

Montana University System Student Insurance Plan

Effective August 1, 2025

PPO

MEMBER GUIDE



BlueCross BlueShield of Montana

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

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- BCBSMT Provider Directory
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- For Prior Authorizations, fax: 1-877-243-6930

PBM Website

www.myprime.com

Claim Forms

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Pharmacy Locator

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Specialty Care Pharmacy (BCBSMT Specialty Network)

1-833-721-1619

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

Mail-Order Services

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

Blue Cross and Blue Shield of Montana
3645 Alice Street
Helena, MT 59601

FOR CLAIMS

Blue Cross and Blue Shield of Montana
PO Box 660255
Dallas, TX 75266-0255

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 Montana University System Student Insurance Plan has agreed to purchase health coverage from Blue Cross and Blue Shield of Montana. The Member's coverage will not be effective, and you will not be entitled to Benefits, until and unless Montana University System Student Insurance Plan pays the required dues.

MEMBER GUIDE

This Member Guide is a summary of the Benefits available under the Montana University System Student Insurance Plan. Nothing in this Member Guide will alter any of the terms, conditions, limitations, or Exclusions of the Montana University System Student Insurance Plan. If questions should arise, the provisions of the Montana University System Student Insurance Plan will prevail. Please refer to the Montana University System Student Insurance Plan on file if you have any questions which aren't answered in the Member Guide or call Blue Cross and Blue Shield of Montana.

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

MEMBER'S RIGHTS

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

CONTINUITY OF CARE

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

IDENTITY THEFT SERVICES

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

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

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SCHEDULE OF BENEFITS

Student Health Plan Name: Montana University System Student Insurance Plan

Student Health Plan Number: X58188

Effective Date: August 1, 2025

Lifetime Plan Maximum: None

Maximum Benefits for specific Benefits are listed in this Schedule of Benefits.

Benefit Period: August 1, 2025 through July 31, 2026

Additional days of coverage may be available for newly enrolled students, depending on the coverage period registration dates at each specific campus.

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

	In-Network	Out-of-Network
Deductible:		
Individual	\$500	\$1,000
The In-Network and Out-of-Network Deductibles are separate amounts, and one does not accumulate to the other. Copayments (except for insulin) and/or Coinsurance do not accumulate to the Deductible.		
Coinsurance:	20%	40%
Copayments:		
Primary Care Provider (PCP)	\$20	No Copayment; Deductible and Coinsurance Apply
Specialist	\$40	No Copayment; Deductible and Coinsurance Apply
Out of Pocket Amount:		
Individual	\$6,850	\$13,700

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.

Student Health Centers

Services received at a Student Health Center are payable at 100% of the Allowable Fee.

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

Term of Member Guide: Monthly

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Deductible applies to all services unless noted otherwise.		
Accident		
Professional Provider Services	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services	20%	40%
Acupuncture		
Maximum Per Benefit Period – 12 Visits	20%	40%
Ambulance		
	20%	20%
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.	\$40, No Deductible	40%
Medications/prescription drugs are covered under Prescription Drugs.		
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Benefits for Autism Spectrum Disorders are not subject to any applicable Physical, Occupational, or Speech Therapy visit maximum.		
Birthing Centers		
	20%	40%
Breast Examinations		
Preventive	Deductible, Copayment and/or Coinsurance Do Not Apply	40%*
Medical	Deductible, Copayment and/or Coinsurance Do Not Apply	
*Deductible, Copayment and/or Coinsurance do not apply to the payment of the first \$70 for preventive mammograms provided by an Out-of-Network provider.		
Chiropractic Services		
Maximum Benefit Per Benefit Period for Chiropractic manipulations – 10 Visits	20%	40%
Convalescent Home Services		
Maximum Per Benefit Period – 60 Days	20%	40%
Diabetic Education Benefit		
First \$250	Deductible, Copayment and/or Coinsurance Do Not Apply	
After the first \$250 in payment	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Diagnostic Services		
Professional Provider Services Outpatient	20%	40%
Facility Services	20%	40%
Deductible, Copayment and/or Coinsurance do not apply to Diagnostic or Supplemental Breast Examinations. Please refer to the Breast Examination Benefit.		
Refer to the section of the Schedule of Benefits entitled Office Visits.		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Deductible applies to all services unless noted otherwise.		
Diagnostic Services – Hi-Tech Radiology (Cat Scan, MRI, PET) Deductible, Copayment and/or Coinsurance do not apply to Diagnostic or Supplemental Breast Examinations. Please refer to the Breast Examination Benefit.	\$100, No Deductible	40%
Durable Medical Equipment Rental (up to Purchase Price), Purchase, Repair, and Replacement of Durable Medical Equipment	20%	40%
Emergency Room Care – Emergency Conditions	\$100 Copayment in addition to 20%, No Deductible	\$100 Copayment in addition to 20%, No Deductible
Other Facility Charges	20%, No Deductible	20%, No Deductible
Emergency Room Physician Charges	20%, No Deductible	20%, No Deductible
Emergency Room Care – Nonemergency Conditions	\$100 Copayment in addition to 20%, No Deductible*	40%*
*Nonemergency Mental Illness and Substance Use Disorder services provided by an In-Network provider, or an Out-of-Network provider, pay as Emergency Room Care – Emergency Conditions.		
Emergency Room Care – Nonemergency Conditions not related to an Emergency Medical Condition, accidental Injury, Mental Illness or Substance Use Disorder		
Other Facility Charges	20%	40%
Emergency Room Physician Charges	20%	40%
Foot Orthotics	20%	40%
Hearing Coverage for Members Under Age 19 Maximum one Amplification Device per ear every 3 years or as required by an audiologist. Refer to the section of the Schedule of Benefits entitled Office Visits.		
Home Health Care Maximum Per Benefit Period – 180 Visits	20%	40%
Hospice Care		
Professional Provider Services	20%	40%
Facility Services	20%	40%
Hospital		
Professional Provider Services (when the professional provider is employed by the Hospital)		
Outpatient	20%	40%
Inpatient	20%	40%
Facility Services		
Outpatient	20%	40%
Inpatient	20%	40%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Deductible applies to all services unless noted otherwise.		
Maternity Services		
Professional Provider Services	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
However, the Office Visit Copayment only applies to the initial visit. Subsequent visits are included in the charges for labor and delivery.		
Facility Services	20%	40%
Medical Supplies		
	20%	40%
Mental Health		
Professional Provider Services		
Outpatient	20%	40%
Inpatient	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services		
Outpatient	20%	40%
Inpatient	20%	40%
Newborn Initial Care		
Professional Provider Services	20%, No Deductible	40%, No Deductible
Facility Services	20%, No Deductible	40%, No Deductible
Office Visit		
Primary Care Provider (PCP), including Mental Health and Substance Use Disorder providers.	\$20, No Deductible	40%
Office Visit and any covered services provided during the Office Visit.		
Specialist	\$40, No Deductible	40%
Office Visit and any covered services provided during the Office Visit.		
Deductible, Copayment and/or Coinsurance do not apply to Preventive Health Care services.		
Refer to the section entitled Preventive Health Care.		
Orthopedic Devices/Orthotic Devices	20%	40%
Other Facility Services – Inpatient and Outpatient	20%	40%
Pediatric Vision Care (for Members under 19 years of age)		
Routine Exam	Deductible, Copayment and/or Coinsurance Do Not Apply	
Maximum Per Benefit Period – 1 Exam		
Frames and Lenses	20%	40%
Maximum Per Benefit Period – 1 Pair of Glasses or 1 Pair of Contact Lenses		
Physician Medical Services	20%	40%
(Other than the Office Visit)		
Prescription Drugs		
Refer to the last page of this Schedule of Benefits.		
Preventive Health Care		
Preventive Services	Deductible, Copayment and/or Coinsurance Do Not Apply	
Private Duty Nursing	20%	40%
Maximum Per Benefit Period – \$10,000		

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Deductible applies to all services unless noted otherwise.		
Prostheses Benefit		
Rental (up to Purchase Price), Purchase, Repair, and Replacement of Prosthetics	20%	40%
Rehabilitation Therapy		
Professional Provider Services		
Outpatient	20%	40%
Inpatient	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services		
Outpatient	20%	40%
Inpatient	20%	40%
Substance Use Disorder		
Professional Provider Services		
Outpatient	20%	40%
Inpatient	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services		
Outpatient	20%	40%
Inpatient	20%	40%
Surgery Center Services - Outpatient		
Professional Provider Services	20%	40%
Facility Services	20%	40%
Telehealth		
Primary Care Provider (PDP), including Mental Health and Substance Use Disorder providers.	20%	40%
Therapies – Outpatient		
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy		
Professional Provider Services	20%	40%
Facility Services	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Refer to the Autism Spectrum Disorders section for information on Autism Spectrum Disorder therapies.		
Transplants		
Professional Provider Services		
Outpatient	20%	40%
Inpatient	20%	40%
Refer to the section of the Schedule of Benefits entitled Office Visits.		
Facility Services		
Outpatient	20%	40%
Inpatient	20%	40%

SCHEDULE OF BENEFITS, continued

BENEFIT INFORMATION	IN-NETWORK COINSURANCE/ COPAYMENT	OUT-OF-NETWORK COINSURANCE/ COPAYMENT
Deductible applies to all services unless noted otherwise.		
Urgent Care		
Urgent Care Visit and any Covered Services Provided During the Urgent Care Visit	\$40 Copayment in addition to 20%, No Deductible	40%
Deductible, Copayment and Coinsurance do not apply to Preventive Health Care services.		
Refer to the section entitled Preventive Health Care.		
Virtual Visits – MDLIVE Providers Only	\$20, No Deductible	Not a Benefit
Well-Child Care Services	Deductible, Copayment and/or Coinsurance Do Not Apply	

SCHEDULE OF BENEFITS, continued

PRESCRIPTION DRUG INFORMATION	DEDUCTIBLE	COPAYMENT/ COINSURANCE
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Prescription Drugs

The Prescription Drugs Benefit utilizes a Drug List. Any Deductible, Copayment and/or Coinsurance do not apply to certain Contraceptive products. Refer to the Preventive Health Care Benefit. Any Deductible, Copayment and/or Coinsurance also do not apply to prescription smoking cessation products and over-the-counter smoking cessation aids/medications, for two 90-day treatment regimens.

Deductible Per Member Per Benefit Period	None
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Retail Pharmacy Prescriptions

Copayments and/or Coinsurance for a 30-day supply are:

Preferred Generic Drug:	\$15
Non-Preferred Generic Drug:	\$15
*Preferred Brand-Name Drug:	\$30
*Non-Preferred Brand-Name Drug:	\$50

Mail Service Maintenance Prescriptions

Available from an approved Mail-Order Pharmacy

Copayments and/or Coinsurance for a 90-day supply are:

Preferred Generic Drug:	\$45
Non-Preferred Generic Drug:	\$45
*Preferred Brand-Name Drug:	\$90
*Non-Preferred Brand-Name Drug:	\$150

Extended Supply Network

Copayments and/or Coinsurance for a 90-day supply are:

Preferred Generic Drug:	\$45
Non-Preferred Generic Drug:	\$45
*Preferred Brand-Name Drug:	\$90
*Non-Preferred Brand-Name Drug:	\$150

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

Specialty Medications purchased at participating Specialty Pharmacies in the Blue Cross and Blue Shield of Montana Specialty Network

(30-day supply only)

Preferred Specialty Drug:	\$30
Non-Preferred Specialty Drug:	\$50

Coverage for Specialty Medications are limited to a 30-day supply. However, some Specialty Medications have FDA approved dosing regimens exceeding the 30-day supply limit and may be allowed greater than a 30-day supply if allowed by The Plan Benefits. Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

A covered insulin drug, regardless of the amount or type that is prescribed, will not exceed a \$25 Copayment for a 30-day supply. Copayment accumulates to the Deductible.

Certain covered drugs may be available at no cost-share through a Participating Pharmacy for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses, and nitrates. For further information, call the number on the back of the Member's identification card.

Payment for Prescription Drug Products purchased at a non-Participating Pharmacy will be paid at 60%, in addition to any Copayment.

*The Member must pay the difference between a Brand-Name Drug and the Generic Drug equivalent in addition to the Copayment if the Member chooses a Brand-Name drug when a Generic Drug is available. The amount the Member pays for the difference between a Brand-Name Drug and the Generic Drug equivalent does not apply to the Out of Pocket Amount and will continue to be applicable after the Out of Pocket Maximum is met.

Refer to the Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefit section of this Member Guide.

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, chiropractors, acupuncturists, and physical therapists.

Primary Care Providers (PCPs) include general practitioners, family practitioners, internists, pediatricians, obstetricians and gynecologists, Physician assistants, registered nurse practitioners, psychologists, psychiatrists, licensed addiction counselors, licensed clinical professional counselors and licensed clinical social workers.

A specialist is a Physician, not included in the list of PCPs, who provides medical services in any generally accepted medical specialty or sub-specialty.

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

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

PPO Providers

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

The exceptions to the Benefit reduction are:

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

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

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

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

Emergency Services and services that are unavailable within the PPO Network will be covered as In-Network.

However, any nonparticipating provider or non-PPO provider can bill the Member for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus Deductible, Coinsurance and/or Copayment even if Prior Authorization was obtained for such services. The Member will be responsible for the balance of the nonparticipating provider's or non-PPO provider's charges after payment by Blue Cross and Blue Shield and payment by the Member of any Deductible, 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 that the Member's attending Physician contact The Plan for an out

of PPO Network referral. If the referral is not approved, and the Member chooses to obtain services from a non-PPO Network provider, the Member will be responsible for the Out-of-Network Deductible and Coinsurance, in addition to any difference between the Blue Cross and Blue Shield of Montana Allowable Fee and the provider's billed charges.

If The Plan approves the referral, those services will process with the In-Network Deductible 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 of Montana 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. For an estimate of the Member's cost-sharing liability for covered items or services furnished by a particular provider, visit www.bcbsmt.com or call the number on the back of the Member's identification card.

In-Network providers agree 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 of Montana 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 of Montana 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 charge after payment by Blue Cross and Blue Shield of Montana 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 services are provided. For an estimate of the Member's cost-sharing liability for covered items or services furnished by a particular provider, visit www.bcbsmt.com or call the number on the back of the Member's identification card.

In-Network providers agree 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 of Montana 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 of Montana 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 charge after payment by Blue Cross and Blue Shield of Montana and payment of any Deductible, Coinsurance and/or Copayment.

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

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

MEMBERS RIGHTS AND RESPONSIBILITIES

A Member has the right to:

1. Receive information about The Plan, the quality assurance program, the Member's health Benefit Plan, the names of participating health care providers, and the Member's rights and responsibilities;
2. Be treated with respect and recognition of the Member's dignity and right to privacy;
3. Have a candid discussion of appropriate or Medically Necessary treatment options for the Member's condition, regardless of cost or Benefit coverage;
4. Participate with health care providers in decision-making regarding the Member's health care;
5. Voice complaints or appeals about the managed care organization, health care providers or the care provided;
6. Talk to the Member's health care provider and expect that the Member's records and conversations are kept confidential; and
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; and
2. Follow the treatment plans and instruction for care the Member has agreed upon with the Member's health care providers.

OUT-OF-AREA SERVICES – THE BLUECARD PROGRAM

Out-of-Area Services

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

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

1. BlueCard® Program

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

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

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with

the Member's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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

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

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

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

a. Member Liability Calculation

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

b. Exceptions

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

3. Blue Cross Blue Shield Global Core

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

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

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

a. Inpatient Services

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

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

b. Outpatient Services

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

c. Submitting a Blue Cross Blue Shield Global Core Claim

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

COMPLAINTS AND GRIEVANCES

Complaints and Grievances

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

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

APPEALS

Claims Procedures

Types of Claims

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

1. Pre-Service Claims

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

2. Urgent Care Claims

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

3. Post-Service Claims

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

4. Rescission Claims

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

5. Concurrent Care Claim

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

Initial Claim Determination by Type of Claim

1. Pre-Service Claim Determination and Notice

a. Notice of Determination

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

b. Notice of Extension

1. For reasons beyond the control of The Plan

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

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

If the extension is necessary due to the Member's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the Member will be given 45 days from receipt of the notice within which to provide the specified information. The Plan will notify the Member of the initial claim determination no later than 7 days after the earlier of the date The Plan receives the specific information requested or the due date for the requested information.

c. Notice of Improperly Submitted Claim

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

2. Urgent Care Claim Determination and Notice

a. Designation of Claim

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

b. Notice of Determination

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

c. Notice of Incomplete or Improperly Submitted Claim

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

3. Post-Service Claim Determination and Notice

a. Notice of Determination

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

b. Notice of Extension

1. For reasons beyond the control of The Plan

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

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

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

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

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

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

2. If the Member's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Member's claim will be treated as and decided within the timeframes for an Urgent Care claim as described in the section entitled, "Initial Claim Determination by Type of Claim."

3. If the Member's claim did not involve Urgent Care, the time periods for deciding pre-service claims and post-service claims, as applicable, will govern.

b. Reduction or Termination of Ongoing Course of Treatment

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

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

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

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

Notice of an Adverse Benefit Determination

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

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

How to File an Internal Appeal of an Adverse Benefit Determination

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

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

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

2. Access to Plan Documents

The Member may at any time during the filing period, receive reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination upon request and free of charge. Documents may

be viewed at The Plan's office, at 3645 Alice Street, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m., Mountain Time, Monday through Friday, excluding holidays. The Member may also request that Blue Cross and Blue Shield of Montana mail copies of all documentation to the Member free of charge.

3. Submission of Information and Documents

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

4. Consideration of Comments

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

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

5. Scope of Review

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

6. Consultation with Medical Professionals

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

Time Period for Notifying Member of Final Internal Adverse Benefit Determination

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

Type of Claim on Appeal	Time Period for Notification of Final Internal Adverse Benefit Determination
Urgent Care Claim	No later than 72 hours from the date The Plan received the Member's appeal, taking into account the medical exigency.
Pre-Service Claim	No later than 30 days from the date The Plan received the Member's appeal.
Post-Service Claim	No later than 60 days from the date The Plan received the Member's appeal.
Concurrent Care Claim	<ul style="list-style-type: none"> • 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; and/or
- d.** The Member has provided all the information and forms required to process the external review.

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

3. Assignment of an IRO

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

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

Within 1 business day of assigning the IRO, The Plan will notify the Member, 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; and/or
- h.** The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider them appropriate.

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

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

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

9. Compliance with IRO Decision

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

Expedited External Review Procedures

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

1. Request for Expedited External Review

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

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

2. Preliminary Review

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

3. Assignment of an IRO

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

4. Standard of Review

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

5. Notice of Final External Review Decision

The IRO will provide the Member and The Plan with notice of its final external review decision as expeditiously as the Member's medical condition or circumstances require, but not more than 72 hours after the IRO receives the expedited external review request. If the notice is not in writing, the IRO must provide written confirmation of its decision to the Member and to The Plan within 48 hours after the date the IRO verbally conveyed the decision. The written notice will include:

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

6. Compliance with IRO Decision

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

7. Inapplicability of Expedited External Review

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

External Review Procedures – Experimental or Investigational

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

Standard External Review Procedures

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

1. Request for a Standard External Review

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

2. Preliminary Review

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

- a.** The Member is or was covered under The Plan when the health care service or treatment was requested or, in the case of a retrospective review, whether the Member was covered under The Plan when the health care service or treatment was provided;
- b.** The requested health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination: (i) is a covered benefit under the Member's health plan except for The Plan's determination that the health care service or treatment is experimental or investigational for a particular medical condition; and (ii) is not explicitly listed as an excluded Benefit under the Member's health plan;
- c.** The Member's treating health care provider has certified that one of the following situations is applicable: (i) standard health care services or treatments have not been effective in improving the condition of the Member; (ii) standard health care services or treatments are not medically appropriate for the Member; or (iii) there is no available standard health care service or treatment covered by The Plan that is more beneficial than the requested health care service or treatment;
- d.** 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 time frame for decisions and notifications is shorter.

1. Request for an Expedited External Review

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

2. Preliminary Review

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

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

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

3. Assignment of an IRO

If the request is eligible for external review, The Plan will immediately assign an IRO on a random basis or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of

approved IROs compiled and maintained by the Commissioner of Securities and Insurance, to conduct the external review. In making the assignment, The Plan will consider whether an IRO is qualified to conduct the particular expedited external review based on the nature of the health care service or treatment that is the subject of the adverse benefit determination or final internal adverse benefit determination and will also take into account other circumstances, including conflict of interest concerns.

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

4. Plan Submission of Documents to the IRO

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

5. Standard of Review

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

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

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

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

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

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

The IRO will include in its written notice:

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

7. Compliance with IRO Decision

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

Deemed Exhaustion of Internal Appeal Process

1. The Member will be deemed to have exhausted the internal appeal process and may request external review or pursue any available remedies under state law or if applicable, a civil action under 502(a) of ERISA, if The Plan fails to comply with its claims and appeals procedures, except that claims and appeals procedures will not be deemed exhausted based on violations that are:
 - a. De minimis;
 - b. Non-prejudicial to the Member;
 - c. Attributable to good cause or matters beyond The Plan's control;
 - d. In the context of an ongoing, good faith exchange of information between the Member and The Plan; and
 - e. Not reflective of a pattern or practice of violations by The Plan.
2. Upon request of the Member, The Plan will provide an explanation of a violation within 10 days. The explanation will include a description of the basis for The Plan's assertion that the violation does not result in the deemed exhaustion of The Plan's internal claims and appeals procedures.
3. If the Member seeks external or judicial review based on deemed exhaustion of The Plan's internal claims and appeals procedures, and the external reviewer or court rejects the Member's request, The Plan will notify the Member within a reasonable period of time, not to exceed 10 days of the Member's right to resubmit the Member's internal appeal. The timeframe for appealing the adverse benefit determination begins to run when the Member receives the notice of the right to resubmit the Member's internal appeal.

UTILIZATION MANAGEMENT

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

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

Prior Authorization

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

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

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

Prior Authorization Responsibility

Participating Provider (In-Network) Prior Authorization

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

For additional information about Prior Authorization for services outside of the BCBSMT service area, see the section entitled, Out-of-Area Services – The BlueCard Program®.

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

Non-Participating Provider (Out-of-Network) Prior Authorization

If any provider outside of Montana (except for those contracting as Participating Providers directly with The Plan) or any Non-Participating Provider recommends an Admission or a service that requires Prior Authorization, the provider is not obligated to obtain the Prior Authorization for the Member. In such cases, it is the Member's responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, the Member may be entirely responsible for the charges if the service is determined not to be Medically Necessary. If the services were determined to be Medically Necessary, Out-of-Network Benefits will apply. The provider may call on the Member's behalf, but it is the Member's responsibility to ensure that The Plan is called.

Inpatient Admissions

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

The Member's Network Provider is required to obtain Prior Authorization for any inpatient admissions that may require Prior Authorization. If Prior Authorization is not obtained for inpatient services and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Member for the services.

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

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

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

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

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, Member's Provider, or other appropriate party, as identified above, does not request Prior Authorization, The Plan will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not

Medically Necessary, were Experimental/Investigational/Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Contract, the Member may be responsible for the full cost of the services.

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

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

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

- Maternity Care;
 - 48 hours following an uncomplicated vaginal delivery; and
 - 96 hours following an uncomplicated delivery by caesarean section

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

Outpatient Service Prior Authorization Review

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

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

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

Prior Authorization Duration

A Prior Authorization is valid for at least three (3) months from the date the Member's provider receives approval from The Plan. Actual availability of Benefits is subject to eligibility and other terms, conditions and limitations and exclusions of this Contract.

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

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

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

Response to Prior Authorization Request Involving Non-Urgent Care

Except in the case of a Prior Authorization request involving Urgent Care (see below), The Plan will provide a written response to the Member's Prior Authorization request no later than seven business days following the date we receive the Member's request. This period may be extended one time for up to seven additional business 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 seven business day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which The Plan expects to make the determination.

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

The Plan will provide a written response to the Member's request for Prior Authorization within seven business days following receipt of the additional information. The procedure for appealing an adverse Prior Authorization determination is set forth in the section entitled Complaints and Grievances.

Prior Authorization Request Involving Urgent Care

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

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

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

Prior Authorization Required For Certain Prescription Drug Products and Other Medications

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

1. Prescription Drugs – Covered Under the Prescription Drugs Benefit

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

2. Other Medications – Covered Under Medical Benefits

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

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

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

General Provisions Applicable to All Required Prior Authorizations

1. No Guarantee of Payment

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

2. Request for Additional Information

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

3. Failure to Obtain Prior Authorization

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

Length of Stay/Service Review

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

Upon completion of the inpatient or emergency admission review, Blue Cross and Blue Shield of Montana will send a letter to the Member, the Member's Physician, Behavioral Health Practitioner, and/or the Hospital for facility with a determination of the approved length of service or length of stay..

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

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

Recommended Clinical Review

Some services that do not require Prior Authorization may be subject to review for evidence of Medical Necessity for coverage determinations that may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review.

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

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

Recommended Clinical Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and Exclusions under this Contract. Please coordinate with the Provider to submit a written request for a Recommended Clinical Review.

Contacting Behavioral Health

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

behavioral health line is answered by clinicians available for inpatient acute reviews only. Requests for residential or Partial Hospitalization are reviewed during regular business hours.

General Provisions Applicable to All Recommended Clinical Reviews

1. No Guarantee of Payment

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

2. Request for Additional Information

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

Post-Service Medical Necessity Review

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

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

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

2. Request for Additional Information

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

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

1. All students are eligible if they are a fee-paying student taking at least 6 (six) credit hours or more at a participating campus. A student enrolled for less than 6 credit hours is not eligible to enroll in the Student Health Plan.

2. Participation Requirements

a. All students enrolled for 6 credit hours or more are required to carry health insurance coverage. Students can enroll for coverage when they register on-line for classes.

The Student Health Plan fee will be assessed each Fall and Spring coverage period at registration.

b. Enrollment in the Student Health Plan is required for all International Students (residing within the United States), at all campuses regardless of the number of credit hours, unless proof of other coverage in the United States is submitted to the campus.

The Student Health Plan fee will be assessed each Fall and Spring coverage period at registration.

c. Waiver of coverage must be made within the first 15 class days of the coverage period. Fall and Spring students with proof of other coverage will be allowed to waive coverage.

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/Waiver Process

The Effective Date of coverage (for those who apply within the periods of eligibility) will be the date assigned by the Montana University System Student Insurance Plan.

A specific period of time is allowed at the beginning of each coverage period for enrolling in The Plan or waiving coverage. For the Fall and Spring coverage periods, the enrollment/waiver period begins on the first day of scheduled classes each coverage period and ends 15 class days later.

Effective Date of Coverage

1. For the Student.

a. The effective date of coverage for eligible students shall be the first day of the applicable coverage period.

b. If a student becomes eligible after the beginning of the applicable coverage period, the student's effective date will be the first day of the applicable coverage period after the required premium is paid.

2. For Newborn Children.

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

3. For Adoption or Placement for Adoption.

In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption. In the event the placement is disrupted prior to legal adoption and the child is removed from placement, coverage shall cease upon the date the placement is disrupted. Coverage will continue for 31 days only. Coverage for the child will be provided only if the Member remains covered on the health plan during the 31-day period. If the Member does not remain covered for 31 days, the child will only be covered for the amount of time (during the 31 days) that the Member is covered.

Special Enrollment for Loss of Eligibility

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

Conditions for Special Enrollment for Loss of Eligibility

- 1.** When the student declined enrollment for the Student Insurance Plan, the student stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment; and
 - a.** The student had COBRA continuation coverage and the COBRA continuation coverage has expired; or
 - b.** The student had other coverage that was not under a COBRA continuation provision and the other coverage has been terminated because of:
 - 1.** 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 Member to pay premiums on a timely basis or termination of coverage for cause; or
 - 2.** Employer contributions towards the other coverage have been terminated; or
 - 3.** A situation in which The Plan no longer offers any Benefits to the class of similarly situated individuals that includes the individual.
 - c.** The student loses eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the student becomes eligible for financial assistance for group health coverage, under either the Children's Health Insurance Program or the Medicaid Program.
- 2.** The student must request enrollment not later than 31 days after the exhaustion of the COBRA continuation coverage or termination of the other coverage because of loss of eligibility or termination of employer contributions.
- 3.** The student must request enrollment not later than 60 days after the date of termination of coverage under either the Children's Health Insurance Program or the Medicaid Program.
- 4.** The student must request enrollment not later than 60 days after the date the student is determined to be eligible for financial assistance under the Children's Health Insurance Program or the Medicaid Program.
- 5.** Enrollment during a special enrollment period is subject to all other applicable enrollment requirements of The Plan and the provisions of this Member Guide.

Effective Date of Enrollment

Enrollment due to loss of eligibility will be the first day of the applicable coverage period after the required premium is paid.

When Benefits Begin

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

Change of Status

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

- 1.** Name changes; or
- 2.** Address changes.

WOMENS HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain Benefits under WHCRA. For individuals receiving mastectomy-related Benefits, coverage will be provided in a manner determined by the Plan in consultation with the attending Physician and the patient, for:

1. All stages of reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to establish a symmetrical appearance;
3. Chemotherapy; and
4. Prostheses and physical complications of all stages of a mastectomy and breast reconstruction, including lymphedemas.

These Benefits will be provided subject to any Deductible, Coinsurance and/or Copayment provisions of your health Plan. For specific Deductible, Coinsurance and/or Copayment information on your Plan, please refer to your Schedule of Benefits.

For further information about this notice or the Benefits provided under WHCRA, please contact Customer Service at 1-855-267-0214 or visit our website www.bcbsmt.com.

COVERAGE FOR MINIMUM HOSPITAL STAYS FOLLOWING CHILDBIRTH

Health insurance for maternity services, including Benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient care, following delivery by cesarean section for a mother and newborn infant in a health care facility.

Any decision to shorten the length of inpatient stay to less than that stated above must be made by the attending health care provider and the mother. A health Benefit plan may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with these provisions. Under this same requirement a health plan may not require that the provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

A health Benefit plan that provides coverage for post-delivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care unless the inpatient care is determined to be medically necessary by the attending health care provider.

For further information about this notice, please contact Customer Service at 1-855-267-0214 or visit our website www.bcbsmt.com.

TERMINATION OF COVERAGE

Termination When No Longer Eligible for Coverage

When No Longer Eligible for Coverage

Your student membership will terminate on the earlier of:

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

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

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

Benefits after Termination of Coverage

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

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

- 1.** Until the inpatient stay ends;
- 2.** Until the end of a 90-day period from the day coverage terminates; or
- 3.** Until the Member becomes covered without limitation as to the condition for which the Member is receiving Inpatient Care under any group coverage, whichever occurs first.

BENEFITS

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

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.

Certain services are covered pursuant to Blue Cross and Blue Shield of Montana Medical Policy and clinical procedure and coding policies, which are updated throughout the plan year. The Plan's Medical Policy is a guide considered by Blue Cross and Blue Shield of Montana when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug, or device is Medically Necessary and is eligible as a Covered Medical Expense or is Experimental/Investigational/Unproven, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Benefit plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsmt.com or contact Blue Cross and Blue Shield of Montana Customer Service at the telephone number shown on the back of the Member's identification card for more information.

Each campus has a Health Center and Members are encouraged to use the Health Center. This facility provides primary care to the campus community. Help is available not only for medical problems and concerns, but also for maintaining and improving health. Health Center personnel strive to involve students in their health care through teaching and self-help.

If medical care is required, outside of the Health Center either because the Health Center is closed or the Health Center refers the Member to another provider, regular Benefits will apply.

Accident

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

Acupuncture

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

The Schedule of Benefits describes payment limitations for these services.

Advanced Practice Registered Nurses and Physician Assistants - Certified

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

Ambulance

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

Anesthesia Services

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

The Plan will not pay for:

1. Hypnosis;
2. Local anesthesia or intravenous (IV) sedation that is considered to be an Inclusive Service/Procedure;
3. Anesthesia consultations before surgery that are considered to be Inclusive Services/Procedures because the Allowable Fee for the anesthesia performed during the surgery includes this anesthesia consultation; or
4. Anesthesia for Dental Services or extraction of teeth, except anesthesia provided at a Hospital in conjunction with dental treatment will be covered only when a nondental physical illness or Injury exists which makes Hospital care Medically Necessary to safeguard the Member's health. Dental Services and treatment are not a Benefit of this Member Guide, except:
 - a. As specifically included in the Dental Accident and Pediatric Dental Benefit; or
 - b. Anesthesia Services associated with any Medically Necessary dental procedure when provided to a Member who is severely disabled; or who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or who, in the judgment of the treating provider, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

Approved Clinical Trials

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

Autism Spectrum Disorders

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

Covered services include:

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

Birthing Centers

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

Blood Transfusions

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

Breast Examinations (Preventive and Medical)

Mammography examinations

The minimum mammography examination recommendations are:

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

NOTE: Benefits will be provided for Medically Necessary Diagnostic and Supplemental Breast Examinations at no cost-share.

Chemotherapy

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

Chiropractic Services

Services of a licensed chiropractor.

The Schedule of Benefits describes payment limitations for these services.

Contraceptives

Services and supplies related to Contraception, including but not limited to, oral Contraceptives, Contraceptive devices and injections, subject to the terms and limitations of the Member Guide.

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

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

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

Convalescent Home Services

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

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

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

The Schedule of Benefits describes payment limitations for these services.

Dental Accident Services

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

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

Diabetic Education

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

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

The Schedule of Benefits describes payment limitations for these services.

Diabetes Treatment (Office Visit)

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

Diagnostic Services

1. Diagnostic Imaging Procedures

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

2. All Other Covered Diagnostic Services

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

- 1.** Nuclear medicine; and
- 2.** Ultrasound.

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

- 1.** Urinalysis;
- 2.** Blood tests; and
- 3.** Throat cultures.

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

- 1.** Electroencephalograms (EEG); and
- 2.** Electrocardiograms (EKG or ECG).

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

Durable Medical Equipment

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

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

The Plan will not pay for the following items:

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

Emergency Room Care

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

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

Fertility Preservation Services

Coverage is available for Standard Fertility Preservation Services if a Medically Necessary treatment for cancer may directly or indirectly cause Iatrogenic Infertility in a Member.

Foot Orthotics

Foot orthotics provided by a Covered Provider, except for the treatment of flat foot conditions.

Hearing Coverage for Members Under Age 19

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

Home Health Care

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

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

The Plan will not pay for:

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

Prior Authorization is required for Home Health Care. Please refer to the section entitled Utilization Management.

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 and the Member's caregiver;

2. Pharmacy;
3. Supplies;
4. Equipment; and
5. Skilled nursing services when billed by a Home Infusion Therapy Agency.

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

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

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

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 who are caring for the terminally ill Member. 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.

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

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

Hospital Services - Facility and Professional

Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations
 - a. Room and board, which includes special diets and nursing services.
 - b. Intensive care and cardiac care units which include special equipment and concentrated nursing services provided by nurses who are Hospital employees.
2. Miscellaneous Hospital Services
 - a. Laboratory procedures.
 - b. Operating room, delivery room and recovery room.
 - c. Anesthetic supplies.
 - d. Surgical supplies.
 - e. Oxygen and use of equipment for its administration.
 - f. X-ray.
 - g. Intravenous injections and setups for intravenous solutions.
 - h. Special diets when Medically Necessary.
 - i. Respiratory therapy, Chemotherapy, radiation therapy and dialysis therapy.
 - j. Physical Therapy, Speech Therapy and Occupational Therapy.

k. Drugs and medicines which:

1. Are approved for use in humans by the FDA;
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.

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

Inpatient Care services are subject to the following conditions:

1. Days of care

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

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

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

Inpatient Care Medical Services Billed by a Professional Provider

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

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

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

Observation Beds/Rooms

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

Outpatient Hospital Services

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

Inborn Errors of Metabolism

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

Infertility - Diagnosis and Treatment

The Plan will pay for:

The diagnosis and treatment of infertility, including:

1. Medically Necessary evaluation to determine cause of infertility;
2. Artificial insemination (AI) or intrauterine insemination (IUI); and

3. Medically Necessary Reproductive procedures not related to in vitro fertilization.

The Plan will not pay for:

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

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 Prior Authorization from The Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

Please refer also to the Newborn Initial Care section.

Medical Supplies

The following supplies for use outside of a Hospital:

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

Medical supplies are covered only when:

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

Mental Health

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

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

Payment for mental health Benefits will be made as for 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 Substance Use Disorder Treatment Center;
5. A licensed psychologist;
6. A licensed social worker;
7. A licensed professional counselor;
8. A licensed addiction counselor;
9. A licensed psychiatrist;
10. A licensed Advanced Practice Registered Nurse with a specialty in mental health;
11. A licensed Advanced Practice Registered Nurse with prescriptive authority and specializing in mental health; or
12. Other Qualified Health Care Provider.

Outpatient Benefits are subject to the following conditions:

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

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

Inpatient Services

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

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

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

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

Partial Hospitalization

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

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

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

Midwives

Maternity services provided by Registered Nurse (RN) midwives and non-RN midwives.

Naturopathy

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

Newborn Initial Care

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

Office 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.

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.

Pediatric Vision Care

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

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

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

Physician Medical Services

Medical services by a Covered Provider for:

1. Inpatient Hospital Physician visits;
2. Convalescent home facility Physician visits; and
3. Surgical facility Physician services.

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

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

Postmastectomy Care and Reconstructive Breast Surgery

Postmastectomy Care

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

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

Reconstructive Breast Surgery

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

Coverage described in 1(a) through 1(d) will be provided in a manner determined in consultation with the Attending Physician and the patient.

2. Breast prostheses as the result of a mastectomy.

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

Prescription Drugs

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

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

complete information about the medications that are subject to the Member's medical Benefits, the process for requesting Prior Authorization for medications subject to the Member's medical Benefits, and related information.

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

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

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

Drug Lists

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

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

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

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

If the Member has a health condition that may jeopardize the Member's life, health or keep the Member from regaining function, or the Member's current drug therapy uses a non-covered drug, the Member's prescriber, may be able to ask for an expedited review process by marking the review as an urgent request. Blue Cross and Blue Shield of Montana will notify the Member or the Member's prescriber, of the coverage decision within 24 hours after they receive the request for an expedited review. If the coverage request is denied, Blue Cross and Blue Shield of Montana will let the Member and the Member's prescriber, know why it was denied and offer the Member a covered alternative drug (if applicable). If the Member's exception is denied, the Member may appeal the decision according to the appeals process the Member will receive with the denial determination. The Member should call the number on the back of the Member's identification card if the Member has any questions.

Covered Prescription Drug Products

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

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

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

Non-Covered Prescription Drug Products

The Plan will not pay for:

- 1.** Drugs which are not included on the Drug List, unless specifically covered elsewhere in this Member Guide and/or such coverage is required in accordance with applicable law or regulatory guidance;
- 2.** Non-FDA approved Drugs;
- 3.** Compounded Drugs;
- 4.** Drugs, that the use or intended use of which would be illegal, abusive, not Medically Necessary, or otherwise improper such as anabolic steroids;
- 5.** Any drug used for the purpose of weight loss;
- 6.** Fluoride supplements, except as required by the Affordable Care Act for children under age 6;
- 7.** Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. Prescription Drug Products which are used in off-label situations may be reviewed for Medical Necessity;
- 8.** Over-the-counter drugs that do not require a prescription, except over-the-counter smoking cessation aids with a written prescription;
- 9.** Prescription Drug Products for which there is an exact over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined;
- 10.** Prescription Drug Products for cosmetic purposes, including the treatment of alopecia (hair loss) (e.g., Minoxidil, Rogaine);
- 11.** Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those otherwise covered under this section;
- 12.** Prescription Drug Products used for erectile dysfunction;
- 13.** Prescription Drug Products used for the treatment of infertility;
- 14.** Insulin pumps and glucose meters. Insulin pumps and glucose meters are covered under the Durable Medical Equipment Benefit. Insulin pump supplies are covered under the Medical Supplies Benefit;
- 15.** Drugs or items labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Member is charged for the item;
- 16.** Biological sera, blood, or blood plasma;
- 17.** Prescription Drug Products which are to be taken by or administered to the Member, in whole or in part, while the Member is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution which operates or allows to be operated on its premises, a facility for dispensing pharmaceuticals. Medication in these situations is part of the facility's charge;
- 18.** Any Prescription Drug Product refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;
- 19.** Replacement prescription drugs or Prescription Drug Products due to loss, theft or spoilage;
- 20.** Prescription Drug Products obtained from a Pharmacy located outside the United States for consumption within the United States;
- 21.** Prescription Drug Products provided by a mail-order Pharmacy that is not approved by The Plan;
- 22.** Non-sedating antihistamines;
- 23.** Brand-Name Proton Pump Inhibitors (PPIs);
- 24.** Prescription Drug Products determined by The Plan to have inferior efficacy or significant safety issues;
- 25.** Administration or injection of any drugs;
- 26.** Repackages, Institutional Packs, Clinic Packs or other custom packaging;
- 27.** Pharmaceutical aids, such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary), including, but not limited to, preservatives, solvents, ointment bases, flavoring, coloring, diluting, emulsifying and suspending agents;
- 28.** Bulk powders;
- 29.** Surgical supplies (e.g., Amvisc, Cellugel, Duovisc, Hyalgan, Provisc, Supartz, Synvisc, Viscoat);

30. Any portion of Covered Services or Covered Drugs paid for through Prohibited Third-Party Cost Sharing Payments, such as certain Pharmacy coupons, drug cards or rebates;
31. Drugs which do not by law require a Prescription from a provider or Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies); and drugs or covered devices for which no valid Prescription is obtained;
32. Vitamins (except those vitamins which by law require a Prescription and for which there is not a non-prescription alternative);
33. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select vaccinations administered through certain Value and Participating Pharmacies are an exception to this Exclusion;
34. Fluids, solutions, nutrients, or medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically mentioned in this Member Guide. NOTE: This exception does not apply to dietary formula necessary for the treatment of Inborn Errors of Metabolism;
35. Drugs used or intended to be used in the treatment of a condition, sickness, disease, Injury, or bodily malfunction which is not covered under the Member Guide, or for which Benefits have been exhausted;
36. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card;
37. Benefits will not be provided for any self-administered drugs dispensed by a Physician;
38. Some therapeutic equivalent drugs are manufactured under multiple names. In some cases, The Plan may limit Benefits to only one of the therapeutic equivalents available as specified on the Drug List. If the Member does not choose the therapeutic equivalents that are covered under the Prescription Drug Program, the drug purchased will not be covered under any Benefit level;
39. Experimental/Investigational/Unproven status of a drug or device is determined by Blue Cross and Blue Shield of Montana taking into consideration a variety of factors, including demonstration of efficacy in peer reviewed literature. With respect to FDA approval, if FDA approval is not obtained, the drug will be considered Experimental/Investigational/Unproven, but if FDA approval is obtained, while this will be considered by Blue Cross and Blue Shield of Montana in making its determination of Experimental/Investigational/Unproven status, such approval will not be determinative;
40. Certain drug classes where there are over-the-counter alternatives available;
41. Diagnostic agents (except for diabetic testing supplies or test strips); or
42. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines;
43. Prescription drug coverage is not provided for:
 - a. Refills in excess of the number specified or dispensed after one (1) year from the date of the prescription; except as specifically provided in this Contract;
 - b. Drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs;
 - c. Drugs/products which are not included on the drug list;
 - d. Lost or stolen prescriptions; or
 - e. Compound Medications.

Controlled Substances Limitation

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

MedsYourWay™

MedsYourWay may lower the Member's out of pocket costs for select covered generic drugs purchased at select In-Network retail Pharmacies. MedsYourWay is a program that automatically compares available drug discount card prices and prices under the Member's Benefit Plan for select covered generic drugs and establishes the Member's out of pocket cost to the

lower price available. The Member should present their identification card to the pharmacist. This will identify participation in the MedsYourWay program and allow the Member a lower price for select covered generic drugs, if available.

The amount the Member pays for the prescription will be applied, if applicable, to the Member's Deductible and Out of Pocket Amount. Select covered generic drugs and drug discount card pricing through MedsYourWay may change occasionally. If a Member has any questions regarding the MedsYourWay program, the Member may call the Customer Service number on the back of the Member's identification card. Not all pharmacies may participate, and certain covered generic drugs or drug discount cards may not be available for the MedsYourWay program. The Member may experience a different out of pocket cost for select covered generic drugs depending upon which retail Pharmacy is utilized. For additional information regarding MedsYourWay, contact a Customer Service representative at the toll-free telephone number on the back of the Member's identification card. Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting Customer Service.

Purchase and Payment of Prescription Drug Products

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

Available Prescription Drug Products include Brand-Name Drugs and Generic Drugs. If a generic equivalent becomes available during the period of coverage for this policy, it will be added to the Drug List maintained by and available to the Member on the Blue Cross and Blue Shield of Montana website and the Pharmacy

Benefit Manager's Website

Refer to the inside cover of this Member Guide for information on Blue Cross and Blue Shield of Montana's Pharmacy Benefit Manager. The availability of a Generic Drug may allow the Member to obtain a drug at a potentially lower out of pocket cost. The factors that determine the costs to a Member include the terms of the coverage and the Drug List in effect as of the date of the prescription and the Pharmacy service date, as well as the use of a Participating Pharmacy or nonparticipating Pharmacy. In addition to any Deductible, Copayment and/or Coinsurance, if the Member chooses a Brand-Name Drug for which a generic equivalent is available, the Member is required to pay the difference between the cost of the Brand-Name Drug and the generic equivalent.

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

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

If drugs or Prescription Drug Products are purchased at a Participating Pharmacy, an extended supply Pharmacy or a mail-order Pharmacy approved by The Plan, and the Member presents the Member's identification card at the time of purchase, the Member must pay the required Copayment. In addition to the Copayment, if the Member chooses a Brand-Name Drug for which a generic substitute is available, the Member is required to pay the difference between the cost of the Brand-Name Drug and the generic equivalent. The Member will only be required to pay the appropriate Copayment and the difference between the cost of the Brand-Name Drug and the generic equivalent if the amount can be determined by the Pharmacy at the time of purchase.

If a covered prescription drug was paid for using a drug manufacturer's coupon or Copayment card, the coupon or Copayment card amount will apply to the Member's Deductible or Out of Pocket Amount.

If the Member uses a Participating Pharmacy to fill a prescription but elects to submit the claim directly to The Plan's Pharmacy Benefit Manager, instead of having the Participating Pharmacy submit the claim, the Member will be reimbursed

for the prescription drug based on the amount that would have been paid to the Participating Pharmacy, less the Member's 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 file a prescription drug claim form with The Plan's Pharmacy Benefit Manager for reimbursement. The Member will be reimbursed for the prescription drug at 60% of the amount that would have been paid to a Participating Pharmacy, less the Member's Copayment and any additional charge for the difference between the cost of the Brand-Name Drug and the generic equivalent. The 60% Benefit reduction does not apply to any Out of Pocket Amounts. Please refer to the Prescription Drugs, Purchase and Payment of Prescription Drug Products in the Benefit section of this Member Guide for additional information.

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

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

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

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

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

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

Prescription Eye Drop Refills

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

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

3. Not earlier than the 63rd day after the date a prescription order for a 90-day supply is dispensed.

Multi-Category Split Fill Program

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

Specialty Medications

1. Specialty Medications are generally prescribed for individuals with complex medical conditions such as multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These medications also have one or more of the following characteristics:
 - a. Injected or infused, but some may be taken by mouth;
 - b. Unique storage or shipment requirements;
 - c. Additional education and support required from a health care professional; or
 - d. Usually not stocked at retail pharmacies.
2. For the highest level of Benefits, Specialty Medications must be acquired through The Plan's contracted Specialty Pharmacies listed on the inside cover of this Member Guide. A list of covered Specialty Medications may be found on The Plan website at www.bcbsmt.com. Registration and other applicable forms are also located on the website.
3. Coverage for Specialty Medications are limited to a 30-day supply. However, some Specialty Medications have FDA approved dosing regimens exceeding the 30-day supply limit and may be allowed greater than a 30 day-supply, if allowed by The Plan Benefits. Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

Preventive Health Care

Covered preventive services include, but are not limited to:

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

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

a. Lactation Services

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

b. Contraceptives

FDA approved Contraceptive methods, including certain Contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity; and

4. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to or after November 2009.

5. Current recommendations of the United States Preventive Service Task Force regarding obesity screening and counseling.

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

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

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a nonparticipating Pharmacy may be subject to any applicable Deductible, Copayment and/or Coinsurance, or dollar maximums.

A Copayment waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug list.

Private Duty Nursing

Services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN).

The Schedule of Benefits describes payment limitations for these services.

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; or
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; or
6. Visual, speech, or auditory disorders because of learning and developmental disabilities or psychoneurotic and psychotic conditions.

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

Benefits will be provided for services, supplies and other items that are within the scope of the rehabilitation Benefit described in this Rehabilitation Benefit 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 and recovery room;
- i.** Anesthetic and surgical supplies; and
- j.** Drugs and medicines which:
 - 1.** Are approved for use in humans by the FDA;
 - 2.** Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
 - 3.** Require a Physician's written prescription.

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

3. Rehabilitation Facility Inpatient Care Services do not include services, supplies or items for any period during which the Member is absent from the Rehabilitation Facility for purposes not related to rehabilitation, including but not limited to intervening inpatient admissions to an acute care Hospital.

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

Rehabilitation Facility Inpatient Care is subject to the following conditions:

- 1.** The Member will be responsible to the Rehabilitation Facility for payment of the Facility's charges if the Member remains as an Inpatient Member when Rehabilitation Facility Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed "reserved" for a Member.
- 2.** The term "Rehabilitation Facility" does not include:
 - a.** A Hospital when a Member is admitted to a general medical, surgical or specialty floor or unit (other than a rehabilitation unit) for acute Hospital care, even though rehabilitation services are or may be provided as a part of acute care;
 - b.** A nursing home;
 - c.** A rest home;
 - d.** Hospice;
 - e.** A skilled nursing facility;

- f. A Convalescent Home;
- g. A place for care and treatment of Substance Use Disorder;
- h. A place for treatment of Mental Illness; or
- i. A long-term, chronic-care institution or facility providing the type of care listed above.

Rehabilitation Facility Inpatient Care Services Billed by a Professional Provider

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

Outpatient Rehabilitation

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

Routine Foot Care

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

Substance Use Disorder

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

Outpatient Services

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

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

Outpatient services are subject to the following conditions:

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

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

Inpatient Care Services

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

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

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

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

Partial Hospitalization

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

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

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

Surgical Services

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

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

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

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

Surgical Benefits include Oral Surgery for the following:

1. Maxillary or mandibular frenectomy;
2. Alveolectomy when related to tooth extraction;
3. Orthognathic surgery in the presence of severe handicapping malocclusion; and

NOTE: Blue Cross and Blue Shield of Montana must approve this surgery in advance.

4. Surgical services performed on the soft tissue in the mouth when the primary purpose is not to treat or benefit the teeth. For example, periodontal work on the soft tissue supporting the teeth is intended to benefit the teeth and is excluded. Removal of a tumor located in the mouth is not intended to benefit the teeth and would be covered.

Surgical Services Billed by a Hospital (Inpatient and Outpatient)

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

Telehealth

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

Therapies for Down Syndrome

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

1. Habilitative Care or Rehabilitative Care that is prescribed, provided, or ordered by a licensed Physician, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child. Habilitative Care and Rehabilitative Care includes Medically Necessary interactive therapies derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention; and
2. Medically Necessary therapeutic care that is provided by a licensed speech-language pathologist a physical therapist or an occupational therapist. Visit limits do not apply.

When treatment is expected to require extended services, Blue Cross and Blue Shield of Montana may request that the treating Physician provide a treatment plan based on evidence-based screening criteria. The treatment plan will consist of the diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes

stated as goals, and the reasons the treatment is Medically Necessary. Blue Cross and Blue Shield of Montana may request that the treatment plan be updated every 6 Months.

Therapies - Outpatient

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

Transplants

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

Transplant services include:

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

Payment by The Plan is subject to the following conditions:

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

The Plan will not pay for:

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

Prior Authorization is required for Transplants. Please refer to the section entitled Utilization Management.

Well-Child Care

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

Benefits shall include coverage for:

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

COORDINATION OF BENEFITS WITH OTHER INSURANCE

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

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

Definitions

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

Plan

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

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

The term plan does not include:

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

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

This Plan

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

Order of Benefit Determination Rules

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

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

Allowable Expense

A Covered Medical Expense, including Deductibles, 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; or
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 Montana University System Student Insurance Plan. 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; and
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:
 - 1. The plan covering the custodial parent;
 - 2. The plan covering the spouse of the custodial parent;
 - 3. The plan covering the non-custodial parent; and then
 - 4. The plan covering the spouse of the non-custodial parent.

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

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

4. Active Employee or Retired or Laid-off Employee

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

5. COBRA or State Continuation Coverage

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

6. Longer or Shorter Length of Coverage

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

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

Effect on the Benefits of This Plan

When this plan is secondary, it may reduce its Benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary

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

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this plan and other plans. Blue Cross and Blue Shield of Montana may 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.

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; and/or
 - f.** The Member was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

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

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

- 2.** Services, supplies, drugs and devices which the Member is entitled to receive or does receive from TRICARE and the Veteran's Administration (VA), but not Medicaid. This Exclusion is not intended to exclude Covered Medical Expenses from coverage if a Member is a resident of a Montana State institution when 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 the commission of a felony or serious illegal act, or an attempt to commit a felony or a serious illegal act, for which the Member has been found guilty in a court of competent jurisdiction or to which the Member has plead guilty or no contest. This Exclusion does not apply to the extent the Member suffers a loss as a victim of domestic violence;
- 5.** Services for which a Member is not legally required to pay or charges that are made only because Benefits are available under this Member Guide;
- 6.** Services, supplies, drugs and devices provided to the Member before the Member's Effective Date or after the Member's coverage terminates;
- 7.** Nonsurgical treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction, anterior or internal dislocations, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances;
- 8.** Orthodontics;
- 9.** All dental services, including but not limited to ridge augmentation and vestibuloplasty, whether performed by Physicians, dentists, oral surgeons and/or any other provider, except for (a) services provided as the result of a dental Accident; (b) services covered under the Pediatric Dental Care Benefit; (c) services provided as a result of or to treat either a congenital defect or a cancer; or (d) services in connection with a transplant.
- 10.** Vision services, including but not limited to prescription, fitting or provision of eyeglasses or contact lenses and Lasik Surgery, except for services covered under the Pediatric Vision Care Benefit. In addition, vision services may be covered for specific conditions in this Contract;
- 11.** Hearing aids, except that Medically Necessary cochlear implants may be covered per this Contract;
- 12.** Cosmetic services and complications resulting therefrom 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 this Contract;
- 13.** For travel by a Member or provider;
- 14.** Any related services to a non-covered service except for Routine Patient Costs for Members in an Approved Clinical Trial. Related services are:
 - a.** Services in preparation for the non-covered service;
 - b.** Services in connection with providing the non-covered service;
 - c.** Hospitalization required to perform the non-covered service; or
 - d.** Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
- 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; or
 - 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.** Reversal of an elective sterilization;
- 20.** Services, supplies, drugs and devices related to infertility;
- 21.** Services, supplies, drugs and devices related to in vitro fertilization;
- 22.** Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot;
- 23.** Services, supplies, drugs and devices related to treatment for psychological or psychogenic sexual dysfunctions;
- 24.** Services, supplies, drugs and devices relating to any of the following treatments or related procedures:
 - a.** Homeopathy;
 - b.** Hypnotherapy;
 - c.** Rolfing;
 - d.** Holistic medicine;
 - e.** Religious counseling;
 - f.** Self-help programs;
 - g.** Stress management;
 - h.** Biofeedback; or
 - i.** Massage therapy.
- 25.** Services provided by a massage therapist;
- 26.** 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; and
 - 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.

- 27.** Vitamins, except that vitamins may be covered in Medical Policy;
- 28.** Over-the-counter food supplements, formulas, and/or Medical Foods, regardless of how administered except when used for Inborn Errors of Metabolism, except to the extent as required by the Affordable Care Act;

29. Services, supplies, drugs and devices for the surgical treatment of any degree of obesity, whether provided for weight control or any medical condition;
30. Services, supplies, drugs and devices for weight reduction or weight control. This Exclusion does not include intensive behavioral dietary counseling or obesity screening;
31. Services, supplies, drugs and devices for obesity, weight reduction or control whether rendered for weight control or any other condition, except for if Prior Authorization has been obtained and a Benefit of this Member Guide;
32. Charges associated with health clubs, weight loss clubs or clinics;
33. Services, supplies, drugs and devices for the treatment of Illness, Injury and/or complications resulting from services that are not Covered Medical Expenses, except for any services, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial;
34. Tutoring services;
35. Any services, supplies, drugs and devices not provided in or by a Covered Provider;
36. Services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature;
37. Deluxe medical equipment including, but not limited to, durable medical equipment, prosthetics and communication devices except as included in the Durable Medical Equipment Benefit and the Prosthetic Benefit in the section entitled "Benefits";
38. Services, supplies, drugs and devices not provided in a student health center or by a Covered Provider;
39. Services, supplies, drugs and devices provided normally without charge by the Health Center on the campus, or by any person employed or retained by the Member's Health Center, or services provided by the student medical fee;
40. Applied Behavior Analysis (ABA) services, except as specifically included in this Member Guide under Autism Spectrum Disorders;
41. The Plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana; or
42. Services, supplies, drugs and devices which are not listed as a Benefit as described in this Member Guide.

ADDITIONAL BENEFIT

Academic Emergency Services

The following services and Benefits are available to you 24 hours a day, 7 days a week:

Medical Assistance: Pre-travel information; doctor, dentist or ophthalmologist referrals; medical monitoring to ensure adequate care; 24/7 Nurse Help Line; prescription assistance or medicine dispatch.

Emergency Medical Evacuation and Repatriation: Unlimited Benefit for evacuation from inadequate facility to closest adequate facility, repatriation home for continued care or recovery and repatriation of deceased remains.

Accidental Death and Dismemberment: \$25,000 Benefit.

Emergency Family Assistance: Benefits for visit of a family member or friend if hospitalized for 7 or more days, return of children if left unattended, bereavement reunion, emergency return home in the event a Member's family member suffers life threatening illness or death and return of Member's personal belongings in the event of evacuation or death.

Travel, Legal and Security Assistance: Pre-travel destination information or security advice; assistance locating lost luggage; passport replacement assistance; emergency travel arrangements; translation assistance; interpreter referral; legal consultation and referral; emergency message forwarding.

NOTE: The Academic Emergency Services Benefit is administered by an independent company not Affiliated with Blue Cross and Blue Shield of Montana. Contact Customer Service at the telephone number listed on the inside cover of this document.

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 no later than 12 Months after the date on which the 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.
2. 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 Drugs Benefit. Prime Therapeutics is the Pharmacy Benefit Manager.

1. Go to a Prime Therapeutics Participating Pharmacy or a Participating Pharmacy that accepts Member identification cards. To find a Prime Therapeutics Participating Pharmacy or a Participating Pharmacy nearest the Member, check the list on the website www.bcbsmt.com or call the Pharmacy locator at the telephone number on the inside cover of this document.
2. Present the prescription and the Member's identification card to the pharmacist.
3. Make sure that the pharmacist has complete and correct information about the Member for whom the prescription is written, including sex and date of birth.
4. When the Member receives a prescription, he or she should sign the pharmacy log and pay his or her share of the cost.
5. If a Member purchases prescription drugs from a participating Pharmacy or mail-service Pharmacy approved by The Plan, the Member must pay for the Prescription Drug Product and the Pharmacy will submit the prescription drug claims to Pharmacy Benefit Manager.
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 Drug is available.
7. The Plan makes use of a Drug List, which is a list of covered prescription drugs for dispensing to Members as appropriate.
8. For prescriptions filled at a Pharmacy that is not part of the network, the Member will need to pay the entire cost of the prescription at the time the prescription is filled and dispensed and submit a paper claim to the Pharmacy Benefit Manager for reimbursement. The Member will be reimbursed for the prescription drug at 60% of the amount that would have been paid to a Participating Pharmacy less any Out-of-Network Deductible, Copayment and/or Coinsurance. The Member will not receive the preferred pricing.
9. Prescriptions filled at Hospital pharmacies are not eligible for reimbursement unless they are listed as a network Pharmacy.

Pharmacy Benefit Manager claim forms are available by calling The Plan at the telephone number on the inside cover of this document.

Mail-Service Pharmacy

The Member may obtain maintenance prescriptions through the mail. Maintenance prescriptions are those that the Member expects to continue using for an extended period of time and for which a prescription can be written for up to a 90-day supply. Coverage for costly prescriptions should be verified prior to ordering. Specific Benefits are outlined in the Prescription Drugs section in this document.

To obtain a mail service claim form, call The Plan at the telephone number on the inside cover of this document.

To order a prescription:

1. Complete all sections and sign the Mail-Service order form.
2. Enclose the following:
 - a. The original prescription written for 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.

GENERAL PROVISIONS

Modification of Member Guide

The Plan may make administrative changes or changes in dues, terms or Benefits in the Montana University System Student Insurance Plan by giving written notice to the Montana University System Student Insurance Plan 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 Member Guide 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 this Member Guide. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits will be made. Clerical errors shall not prevent administration of the Member Guide in strict accordance with its terms.

Notices Under Contract

Any notice required by the Contract may be given by United States mail, postage paid. Notice to the 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 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 Member listed on the subscriber application for membership and accepted by The Plan, is entitled to Benefits under the 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. The Plan will provide at least 30 days advance written notice to the subscriber before coverage may be rescinded.

Validity of Contract

If any part, term, or provision of the 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 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 this Member Guide 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 Contract is not assignable by the Member to any third party. Payment made by The Plan shall satisfy any further obligation of The Plan.

Conformity with Montana Statutes

The provisions of this Member Guide conform to the minimum requirements of Montana law and have control over any conflicting statutes of any state in which the insured resides or may receive health services on or after the Effective Date of this Member Guide.

Forms for Proof of Loss

The Plan shall furnish, upon request of a Member, forms for filing proof of loss. If forms are not furnished within 15 days after the Member provided notice of sickness or Injury to The Plan, the Member is considered to have complied with the requirements of the Contract as to proof of loss upon submitting, with the time established in the Contract for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proofs of Loss

Written proof of loss must be furnished to The Plan at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which The Plan is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

Legal Actions

No action at law or inequity shall be brought to recover on this Member Guide prior to the expiration of 60 days after written Proof of Loss has been furnished in accordance with the requirements of this Member Guide. No such action shall be brought after the expiration of three years after the written Proof of Loss is required to be furnished.

Time of Payment of Claims

The Plan will pay or deny a claim within 30 days after receipt of a Proof of Loss unless The Plan makes a reasonable request for additional information or documents in order to evaluate the claim. If The Plan makes a reasonable request for additional information or documents, The Plan shall pay or deny the claim within 60 days of receiving the Proof of Loss unless The Plan has notified the Member, the Member's authorized representative, or the claimant of the reasons for failure to pay the claim in full or unless The Plan has a reasonable belief that insurance fraud has been committed and The Plan has reported the possible insurance fraud to the Commissioner of Insurance. This section does not eliminate a Plan's right to conduct a thorough investigation of all the facts necessary to determine payment of a claim.

If The Plan fails to comply with this section and The Plan is liable for payment of the claim, The Plan shall pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after The Plan's receipt of the Proof of Loss or 60 days after receipt of the Proof of Loss if The Plan made a reasonable request for information or documents. Interest payments must be made to the person who receives the claims payment. Interest is payable under this subsection only if the amount of interest due on a claim exceeds \$5.

Physical Examinations

The Plan, at its own expense, shall have the right and opportunity to examine the person of a Member when and as often as it may reasonably require during the pending of a claim and also the right and opportunity to make an autopsy in case of death when it is not prohibited by law.

Members Rights

Members have only those rights as specifically provided in this Member Guide. In addition, when requested by the insured or the insured's agent, Montana law requires The Plan to provide a summary of a Member's coverage for a specific health care service or Course of Treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or Hospital exceeds \$500.

Alternate Care

The Plan may make payment for services which are not listed as a Benefit of this Member Guide 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.

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 this Member Guide.

Pilot Programs

The Plan reserves the right to develop and enter into pilot programs under which health care services not normally covered under this Contract will be paid. The existence of a pilot program does not guarantee any Member the right to participate in the pilot program or that the pilot program will be permanent. A pilot program is an initial small-scale implementation that is used to prove the variability of a project idea. This could involve either the exploration of a novel new approach or idea or the application of a standard approach new to the organization. It enables an organization to manage the risk of a new idea and identify any deficiencies before substantial resources are committed. BCBSMT will submit and obtain approval from the Commissioner of Securities and Insurance for any pilot program prior to its offering to Members.

Subrogation

1. To the extent that Benefits have been provided or paid under this Member Guide, 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 this Member Guide.
3. If the Member intends to institute an action for damages against a third party, the Member will give The Plan reasonable notice of intention to institute the action. Reasonable notice will include information reasonably calculated to inform The Plan of facts giving rise to the third party action.
4. The Member may request that The Plan pay a proportional share of the reasonable costs of the third-party action, including attorney fees. If The Plan elects not to participate in the cost of the action, The Plan waives 50 percent of its subrogation interest.
5. The right of subrogation may not be enforced until the Member has been completely compensated for the injuries.

Statements are Representations

All statements and descriptions in any application shall be considered representations and not warranties. 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.

Right to Audit

The Plan reserves the right to audit the eligibility records to determine whether all students 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 Montana University System Student Insurance Plan, on behalf of itself and its students, hereby expressly acknowledges its understanding that this Member Guide constitutes a contract solely between the Montana University System Student Insurance Plan 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 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 Montana University System Student Insurance Plan further acknowledges and agrees that it has not entered into the 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 Montana University System Student Insurance Plan for any of The Plan's obligations to the Montana University System Student Insurance Plan created under the 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 Contract.

Federal Balance Billing and Other Protections

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Montana law, if there is a conflict between the terms of this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section and the terms in the rest of this Contract, the terms of this section will apply. However, definitions set forth in the **FEDERAL NO SURPRISES ACT DEFINITIONS** provision of this section are for purposes of covered services under this section only.

- **Continuity of Care**

If the Member is under the care of an In-Network provider as defined in this Contract, who ceases participating in The Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), the Member may be able to continue coverage for that provider's covered services at the In-Network Benefit level if one of the following conditions is met:

1. The Member is undergoing a course of treatment for a serious and complex condition;
2. The Member is undergoing institutional or Inpatient Care;
3. The Member is scheduled to undergo nonelective surgery from the provider (including receipt of postoperative care from such provider or facility with respect to such surgery);
4. The Member is pregnant or undergoing a course of treatment for their pregnancy; or
5. The Member is, or was, determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if the Member is currently receiving Chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), or (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies the Member of the provider's termination, or any longer period provided by state law. If the Member is in the second or third trimester of pregnancy when the provider's termination takes effect, continuity of coverage may be extended through the postpartum period. The Member has the right to appeal any decision made for a request for Benefits under this provision, as explained in the **APPEALS** section of this Contract.

- **Federal No Surprises Act Definitions**

The definitions below apply only to this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section. To the extent the same terms are also defined in the **DEFINITIONS** section in this Contract, those terms will apply only to their use in this Contract, or this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section, respectively.

"Air Ambulance Services" means, for purposes of this section only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this section only, a medical condition, including a mental health condition or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this section only;

1. A medical screening examination performed in the emergency department of a Hospital or a freestanding emergency department;
2. Further medical examination or treatment the Member receives at a Hospital, regardless of the department of the Hospital, or a freestanding emergency department to evaluate and treat an Emergency Medical Condition until the Member's condition is stabilized; and
3. Covered services the Member receives from a Non-Participating Provider during the same visit after the Member's Emergency Medical Condition has stabilized unless:
 - a. The Member's Non-Participating Provider determines the Member can travel by non-medical or nonemergency transport;
 - b. The Member's Non-Participating Provider has provided the Member with a notice to consent form for balance billing of services; and
 - c. The Member has provided informed consent for additional post stabilization care and services.

"Non-Participating Provider" means, for purposes of this section only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with BCBSMT for furnishing such item or service under The Plan.

"Non-Participating Emergency Facility" means, for purposes of this section only, with respect to a covered item or service, an emergency department of a Hospital or an independent freestanding emergency department that does not have a direct or indirect contractual relationship with BCBSMT for furnishing such item or service under The Plan.

"Participating Provider" means, for purposes of this section only, with respect to a covered service, a facility, Physician or other health care provider who has a contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Member) for furnishing such item or service under The Plan, regardless of whether the provider is considered a preferred or In-Network provider for purposes of In-Network or Out-of-Network Benefits under The Plan.

"Participating Facility" means, for purposes of this section only, with respect to covered service, a Hospital, Hospital outpatient department, critical access Hospital, ambulatory surgical center or any other facility as otherwise required by law, that has a direct or indirect contractual relationship with BCBSMT setting a rate (above which the provider cannot bill the Member) for furnishing such item or service under The Plan, regardless of whether the provider is considered a preferred or In-Network provider for purposes of In-Network or Out-of-Network Benefits under The Plan.

"Qualifying Payment Amount" means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

“Recognized Amount” means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

“Visit” includes, for purposes of this section only, covered items and services provided as part of nonemergency services furnished by a Non-Participating Provider, regardless of whether the Non-Participating Provider is present at a Participating Facility when furnishing the covered items or services.

- **Federal No Surprises Act Surprise Billing Protections**

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections (“Included Services”) are listed below.

1. Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
2. Covered nonemergency services performed by a Non-Participating Provider at a Participating Facility (unless the Member gives written consent and gives up balance billing protections).
3. Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

- **Claims Payments**

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the provider.

- **Cost-Sharing**

For nonemergency services performed by Non-Participating Providers during the Member’s visit at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate the Member’s cost-share requirements, including Deductibles, Copayments, and/or Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate the Member’s cost-share requirements, including Deductibles, Copayments, and/or Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward the Member’s In-Network Deductible and/or Out of Pocket Amount, if any.

- **Federal No Surprises Act Prohibition of Balance Billing**

The Member is protected from balance billing on Included Services as set forth below.

If the Member receives Emergency Services from a Non-Participating Provider or Non-Participating Emergency Facility, the most the Non-Participating Provider or Non-Participating Emergency Facility may bill the Member is the In-Network cost-share. The Member cannot be balance billed for these Emergency Services unless the Member gives written consent for services once their Emergency Medical Condition has stabilized and gives up their protections not to be balanced billed for services received after they are in a stable condition.

When the Member receives covered nonemergency services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill the Member is The Plan’s In-Network cost-share requirements. When the Member receives emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, or other items and services as otherwise required by law at a Participating Facility, or if the Member receives services from a Non-Participating Provider if there is no Participating Provider who can furnish such service at that Participating Facility, Non-Participating Providers can’t balance bill the Member and may not ask the Member to give up their protections not to be balance billed. If the Member receives other services at Participating Facilities, Non-Participating Providers can’t balance bill the Member unless they give written consent and give up their protections.

If The Plan includes Air Ambulance Services as a covered service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill the Member is the In-Network cost-share. The Member cannot be balance billed for these Air Ambulance Services.

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 or laceration;
4. Contusion;
5. Embedded foreign body;
6. Burns; and
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;
2. Diagnosis-related group (DRG) methodology is a system used to classify Hospital cases into one of approximately 500 to 900 groups that are expected to have similar Hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of Hospital resources for the given DRG regardless of the actual Hospital resources used. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating provider under the DRG system can be considerably less than the nonparticipating providers’ billed charge;
3. Billed charge is the amount billed by the provider;
4. Case rate methodology is an all-inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the case rate system can be considerably less than the nonparticipating providers’ billed charge;

5. Per diem methodology is an all-inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the per diem system can be considerably less than the nonparticipating providers' billed charge;
6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating provider under the flat fee per category of service system can be considerably less than the nonparticipating providers' billed charge;
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;
8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges;
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;
10. The amount negotiated with the Pharmacy Benefit Manager or manufacturer or the actual price for prescription or drugs;
11. The American Society of Anesthesiologists' Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a "work unit." The payment value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the system can be considerably less than the nonparticipating providers' billed charge;
12. For nonparticipating providers in Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for nonparticipating providers will represent an average contract rate for Participating Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. Blue Cross and Blue Shield of Montana will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by nonparticipating providers which may also alter the Allowable Fee for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by The Plan within 90 days after the Effective Date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor; or

13. For nonparticipating providers outside Montana, (unless otherwise required by applicable law or arrangement with the nonparticipating provider) the Allowable Fee (i) for professional providers is based on publicly available data and historic reimbursement to providers for the same or similar professional services, adjusted for geographic differences where applicable, or (ii) for Hospital or other facility providers is based on publicly available data reflecting the approximate cost that Hospitals or other facilities have incurred historically to provide the same or similar service, adjusted for geographic differences where applicable, plus a margin factor for the Hospital or facility.

In the event the nonparticipating Allowable Fee does not equate to the nonparticipating provider's billed charges, the Member will be responsible for the difference, along with any applicable 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 the Member's identification card.

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

ALLOWABLE FEE (Dental Services)

The amount determined by The Plan as the maximum amount eligible for payment of Benefits. A participating Dentist agrees to accept payment of the Allowable Fee from The Plan for covered Dental Services, together with any Deductible, 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.

AMPLIFICATION DEVICE

A hearing device, hearing aid, or a wearable, non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold, batteries, and cords.

APPLIED BEHAVIOR ANALYSIS (ABA) – (ALSO KNOWN AS LOVAAS THERAPY)

Medically Necessary interactive therapies or treatment derived from evidence-based research. The goal of ABA is to improve socially significant behaviors to a meaningful degree, including:

1. Increase desired behaviors or social interaction skills;
2. Teach new functional life, communication, or social, skills;
3. Maintain desired behaviors, such as teaching self-control and self-monitoring procedures;
4. Appropriate transfer of behavior from one situation or response to another;
5. Restrict or narrow conditions under which interfering behaviors occur; and
6. Reduce interfering behaviors such as self-Injury.

ABA therapy and treatment includes Pivotal Response Training, Intensive Intervention Programs, and Early Intensive Behavioral Intervention, and the terms are often used interchangeably. The ABA Benefit also includes Discrete Trial Training, a single cycle of behaviorally based instruction routine that is a companion treatment with ABA.

Services must be provided by an appropriately certified provider.

APPROVED CLINICAL TRIAL

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV, clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition. The trial must be:

1. Conducted under an investigational new drug application reviewed by the FDA;
2. Exempt from an investigational new drug application; and
3. Approved or funded by:
 - a. The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
 - b. A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
 - c. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
 - d. The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and provide unbiased scientific review by individuals who have no interest in the outcome of the review.

BENEFIT(S)

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

BENEFIT PERIOD

For the Member Guide - Is the period of time shown in the Schedule of Benefits.

For the Member - Is the same as for the Member Guide except if the Member's Effective Date is after the Effective Date of the Member Guide, the Benefit Period begins on the Member's Effective Date and ends on the same date the Member Guide Benefit Period ends. Thus, the Member's Benefit Period may be less than 12 Months.

BEST EVIDENCE

Means evidence based on:

1. Randomized Clinical Trials;
2. A Cohort Study or Case-Control Study, if Randomized Clinical Trials are not available;
3. A Case Series, if Randomized Clinical Trials, Cohort Studies or Case-Control Studies are unavailable; and/or
4. An Expert Opinion if Randomized Clinical Trials, Cohort Studies, Case-Control Studies or Case Series are unavailable.

BLUE CROSS AND BLUE SHIELD OF MONTANA SPECIALTY NETWORK

Specialty Pharmacy providers who have entered into an agreement with The Plan or a third party on behalf of The Plan to provide Specialty Medications to Members and which have agreed to accept specified reimbursement rates.

BRAND-NAME DRUG

A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand-Name Drug. There may also be situations where a drug's classification changes from Generic Drug to Brand-Name Drug 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 the Member's payment obligations from Generic Drug to Brand-Name Drug.

CARE MANAGEMENT

A process that assesses and evaluates options and services required to meet the Member's health care needs. Care Management may involve a team of health care professionals, including Covered Providers, The Plan and other resources to work with the Member to promote quality, cost-effective care.

CASE-CONTROL STUDY

A retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

CASE SERIES

An evaluation of a series of patients with a particular outcome, without the use of a control group.

CLINICAL PEER

A Physician or other health care provider who:

1. Holds a nonrestricted license in a state of the United States; and
2. Is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

COHORT STUDY

A prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

COINSURANCE

The percentage of the Allowable Fee payable by the Member for Covered Medical Expenses or Dental Services. The applicable Coinsurance for In-Network Covered Medical Expenses or Dental Services and Out-of-Network Covered Medical Expenses or Dental Services is stated in the Schedule of Benefits.

COMPOUNDED DRUGS

Drugs or inert ingredients that have been measured and mixed by a pharmacist to produce a unique formulation because commercial products either do not exist or do not exist in the prescribed dosage, size, or form.

CONCURRENT CARE

1. 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
2. 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.

CONVALESCENT HOME

An institution, or distinct part thereof, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is:

1. A skilled nursing facility;
2. An extended care facility;
3. An extended care unit; or
4. A transitional care unit.

A Convalescent Home is primarily engaged in providing continuous nursing care by or under the direction and supervision of a registered nurse for sick or injured persons during the convalescent stage of their Illness or Injuries and is not, other than incidentally, a rest home or home for Custodial Care, or for the aged.

NOTE: A Convalescent Home shall not include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and treatment of Mental Illness or Substance Use Disorder.

COPAYMENT

The specific dollar amount payable by the Member for Covered Medical Expenses. The applicable Copayments are stated in the Schedule of Benefits.

COSMETIC

Services that are provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical function are considered to be cosmetic.

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 this Member Guide;
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, chiropractors, psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, acupuncturists, physical therapists, speech-language pathologists, licensed addiction counselors, Hospitals and Freestanding Surgical Facilities.

CREDITABLE COVERAGE

Coverage that the Member had for medical Benefits under any of the following plans, programs, and coverages:

1. A group health plan;
2. Health insurance coverage;
3. Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4 (Medicare);
4. Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s (Medicaid);
5. Title 10, chapter 55, United States Code (TRICARE);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A health plan offered under Title 5, chapter 89, of the United States Code (Federal Employee Health Benefits Program);
8. A public health plan;
9. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e); or
10. A high-risk pool in any state.

Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits.

CUSTODIAL CARE

Any service, primarily for personal comfort or convenience, that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the Member's condition. Custodial Care services also means those services which do not require the technical skills, professional training, and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable nonprofessional personnel, are to assist with Routine medical needs (e.g., simple care and dressings, administration of Routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

DEDUCTIBLE

The dollar amount each Member must pay for In-Network Covered Medical Expenses and Out-of-Network Covered Medical Expenses incurred during the Benefit Period before The Plan will make payment for any Covered Medical Expense 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 and the insulin Copayment are applied to the Deductible. Thus, Coinsurance and/or Copayment, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Member's responsibility.

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.

DIAGNOSTIC BREAST EXAMINATION

A Medically Necessary and clinically appropriate examination of the breast, including diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound, that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

DRUG LIST

A list of all drugs that may be covered under the Prescription Drugs section of this Member Guide. A current list is available on The Plan's website at www.bcbsmt.com/member/prescription-drug-plan-information/drug-lists. Contact a Customer Service Representative at the telephone number shown on the back of the Member's identification card for more information.

EFFECTIVE DATE

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

1. Has met the requirements of The Plan stated in this Member Guide; and
2. Is shown on the records of The Plan to be eligible to receive Benefits.

For the Member Guide - the Effective Date of the Member Guide is the date shown on the face of this Member Guide.

For any endorsement, rider, or amendment - the Effective Date is the date shown on the Member Guide unless otherwise shown on the endorsement, rider and amendment.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another Hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn fetus.

EMERGENCY SERVICES

Health care items or services or furnished or required to evaluate and treat an Emergency Medical Condition.

ENROLLMENT DATE

The first day of coverage.

EVIDENCE-BASED STANDARD

The conscientious, explicit, and judicious use of the current Best Evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

EXCLUSION

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

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device, biological product or medical treatment or procedure is Experimental, Investigational and/or Unproven if **The Plan determines** that:

1. The drug, device, biological product or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product or medical treatment or procedure is furnished;
2. The drug, device, biological product or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials, or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
3. The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Approval by a governmental or regulatory agency will be taken into consideration in assessing the Experimental/Investigational/Unproven status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

EXPERT OPINION

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

FREESTANDING INPATIENT FACILITY

For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorder in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment Center. Services include medical evaluation and health supervision; Substance Use Disorder education; organized individual, group and family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up program after discharge.

For treatment of Mental Illness, it means a facility licensed by the state and specializing in the treatment of Mental Illness.

GENERIC DRUG

A drug that has the same active ingredient as a Brand-Name Drug and is allowed to be produced after the Brand-Name Drug's patent has expired. In determining the brand or generic classification for covered drugs, Blue Cross and Blue Shield of Montana uses the generic/brand status assigned by a nationally recognized provider of drug product database information. Not all drugs identified as a "generic" by the drug product database, manufacturer, Pharmacy or Physician may process as a Generic Drug. Generic Drugs are listed on the Drug List which is available on the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/rx-drugs/drug-lists/drug-lists. The Member may also contact Customer Service for more information.

HABILITATIVE CARE

Coverage will be provided for Habilitative Care services when the Member requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Other services for people with disabilities.

These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician.

HOME HEALTH AGENCY

An agency licensed by the state which provides home health care to Members in the Member's home.

HOME HEALTH AIDE

A nonprofessional worker who has been trained for home care of the sick and is employed by a Home Health Agency.

HOME INFUSION THERAPY AGENCY

A health care provider that provides home infusion therapy services.

HOSPITAL

A facility providing, by or under the supervision of licensed Physicians, services for medical diagnosis, treatment, rehabilitation and care of injured, disabled, or sick individuals. A Hospital has an organized medical staff that is on call and available within 20 minutes, 24-hours a day, 7 days a week and provides 24-hour nursing care by licensed registered nurses. Hospital does not include the following, even if such facilities are associated with a Hospital:

1. A nursing home;
2. A rest home;
3. A Convalescent Home; or
4. A long-term, chronic-care institution or facility providing the type of care listed above.

IATROGENIC INFERTILITY

An impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

ILLNESS

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

IN HOME HEALTH ASSESSMENT

Covered services may include, but are not limited to, health history, blood pressure and blood sugar level screening. The assessment is designed to provide the Member with information regarding their health that can be discussed with the Member's health care provider, and is not a substitute for diagnosis, management and treatment by the Member's health care provider.

IN-NETWORK

Providers who are:

1. Participating Blue Cross and Blue Shield of Montana Professional Providers;
2. Participating Blue Cross and Blue Shield of Montana Facility Providers, except for Hospitals and surgery centers;
3. PPO Hospitals and surgery centers; or
4. Blue Cross and/or Blue Shield PPO providers outside of Montana.

INCLUSIVE SERVICES/PROCEDURES

A portion of a service or procedure which is necessary for completion of the service or procedure or a service or procedure which is already described or considered to be part of another service or procedure.

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; and/or
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 FDA; and
 - g. Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6. Any other Medical or Scientific Evidence that is comparable to the sources listed in subsection 4 or 5.

MEDICAL POLICY

The policy of The Plan which is used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

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

MEDICALLY NECESSARY (FOR AUTISM, ASPERGER'S DISORDER AND PERVASIVE DEVELOPMENTAL DISORDER)

Any care, treatment, intervention, service, or item that is prescribed, provided or ordered by a Physician or psychologist and that will or is reasonably expected to:

1. Prevent the onset of an illness, condition, injury, or disability;
2. Reduce or improve the physical, mental, or developmental effects of an illness, condition, or injury, or disability; or
3. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

MEDICALLY NECESSARY (FOR DOWN SYNDROME)

Any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician licensed in this state and that will or is reasonably expected to:

1. Reduce or improve the physical, mental, or developmental effects of Down syndrome; or
2. Assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors.

The fact that services were recommended or performed by a Covered Provider does not automatically make the services Medically Necessary. The decision as to whether the services were Medically Necessary can be made only after the Member receives the services, supplies, or medications and a claim is submitted to The Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MEMBER

The student who has applied for, been accepted as a Member, and maintains membership in The Plan under the terms of this Member Guide.

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 Member if the Member is receiving hospice care.

MENTAL HEALTH TREATMENT CENTER

A treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider. The facility must be:

1. Licensed as a Mental Health Treatment Center by the state;
2. Funded or eligible for funding under federal or state law; or
3. Affiliated with a Hospital under a contractual agreement with an established system for patient referral.

MENTAL ILLNESS

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

1. Present distress or a painful symptom;
2. A disability or impairment in one or more areas of functioning; or
3. A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental Illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

Mental Illness does not include:

1. Developmental disorders;
2. Speech disorders;
3. Psychoactive Substance Use Disorders;
4. Eating disorders (except for bulimia and anorexia nervosa); or

5. Impulse control disorders (except for intermittent explosive disorder and trichotillomania).

MONTH

For the purposes of this Member Guide, a Month has 30 days even if the actual calendar Month is longer or shorter.

MULTIDISCIPLINARY TEAM

A group of health service providers who are either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. Members of the Multidisciplinary Team may include, but are not limited to, a licensed psychologist, licensed speech therapist, registered physical therapist, or licensed occupational therapist.

NON-PREFERRED BRAND-NAME DRUG

A Brand-Name Drug that is identified on the Drug List as a Non-Preferred Brand-Name Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

NON-PREFERRED GENERIC DRUG

A Generic Drug that is identified on the Drug List as a Non-Preferred Generic Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

NON-PREFERRED SPECIALTY MEDICATION

A Specialty Drug, which may be a Generic Drug or Brand-Name Drug, that is identified on the Drug List as a Non-Preferred Specialty Medication. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

OCCUPATIONAL THERAPY

Therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of speech tasks or goal-directed activities designed to improve the functional performance of an individual.

ORTHOPEDIC DEVICES

Rigid or semirigid supportive devices which restrict or eliminate motion of a weak or diseased body part. Orthopedic Devices are limited to braces, corsets and trusses.

OUT-OF-NETWORK

Providers who are:

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

OUT OF POCKET AMOUNT

For the Member:

The total amount of In-Network Deductible and applicable Coinsurance and/or Copayment and the Out-of-Network Deductible and applicable Coinsurance and/or Copayment 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 and applicable Coinsurance and/or Copayment for Covered Medical Expenses for the remainder of that Benefit Period. The Out of Pocket Amount for the Member is listed in the Schedule of Benefits. 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 and Coinsurance 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 or Coinsurance will be applied to that stay.

Non-covered services, the amount the Member pays for the difference between a Brand-Name Drug and the generic-Drug equivalent, the nonparticipating Pharmacy 60% Benefit reduction and amounts over the allowed amount billed by

a nonparticipating provider, do not accumulate to the Out of Pocket Amount and are the Member's responsibility.

OUTPATIENT

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

PARTIAL HOSPITALIZATION

A time-limited ambulatory (Outpatient) program offering active treatment, which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

A Partial Hospitalization program should offer four to eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA FACILITY PROVIDER

A facility which has a contract with Blue Cross and Blue Shield of Montana and may include, but are not limited to, Hospitals, Home Health Agencies, Convalescent Homes, skilled nursing facilities, Freestanding Inpatient Facilities and freestanding surgical facilities. Please read the section entitled Providers of Care for Members.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA PROFESSIONAL PROVIDER

A provider who has a contract with Blue Cross and Blue Shield of Montana and may include, but are not limited to, Physicians, Physician assistants, nurse specialists, dentists, podiatrists, speech therapists, physical therapists and occupational therapists. Please read the section entitled Providers of Care for Members.

PARTICIPATING PHARMACY

A Pharmacy which has entered into an agreement with The Plan or a third party on behalf of The Plan to provide Prescription Drug Products to Members and has agreed to accept specified reimbursement rates.

PARTICIPATING PROVIDER

A Participating Blue Cross and Blue Shield of Montana Professional Provider or a Participating Blue Cross and Blue Shield of Montana Facility Provider.

PHARMACY

A state and federally licensed establishment that is physically separate and apart from any provider's office, and where legend drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he or she practices.

PHARMACY BENEFIT MANAGER

The company with whom The Plan has entered into an agreement for the processing of prescription drug claims.

PHYSICAL THERAPY

Treatment of disease or Injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and pain relief.

PHYSICIAN

A person licensed to practice medicine in the state where the service is provided.

PLAN - THE PLAN

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

PPO - A PREFERRED PROVIDER ORGANIZATION

A provider or group of providers which have contracted with The Plan to provide services to Members covered under PPO Benefit contracts.

PPO NETWORK

A provider or group of providers which have a PPO contract with Blue Cross and Blue Shield of Montana. The Member may obtain a list of PPO providers from Blue Cross and 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.

PREFERRED BRAND-NAME DRUG

A Brand-Name Drug that is identified on the Drug List as a Preferred Brand-Name Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PREFERRED GENERIC DRUG

A Generic Drug that is identified on the Drug List as a Preferred Generic Drug. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PREFERRED SPECIALTY MEDICATION

Specialty Medication, which may be a Generic Drug or Brand-Name Drug, that is identified on the Drug List as a Preferred Specialty Medication. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com/rx-drugs/drug-lists/drug-lists.

PRESCRIPTION DRUG PRODUCT

A medication, product or device approved by the FDA.

PRIOR AUTHORIZATION

The process that determines in advance the Medical Necessity or Experimental, Investigational and/or Unproven nature of certain care and services under the Contract. Prior Authorization is used to inform the Member whether or not a proposed service, medication, supply, or on-going treatment is Medically Necessary and is a Covered Medical Expense of the Contract.

Prior Authorization does not guarantee that the care and services a Member receives are eligible for Benefits under the Contract. At the time the Member's claims are submitted, they will be reviewed in accordance with the terms of the Contract.

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 Telehealth.

PROOF OF LOSS

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

QUALIFIED HEALTH CARE PROVIDER

A person licensed as a Physician, psychologist, social worker, clinical professional counselor, marriage and family therapist, or addiction counselor or another appropriate licensed health care practitioner.

QUALIFIED INDIVIDUAL (FOR AN APPROVED CLINICAL TRIAL)

An individual with group health coverage or group or individual health insurance coverage who is eligible to participate in an Approved Clinical Trial according to the trial protocol for the treatment of cancer or other Life-Threatening Condition because:

1. The referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate; or
2. The individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

RANDOMIZED CLINICAL TRIAL

A controlled, prospective study of patients who have been assigned at random to an experimental group or a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention. The term includes a study of the groups for variables and anticipated outcomes over time.

RECOMMENDED CLINICAL REVIEW

An optional voluntary review of a provider's recommended medical procedure, treatment, or test, that does not require Prior Authorization, to make sure it meets approved Blue Cross and Blue Shield of Montana Medical Policy guidelines and Medical Necessity requirements.

RECONSTRUCTIVE BREAST SURGERY

Surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

RECOVERY CARE BED

A bed occupied in an Outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATION FACILITY

A facility, or a designated unit of a facility, licensed, certified or accredited to provide Rehabilitation Therapy including:

1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or a facility associated or co-located with a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital; and/or
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Member, regardless of the category of facility licensure.

REHABILITATION THERAPY

A specialized, intense and comprehensive program of therapies and treatment services (including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy) provided by a Multidisciplinary Team for treatment of an Injury or physical deficit. A Rehabilitation Therapy program is:

1. Provided by a Rehabilitation Facility in an Inpatient Care or Outpatient setting;
2. Provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;
3. Designed to restore the patient's maximum function and independence; and
4. Medically Necessary to improve or restore bodily function and the Member must continue to show measurable progress.

REHABILITATIVE CARE

Coverage will be provided for Rehabilitative Care services when the Member requires help to keep, recover or improve skills and functioning for daily living that have been lost or impaired because the Member was sick, hurt or disabled. These services include, but are not limited to:

1. Physical and Occupational Therapy;
2. Speech-language pathology; and
3. Psychiatric rehabilitation.

These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician.

RESIDENTIAL TREATMENT CENTER

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, 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 Disorder. Requirements: Blue Cross and Blue Shield of Montana requires that any Mental Health 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.

SPECIALTY MEDICATIONS

Specialty Medications are used to treat complex medical conditions and are typically given by injection but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies. Some conditions such as hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with Specialty Medications.

SPECIALTY PHARMACY

A Pharmacy which has entered into an agreement with The Plan or a third party on behalf of The Plan to provide Specialty Medications to Members and which has agreed to accept specified reimbursement rates.

SPEECH THERAPY

The treatment of communication impairment and swallowing disorders.

STANDARD FERTILITY PRESERVATION SERVICES

Procedures consistent with established medical practices and professional guidelines, including those established by the American Society for Reproductive Medicine and the American Society of Clinical Oncology.

SUBSTANCE USE DISORDER

The uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a licensed addiction counselor or other appropriate medical practitioner.

SUBSTANCE USE DISORDER TREATMENT CENTER

A treatment facility that provides a program for the treatment of Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider licensed by the state. The facility must also be licensed or approved as a Substance Use Disorder Treatment Center by the department of health and human services or must be licensed or approved by the state where the facility is located.

SUPPLEMENTAL BREAST EXAMINATION

A Medically Necessary and appropriate examination of the breast, including breast magnetic resonance imaging or breast ultrasound, that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person's risk of breast cancer.

TELEHEALTH

The use of audio, video, or another telecommunications technology or media, including audio-only communication that is:

1. Used by a health care provider or health care facility to deliver health care services; and
2. Delivered over a secure connection that complies with state and federal law.

Telehealth does not include delivery of health care services by means of facsimile machine or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

URGENT CARE

Urgent Care services are considered treatment in any setting that, when delayed, could seriously jeopardize the Member's life and health or ability to regain maximum function or would subject the Member, in the opinion of a health care provider with knowledge of the Member's medical condition, to severe pain that cannot be adequately managed without the service or treatment.

VIRTUAL VISIT

Consultation with a licensed provider through interactive video, or other communication technology allowed by applicable law, via online portal or mobile application.

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.

For additional information regarding these notices, contact:

Blue Cross and Blue Shield of Montana
3645 Alice Street Helena, MT 59601
P.O. Box 660255
Dallas, TX 75266-0255
1-800-447-7828



Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

To receive language or communication assistance free of charge, please call us at 855-710-6984.

Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لنتلقى المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínizingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jí' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.



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