.

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 assure 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 pay 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.

Telemedicine

Benefits for services provided by Telemedicine when such services are Medically Necessary Covered Medical Expenses 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:

- Medically Necessary 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.

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

- Medically Necessary therapeutic care that is provided by a licensed speech-language pathologist a physical therapist or an occupational therapist;

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.

Preauthorization is required for Outpatient therapies. Please refer to the section entitled Preauthorization.

Transplants

A heart, heart/lung, single lung, double lung, liver, pancreas, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplants to a Member.

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.
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.
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.
3. Donor searches.

Preauthorization is required for Transplants. Please refer to the section entitled Preauthorization.

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;
6. Routine 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. excepted benefits pursuant to 33-22-140(8)(a), (b), (c), (d), (e), (f), (g), (h), (j), and (k), MCA;
2. school accident type coverage;
3. benefits for non-medical components of long-term care policies; or
4. a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

Each contract 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 contract 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, coinsurance and copayments, 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 (a) 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 (a) 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:

      - The plan covering the custodial parent;
      - The plan covering the Spouse of the custodial parent;
      - The plan covering the non-custodial parent; and then;
      - 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 get the facts it needs from or give them to other organizations or persons for the purpose of applying these 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 do this. Each Member claiming benefits under this plan must give 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

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 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.
   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), 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 or if the commission of the felony is related to a preexisting medical condition.
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. 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. Cosmetic 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. 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.
    e. Not covered under applicable Medical Policy.
17. 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, efficacy or efficacy as compared with standard treatment, or for the diagnosis of the condition in question.
18. Transplants of a nonhuman organ or artificial organ implant.
19. Private duty nursing.
20. Abortions 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.
21. Reversal of an elective sterilization.
22. Services, supplies, drugs and devices related to in vitro fertilization.

23. Chiropractic services and supplies.

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

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

26. Foot orthotics.

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

28. Services or supplies related to sexual reassignment and reversal of such procedures.

29. 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.

30. Services provided by a massage therapist.

31. 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.

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

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

34. 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.

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

36. 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.

37. Tutoring services.

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

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

40. 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.”

41. 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.

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. 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 or a mail order pharmacy approved by The Plan, and the ID 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 cost of the covered drug or Prescription Drug Product will then accumulate to the Member’s Deductible and Out-of-Pocket Amount. Once the Deductible is met, the Member will only be required to pay the appropriate 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 will be reimbursed for the prescription drug at 50% of the amount that would have been paid to a Participating Pharmacy, less the Member’s Deductible and Coinsurance.

3. Claims must be submitted to the address listed on the inside cover of this Member Guide.

Prescription Drug Claims - Filling Prescriptions at a Retail Pharmacy

Outpatient prescription drugs are available through the Prime Therapeutics Prescription Drug Pharmacy Integrated Benefit. Prime Therapeutics is the Pharmacy Benefit Manager.

1. Go to a Prime Therapeutics Value Participating Pharmacy or a Participating Pharmacy that accepts Member ID 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 ID 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 outpatient 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 Prime Therapeutics.
6. The Member must pay the difference between a Brand-Name Drug and the Generic equivalent if the Member purchases a Brand-name Prescription Drug when a Generic Prescription Drug substitute is available.
7. For prescriptions filled at a pharmacy that is not part of the network, the Member will need to pay the pharmacist the entire cost of the prescription at the time the prescription is filled and dispensed and submit a paper claim to Prime Therapeutics for reimbursement. If a Member does not present his or her ID card at a Participating Pharmacy, a paper claim must be submitted by the Member to Prime Therapeutics for reimbursement. The Member will be reimbursed at 50% of the contracted rate minus Coinsurance and Deductible, if applicable, in both situations. The Member will not receive the preferred pricing.
8. The Plan makes use of a Drug List, which is a list of covered prescription drugs for dispensing to Members as appropriate.
9. Prescriptions filled at Hospital pharmacies are not eligible for reimbursement unless they are listed as a network pharmacy.

Prime Therapeutics claim forms are available by calling The Plan at the telephone number on the inside cover of this document.

Mail-Service Pharmacy - A Special Cost Saving Opportunity

A convenient way to get maintenance prescriptions is 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 Drug Pharmacy Integrated Benefit section in this document.

Ordering prescriptions through the mail service pharmacy is very easy. 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 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.

PREMIUM (DUES) REBATES

Distribution and Accounting of Premium (Dues) Rebates

In the event federal or state law requires Blue Cross and Blue Shield of Montana to rebate a portion of an annual premium (dues) payment, Blue Cross and Blue Shield of Montana will pay the Group the total rebate applicable to the Member Guide, and the Group will distribute from the rebate a pro-rata share of the rebate to each Employee

and former Employee based upon the respective contribution to the premium (dues) rebated.

The Group shall assure appropriate notification to federal and state tax agencies and that each payment to Employees and former Employees will be accompanied by appropriate federal and state documentation.

The Group shall develop and retain records and documentation evidencing accurate distribution of any rebate and shall provide such records to Blue Cross and Blue Shield of Montana as follows:

1. Prior to March 15, the following information will be required for the prior year:
    a. The percent of the premium (dues) paid by each Employee;
    b. The percent of the premium (dues) paid by the Group;
    c. The percent of the rebate to be provided to each Employee; and
    d. The percent of the rebate to be retained by the Group.
2. Following actual distribution of the rebate, the following information will be required:
    a. Amount of rebate paid to each Employee;
    b. Amount of rebate retained by the Group; and
    c. Amount of any unclaimed rebate and how it will be reported to the State.

The Group will assure that any unclaimed rebate amounts will be reported in accordance with the unclaimed property laws of the applicable Employee's state of domicile.

COBRA

If Blue Cross and Blue Shield of Montana does not administer the Group's COBRA requirements, then the rebate payment will include COBRA premiums that the Group must return to each COBRA recipient.

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.

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 State 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 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 the requirement to furnish such forms, have any responsibility for or with reference to the completion of such form or the manner of any such completion or attempted completion.

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, at its sole discretion, 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 Group Plan.

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.

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 and of the prospects for recovery.
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. 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.

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 (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 a 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; 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 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, 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.

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.

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, Coinsurance and/or Copayment 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, Coinsurance and/or Copayment. The Member will be responsible for the balance of the nonparticipating Dentist's charges after payment by the Plan and payment of any Deductible, Coinsurance and/or Copayment.

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:

- increase desired behaviors or social interaction skills;
- teach new functional life, communication, or social, skills;
- maintain desired behaviors, such as teaching self control and self-monitoring procedures;
- appropriate transfer of behavior from one situation or response to another;
- restrict or narrow conditions under which interfering behaviors occur;
- 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 United States Food and Drug Administration;
2. Exempt from an investigational new drug application; or
3. Approved or funded by:

    - 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;
    - A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes for Health for center support groups; or
    - 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.

BASIC HEALTH BENEFIT PLAN

A health benefit plan, (except a Uniform Health Benefit Plan), developed by a Small Employer carrier that has a lower benefit value than the Small Employer carrier's standard benefit plan and that provides the benefits required under the Small Employer Health Insurance Availability Act.

BENEFICIARY MEMBER

A person in the employee 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;
4. An Expert Opinion, if Randomized Clinical Trials, Cohort Studies, Case-Control Studies or Case Series are unavailable.

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 Preferred or Non-preferred 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 your payment obligations from Generic to Preferred or Non-preferred 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.

CHEMICAL DEPENDENCY

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 Behavioral Health Practitioner or other appropriate medical practitioner.

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.

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.

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 Chemical Dependency.

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, nurse specialists, naturopathic physicians, Advanced Practice Registered Nurses, physician assistants, 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. the Montana Comprehensive Health Association provided for in 33-22-1503 (MCHA)
8. a health plan offered under Title 5, chapter 89, of the United States Code (Federal Employee Health Benefits Program)
9. a public health plan
10. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e)
11. 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 non-professional 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, 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 Contract.

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.

DRUG LIST

A list that identifies those Prescription Drug Products that are covered by The Plan for dispensing to Members when appropriate. This list is reviewed quarterly and subject to modification. Details can be found on the pharmacy page at www.bcbsmt.com or by visiting www.myprime.com.

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 condition manifesting itself by 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 any of the following:

1. the Member's health would be in serious jeopardy;
2. the Member's bodily functions would be seriously impaired; or
3. a bodily organ or part would be seriously damaged.

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:

- 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
- 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
- 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.

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 Chemical Dependency, it means a facility which provides treatment for Chemical Dependency in a community-based residential setting for persons requiring 24-hour supervision and which is a Chemical Dependency Treatment Center. Services include medical evaluation and health supervision; Chemical Dependency 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. A list of Preferred Generic Drugs is available on the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com. 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.

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-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; and
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:

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.

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 Food and Drug Administration; 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 an interdisciplinary team, including a licensed Physician, psychiatric social worker and psychologist. 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);
5. impulse control disorders (except for intermittent explosive disorder and trichotillomania); or
6. Severe Mental Illness.

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.

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. 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.

OUT OF POCKET AMOUNT

For the Member:

The total amount of In-Network Deductible and the Out-of-Network Deductible each Member must pay for Covered Medical Expenses 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 Deductible 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. 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 Deductible for the entire Hospital stay (facility charges only) 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 will be applied to that stay.

Non-covered services, the non-participating pharmacy 50% benefit reduction and amounts over the allowed amount billed by a non-participating provider do not accumulate to the Out of Pocket Amount and are the Member's responsibility.

For the Family:

The total amount of In-Network Deductible and the Out-of-Network Deductible for Covered Medical Expenses a Family Membership must pay for services incurred during that Benefit Period. Once the Deductible 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 Deductible for Covered Medical Expenses 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 non-participating pharmacy 50% benefit reduction and amounts over the allowed amount billed by a non-participating 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 pharmacy benefit manager 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.

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.

PREAUTHORIZATION

The process that determines in advance the Medical Necessity or Experimental, Investigational and/or Unproven nature of certain care and services under the Member Guide. Preauthorization 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.

Preauthorization 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.

PRESCRIPTION DRUG PRODUCT

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

PROFESSIONAL CALL

An interview between the Member and the professional provider in attendance. The professional provider must examine the Member and 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 section entitled Telemedicine.

PROOF OF LOSS

The documentation accepted by Blue Cross and Blue Shield of Montana upon which payment of Benefits is made.

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.

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;
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.

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, wilderness programs, supervised living, group homes, 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 24 hour onsite nursing service for patients with Mental Illness and/or Substance Use Disorders. Requirements: 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, 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.

SEVERE MENTAL ILLNESS

The following disorders as defined by the American psychiatric association:

1. schizophrenia;
2. schizoaffective disorder;
3. bipolar disorder;
4. major depression;
5. panic disorder;
6. obsessive-compulsive disorder; and
7. autism.

Coverage for a child with autism who is 18 years of age or younger is provided under the Autism Spectrum Disorders Benefit if the child is diagnosed with:

1. Autistic Disorder;
2. Asperger’s Disorder; or
3. Pervasive Developmental Disorder not otherwise specified.

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

High cost, hard to manage injectables, select orals, and/or infused therapies that are administered by the patient or Physician for the treatment of chronic Illness.

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.

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.

TELEMEDICINE

Telemedicine means the use of interactive audio, video, or other telecommunications technology that is:

1. Used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and
2. Delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq.

The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology. The term does not include the use of audio-only telephone, e-mail, or facsimile transmissions.

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.

Enrollment will be effective retroactively to the first day of the plan year beginning on or after September 23, 2010.

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.

Enrollment will be effective retroactively to the first day of the plan year beginning on or after September 23, 2010.

For additional information regarding these notices, contact:

Blue Cross and Blue Shield of Montana
560 North Park Ave.
Helena, MT 59604-4309
1-800-447-7828

Blue Cross and Blue Shield of Montana
560 North Park Avenue
P.O. Box 4309
Helena, MT 59604-4309

BLUE PREFERRED SILVER PPO 022

BlueCross BlueShield of Montana

www.bcbsmt.com

To learn more, call Blue Cross and Blue Shield of Montana at 800-447-7828 or your local agent

Outline of Coverage	2016	This plan does not have an Annual or Lifetime Plan Maximum This plan is a Health Saving Account (HSA) Qualified Plan	
Benefit Period	January 1 – December 31		
Deductible *Copayments do not accumulate to the plan deductible.*	In-Network:	Individual: $3,500	Family: $7,000
	Out-of-Network:	Individual: $7,000	Family: $14,000
Out-of-Pocket Amount	In-Network:	Individual: $3,500	Family: $7,000
	Out-of-Network:	Individual: $7,000	Family: $14,000
Coinsurance		In-Network: None	Out-of-Network: None
Deductible Waived For:	**In and Out-of-Network:** Diabetic Education Benefit (the first $250) **In-Network:** Preventive Health Care; Routine Mammograms; Well-Child Care **Out-of-Network:** The first $70 for Routine Mammograms; Well-Child Care		

Blue Cross and Blue Shield of Montana (BCBSMT) Provider Networks

Preferred Provider Organization (PPO) (In-Network) - An innovative health care partnership developed by BCBSMT and our Preferred Hospital Providers to offer health care services to Members at lower premiums. This network is composed of hospitals or surgery centers across the state that accept lower payments for each hospital or surgery center service or inpatient stay. Currently, all hospitals in Montana participate in this network.

Traditional Network Participating Providers (In-Network) - This is the most extensive provider network available in Montana, composed of professional providers and facility providers, other than hospitals and surgery centers that have contracted with BCBSMT to provide services to our Members at discounted rates. Currently, approximately 95% off all physicians and 100% of hospitals in Montana participate in this network.

Participating Providers accept the BCBSMT allowable fee, in addition to the deductible, coinsurance and copayment, as payment in full for covered services. These providers will submit claims for you, and BCBSMT will pay the participating provider directly. There is no billing to you over your deductible, coinsurance and copayment.

Nonparticipating Provider (Out-of-Network) - Nonparticipating Providers have not contracted with BCBSMT to provide services at negotiated rates, and your out of pocket expenses can be significantly higher. Nonparticipating providers are under no obligation to submit claims for you. You may receive payment for claims received from a nonparticipating provider.

Finding Participating Providers–To locate Participating Providers and PPO hospitals and surgery centers in Montana check our on-line provider directory at www.bcbsmt.com or contact Customer Service at 1-800-447-7828. Be sure to have your health plan identification number available when you call.

Out of State Networks at Your Fingertips – With BlueCard you have access to Participating Providers across the country. No matter where you are, you'll receive the same great benefits you get when you're at home. To find BlueCard Participating Providers, visit the BlueCross and BlueShield Association website at htpp://provider.bcbs.com or call 1-800-810-BLUE (2593).

Deductible: The dollar amount each Member must pay for covered medical expenses incurred during the benefit period before BCBSMT will make payment for any covered medical expense to which the deductible applies. This plan has an In-Network deductible and separate Out-of-Network deductible.

Out-of-Pocket Amount: The total amount of deductible, coinsurance and copayment that each Member would pay in a single benefit period. Once the out-of-pocket amount is met, the Plan pays 100% of the allowable fee on covered services. However, any amount each Member pays for balances owed to nonparticipating providers does not apply to the out-of-pocket amount. This plan has an In-Network out-of-pocket amount and a separate Out-of-Network out-of-pocket amount.

Coinsurance: The percentage of the allowable fee payable by the Member for covered medical expenses.

Rating Factors and Trend: The following factors are used in setting rates: the income and claims experience for the 12 months prior to rating calculations for the category of product being rated, the benefit difference for the deductible, coinsurance and copayment relationship for the specific products in a product category, the projected claims, income and enrollment for the next 12-month rating period, projected expenses for the plan of the next rating period, and/or age of the application or subscriber, industry, and risk characteristics. The trend of premium increases during the preceding five years is: 2011 – 13%, 2012 – 11%, 2013 – 13%, 2014 – 7.1%, 2015 -7.2%

The Appeals section in the Member guide contains information regarding utilization review procedures, including procedures for obtaining review of adverse determinations, and the Member's rights with respect to those procedures.

Deductible, copayment and coinsurance apply to all services listed below, unless otherwise noted. This is only a summary of benefits. Benefits and general provisions are subject to the terms of the Contract. Preauthorization is not a guarantee of payment but is required for some services, supplies, treatments and prescription drugs to determine if services are Medically Necessary and a benefit of the Contract.

Professional Provider Services	Covered services include home and office calls, x-ray, lab and other services provided by a professional provider.	
Preventive Health Care, including Routine Mammograms and Well-Child Care	Services include: 1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's (USPSTF) current recommendations; and 2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention; and 3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women; and 4. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued prior to November 2009. Examples of services include, but are not limited to, physical examinations, vaccinations, immunizations, lactation services, a breast pump (maximum of two electric), certain contraceptives and certain tobacco cessation products. Deductible does not apply to In-Network services which are paid at 100% of the allowable fee. Deductible applies to Out-of-Network services, except for the first $70 for Out-of-Network routine mammograms. Deductible does not apply to Out-of-Network Well-Child Care.	
Inpatient Hospital	Room and board, special care units, ancillary charges, and transplant coverage.	
Outpatient Hospital	Accidental injury, x-ray/lab, surgery, chemotherapy, respiratory therapy, medical emergencies and other services.	
Maternity Services	Professional and facility services are processed under regular medical benefits.	
Emergency Room Care	Services provided for accidental injury and emergency services.	
Transplants	Processed under regular medical benefits.	
Convalescent Home	Skilled nursing facility, transitional care units and extended care facilities. 60 days per benefit period.	
Chiropractic and Acupuncture Services	Chiropractic: 10 visit maximum per benefit period. Acupuncture: 12 visit maximum per benefit period.	
Home Health Care	180 visit maximum per benefit period.	
Hospice	Deductible does not apply. Paid at 100% of the allowable fee.	
Individual Therapies	Outpatient physical, occupational, speech and cardiac rehabilitation therapies for professional and facility charges.	
Rehabilitation Therapy	Inpatient and outpatient rehabilitation therapy services.	
Durable Medical Equipment and Prostheses	Initial purchase, replacement, and repair.	
Mental Illness	Mental Illness, including Severe Mental Illness, is processed under regular medical benefits.	
Chemical Dependency	Processed under regular medical benefits.	
Autism Spectrum Disorder	Diagnosis and treatment of Autistic disorder, Asperger's disorder or pervasive developmental disorder. Applied Behavioral Analysis (ABA) therapy is only available to Members 0-18 years of age.	
Mammograms (Medical/Diagnostic)	Deductible does not apply to In-Network services which are paid at 100% of the allowable fee. Deductible applies to Out-of-Network services.	
Diabetic Education Benefit	Deductible does not apply to the first $250 per benefit period for outpatient services. After the first $250 in payment, deductible applies.	
Diagnostic Services	Processed under regular medical benefits.	
Pediatric Dental (under 19 years of age.)	Processed under regular medical benefits. Deductible does not apply to fluoride treatments.	
Pediatric Vision (under 19 years of age.)	Routine eye exam, deductible does not apply. Paid at 100% of the allowable fee. Lenses and frames processed under regular medical benefits.	
Prescription Drugs	**Value Participating Pharmacy Copayment/Coinsurance**	**Participating Pharmacy Copayment/Coinsurance**
Retail: 30-day supply	Retail purchase: None	Retail purchase: None
Retail: 90-day supply **Only available at Value Participating Pharmacies**	Retail purchase: None	
Mail Order: 90-day supply	Mail-order purchase: None	
Specialty Pharmaceuticals	Specialty Pharmaceuticals: None (30 day supply only)	Specialty Pharmaceuticals: $150 (30 day supply only)
***Deductible:** Applies (The member must pay the difference between a brand name drug and the generic equivalent, in addition to the coinsurance, if the member chooses a brand name drug when a generic drug is available.)*	Payment for Prescription Drugs purchased at a nonparticipating pharmacy will be reduced by 50%. Specialty Pharmaceuticals, when purchased at a nonparticipating pharmacy, are not covered. Mail Order is only available through the Preferred Mail Order Pharmacy Network.	

Member Rights – When requested by the Member or the Member's agent, BCBSMT is required 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 or clinic or hospital exceeds $500.

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