Blue Options℠

An HMO Point-of-Service plan that utilizes a limited provider network for the highest level of benefits.

A health benefit plan approved under the health maintenance organization laws of Montana.

SHODAIR CHILDREN'S HOSPITAL

Plan Document

EMPLOYEE HEALTH BENEFIT PLAN

$350 Deductible Plan
and
Vision Plan

This plan is not grandfathered.

Effective June 1, 2018

BlueCross BlueShield of Montana

MEDICAL BENEFITS

FOR CUSTOMER SERVICE
Call 1-855-258-3489

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

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

www.bcbsmt.com
- BCBSMT Provider Directory
- Wellness
- Other Online Services and Information

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

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

MDLIVE®
1-888-684-4233

FOR PRESCRIPTION DRUG BENEFITS

Pharmacy Benefit Manager (PBM)
- Prime Therapeutics 1-855-258-8471
- For Preauthorizations, fax: 1-877-243-6930

PBM Website www.myprime.com
Claim Forms 1-866-325-5230
Pharmacy Locator 1-866-325-5230
Specialty Care Pharmacy (Prime Therapeutics Specialty Pharmacy LLC) 1-877-627-MEDS (6337)
- www.bcbsmt.com or www.myprime.com
- Prescriber Fax 1-877-828-3939

Mail Order Services
- **AllianceRx Walgreens Prime** 1-877-357-7463
  PO Box 29061
  Phoenix, AZ 85038-9061
- **Ridgeway Mail-Order Pharmacy** 1-800-630-3214
  2824 US Hwy 93 North
  Victor, MT 59875

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

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

HEALTH BENEFIT PLAN FOR EMPLOYEES OF SHODAIR CHILDREN'S HOSPITAL

PLAN OPERATION

Plan Name

Shodair Children's Hospital Employee Health Benefit Plan

Type of Plan

Shodair Children's Hospital maintains the Employee Health Benefit Plan, pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), for the exclusive benefit of and to provide health benefits to its eligible Employees, their legal Spouses, Domestic Partners and eligible Dependents. The Plan provides hospital, medical, surgical and vision coverage for eligible Participants.

Type of Participants Covered by the Plan

Employees, their legal Spouses, Domestic Partners and their eligible dependent children may participate based upon the eligibility requirements set forth in the Plan.

Plan Sponsor

Shodair Children's Hospital
2755 Colonial Drive
PO Box 5539
Helena, MT 59604

Plan Sponsor's Identification Number

81-0231789

Plan Number

501

Plan Effective Date

June 1, 2018

Plan Benefit Year

June 1 through June 30

Plan Year

June 1 through June 30

Plan Administrator

Shodair Children's Hospital
c/o Melissa Moore, Director of Human Resources
2755 Colonial Drive
PO Box 5539
Helena, MT 59604
Phone: 406-444-7506
Fax: 406-444-1035
Email: mmoore@shodair.org

Named Fiduciary(ies)

Shodair Children's Hospital
c/o Melissa Moore, Director of Human Resources
2755 Colonial Drive
PO Box 5539
Helena, MT 59604
Phone: 406-444-7506
Fax: 406-444-1035
Email: mmoore@shodair.org

Type of Administration

The Plan is a self-funded Health Plan established to reimburse Participants for covered medical expenses. The Plan Sponsor contracts with a Claim Administrator to process claims, provide claims payment and provide other claims management functions, under the direction of the Plan Administrator. The Plan reimburses the Claim Administrator after claims are paid.

Claim Administrator

Blue Cross and Blue Shield of Montana
3645 Alice Street
P.O. Box 4309
Helena, MT 59604
1-800-447-7828

Claim Administrator's Disclosures

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

The Plan Sponsor, on behalf of itself and its employees, hereby expressly acknowledges its understanding that the "Agreement" constitutes an agreement solely between the Plan Sponsor and Blue Cross and Blue Shield of Montana, that Blue Cross and Blue Shield of Montana is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, which 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 Health Care Service Corporation to use the Blue Cross and Blue Shield Service Marks in the state of Montana, and that Blue Cross and Blue Shield of Montana is not contracting as the agent of the Association. The Plan Sponsor further acknowledges and agrees that it has not entered into the "Agreement" based upon representations by any person other than Blue Cross and Blue Shield of Montana and that no person, entity, or organization other than Blue Cross and Blue Shield of Montana shall be held accountable or liable to the Plan Sponsor for any of the Blue Cross and Blue Shield of Montana obligations to the Plan Sponsor created under the "Agreement." This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Montana other than those obligations created under the provisions of the "Agreement" with the Plan Sponsor.

Certain Responsibilities of the Employer and the Claim Administrator

Employer responsibility

The Employer retains full and final authority and responsibility for the Plan and its operation. The Claim Administrator is empowered to act on behalf of the Employer in connection with the Plan only as expressly stated in this Plan Document or as mutually agreed to in writing by the parties hereto.

Claim Administrator responsibility

The Claim Administrator shall have no responsibility for or liability with respect to the compliance or non - compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and the Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including but not limited to local, state or federal taxes, penalties, surcharges or other fees or amounts regardless of whether payable directly by the Employer or by or through the Claim Administrator; provided, however, the Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to the Claim Administrator in connection with the performance of its obligations under this Agreement.

Relationship of Parties

The Claim Administrator is an independent contractor with respect to the Employer. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venture nor employee of the other. Further, nothing in this Plan Document shall create or be construed to create the relationship of employer and employee between the Claim Administrator and the Employer; nor shall the Employer's agents, officers or employees be considered or construed to be considered employees of the Claim Administrator for any purpose whatsoever.

ERISA

In relation to the Plan

The Employer hereby acknowledges (i) that an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee welfare benefit plan document of the Employer, the Employer agrees that no allocation or delegation of any fiduciary or non–fiduciary responsibilities under the Plan or any other employee welfare benefit plan of the Employer is effective with respect to or accepted by the Claim Administrator.

In relation to the Plan Administrator/Named Fiduciary(ies)

The Claim Administrator is not the plan administrator of the Employer's separate employee welfare benefit plan as defined under ERISA. It is understood and agreed that (i) the Employer has a named Plan Administrator and a Named Fiduciary within the meaning of § 414(g) of the Internal Revenue Code of 1986, as amended; (ii) said Plan Administrator serves within the meaning of § 3(16)(A) of ERISA; and (iii) the Claim Administrator is not a fiduciary of the Employer, the Plan Administrator or of the Plan.

In relation to the Claim Administrator's responsibilities

The Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of the Employer's plan. As such, the Claim Administrator is intended to be a service provider but not a fiduciary with respect to the Employer's ERISA employee welfare benefit plan. The Employer represents that its ERISA employee welfare benefit plan contains the plan procedure described above regarding the designation of responsibilities under a plan and, accordingly, the Claim Administrator may, pursuant to Sections 402(c)(2) and 405(c)(1)(B) of ERISA, render advice with respect to claims and administer claims on behalf of the plan administrator of the Employer's ERISA welfare benefit plan. The Claim Administrator has no other authority or responsibility with respect to Employer's ERISA employee welfare benefit plan.

Funding Mechanism

Benefits under this Plan are funded from Employee and Employer contributions up to the benefit limits defined in the Plan Document. Payments are made from this fund to pay benefits.

Source of Contribution

Contributions for Employees and covered family members are paid in part by the Plan Sponsor out of its general assets and in part by Employees.

Agent for Service of Legal Process

The Plan Administrator has authority to control and manage the Plan and the agent for service of legal process is:

Amy Christensen
Christensen & Prezeau, PLLP
314 N Last Chance Gulch
Helena, MT 59601

Amendment, Termination, or Modification of the Plan

The Plan Administrator reserves the right to amend, modify or terminate the Plan in whole or in part at any time.

Expenses incurred prior to the effective date of any amendment are based on the provisions in effect at the time the expenses were incurred.

Plan Coverage Status

This Plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act (The Affordable Care Act).

STATEMENT OF ERISA RIGHTS

As a Participant in the Shodair Children's Hospital Employee Health Benefit Plan, the Participant is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and beneficiaries. No one, including the Plan Participant's Employer, union, or any other person, may fire the Employee or otherwise discriminate against any Plan Participant in any way to prevent the Plan Participant from obtaining a welfare benefit or exercising the Plan Participant's rights under ERISA.

If the Plan Participant's claim for a welfare benefit is denied, in whole or in part, the Plan Participant must receive a written explanation of the reason for the denial. The Plan Participant has the right to have the Plan review and reconsider the claim.

Under ERISA, there are steps the Plan Participant can take to enforce the above rights. For instance, if the Plan Participant requests materials from the Plan and does not receive them within thirty (30) days, the Plan Participant may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Plan Participant up to $110 a day until the Plan Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If the Plan Participant has a claim for Benefits which is denied or ignored, in whole or in part, the Plan Participant may file suit in a state or federal court. In addition, if the Plan Participant disagrees with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the Plan Participant may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if the Plan Participant is discriminated against for asserting his or her rights, the Plan Participant may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If the Plan Participant is successful, the court may order the person the Plan Participant sued to pay these court costs and fees. If the Plan Participant loses, the court may order the Plan Participant to pay these costs and fees, for example, if it finds the Plan Participant's claim is frivolous.

If the Plan Participant has any questions about his or her Plan, the Plan Participant should contact the Plan Administrator. If the Plan Participant has any questions about this statement or about his or her rights under ERISA, the Plan Participant should contact the nearest office of the Employee Benefits Security Administration (EBSA), (the former Pension and Welfare Benefits Administration (PWBA)), U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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SCHEDULE OF BENEFITS

Blue Options℠

Group Name:	**Shodair Children's Hospital**
Group Number:	**200281**
Effective Date:	**June 1, 2018**
Annual and Lifetime Plan Maximum:	**None**
Benefit Period:	**June 1, 2018 to June 30, 2019**

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

Deductible:	**Tier 1:**	**Individual:**	**$350**
		Family:	**$700**
	Tier 2	**Individual:**	**$2,000**
		Family:	**$4,000**
	Tier 3:	**Individual:**	**$5,000**
		Family:	**$10,000**

The Tier 1, 2 and 3 Deductibles are separate amounts and do not accumulate to each other.

Coinsurance:	**Tier 1:**	**10% unless noted otherwise**
	Tier 2:	**30% unless noted otherwise**
	Tier 3	**50% unless noted otherwise**

Coinsurance is listed by Benefit in this Schedule of Benefits. Any Copayment and/or Coinsurance for Prescription Drugs are also listed. Any Copayment and/or Coinsurance a Participant pays do not accumulate to the Deductible.

Copayment:	**Varies**

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 Tier 2 or Tier 3 providers, Benefits will be provided as if such services were provided by a Tier 1 provider.
- Tier 3 providers may bill the Participant the difference between the Allowable Fee and the provider's charge (balance billing), even if Preauthorization is obtained for the service, or if treatment is provided for Emergency Services. Any billing by the Provider is in addition to any applicable Deductible, Copayment and/or Coinsurance for which the Participant is responsible.

Out of Pocket Amount:	**Tier 1:**	**Individual:**	**$1,850**
		Family:	**$3,700**
	Tier 2:	**Individual:**	**$4,000**
		Family:	**$8,000**
	Tier 3:	**Individual:**	**$6,000**
		Family:	**$12,000**

The Out of Pocket Amounts for Tiers 1 and 2 accumulate to each other. However, Tier 3 Out of Pocket Amounts do not accumulate to any other Out of Pocket Amounts.

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

The Out of Pocket Amount does not apply to the charges in excess of the Allowable Fee.

Term of Plan Document:	**Monthly**

ADDITIONAL BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	TIER 1 COINSURANCE	TIER 2 COINSURANCE	TIER 3 COINSURANCE
Accident Benefit			
Professional Provider Services	10%	30%	50%
Facility Services	10%	30%	50%
Tiers 1 and 2 - For Accidents: $300 for services within 90 days of each Accident. The Deductible and Coinsurance do not apply. Services must be Covered Medical Expenses and are paid as any other Illness after 90 days following the Accident or after the $300 is paid, whichever comes first.			
Acupuncture Services Maximum Per Benefit Period for Treatments/Office Visits - 6 Visits	10%	30%	50%
Ambulance	10%*	10%*	10%*
*Tier 1 Deductible applies.			
Autism Spectrum Disorder			
Services, except medications/prescription drugs and Applied Behavior Analysis (ABA) services that are described in the Benefit section entitled Autism Spectrum Disorders, are covered under medical Benefits.			
Medications/prescription drugs are covered under Prescription Drugs.			
ABA services are only covered for Participants under 19 years of age	10%	30%	50%
Refer to the section of the Schedule of Benefits entitled Office Visits.			
Chiropractic Services	10%	10%*	10%*
Maximum Benefit per Benefit Period for chiropractic manipulations – 35 Visits			
After Deductible, the maximum payable per visit – $25			
*Tier 1 Deductible, Coinsurance and Out-of-Pocket Amount apply to services provided by a Tier 2 and Tier 3 provider.			
Convalescent Home Services	10%	30%	50%
Maximum Per Benefit Period – 60 Days			
Diabetic Education Benefit			
The Deductible and Coinsurance do not apply to the payment of the first $250. After the payment of $250, Deductible and Coinsurance will apply.			
First $250	Deductible, Coinsurance and Copayment Do Not Apply		
After the first $250 in payment	10%	30%	50%
Refer to the section of the Schedule of Benefits entitled Office Visits.			
Diagnostic Services			
Professional Provider Services	10%	30%	50%
Refer to the section of the Schedule of Benefits entitled Office Visits.			
Facility Services	10%	30%	50%
Durable Medical Equipment			
Rental (up to Purchase Price), Purchase and Repair and Replacement of Durable Medical Equipment	10%	30%	50%

ADDITIONAL BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	TIER 1 COINSURANCE	TIER 2 COINSURANCE	TIER 3 COINSURANCE
Emergency Room Care			
Professional Provider Services	10%	10%	10%
Facility Services	10%	10%	10%
Genetic Testing, Including BRCA1 and BRCA2	10%	30%	50%
Hearing Aids and Hearing Exam			
Hearing aids, exams and related medical services covered if loss of hearing is the result of a surgical procedure while coverage was in effect.	10%	30%	50%
Home Health Care	10%	30%	50%
Maximum Per Benefit Period - 180 Visits			
Hospice Care			
Professional Provider Services	Deductible, Coinsurance and Copayment Do Not Apply		
Facility Services	Deductible, Coinsurance and Copayment Do Not Apply		
Hospital			
Professional Services (when the Professional Provider is employed by the Hospital)			
Outpatient	10%	30%	50%
Inpatient	10%	30%	50%
Facility Services			
Outpatient	10%	30%	50%
Inpatient	10%	30%	50%
Mammograms			
Preventive	None, No Deductible	None, No Deductible	50%*
Medical	10%**	30%**	50%
*Deductible and Coinsurance do not apply to the payment of the first $70 for preventive mammograms provided by an Out-of-Network provider.			
**The first medical mammogram per Benefit Period is paid at 100% of the Allowable Fee for Tier 1 and Tier 2.			
Maternity Services			
Professional Provider Services	10%	30%	50%
Refer to the section of the Schedule of Benefits entitled Office Visits.			
Facility Services	10%	30%	50%
Medical Supplies	10%	30%	50%
Mental Health			
Professional Provider Services			
Outpatient	10%	30%	50%
Inpatient	10%	30%	50%
Refer to the section of the Schedule of Benefits entitled Office Visits.			
Facility Services			
Outpatient	10%	30%	50%
Inpatient	10%	30%	50%
Partial Hospitalization is covered under the Inpatient Treatment Benefit.			

ADDITIONAL BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	TIER 1 COINSURANCE	TIER 2 COINSURANCE	TIER 3 COINSURANCE
Naturopathic*	10%	30%	50%
Maximum Benefit per Benefit Period for treatments/office visits - 6 Visits			
After Deductible, the maximum payable per visit – $75			
*Preventive services by a Naturopath are not included in the 6 visit maximum.			
Newborn Initial Care			
Professional Provider Services	10%	30%	50%
Facility Services	10%	30%	50%
The Deductible and Coinsurance do not apply to the first 5 days of initial care for Tiers 1 and 2.			
Deductible and Coinsurance apply to Tier 3.			
Office Visit			
PCP	$30, No Deductible*	30%*	50%
Specialist	10%*	30%*	50%
*Deductible, Coinsurance and Copayment do not apply to In-Network (Tiers 1 and 2) Preventive Health Care services. Refer to the section entitled Preventive Health Care.			
The Copayment applies to the Tier 1 office visits and covered services provided during the office visit, except durable medical equipment, prosthetics and Orthopedic Devices/orthotic devices.			
Orthopedic Devices/Orthotic Devices	10%	30%	50%
Other Facility Services – Inpatient and Outpatient	10%	30%	50%
Physician Medical Services	10%	30%	50%
Preventive Health Care			
Preventive Services	None, No Deductible	None, No Deductible	50%
Private Duty Nursing	10%	30%	50%
Prostheses Benefit			
Rental (up to Purchase Price), Purchase and Repair and Replacement of Prosthetics	10%	30%	50%
Rehabilitation Therapy			
Professional Provider Services	10%	30%	50%
Facility Services	10%	30%	50%
Substance Use Disorder			
Professional Provider Services			
Outpatient	10%	30%	50%
Inpatient	10%	30%	50%
Refer to the section of the Schedule of Benefits entitled Office Visits.			
Facility Services			
Outpatient	10%	30%	50%
Inpatient	10%	30%	50%
Surgery Center Services – Outpatient			
Professional Provider Services	10%	30%	50%
Facility Services	10%	30%	50%

ADDITIONAL BENEFIT INFORMATION Deductible applies to all services unless noted otherwise.	TIER 1 COINSURANCE	TIER 2 COINSURANCE	TIER 3 COINSURANCE
Therapies - Outpatient			
Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy			
Professional Provider Services	10%	30%	50%
Facility Services	10%	30%	50%
Transplants			
Professional Provider Services			
Outpatient	10%	30%	50%
Inpatient	10%	30%	50%
Facility Services			
Outpatient	10%	30%	50%
Inpatient	10%	30%	50%
Urgent Care			
Deductible, Coinsurance and Copayment do not apply to In-Network (Tiers 1 and 2) Preventive Health Care services. Refer to the section entitled Preventive Health Care	10%	30%	50%
Virtual Visits – MDLIVE Providers Only			
Medical	$30, No Deductible	Not a Benefit	Not a Benefit
Behavioral Health	$80 - $175, No Deductible	Not a Benefit	Not a Benefit
Well-Child Care Services	None, No Deductible	None, No Deductible	50%, No Deductible
Wigs (as a result of an Illness or health condition) Limited to one per Benefit Period	10%	30%	50%

PRESCRIPTION DRUG INFORMATION	DEDUCTIBLE	COPAYMENT/ COINSURANCE
Prescription Drugs (The Prescription Drugs Benefit utilizes a Drug List.) Any Copayments do not apply to certain contraceptive products. Refer to the Preventive Health Care Benefit. Any Copayments also do not apply to smoking cessation products and over-the-counter aids/medications, for two 90-day treatment regimens.		
Retail Value Participating Pharmacy Prescriptions Copayments and/or Coinsurance for a 30-day supply are:		
Preferred Generic Drug:		No Copayment
Non-Preferred Generic Drug:		$10
Preferred Brand-Name Drug:		$50
Non-Preferred Brand-Name Drug:		$100
Retail Participating Pharmacy Prescriptions Copayments and/or Coinsurance for a 30-day supply are:		
Preferred Generic Drug:		$5
Non-Preferred Generic Drug:		$15
Preferred Brand-Name Drug:		$60
Non-Preferred Brand-Name Drug:		$110
Retail Non-Participating Pharmacy Prescriptions Copayments and/or Coinsurance for a 30-day supply are:		
Preferred Generic Drug:		$5
Non-Preferred Generic Drug:		$15
Preferred Brand-Name Drug:		$60
Non-Preferred Brand-Name Drug:		$110
Mail Service Maintenance Prescriptions Copayments and/or Coinsurance for a 90-day supply are:		
Preferred Generic Drug:		No Copayment
Non-Preferred Generic Drug:		$20
Preferred Brand-Name Drug:		$100
Non-Preferred Brand-Name Drug:		$200
Retail Value Participating Pharmacy Prescriptions Copayments and/or Coinsurance for a 90-day supply are:		
Preferred Generic Drug:		No Copayment
Non-Preferred Generic Drug:		$30
Preferred Brand-Name Drug:		$150
Non-Preferred Brand-Name Drug:		$300
Specialty Medications (30-day supply only)		$150

The Participant must pay the difference between a Brand-Name Drug and the Generic Drug equivalent in addition to the Copayment and/or Coinsurance if the Participant chooses a Brand-Name Drug when a Generic Drug is available. The amount the Participant pays for the difference between a Brand-Name Drug and the Generic Drug equivalent does not apply to the Out of Pocket Amount.

Any Copayment and/or Coinsurance amounts paid for prescription drugs do not apply to the Deductible.

ADDITIONAL BENEFIT INFORMATION **Deductible applies to all services unless noted otherwise.**	TIER 1 COINSURANCE	TIER 2 COINSURANCE	TIER 3 COINSURANCE
Vision Services			
Routine eye exam (per Benefit Period) Maximum per Benefit Period - $100	None, No Deductible	None, No Deductible	None, No Deductible
Lenses, frames and contact lenses Combined maximum per Benefit Period - $150	None, No Deductible	None, No Deductible	None, No Deductible

PROVIDERS OF CARE FOR PARTICIPANTS

Blue Options is a point of service product that allows a Participant the choice of receiving services from providers in the Blue Options℠ Provider Network, or the Blue Cross and Blue Shield of Montana Participating Provider network or from nonparticipating providers. The highest level of benefits will be for services provided by a Blue Options network provider.

The Participant may self-refer for services provided by an obstetrician/gynecologist. This self-referral is for any obstetrical (maternity) and gynecological examination or care, or services required as the result of any obstetrical or gynecological examination or condition. In order to receive the highest level of payment from the Plan, the Participant must receive services from a Blue Options Participating Professional Provider who is an obstetrician/gynecologist.

In-Network and Out-of-Network Providers

1. In-Network Providers (Tiers 1 and 2) include:

    a. **Tier 1 - The Blue Options provider network** includes those providers who or which have a contract with Blue Cross and Blue Shield of Montana as Blue Options providers and are listed in the current provider directory. This network includes Blue Options Participating Professional Providers and Blue Options Participating Facility Providers.

    b. **Tier 2 - The Blue Cross and Blue Shield of Montana Participating Provider network** includes those providers who or which have a contract with Blue Cross and Blue Shield of Montana and are listed in the current provider directory. The providers include Participating Professional Providers and Participating Facility Providers.

2. Out-of-Network providers (Tier 3)

    Out-of-Network providers are non-participating professional and facility providers.

The Participant will be responsible for a greater portion of the cost for any Benefits received from a Participating Blue Cross and Blue Shield of Montana Professional Provider, a Blue Cross and Blue Shield of Montana Facility Participating Provider or an Out-of-Network professional or facility provider than if the Participant had received the same services from a Blue Options Participating Professional provider or Participating Facility Blue Options provider whether or not there is a referral from the Participant's Primary Care Provider.

Professional Providers and Facility Providers

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

For purposes of the Tier I In Network Office Visit Copayment Benefit after Deductible is met, Primary Care Providers (PCPs) include general practitioners, family practitioners, internists, pediatricians, obstetricians and gynecologists, naturopaths, physicians' assistants, registered nurse practitioners, 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.

PCPs and specialists do not include chiropractors, acupuncturists, speech therapists, physical therapists, or occupational therapists.

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

The Participant 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 Plan Document.

Nonparticipating Providers

A nonparticipating professional or facility provider does not have a contract with Blue Cross and Blue Shield of Montana.

The Participant will be responsible for a greater portion of the cost for any Covered Medical Expenses received from the nonparticipating provider than if the Participant had received the same Covered Medical Expenses from a Participating Provider whether or not there is a referral from the Participant's Primary Care Provider.

How Providers are Paid by the Claim Administrator and Participant Responsibility

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

A **Blue Options Participating Provider** and Participating 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 Participant, as payment in full. Generally, the Claim Administrator will pay the Allowable Fee for a Covered Medical Expense directly to the Blue Options Participating Provider or Participating Provider. In any event, the Plan may, in its discretion, make payment to the Participant, the provider, the Participant and provider jointly, or any person, firm, or corporation who paid for the services on the Participant's behalf.

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

How Providers are Paid by the Claim Administrator and Participant Responsibility Outside of Montana

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

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

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

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

The Claim Administrator 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 Participant will be responsible for all charges for such services, supplies, or medications.

Claim Payment Assignment

All benefits payable to the Participant which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Participant.

Claim Dispute

Once Covered Medical Expenses are rendered by a provider, the Participant has no right to request the Claim Administrator not to pay the claim submitted by such provider and no such request by a Participant or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Participant or any other person because of its rejection of such request.

PRIMARY CARE PROVIDERS

Selection of a Primary Care Provider

At the time of application, each person applying for Membership must select a Primary Care Provider from the Blue Options Provider Network. Each Family Member must select a Primary Care Provider, although the Primary Care Provider may be different for each Family Member. If a Primary Care Provider is not selected, the Plan will assign a Primary Care Provider for each Family Member. Each Family Member must always have a Primary Care Provider.

Participating Primary Care Providers have contracted with the Blue Options Provider Network and have agreed to accept Participants for care and to adhere to the network's policies concerning waiting time for appointments, on-call coverage, preventive care, credentialing, and quality improvement. Primary Care Providers generally include general practitioners, family practitioners, internists, OB/GYNs and pediatricians.

Changing the Primary Care Provider Selection

A Participant may choose to select a different Primary Care Provider no more than once every month. Any selection of a new Primary Care Provider must be communicated to and approved by the Plan and the change will be effective the first of the month following the request.

Services Performed by the Primary Care Provider

The Participant's Primary Care Provider is responsible for providing and arranging for the Participant's health care except for Urgent Care or Emergency Services. Any follow-up care after Urgent Care or Emergency Services should be coordinated by the Participant's Primary Care Provider.

If it is Medically Necessary in the Primary Care Provider's judgment, the Primary Care Provider will recommend a specialist who will provide services for the specific episode of care. The specialist and the Participant's Primary Care Provider will coordinate the management of care.

Continuity of Care and Transitional Care

Although each Participant has a Primary Care Provider, a Participant may continue to receive services from the Participant's previous provider if the Participant is a new enrollee to the Plan, if the Blue Options Provider's or Participating Provider's contract is terminated without cause, or when the Blue Options Provider or Participating Provider voluntarily terminates the contract with the Plan, and the Participant:

1. Has a life threatening, disabling, or degenerative condition, or a serious acute condition requiring complex ongoing care. Coverage by the previous provider will be allowed for 90 days beginning on the date of the Participant's enrollment or the provider's termination.
2. Has a terminal illness with life expectancy of less than 6 months. Coverage by the previous provider will be allowed for 6 months from the date of the Participant's enrollment or to the date of death, whichever occurs first. If death does not occur within the first 6 months, the situation will be evaluated to determine if transition to the selected Primary Care Provider is appropriate.
3. Is in the second or third trimester of pregnancy. Coverage by the previous provider will be allowed through the completion of the postpartum period.

The previous provider must agree to meet the contractual terms applicable to comparable Blue Options Providers or Participating Professional Providers.

LEVELS OF PAYMENT

Payment by the Plan for Covered Medical Expenses is categorized into three levels, Tier 1, Tier 2 and Tier 3. The level of payment by the Plan is impacted by whether the provider who or which provides the services is a Blue Options Network Provider, a Blue Cross and Blue Shield of Montana Participating Provider, or is a nonparticipating provider.

In certain circumstances, as outlined in the Network Exception Policy of the Plan's Managed Care Network Adequacy and Quality Assurance (MCNAQA) Policies, Tier 1 Benefits may be available for services provided by a nonparticipating specialist when a local participating specialist is not available. A copy of the Network Exception Policy is available upon request. Contact customer service at the number listed on the inside cover of this document before seeing a nonparticipating specialist in order to determine whether the Tier 1 Benefit is available for services provided by a nonparticipating specialist.

The following outlines each level of payment by the Plan – Tier 1 is the highest, Tier 2 is the next highest and Tier 3 is the lowest. As payment by the Plan decreases, Participant responsibility typically increases. The levels of payment by the Plan and the impact of choice of providers are:

Tier 1 includes payment for Benefits that are:

- Provided by Blue Options Participating Professional Providers and Blue Options Participating Facility Providers

Tier 2 includes payment for Benefits that are:

- Provided by Participating Blue Cross and Blue Shield of Montana Professional or Facility Providers.
- Hospital Inpatient Care services when provided by a Participating Blue Cross and Blue Shield of Montana Facility Provider.
- Hospital and surgery center Outpatient services when provided by a Blue Cross and Blue Shield of Montana Facility Provider.
- Provided by a professional or facility provider outside of Montana, who is a participating provider with the local Blue Cross and/or Blue Shield plan in the state in which services are provided.
- Provided by an out-of-country facility or professional provider. The Participant will be responsible for the difference between the provider's charge and the Blue Cross and Blue Shield of Montana Allowable Fee if the provider is not a member of the BlueCard Worldwide Program.

Tier 3 includes payment for Benefits that are:

- Provided by professional and facility providers who are not participating providers with a Blue Cross and/or Blue Shield Plan.

The Participant may be balanced billed by the provider for Benefits paid on Tier 3. Please refer to each specific Benefit outlined in the Benefit section of this Plan Document to determine Participant responsibility at each level of payment.

SPECIAL PROVISIONS

Referrals

Although referrals are not required, it is extremely important that care be coordinated by the Participant's Primary Care Provider. All health care services should be provided by or arranged by the Participant's Primary Care Provider. The Plan recommends that any referrals, including standing referrals for specialty care, be coordinated by the Participant's Primary Care Provider; however, referrals do not require any special forms or any authorization number from the Plan.

The Participant may self-refer for services provided by an obstetrician/gynecologist. This self-referral is for any obstetrical (maternity) and gynecological examination or care, or services required as the result of any obstetrical or gynecological examination or condition. In order to receive the highest level of payment from the Plan, the Participant must receive services from an In-Network Provider who is an obstetrician/gynecologist.

Any nonparticipating provider can bill the Participant for the difference between payment by Blue Cross and Blue Shield and provider charges plus Deductible and Coinsurance even if the Participant's Primary Care Provider approves the referral.

Urgent Care and Emergency Services

The Plan will pay for Urgent Care and emergency services when provided by an Urgent Care center or emergency room, subject to the applicable Deductible and Coinsurance. If the Participant is admitted to the Hospital from the emergency room as a result of the condition requiring emergency services, the emergency room Copayment will be waived. Plan payment and Participant responsibility will be determined according to the Hospital Services Inpatient Care Services section.

To facilitate the coordination of follow-up care, the Participant should notify his/her Primary Care Provider and the Plan of the Urgent Care or emergency services within 24 hours or on the first working day after the day the services were provided.

Out-of-Area Services

Out-of-Network Benefits are available outside of the Geographic Service Area. The Participant should notify his/her Primary Care Provider and the Plan if he/she receives services outside of the Geographic Service Area.

Maximum Wait Times for Appointments

The following are the maximum wait times for appointments:

1. Emergency services must be available and accessible at all times;
2. Urgent Care appointments must be available within 24 hours;
3. Appointments for non-urgent care with symptoms must be available within 10 calendar days;
4. Appointments for immunizations must be available within 21 calendar days; and
5. Appointments for routine or preventive care must be available within 45 calendar days.

QUALITY ASSURANCE PROGRAM

The Blue Cross and Blue Shield of Montana ongoing quality assurance program is designed to objectively and systematically assess and monitor the quality and appropriateness of clinical care and services based upon the collection, analysis, and reporting of relevant data. The program focuses on identifying opportunities to improve care and implementing appropriate improvement strategies based upon quality assessment findings. As part of the quality assurance program, important issues such as member and provider satisfaction, utilization of health care services, access to care, and preventive health care services are tracked.

PARTICIPANTS RIGHTS AND RESPONSIBILITIES

A Participant has the right to:

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

A Participant 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 Participant.
2. Follow the treatment plans and instruction for care the Participant has agreed upon with the Participant'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 referred to generally as "Inter-Plan Programs." Whenever a Plan Participant obtains healthcare services outside of the Blue Cross and Blue Shield of Montana service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

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

1. **BlueCard® Program**

   Under the BlueCard® Program, when a Plan Participant incurs Covered Medical Expenses within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Montana will remain responsible for fulfilling Blue Cross and Blue Shield of Montana's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   Whenever the Plan Participant incurs 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 Plan Participant pays for Covered Medical Expenses is calculated based on the lower of:

   - The billed covered charges for the Plan Participant's covered services; or
   - The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Montana.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Plan Participant's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Plan Participant'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 modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield of Montana uses for the Plan Participant's claim because they will not be applied retroactively to claims already paid.

   Federal laws or the laws in a small number of states may require the Host Blue to add a surcharge to the Plan Participant's calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Blue Cross and Blue Shield of Montana would then calculate the Plan Participant's liability for any Covered Medical Expenses according to applicable law.

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

   a. Plan Participant Liability Calculation

      When the Plan Participant incurs Covered Medical Expenses outside of the Blue Cross and Blue Shield of Montana service area for services provided by non-participating healthcare providers, the amount the Plan Participant pays for such services will generally be based on either the Host Blue's non-participating

healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Plan Participant may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services 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 received 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 non-participating providers outside of Montana to pay for services provided by non-participating providers. In these situations, the Plan Participant may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Blue Cross and Blue Shield of Montana will make for the covered services as set forth in this paragraph.

3. Blue Cross Blue Shield Global Core

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

If the Participant needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Participant 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, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

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

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

- **Outpatient Services**

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

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When the Participant pays for Covered Medical Expenses outside the BlueCard service area, the Participant must submit a claim to obtain reimbursement. For institutional and professional claims, the Participant should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the Participant claim. The claim form is available from the Plan, service center or online at www.bcbsglobalcore.com. If the Participant needs assistance with the Participant claim submission, the Participant 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 Participant 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 Plan Document. The Participant may also file a written complaint or grievance with the Claim Administrator. The fax number, email address, and mailing address of the Claim Administrator appears on the inside cover of this Plan Document. Written complaints or grievances will be acknowledged within 10 days of receipt. The Participant will be notified of the Claim Administrator's response within 60 days from receipt of the Participant'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 Participant'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 Plan Document, requires authorization or approval from the Claim Administrator or the Claim Administrator'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 Participant's life or health or ability to regain maximum function or subject the Participant 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 Participant'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, that are not based on fraud or a misrepresentation of a material fact. 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 Participant 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 Participant for an extension of the number of treatments or the termination by the Claim Administrator 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 Claim Administrator will provide timely notice of the initial claim determination once sufficient information is received to make an initial determination, but no later than 15 days after receiving the claim.

b. Notice of Extension

1. For reasons beyond the control of the Claim Administrator

The Claim Administrator may extend the 15-day time period for an additional 15 days for reasons beyond the Claim Administrator's control. The Claim Administrator will notify the Participant in writing of the circumstances requiring an extension and the date by which The Claim Administrator expects to render a decision.

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

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the Participant will be given 45 days from receipt of the notice within which to provide the specified information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator 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 Claim Administrator will notify the Participant about the improper submission as soon as practicable, but no later than 5 days after the Claim Administrator's receipt of the claim, and will advise the Participant 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 Claim Administrator will make a determination if the claim involves urgent care. If a physician with knowledge of the Participant's medical condition determines the claim involves urgent care, the Claim Administrator will treat the claim as an urgent care claim.

b. Notice of Determination

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

c. Notice of Incomplete or Improperly Submitted Claim

If an urgent care claim is incomplete or was not properly submitted, the Claim Administrator will notify the Participant about the incomplete or improper submission no later than 24 hours from the Claim Administrator's receipt of the claim. The Participant will have at least 48 hours to provide the necessary information. The Claim Administrator will notify the Participant of the initial claim determination no later than 48 hours after the earlier of the date the Claim Administrator 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 Claim Administrator 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 Claim Administrator

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

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

If the extension is necessary due to the Participant's failure to submit information necessary to decide the claim, the extension notice will specifically describe the information needed. The Participant will be given 45 days from receipt of the notice to provide the information. The Claim Administrator will notify the Participant of the initial claim determination no later than 15 days after the earlier of the date the Claim Administrator 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 Participant's claim for an extension of a previously approved time period for treatments or number of treatments, and if the Participant's claim involves urgent care, the Claim Administrator will review the claim and notify the Participant of its determination no later than 24 hours from the date the Claim Administrator received the Participant's claim, provided the Participant's claim was filed at least 24 hours prior to the end of the approved time period or number of treatments.

2. If the Participant's claim was not filed at least 24 hours prior to the end of the approved time period or number of treatments, the Participant'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 Participant'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 Claim Administrator may not subsequently reduce or terminate an ongoing course of treatment for which the Participant has received prior approval unless the Claim Administrator provides the Participant with written notice of the reduction or termination and the scheduled date of its occurrence sufficiently in advance to allow the Participant 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 Claim Administrator makes a decision to rescind the Participant's coverage due to a fraud or an intentional misrepresentation of a material fact, the Claim Administrator will provide the Participant 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 Participant will have the right to appeal any final decision of the Claim Administrator to rescind coverage prior to or after the thirty (30) day period, and a description of the Claim Administrator's appeal procedures;

d. A reference to the Plan provision(s) on which the rescission is based;

e. A statement that the Participant 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 Claim Administrator's determination constitutes an adverse benefit determination, the notice to the Participant 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 Plan Document 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 Claim Administrator'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 Participant'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 Participant disagrees with an adverse benefit determination (including a rescission), the Participant may appeal the determination within 180 days from receipt of the adverse benefit determination. With the exception of urgent care claims, The Participant's appeal may be made verbally or in writing, should list the reasons why the Participant 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 Plan Document. If the Participant is appealing an urgent care claim, the Participant may appeal the claim verbally by calling the telephone number listed for urgent care appeals on the inside cover of this Plan Document.

2. Authorized Representative

The Participant may name another individual to act on the Participant's behalf for purposes of an appeal or review of an adverse benefit determination, by filing a written designation with the Claims Administrator. Contact the Claims Administrator at the number listed on the inside cover of this Plan Document for information on how to designate an authorized representative.

3. Access to Plan Documents

The Participant 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 Claim Administrator's office, at 3645 Alice Street, Helena, Montana, between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding holidays. The Participant may also request that Blue Cross and Blue Shield of Montana mail copies of all documentation to the Participant.

4. Submission of Information and Documents

The Participant 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 Claim Administrator until a final determination of the Participant's appeal has been made.

5. 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 Participant submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial adverse benefit determination.

If the Claim Administrator considers, relies on or generates new or additional evidence in connection with its review of the Participant's claim, the Claim Administrator will provide the Participant 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 Claim Administrator. If the Claim Administrator relies on a new or additional rationale in denying the Participant's claim on review, the Claim Administrator will provide the Participant 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 Claim Administrator.

6. Scope of Review

The person who reviews and decides the Participant's appeal will be a different individual than the person who decided the initial adverse benefit determination and will not be a subordinate of the person who made the initial adverse benefit determination. The review on appeal will not give deference to the initial adverse benefit determination and will be made anew. The Claim Administrator 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.

7. Consultation with Medical Professionals

If the claim is, in whole or in part, based on medical judgment, the Claim Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not have been involved in the initial adverse benefit determination (nor have been a subordinate of any person previously consulted). The Participant may request information regarding the identity of any health care professional whose advice was obtained during the review of the Participant's claim.

Time Period for Notifying Participant of Final Internal Adverse Benefit Determination

The time period for deciding an appeal of an adverse benefit determination and notifying the Participant of the final internal adverse benefit determination depends upon the type of claim. The chart below provides the time period in which the Claim Administrator will notify the Participant 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 Claim Administrator received the Participant's appeal, taking into account the medical exigency.
Pre-Service Claim	No later than 30 days from the date the Claim Administrator received the Participant's appeal.
Post-Service Claim	No later than 60 days from the date the Claim Administrator received the Participant's appeal.
Concurrent Care Claim	• If the Participant's claim involved urgent care, no later than 72 hours from the date the Claim Administrator received the Participant's appeal, taking into account the medical exigency. • If the Participant'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.

Type of Claim on Appeal	Time Period for Notification of Final Internal Adverse Benefit Determination
Rescission Claim	No later than 60 days from the date the Claim Administrator received the Participant'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 Participant'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 Plan Document 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 Participant'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 Participant'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 Participant'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 Participant must follow and exhaust the internal appeals process outlined above before the Participant 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 Participant's medical circumstances, and entitles the Participant 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 Participant or the Participant's authorized representative must submit a written request to the Claim Administrator for a standard external review within 4 months from the date the Participant receives an adverse benefit determination or a final internal adverse benefit determination.

2. Preliminary Review

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

- **a.** The Participant 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 Participant 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 Participant's failure to meet the Plan's eligibility requirements;
- **c.** The Participant has exhausted (or is not required to exhaust) the Claim Administrator's internal appeals process;
- **d.** The Participant has provided all the information and forms required to process the external review.

Within 1 day after completing its review, the Claim Administrator will notify the Participant 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 Participant 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 Claim Administrator will outline the reasons for ineligibility in the notice, include a statement informing the Participant or the Participant's authorized representative of the right to appeal the Claim Administrator's determination to the Commissioner of Securities and Insurance and provide the Participant with contact information for the U.S. Employee Benefits Security Administration (toll free number 866.444.EBSA (3272) and contact information for the Commissioner's office.

3. Assignment of an IRO

If the Participant's request is eligible for external review, the Claim Administrator 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 Claim Administrator 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 Claim Administrator 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 Claim Administrator will notify the Participant, in writing, or the Participant's authorized representative, that the Claim Administrator has initiated an external review and that the Participant or the Participant'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 Claim Administrator must submit the documents and any information considered in making the benefits denial to the IRO. The Claim Administrator's failure to timely provide such documents and information will not constitute cause for delaying the external review. If the Claim Administrator 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 Participant and the Claim Administrator within 1 business day after making the decision.

6. Reconsideration by Plan

On receiving any information submitted by the Participant, the IRO must forward the information to the Claim Administrator within 1 business day. The Claim Administrator may then reconsider its adverse benefit determination or final internal adverse benefit determination. If the Claim Administrator decides to reverse its adverse benefit determination or final internal adverse benefit determination, the Claim Administrator must provide written notice to the Participant and IRO within 1 business day after making the decision. On receiving the Claim Administrator'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 Claim Administrator'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 Participant's medical records;
- **b.** The Participant's treating provider(s)'s recommendations;
- **c.** Reports from appropriate health care professionals and other documents, opinions, and recommendations submitted by the Claim Administrator and the Participant;
- **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 Claim Administrator 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 Claim Administrator;
- **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 Participant and to the Claim Administrator 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 Claim Administrator or the Participant under state or federal law;
- **f.** A statement that judicial review may be available to the Participant 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 Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator will immediately provide coverage or issue payment according to the written terms and benefits of the Plan Document.

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 Participant or the Participant's authorized representative may request an expedited external review:

- **a.** If the Participant received an adverse benefit determination that denied the Participant's claim and: (1) the Participant 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 Participant or the Participant'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 Participant for which a delay in completing the standard external review would seriously jeopardize the Participant's life or health or the Participant'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 Participant received emergency services, but has not been discharged from a facility.

2. Preliminary Review

Upon receiving the Participant's request for expedited external review, the Claim Administrator 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 Claim Administrator will immediately notify the Participant or the Participant's authorized representative in writing of its eligibility determination. If the Plan determines the Participant's request is ineligible for review, the notice must include a statement informing the Participant or the Participant's authorized representative of the right to appeal the Claim Administrator'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 Claim Administrator 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 Claim Administrator 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 Claim Administrator'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 Participant and the Claim Administrator with notice of its final external review decision as expeditiously as the Participant'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 Participant and to the Claim Administrator 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 Claim Administrator or the Participant under state or federal law;

f. A statement that judicial review may be available to the Participant or the Claim Administrator; 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 Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator 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 Plan Document.

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 Participant must follow and exhaust the internal appeals process outlined above before the Participant or the Participant'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 Participant's medical circumstances, and entitles the Participant 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 Participant or the Participant's authorized representative must submit a written request to the Claim Administrator for a standard external review within 4 months from the date the Participant or the Participant'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 Claim Administrator must complete a preliminary review within 5 business days to determine whether:

a. The Participant 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 Participant 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 Participant's health plan except for the Claim Administrator'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 Participant's health plan;

c. The Participant'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 Participant; (ii) standard health care services or treatments are not medically appropriate for the Participant; or (iii) there is no available standard health care service or treatment covered by the Plan that is more beneficial than the requested health care service or treatment;

d. (i) the Participant'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 Participant, 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 Participant's condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the Participant who is subject to the adverse benefit determination or final internal adverse benefit determination is likely to be more beneficial to the Participant than any available standard health care services or treatments; and

e. The Participant has exhausted the Claim Administrator's internal appeals process or the Participant is exempt from exhausting the Claim Administrator's internal appeals process.

Within 1 business day after completion of the preliminary review, the Claim Administrator will notify the Participant or the Participant'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 Claim Administrator will inform the Participant or the Participant'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 Claim Administrator will inform the Participant or the Participant'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 Participant or the Participant'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 Claim Administrator 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 Claim Administrator will notify the Participant or the Participant's authorized representative in writing that the Claim Administrator has initiated an external review and that the Participant or the Participant'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 Claim Administrator 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 Participant or the Participant's authorized representative and the Claim Administrator of its decision.

5. Reconsideration by the Claim Administrator

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

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 Participant'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 Participant or the Participant's authorized representative or the Claim Administrator.

Each Clinical Peer selected pursuant will review and consider all of the information and documents considered by the Claim Administrator in making the adverse benefit determination or the final internal benefit determination and any other information submitted in writing by the Participant or the Participant'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 Claim Administrator's internal appeals process.

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

a. a description of the Participant'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 Participant 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 Participant'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 Participant or the Participant's authorized representative and to the Claim Administrator.

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 Claim Administrator'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 Claim Administrator'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 Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse benefit determination or final internal adverse benefit determination.

Expedited External Review Procedures

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

1. Request for an Expedited External Review

The Participant or the Participant'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 Participant'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 Claim Administrator 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 Claim Administrator will notify the Participant or the Participant'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 Claim Administrator will inform the Participant or the Participant'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 Claim Administrator will inform the Participant or the Participant'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 Participant or the Participant'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 Claim Administrator 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 Claim Administrator will notify the Participant or the Participant's authorized representative, in writing, that the Claim Administrator has initiated an external review and that the Participant or the Participant'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 Claim Administrator 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 Participant or the Participant's authorized representative and the Claim Administrator 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 Participant or the Participant's authorized representative or the Claim Administrator.

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

Each Clinical Peer will provide an opinion to the assigned IRO as expeditiously and the Participant'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 Claim Administrator. 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 Participant or the Participant'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 Claim Administrator's adverse benefit determination or final internal adverse benefit determination, the Claim Administrator 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 Participant 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 Claim Administrator 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 Participant;
- **c.** Attributable to good cause or matters beyond the Claim Administrator's control;
- **d.** In the context of an ongoing, good faith exchange of information between the Participant and the Claim Administrator; and
- **e.** Not reflective of a pattern or practice of violations by the Claim Administrator.

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

PREAUTHORIZATION

The Claim Administrator has designated certain covered services which require Preauthorization in order for the Participant to receive the maximum Benefits possible under this Plan Document.

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

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

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

Preauthorization Process for Inpatient Services

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

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

If the Participant does not request Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant will be responsible for the full cost of the services.

Preauthorization Process for Mental Illness and Substance Use Disorder Services

All Inpatient and partial hospitalization services related to treatment of Mental Illness and Substance Use Disorder must be Preauthorized by the Claim Administrator.

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

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

If the Participant does not request Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

Preauthorization Process for Other Outpatient Procedures/Services

In addition to the Preauthorization requirements outlined above, the Claim Administrator also requires Preauthorization for certain Outpatient services, including Home Health Care, Hospice Services and Home Infusion Therapy. For additional information on Preauthorization, the Participant or the Provider may call the Customer Service number on the Participant's identification card.

It is NOT necessary to preauthorize standard x-ray and lab services or Routine office visits.

If the Claim Administrator does not approve the Outpatient Service, the Participant and the Participant's Provider will be notified of that decision. If the Participant proceeds with the services without the Claim Administrator's approval, the Participant may be responsible to pay the full cost of the services received.

If the Participant does not request Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

The Benefits section of this Plan Document details the services which are subject to Preauthorization.

Preauthorization Request Involving Non-Urgent Care

Except in the case of a Preauthorization Request Involving Urgent Care (see below), the Claim Administrator will provide a written response to the Participant's Preauthorization request no later than 15 days following the date we receive the Participant's request. This period may be extended one time for up to 15 additional days, if we determine that additional time is necessary due to matters beyond our control.

If the Claim Administrator determines that additional time is necessary, the Claim Administrator will notify the Participant in writing, prior to the expiration of the original 15-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to make the determination.

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

The Claim Administrator will provide a written response to the Participant's request for Preauthorization within 15 days following receipt of the additional information. The procedure for appealing an adverse Preauthorization determination is set forth in the section entitled Complaints and Grievances.

Preauthorization Request Involving Urgent Care

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

In case of a Preauthorization Request Involving Urgent Care*,* the Claim Administrator will respond to the Participant no later than 72 hours after receipt of the request, unless the Participant fails to provide sufficient information, in which case, the Participant will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. A Benefit determination will be made as soon as possible (taking into account

medical exigencies) but no later than 72 hours after the initial request, or within 48 hours after the missing information is received (if the initial request is incomplete).

NOTE: The Claim Administrator's response to the Participant's Preauthorization Request Involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Preauthorization Request Involving Emergency Care

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

Preauthorization Required For Certain Prescription Drug Products and Other Medications

Prescription Drug Products, which are self-administered, process under the Prescription Drugs section of this Plan Document. 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 Preauthorization. Please refer to the Prescription Drugs section for complete information about the Prescription Drug Products that are subject to Preauthorization, step therapy, and quantity limits, the process for requesting Preauthorization, and related information.

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

   Medications that are administered by a Covered Provider will process under the medical Benefits of this Plan Document. Certain medications administered by a Covered Provider require Preauthorization. The medications that require Preauthorization are subject to change by the Claim Administrator.

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

   In making determinations of coverage, the Claim Administrator 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 Claim Administrator's website at www.bcbsmt.com.

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

General Provisions Applicable to All Required Preauthorizations

1. **No Guarantee of Payment**

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

2. **Request for Additional Information**

   The Preauthorization process may require additional documentation from the Participant's health care provider or pharmacist. In addition to the written request for Preauthorization, the health care provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested

by the Claim Administrator to make a determination of coverage pursuant to the terms and conditions of this Plan Document.

3. **Failure to Obtain Preauthorization**

   If the Participant does not obtain Preauthorization, the Claim Administrator will conduct a retrospective review after the claims have been submitted. If it is determined that the services were not Medically Necessary, were Experimental, Investigational or Unproven, were not performed in the appropriate treatment setting, or did not otherwise meet the terms and conditions of the Plan Document, the Participant may be responsible for the full cost of the services.

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

Concurrent Review

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

Care Coordination

The goal of care coordination is to help the Participant receive the most appropriate care that is also cost effective. If the Participant has an ongoing medical condition or a catastrophic Illness, the Participant or their designee should contact the Claim Administrator. If appropriate, a care coordinator will be assigned to work with the Participant and the Participant's providers to design a treatment plan. Care coordination is a voluntary program. Care coordination involves Participant education, referral coordination, utilization review, and individual case planning and/or alternative care.

Care coordination shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Claim Administrator to provide the same or similar alternative benefits for the same or any other Plan Participant, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A care coordinator collaborates with the Participant, the family and the attending Physician in order to develop a plan of care to meet the Participant's health service needs. Coverage may be provided for noncovered benefits if the result is improved care at a lesser cost. The plan of care may include some of the following:

1. Personal support and education for the Participant;
2. Contacting the family to offer assistance for coordination of medical care needs;
3. Monitoring response to treatment;
4. Monitoring Hospital or Skilled Nursing Facility;
5. Determining alternative care options; and
6. Assisting in obtaining any necessary equipment and services.

ELIGIBILITY AND COVERAGE

Eligibility for Participation

The following Participants are eligible for participation in the Plan:

1. Full-time Employees regularly scheduled to work 30 - 40 or more hours per week
2. Part-time Employees regularly scheduled to work 20 - 29 hours per week
3. Class 1 Employees who are contracted to work on a continuing and regular basis and are scheduled to work at least 20 hours per week
4. Class II Employees are variable hour Employees who have completed a measurement period of 12 consecutive months, during which the variable hour Employee averages 130 hours per month of actual work and/or paid leave for 12 consecutive months
5. COBRA-qualified beneficiaries

Declining Coverage

If an eligible person, as outlined above, declines coverage under this Plan, he/she will state his/her reason(s) for declining in writing. Failure to provide these reasons in writing may result in the Plan refusing enrollment at a later date or may require that the only time in the future the eligible person may enroll is during an open enrollment period, if applicable

Enrollment

1. Initial Periods of Enrollment.

   New Employees are eligible to apply for participation within 31 days of eligibility. If the application is made within 31 days of the end of the probationary waiting period or the date the Employee first becomes eligible under the Plan, the Effective Date of coverage for the eligible Employee will be:

   - For full-time and part-time Employees, the first of the month following 60 days of employment;
   - For Class 1 Employees, the first of the month following date of hire;
   - For eligible physicians only, if date of hire is the first of the month, the probationary waiting period is waived;
   - For Class II Employees the first day of the month following the end of the applicable measurement period. The Effective Date of coverage for variable hour Employees will be subject to the applicable measurement period established by the Plan.

   Family Members for whom the eligible Employee is or becomes legally responsible by reason of birth, marriage, adoption, or placement for adoption are eligible to apply for participation within 31 days of the date the Employee's responsibility began. Please refer to the definition of Family Member for specific eligibility requirements.

2. Annual Open Enrollment.

   If the Employee does not apply within 31 days of the Employee's hiring or initial eligibility, the Employee and Family Members may not enroll until 31 days prior to the expiration of the Plan Year, in which case the Effective Date of coverage will be the first day of the next Plan Year.

3. How to Enroll.

   A new Employee should complete an enrollment form at the time of employment. However, the Employee has up to 31 days from the end of the probationary waiting period to complete the enrollment form. An enrollment form will be provided by the Employer or can be obtained from the Claim Administrator. Coverage will be:

   - For full-time and part-time Employees, the first of the month following 60 days of employment;
   - For Class 1 Employees, the first of the month following date of hire;
   - For eligible physicians only, if date of hire is the first of the month, the probationary waiting period is waived;
   - For Class II Employees the first day of the month following the end of the applicable measurement period. The Effective Date of coverage for variable hour Employees will be subject to the applicable measurement period established by the Plan.

4. Late Enrollment.

Employees and Family Members who do not apply within 31 days of the end of the Employee's probationary waiting period or first date of eligibility may be considered Late Enrollees and will not be allowed to enroll except as stated below or during an annual open enrollment period.

5. Plan Identification Card.

Participants enrolled in the Plan will be issued Plan Identification cards (ID Card). The ID Card is an important document and should be protected from mutilation or loss. The Participant may need to present the ID Card to providers or pharmacies to receive Benefits under the Plan.

6. Change of Status.

Any addition or deletion of Family Members under the Plan requires completion of a "Change of Status" form that the Participant may obtain from the Employer or Claim Administrator. Completed Change of Status forms must be returned to the Employer.

7. Special Enrollment When Other Coverage is Lost.

a. Eligible Individuals. A special enrollment period may be available if an eligible Employee, when initially eligible, declined enrollment for himself/herself and/or the Spouse and/or Dependents because of coverage under other health insurance. When that coverage ends, the following persons can enroll:

1. Eligible Employee
2. Dependents of the covered Employee, including the Spouse
3. Eligible Employee and Dependents, including the Spouse

b. Conditions for Special Enrollment. When the Employee declined enrollment for the Employee and/or eligible Family Members, and the Employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment, the Employee and/or eligible Family Members will be eligible to enroll if either of the following occurs:

1. The Employee or Family Member had COBRA continuation coverage and the COBRA continuation coverage has expired; or
2. The Employee or Family Member had other coverage that was not under a COBRA continuation provision and the other coverage has been terminated because either of the following occurs:
    a. A loss of eligibility for the coverage. Loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. However, loss of eligibility does not include a loss of coverage due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause; or
    b. Employer contributions toward the other coverage have been terminated.
    c. A situation in which the Employee or Family Member incurs a claim that would meet or exceed a lifetime limit on all Benefits.
    d. A situation in which the Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
3. The Employee or Family Member loses eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the Employee or Family Member becomes eligible for financial assistance for group health coverage, under either the Children's Health Insurance Program or the Medicaid Program.

c. Enrollment Procedures. The Employee must request enrollment for the Employee and/or Family Members not later than 31 days after the exhaustion of COBRA continuation coverage or termination of the other coverage because of loss of eligibility or termination of Employer contributions. Enrollment during a special enrollment period is subject to all other applicable enrollment requirements of the Plan and the provisions of this Plan Document.

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

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

d. Effective Date of Enrollment. Enrollment due to loss of coverage will be effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Plan.

8. Special Enrollment for Marriage, Birth, Adoption, or Placement for Adoption.

a. Eligible Individuals. When a marriage, birth, adoption, or placement for adoption occurs, the following individuals are eligible to enroll:

1. The Employee who previously declined to enroll,
2. The new Spouse or Spouse who previously declined to enroll,
3. Dependents who previously declined to enroll and new Dependents as a result of one of these events.

b. Enrollment Period. The special enrollment period for eligible persons under this provision is that within 60 days of the event, the request for special enrollment is made verbally or in writing. An application must be submitted within 90 days of the event. Enrollment during a special enrollment period is subject to all other applicable enrollment requirements of the Plan.

c. Effective Date of Coverage. Enrollment will be effective as follows:

1. In the case of marriage, the date of marriage if the participant notifies the employer within 60 days of marriage and a completed request for enrollment (application) is received by the Plan within 90 days after the date of marriage. If the application is received after 90 days of the date of marriage, the enrollee will be considered a Late Enrollee.
2. For a newborn born to a Participant, the date of birth. Coverage for the newborn will be provided only if the Participant notifies the Employer within 60 days of the birth and submits an application to add the newborn within 90 days of the date of birth.

   However, coverage will not continue for any newborn child of a covered Dependent child unless the Employee adopts the newborn child or is the legal guardian of the newborn child.
3. In the case of the Dependent's adoption or placement for adoption, the date of such an event. The adopted child or the child placed for adoption must be under age 19 and the Employee must have a legal obligation for the partial or full support of the child, including providing coverage under the plan pursuant to a written agreement. In the event the placement for adoption is disrupted prior to the legal adoption and the child is removed from placement, coverage shall cease upon the date the placement is disrupted.

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

9. When Benefits Begin. Benefits of this Plan begin on the Participant's Effective Date.

10. Break-In-Service. Where an Employee experiences a break-in-service of at least 13-weeks, the Employee may be treated as newly-hired upon their return. A similar result occurs under a "rule of parity" where a rehired Employee may be treated as a new Employee following a break of at least four (4) weeks if the Employee's break in service is longer than the Employee's period of service immediately preceding the break in service. (i.e. An Employee worked for 6 weeks and then had a break in employment of 8 weeks, the Employee will be considered a new hire.) If the break in service is less than four (4) weeks or less than the prior period of service, the Employee will not be treated as a new hire and hours of service prior to and after the break will count during the measurement period.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMSCO)

A Participant can obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Claim Administrator.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

1. The Family and Medical Leave Act of 1993 (FMLA) requires employers, who employ at least 50 workers within a 75 mile radius of the workplace, to provide eligible employees with up to 12 weeks of leave during any 12-month period for any of the following reasons:
   a. To care for a newborn child;
   b. Because a child has been placed with the employee for adoption or foster care;
   c. To care for the employee's spouse, child, or parent, who has a serious health condition;
   d. The employee's own serious health condition makes the employee unable to perform his or her job.
2. Eligible employees are those who have been employed by the employer for at least 12 months and who have worked at least 1,250 hours for that employer during the previous 12-month period.
3. The health benefits of an employee and dependents, if any, will be maintained during FMLA leave on the same terms and conditions as if the employee had not taken leave.
4. The health benefits of an employee and dependents, if any, may lapse at the employer's discretion during FMLA leave if the employee does not pay his or her share of the premiums in a timely manner or the employee does not elect health benefits during the FMLA leave. Upon return from leave, the employee and dependents, if any, will be reenrolled in the health benefit plan as if the coverage had not lapsed.
5. The employee's reenrollment in the health plan will be effective upon the date on which the employee returns to work.
6. An employee who takes FMLA leave and fails to pay any required premium contribution or fails to return from leave will be entitled to COBRA coverage for the maximum COBRA coverage period beginning when the FMLA coverage terminated.

Military Leave - USERRA & MSERRA

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These rights apply only to eligible employees and eligible dependents covered under the Plan before leaving for military service. "Military Service" means the armed forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the Commissioned Corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

The maximum period of coverage of a person under such an election shall be the lesser of:

1. The 24 month period beginning on the date that Uniformed Service leave commences; or
2. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage. Upon return to active employment, the employee's health coverage and that of the employee's eligible dependents will be reinstated. No exclusions or waiting periods may be imposed on the employee or the employee's eligible dependents. However, plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

The Plan is also designed to comply with the Montana Military Service Employment Rights Act (MMSERA) with respect to periods of absence due to recovery from an illness or injury incurred during State Active Duty.

TERMINATION OF COVERAGE

Coverage under the Plan will terminate under the following circumstances:

1. Termination When the Participant is No Longer Eligible for Coverage

   The Participant's and enrolled Family Members' participation in the Plan will terminate the last day of the month in which the Participant becomes ineligible for coverage, including termination of employment.

2. Termination for Nonpayment of Premium

   If the Participant's premiums are not paid when due, coverage will terminate automatically for the eligible Participant and enrolled Family Members on the last day of the month in which premiums were paid.

3. Termination of Coverage of Children and Spouse.

   Coverage will terminate automatically at midnight, Mountain Standard Time, on the last day of the Month in which a child reaches age 26 years. Coverage for a Spouse will terminate at midnight, Mountain Standard Time, on the last day of the Month in which the Spouse's marriage to the Employee is terminated.

Termination of Benefits on Termination of Coverage

When the participation of an eligible Employee and/or Family Members is terminated for any reason listed in this section or any other section of this Plan, the Benefits of this Plan will no longer be provided, and the Plan will not make payment for services provided to the Employee and/or Family Members after the date on which cancellation becomes effective.

Certificate of Creditable Coverage

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

CONTINUATION OF COVERAGE

COBRA

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

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

1. Small Employer Exception

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

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

2. Qualified Beneficiaries

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

a. Any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the spouse of a covered employee, or the dependent child of a covered employee; or

b. Any child born to or placed for adoption with a covered employee during a period of COBRA continuation.

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

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

3. Qualifying Events

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

a. Employee

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

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

b. Spouse

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

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

c. Dependent Children

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

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

d. Retirees

If the plan provides retiree health coverage, a proceeding in bankruptcy under Title 11 of the United States Code can sometimes be a qualifying event. If a proceeding in bankruptcy is filed with respect to the

employer, and that bankruptcy results in the loss of coverage for any retired employee covered under the plan, the covered retiree will become a qualified beneficiary with respect to the bankruptcy. The covered retiree's covered spouse or surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

4. Period of Coverage

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

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

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

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

c. Bankruptcy

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

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

a. the date of death (of the spouse, surviving spouse or dependent child); or
b. 36 months after the death of the covered retiree.

5. Providing Notice of Qualifying Events

a. Responsibilities of Qualified Beneficiaries

1. General Notice Requirements

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

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

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

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

The following information should be included:

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

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

2. Second Qualifying Event

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

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

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

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

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

3. Disability Extension

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

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

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

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

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

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

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

b. Responsibilities of Plan Administrator

The Plan Administrator must notify the party responsible for administering COBRA within 30 days of the following events.

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

c. Responsibilities of the COBRA Administrator

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

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

6. Election of COBRA Coverage - Notice Requirements

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

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

7. Trade Adjustment Assistance Eligible Employees

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

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

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

8. Payment of Premium

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

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

9. Termination of Continued Coverage

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

10. Questions Concerning COBRA Coverage

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

11. Provide Notice of Address Changes

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

BENEFITS

The Plan will pay for the following Covered Medical Expenses when Medically Necessary and provided by a Covered Provider. Payment is based on the Allowable Fee and is subject to any Deductibles, Coinsurance and other provisions, as applicable.

Benefits outlined in this section are subject to any specific exclusions identified for that specific Benefit and to the exclusions and limitations outlined in the Exclusions and Limitations section.

Accident

Services which are provided for bodily injuries resulting from an Accident and are provided within 90 days of the Accident.

After 90 days or after the maximum shown in the Schedule of Benefits is paid, Covered Medical Expenses will be paid as any other Illness.

The Schedule of Benefits describes payment limitations for these services.

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. 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 Participant's health. Dental services and treatment are not a Benefit of this Plan Document, except as specifically included in the Dental Accident Benefit.

Approved Clinical Trials

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

Autism Spectrum Disorders

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

Covered services include:

- Habilitative 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;
- Medications;
- Psychiatric or psychological care; and
- Therapeutic care provided by a speech-language pathologist, audiologist, occupational therapist or physical therapist.

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

The Schedule of Benefits describes payment limitations for these services.

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 Participant has blood drawn and stored for the Participant's own use for a planned surgery.

Chemotherapy

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

Chiropractic Services

Services of a licensed chiropractor.

The Schedule of Benefits describes payment limitations for these services.

Contraceptives

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

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. All other FDA-approved contraceptive methods, including over-the-counter methods for which the method is both FDA-approved and prescribed for a women by a health care provider, are covered under the Prescription Drug Benefit.

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 Participant remains inpatient at the Convalescent Home when a skilled level of care is not Medically Necessary.

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

The Schedule of Benefits describes payment limitations for these services.

Dental Accident Services

Dental services provided by physicians, dentists, oral surgeons and/or any other provider are not covered under this Plan Document 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.

The Plan will not pay for services for the repair of teeth which are damaged as the result of biting and chewing.

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.

Diabetic Education

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

The Schedule of Benefits describes payment limitations for these services.

Diagnostic Services

Diagnostic x-ray examinations, laboratory and tissue diagnostic examinations and medical diagnostic procedures (machine tests such as EKG, EEG) are covered. Covered services include, but are not limited to, the following:

1. X-rays and Other Radiology. Some examples of other radiology include:
   - Computerized tomography scan (CT Scan)
   - MRIs
   - Nuclear medicine
   - Ultrasound

2. Laboratory Tests. Some examples of laboratory tests include:
   - Urinalysis
   - Blood tests
   - Throat cultures
3. Diagnostic Testing. Tests to diagnose an Illness or Injury. Some examples of diagnostic testing include:
   - Electroencephalograms (EEG)
   - Electrocardiograms (EKG or ECG)

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

Durable Medical Equipment

The appropriate type of equipment used for therapeutic purposes **where the Participant 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.

Replacement Equipment.

1. Replacement of durable medical equipment will not be subject to any reduced replacement Coinsurance that may be applicable if the replacement is five (5) years or longer after the original purchase.
2. Durable medical equipment will not be considered a replacement if the current equipment no longer meets the medical needs of the Participant due to physical changes or a deteriorating medical condition.

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 computerized and 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 Participant 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 Emergency Services.

Genetic Testing

Services provided for genetic testing for Medical Necessity and Medical Policy.

Home Health Care

The following services, when prescribed and supervised by the Participant's attending Physician provided in the Participant's home by a licensed Home Health Agency and which are part of the Participant'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 services.
8. Medical supplies and equipment suitable for use in the home.
9. Medically Necessary personal hygiene, grooming and dietary assistance.

The Plan will not pay for:

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

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

The Schedule of Benefits describes payment limitations for these services.

Home Infusion Therapy Services

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

1. Education for the Participant, the Participant's caregiver, or a Family Member;
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 Services Benefit.

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

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

Hospice Care

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

1. Inpatient and Outpatient care;
2. Home care;
3. Nursing services – skilled and unskilled;
4. Counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally ill Participant; and

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

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

Hospital Services - Facility and Professional

Inpatient Care Services Billed by a Facility Provider

1. Room and Board Accommodations
    a. Room and board, which includes special diets and nursing services.
    b. Intensive care and cardiac care units which include special equipment and concentrated nursing services provided by nurses who are Hospital employees.
2. Miscellaneous Hospital Services
    a. Laboratory procedures.
    b. Operating room, delivery room, recovery room.
    c. Anesthetic supplies.
    d. Surgical supplies.
    e. Oxygen and use of equipment for its administration.
    f. X-ray.
    g. Intravenous injections and setups for intravenous solutions.
    h. Special diets when Medically Necessary.
    i. Respiratory therapy, chemotherapy, radiation therapy, dialysis therapy.
    j. Physical Therapy, Speech Therapy and Occupational Therapy.
    k. Drugs and medicines which:
        1. Are approved for use in humans by the U.S. Food and Drug Administration; and
        2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
        3. Require a Physician's written prescription.

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

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

Inpatient Care services are subject to the following conditions:

1. Days of care
    a. The number of days of Inpatient Care provided by the Plan 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 Participant is admitted to a Hospital is counted, but the day a Participant is discharged is not. If a Participant is discharged on the day of admission, one day is counted.
    c. The day a Participant enters a Hospital is the day of admission. The day a Participant leaves a Hospital is the day of discharge.
2. The Participant will be responsible to the Hospital for payment of its charges if the Participant remains as an Inpatient Participant when Inpatient Care is not Medically Necessary. No payment will be made for Inpatient Care provided primarily for diagnostic or therapy services.
3. Preauthorization is required for Inpatient Care. Please refer to the section entitled Preauthorization.

Inpatient Care Medical Services Provided and Billed by a Professional Provider

Nonsurgical services by a Covered Provider, Concurrent Care and Consultation Services. Refer to the Surgical Services section for coverage of surgical services.

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

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

Observation Beds/Rooms

Payment will be made for observation beds when Medically Necessary.

Outpatient Hospital Services

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

Inborn Errors of Metabolism

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

Mammograms (Preventive and Medical)

Mammography examinations.

The minimum mammography examination recommendations are:

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

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 are covered. Inpatient Care following delivery will be covered for whatever length of time is Medically Necessary and will be at least 48 hours following a vaginal delivery and at least 96 hours following a delivery by cesarean section. The decision to shorten the length of stay of Inpatient Care to less than that stated in the preceding sentence must be made by the attending health care provider and the mother.

   Newborns and Mothers Health Protection Act. 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, plans or insurers may not require that a provider obtain Preauthorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

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

Please refer also to the Newborn Initial Care section.

Medical Supplies

The following supplies for use outside of a Hospital:

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

Medical supplies are covered only when:

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

Mental 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 Participant is not an Inpatient Participant 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 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. a 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 Care Services

Care and treatment of Mental Illness, while the Member is an Inpatient Participant, 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 Plan Document.

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

Partial Hospitalization

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

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

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

Naturopathy

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

The Schedule of Benefits describes payment limitations for these services.

Newborn Initial Care

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

Office Visits

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

Oral Surgery

Benefits will be provided for the following:

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

Orthopedic Devices/Orthotic Devices

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

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

Physician Medical Services

Medical services by a Covered Provider for:

1. Inpatient Hospital Physician visits.
2. Convalescent Home facility Physician visits.

3. Surgical facility Physician services.

The Plan will not pay for pre- or postsurgical visits that are considered to be Inclusive Services/Procedures 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 Participant, following a mastectomy.

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

Reconstructive Breast Surgery

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

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

The Women's Health and Cancer Rights Act is federal law that requires the services listed above to be covered under this health Plan.

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 Participant's medical Benefits. **Please refer to the Preauthorization section for complete information about the medications that are subject to the Participant's medical Benefits, the process for requesting Preauthorization for medications subject to the Participant's medical Benefits, and related information.**

Subject to the terms, conditions, and limitations of this Plan Document, the Claim Administrator will pay for Prescription Drug Products, which:

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

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

Drug Lists

Covered drugs are selected by the Claim Administrator based upon the recommendations of a committee, which is made up of current and previously practicing physicians and pharmacists from across the country, some of which are employed by or affiliated with Blue Cross and Blue Shield of Montana. The committee considers drugs regulated by the FDA for inclusion on the Drug List. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost, and how it compares with drugs currently on the Drug List. The committee considers drugs that

are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to the Drug List can be made from time to time.

The Claim Administrator may offer multiple Drug Lists. By accessing www.bcbsmt.com or www.myprime.com or calling the Customer Service toll-free number on the Participant's identification card, the Participant or provider can determine the Drug List that applies to the Participant's Plan and whether a particular drug is on the Drug List.

The Participant, or the Participant's prescribing health care provider, can ask for a Drug List exception if the Participant's drug is not on the Drug List (also known as a formulary). To request this exception, the Participant or the Participant's prescriber, can call the number on the back of the Participant's ID card to ask for a review. If the Participant has a health condition that may jeopardize his/her life, health or keep the Participant from regaining function, or the Participant's current drug therapy uses a non-covered drug, the Participant or the Participant's prescriber, may be able to ask for an expedited review process. Blue Cross and Blue Shield of Montana will notify the Participant or the Participant'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 Participant and the Participant's prescriber, know why it was denied and offer the Participant a covered alternative drug (if applicable). If the Participant's exception is denied, the Participant may appeal the decision according to the appeals process the Participant will receive with the denial determination. The Participant should call the number on the back of the ID card if the Participant has any questions.

Covered Prescription Drug Products

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

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

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

Non-Covered Prescription Drug Products

The Plan will not pay for:

1. Nonlegend drugs other than insulin.
2. Compounded medications.
3. Anabolic Steroids.
4. Any drug used for the purpose of weight loss.
5. Fluoride supplements, except as required by the Affordable Care Act for children under age 6.
6. 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.
7. Over-the-counter drugs that do not require a prescription, except over-the-counter smoking cessation aids with a written prescription.
8. Prescription Drug Products for which there is an exact over-the-counter equivalent.
9. Prescription Drug Products for cosmetic purposes, including the treatment of alopecia (hair loss) (e.g., Minoxidil, Rogaine).

10. 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.
11. Prescription Drug Products used for erectile dysfunction unless preauthorized, and when used to treat specific medical condition or ED secondary to organic disease, surgery, or injury.
12. 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.
13. Drugs or items labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though the Participant is charged for the item.
14. Biological sera, blood, or blood plasma.
15. Fertility drugs.
16. Prescription Drug Products which are to be taken by or administered to the Participant, in whole or in part, while the Participant 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.
17. 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.
18. Replacement prescription drugs or Prescription Drug Products due to loss, theft or spoilage.
19. Prescription Drug Products obtained from a pharmacy located outside the United States for consumption within the United States.
20. Prescription Drug Products provided by a mail-order pharmacy that is not approved by the Plan.
21. Repackaged medications and institutional packs and drugs which are repackaged by anyone other than the original manufacturer.
22. Non-sedating antihistamines.
23. Brand-Name Proton Pump Inhibitors (PPIs).
24. Prescription Drug Products determined by the Claim Administrator to have inferior efficacy or significant safety issues.
25. Some drugs are manufactured under multiple brand names and have many therapeutic equivalents. In such cases, the Claim Administrator may limit Benefits to specific therapeutic equivalents. If the Participant does not accept the therapeutic equivalents that are covered under the Prescription Drug program, the drug purchased will not be covered under any Benefit level.
26. Drugs that are not shown on the Drug List, other than those specifically mentioned in this document.
27. Non-FDA approved drugs.
28. Pharmaceutical aids, such as excipients found in the UPS-NF (United States Pharmacopeia National Formulary) including, but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.
29. Drugs that are in a drug class where there is an over the counter alternative available.
30. Bulk Powders.
31. Drugs related to infertility.

Vaccinations Obtained Through Select Participating Pharmacies

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

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

Controlled Substances Limitation

If the Plan determines that a Participant may be receiving quantities of controlled substance medications not

supported by FDA approved dosages or recognized safety or treatment guidelines, any Benefits for additional drugs may be subject to a review for Medical Necessity, appropriateness and other restrictions such as limiting coverage to services provided by a certain Provider and/or Participating Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. For purposes of this provision, controlled substance medications are medications classified and restricted by state or federal laws because of their potential for addiction or misuse.

Purchase and Payment of Prescription Drug Products

Prescription Drug Products may be obtained using an outpatient retail pharmacy, an extended supply pharmacy or a mail-order pharmacy approved by the Claim Administrator. To use a mail-order pharmacy, the Participant 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. In addition to any Deductible, Copayment and/or Coinsurance, if the Participant chooses a Brand-Name Drug for which a Generic substitute is available; the Participant is required to pay the difference between the cost of the Brand-Name Drug and the Generic equivalent. The address of each mail order pharmacy approved by the Plan is listed on the inside cover of this Plan Document.

If drugs or Prescription Drug Products are purchased at a Participating Pharmacy, an extended supply pharmacy or a mail order pharmacy approved by the Claim Administrator, and the Participant presents the Participant's ID card at the time of purchase, the Participant must pay any required Deductible, Copayment and/or Coinsurance. In addition to any Deductible, Copayment and/or Coinsurance, if the Participant chooses a Brand-Name Drug for which a Generic substitute is available, the Participant is required to pay the difference between the cost of the Brand-Name Drug and the Generic equivalent. The Participant will only be required to pay the appropriate Deductible, Copayment and/or Coinsurance 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. Exceptions to this provision may be allowed for certain preventive medications (including prescription contraceptive medications) if the Participant'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.

If the Participant 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 Participant will be reimbursed for the prescription drug based on the amount that would have been paid to the Participating Pharmacy, less the Participant's Deductible, Copayment and/or Coinsurance.

If drugs or Prescription Drug Products are purchased at a nonparticipating Outpatient pharmacy, the Participant 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 Participant will be reimbursed at the amount that would have been paid to a Participating Pharmacy, less any Deductible and Copayment/Coinsurance and any additional charge for the difference between the cost of the Brand-Name Drug and the Generic equivalent.

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

1. Prescription Drug Products subject to Preauthorization require prior approval from the Plan's Pharmacy Benefit Manager before they can qualify for coverage under the Plan. If the Participant does not obtain Preauthorization before a Prescription Drug Product is dispensed, the Participant 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 Participant should then submit a claim for the prescription drug on a prescription claim form to the Plan's Pharmacy Benefit Manager for reimbursement.
2. Preauthorization does not guarantee payment of the Prescription Drug Product by the Plan. Even if the prescription drug has been preauthorized, coverage or payment can be affected for a variety of reasons. For example, the Participant may have become ineligible as of the date the drug is dispensed or the Participant's Benefits may have changed as of the date the drug is dispensed.
3. The step therapy program requires that the Participant has a prescription history for a "first-line" medication before the Plan will cover a "second-line" drug. A first-line drug is recognized as safe and works well in treating a specific medical condition, as well as being a cost-effective treatment option. A second-line drug is a less preferred or likely a more costly treatment option. If the Participant and his/her doctor decide that a first-line drug is not right for the Participant or is not as good in treating Participant's condition, the doctor should submit a Preauthorization request for coverage of the second-line drug.

4. A dispensing limit is a limitation on the number or amount of a Prescription Drug Product covered within a certain time period. Dispensing limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, to control for billing errors by pharmacies, to encourage dose consolidation, appropriate utilization, and to avoid misuse/abuse of the medication. A prescription written for a quantity in excess of the established limit will require a clinical review before Benefits are available.

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 Participant's provider is prescribing a Prescription Drug Product subject to Preauthorization, step therapy, or dispensing limits, the provider should fax the request for Preauthorization to the Claim Administrator's Pharmacy Benefit Manager at the fax number listed on the inside cover of this Plan Document. The Participant and provider will be notified of the Claim Administrator's Pharmacy Benefit Manager's determination.

In making determinations of coverage, the Claim Administrator'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 Claim Administrator website at www.bcbsmt.com.

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

Specialty Medications

1. Specialty Medications are generally prescribed for individuals with complex or ongoing medical conditions such as multiple sclerosis, hemophilia, hepatitis C and rheumatoid arthritis. These high cost medications also have one or more of the following characteristics:

   a. Injected or infused, but some may be taken by mouth
   b. Unique storage or shipment requirements
   c. Additional education and support required from a health care professional
   d. Usually not stocked at retail pharmacies

2. 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 Plan Document. A list of covered Specialty Medications may be found on the Plan website at www.bcbsmt.com. Registration and other applicable forms are also located on the website.

Preventive Health Care

Covered preventive services include, but are not limited to:

1. Services that have an "A" or "B" rating in the United States Preventive Services Task Force's (USPSTF) current recommendations (additional information is provided by accessing http://www.uspreventiveservicestaskforce.org); and

2. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention (CDC); and

3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;

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

   a. Lactation Services

      Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the

postpartum period. In addition, Benefits are provided for the purchase of manual or electric breast pumps or the rental of Hospital-grade pumps. The purchase of an electric breast pump is limited to one electric breast pump per Benefit Period. Payment will be made according to the Preventive Health Care Benefit on the Schedule of Benefits.

b. Contraceptives

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

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

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 include, but are not limited to, physical examinations, colonoscopies, immunizations and vaccinations.

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

Private Duty Nursing

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

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.

Replacement Prosthesis.

1. Replacement of a prosthesis will not be subject to any reduced replacement Coinsurance that may be applicable if the replacement is five (5) years of longer after the original purchase.
2. A prosthesis will not be considered a replacement if the original prosthesis no longer meets the medical needs of the Participant due to physical changes or a deteriorating medical condition.

The Plan will not pay for the following items:

1. Prostheses required primarily for use in athletic activities;
2. Replacement of lost or stolen prostheses.
3. Duplicate prosthetic devices purchased primarily for Participant convenience when the need is not medical in nature; or
4. Computer-assisted communication devices.

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 Participant.

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

1. Custodial Care;

2. Diagnostic admissions;
3. Maintenance, nonmedical self-help, or vocational educational therapy;
4. Social or cultural rehabilitation;
5. Learning and developmental disabilities; and
7. 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 Illness sections.

Benefits will be provided for services, supplies and other items that are within the scope of the Rehabilitation benefit described in this Rehabilitation section only as provided in and subject to the terms, conditions and limitations applicable to this Rehabilitation benefit section and other applicable terms, conditions and limitations of this Plan Document. Other Benefit sections of this Plan Document, 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 Participant's admission), including but not limited to:
    a. Rehabilitation Therapy services and supplies, including but not limited to Physical Therapy, Occupational Therapy and Speech Therapy.
    b. Laboratory procedures.
    c. Diagnostic testing.
    d. Pulmonary services and supplies, including but not limited to oxygen and use of equipment for its administration.
    e. X-rays and other radiology.
    f. Intravenous injections and setups for intravenous solutions.
    g. Special diets when Medically Necessary.
    h. Operating room, recovery room.
    i. Anesthetic and surgical supplies.
    j. Drugs and medicines which:
        1. Are approved for use in humans by the U.S. Food and Drug Administration; and
        2. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
        3. Require a Physician's written prescription.

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

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

Rehabilitation Facility Inpatient Care is subject to the following conditions:

1. The Participant will be responsible to the Rehabilitation Facility for payment of the Facility's charges if the Participant remains as an Inpatient Participant when Rehabilitation Facility Inpatient Care is not Medically Necessary. No Benefits will be provided for a bed "reserved" for a Participant.

2. The term “Rehabilitation Facility” does not include:

   a. A Hospital when a Participant 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;
   i. A long-term, chronic-care institution or facility providing the type of care listed above.

Rehabilitation Facility Inpatient Care Services Billed by a Professional Provider

All Professional services provided by a Covered Provider who is a physiatrist or other Physician directing the Participant’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 Participant. Professional services provided by other Covered Providers (i.e., who are not the Physician directing the Participant’s Rehabilitation Therapy) are not included in the Rehabilitation Benefit, but are included to the extent provided in and subject to the terms, conditions and limitations of other contract benefits (e.g., Physician Medical Services).

Outpatient Rehabilitation

Rehabilitation Therapy provided on an outpatient basis by a Facility or Professional Provider.

Substance Use Disorder

Outpatient Services

Care and treatment for Substance Use Disorder when the Participant is not an Inpatient Participant and care is provided 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 psychologist;
6. a licensed social worker;
7. a licensed professional counselor;
8. an addiction counselor licensed by the state;
9. a licensed psychiatrist; or
10. a Qualified Health Care Provider.

Outpatient Benefits are subject to the following conditions:

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

The Claim Administrator 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 Participant is an Inpatient Participant, 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 the Plan.

Inpatient Care services and services provided at a Residential Treatment Center must be Preauthorized. Please refer to the section entitled Preauthorization.

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.

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

Surgical Services

Surgical Services Billed by a Professional Provider

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

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

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

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

Surgical Services Billed by a Hospital (Inpatient and Outpatient)

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

Telemedicine

Benefits for services provided by Telemedicine when such services are Medically Necessary Covered Medical Expenses provided by a Covered Provider.

Therapies - Outpatient

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

Transplants

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

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. Participants being considered for a transplant procedure are encouraged to contact Blue Cross and Blue Shield of Montana Customer Service to discuss the possible benefits of utilizing the Centers of Excellence.

Transplant services include:

1. Organ procurement including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ and transportation of the donor or donor organ to the location of the transplant operation.
2. Donor services including the pre-operative services, transplant related diagnostic lab and x-ray services, and the transplant surgery hospitalization. Transplant related services are covered for up to six months after the transplant.
3. Hospital Inpatient Care services.
4. Surgical services.
5. Anesthesia.
6. Professional provider and diagnostic Outpatient services.
7. Licensed ambulance travel or commercial air travel for the Participant 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 Participants, both will receive Benefits.
2. When the transplant recipient is a Participant and the donor is not, both will receive Benefits to the extent that benefits for the donor are not provided under other hospitalization coverage.
3. When the transplant recipient is not a Participant and the donor is, the donor will receive Benefits to the extent that benefits are not provided to the donor by hospitalization coverage of the recipient.

The Plan will not pay for:

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

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

Virtual Visits

Benefits for services provided by consultation with a licensed provider participating in the MDLIVE program through interactive video via an online portal or mobile application. Virtual Visits provide access to providers who can provide diagnosis and treatment of non-emergency medical conditions and Mental Illness in situations that may be handled without a traditional office visits, urgent care visit or emergency room care.

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

Vision Services

The Plan will pay for the reasonable expense up to the maximum allowance shown in the Schedule of Benefits.

1. One routine vision exam per benefit period.
2. Lenses, frames, and contact lenses – up to $150 combined maximum per Benefit Period.

The Schedule of Benefits describes payment limitations for these services.

Well-Child Care

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

Benefits shall include coverage for:

1. Histories;

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

Wigs

Provided as the result of an illness or health condition by a durable medical equipment provider.

The Schedule of Benefits describes payment limitations for these services.

COORDINATION OF BENEFITS WITH OTHER INSURANCE

The Coordination of Benefits (COB) provision applies when a Participant 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 Plan Document 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;
7. Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

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

This Plan

In a COB provision, “this plan” means that part of the Plan Document 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 Plan Document providing health care benefits is separate from this plan. A contract may apply one COB provision to

certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules

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

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

Allowable Expense

A Covered Medical Expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the Participant. 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 Participant 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 Participant 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 Participant 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 Participant 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 Participant is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the primary plan because a Participant 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 Participant is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

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

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

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

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

Non-Dependent or Dependent.

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

Dependent Child Covered Under More Than One Plan.

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

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

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

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

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

  - The plan covering the custodial parent;
  - The plan covering the spouse of the custodial parent;
  - The plan covering the non-custodial parent; and then;
  - The plan covering the spouse of the non-custodial parent.

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

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

4. Active Employee or Retired or Laid-off Employee

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

5. **COBRA or State Continuation Coverage**

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

6. **Longer or Shorter Length of Coverage**

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Blue Cross and Blue Shield of Montana may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the Participant claiming benefits. Blue Cross and Blue Shield of Montana need not inform, or get the consent of, any person to do this. Each Participant 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 Participants 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 Participant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination With Medicare

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

1. For Working Aged

Medicare pays secondary to the Plan for Benefits for Participants and their spouses who are Participants, covered by employers with 20 or more Employees, who qualify for age-based Medicare as a result of attaining age 65 and older and who are covered by virtue of the Participant's current employment status.

Medicare will be the primary for a Participant that refuses coverage under this Plan Document.

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

2. For Disabled Participants under Age 65

Medicare pays secondary to the Plan for Benefits for Participants under age 65, covered by employers with 100 or more employees, who qualify for disability-based Medicare and are covered by virtue of a Participant's current employment status.

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

3. For End-Stage Renal Disease

Medicare pays secondary to the Plan for Benefits for Participants who qualify for Medicare as a result of end-stage renal disease ("ESRD"), regardless of employer size, and are entitled to Benefits payable under this Plan Document, for the first 30 months that a particular Participant qualifies for Medicare as a result of ESRD. After the 30 month period, Medicare will pay primary to the Plan.

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

- **a.** If the Plan is required to pay before Medicare under 1 or 2 above for a Participant before the Participant qualifies for Medicare based on ESRD, the Plan will continue to pay primary to Medicare after the Participant becomes covered under Medicare based on ESRD but only for the 30 month period above, after which Medicare will pay primary to the Plan.
- **b.** If the Plan is required to pay primary to Medicare based on ESRD and the Participant that qualifies for Medicare based on ESRD above later becomes entitled to age-based or disability-based Medicare during the 30 month period, Medicare will pay second to the Plan for the duration of the 30 month period, after which Medicare will pay primary to the Plan. If the Participant qualifies for age-based or disability-based Medicare after the 30 month period, Medicare will pay primary to the Plan.
- **c.** Medicare continues to be primary to the Plan after an aged or disabled Participant becomes eligible for Medicare based on ESRD if:
  - **1.** The Participant is already entitled to Medicare on the basis of age or disability when the Participant becomes eligible for Medicare based on ESRD; and
  - **2.** The Group has fewer than 20 employees in the case of age-based Medicare or fewer than 100 employees in the case of disability-based Medicare.

4. For Retired Persons

Medicare is primary to the Plan for Participants age 65 if the Participant is a qualified individual age 65 and over and retired.

Medicare is primary to the Plan for Participant's spouse who is also a Participant and who is a qualified individual if both the Participant and the Participant spouse are age 65 and over and retired.

5. Current Employment Status

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

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

EXCLUSIONS AND LIMITATIONS

All Benefits provided under this Plan 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 Participant'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 Participant waives his or her rights to such coverage or benefits.
- **d.** The Participant fails to file a claim within the filing period allowed by law for such benefits.
- **e.** The Participant fails to comply with any other provision of the law to obtain such coverage or benefits.
- **f.** The Participant 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 Participant is permitted by statute not to be covered and the Participant elects not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws.

This Exclusion will not apply if the Participant'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 Participant is entitled to receive or does receive TRICARE, the Veteran's Administration (VA), and Indian Health Services but not Medicaid. This Exclusion is not intended to exclude Covered Medical Expenses from coverage if a Participant is a resident of a Montana state institution when services are provided.

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

3. Services, supplies, and medications provided to treat any Injury to the extent the Participant receives, or would be entitled to receive where liability is reasonably clear, benefits under an automobile insurance policy. Such benefits received by the Participant shall be used first to satisfy any remaining Coinsurance, Copayment and Deductible related to the Injury for which claims are submitted to the Plan. The Injury related claims must be submitted to the Plan to apply any applicable credit to Coinsurance, Copayment and/or Deductible.

4. Services, supplies, and medications provided to treat any Injury to the extent the Participant receives, or would be entitled to receive where liability is reasonably clear, benefits from a premises liability policy. Examples of such policies are a homeowners or business liability policy. Such benefits received by the Participant shall be

used first to satisfy any remaining Coinsurance, Copayment and Deductible related to the Injury for which claims are submitted to the Plan. The Injury related claims must be submitted to the Plan to apply any applicable credit to Coinsurance, Copayment and/or Deductible.

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

6. Any loss for which a contributing cause was the commission of a felony or serious illegal act, or an attempt to commit a felony or an attempt to commit a serious illegal act. This exclusion does not apply to the extent the Participant suffers a loss as a victim of domestic violence.

7. Services for which a Participant is not legally required to pay or charges that are made only because Benefits are available on this Plan.

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

9. Surgical and 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.

10. Orthodontics.

11. All dental services, including but not limited to ridge augmentation and vestibuloplasty, whether performed by Physicians, dentists, oral surgeons and/or any other provider, except for services provided as the result of a Dental Accident.

12. Vision services, except as specifically included as a Benefit.

13. Hearing aids, except when hearing loss is the result of a surgical procedure that was performed while the Participant was covered under this health plan. In addition, Medically Necessary cochlear implants may be covered per Medical Policy.

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

15. For travel by a Participant or provider.

16. Elective abortions.

17. Any service or procedure which is determined by the Claim Administrator to be an Inclusive Service/Procedure.

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

    a. Experimental/Investigational/Unproven Services, except for services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial. The Plan has the ultimate authority and right to determine what services are Experimental/Investigational/Unproven and are excluded from coverage.
    b. Not accepted standard medical practice. The Plan may consult with physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice.
    c. Not a Covered Medical Expense.
    d. Not Medically Necessary.
    e. Not covered under applicable Medical Policy.

19. 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 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.

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

21. Reversal of an elective sterilization.

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

23. Services, supplies and drugs provided for the treatment and diagnosis of infertility.

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

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

26. Foot orthotics.

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

28. Services, 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.

29. Services provided by a massage therapist.

30. Sanitarium care, custodial care, rest cures, or convalescent care to help the Participant with daily living tasks. 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. Examples include but are not limited to, help in:

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

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

32. Over-the-counter food supplements, formulas, and/or Medical Foods, regardless of how administered except when used for Inborn Errors of Metabolism, and except to the extent as required by the Affordable Care Act.

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

34. Services, supplies, drugs and devices for weight reduction or weight control. This Exclusion does not include intensive behavioral dietary counseling when services are provided by a Physician, Physician Assistant or Nurse Practitioner.

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

36. Services, supplies, drugs and devices for the treatment of Illness, Injury and/or complications resulting from services that are not Covered Medical Expenses, except for any services, supplies, drugs and devices which are Routine Patient Costs incurred in connection with an Approved Clinical Trial.

37. Tutoring services.

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

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

40. Deluxe medical equipment including, but not limited to, durable medical equipment, prosthetics and communication devices except as included in the Durable Medical Equipment Benefit and the Prosthetic Benefit in the section entitled “Benefits.”

41. Applied Behavior Analysis (ABA) services, except as specifically included in this Plan Document under Autism Spectrum Disorders.

42. Services, supplies, drugs and devices provided by a Family Member.

43. Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution or provider, as determined by the Plan Administrator, in its desecration, in light of applicable laws and evidence available to the Plan Administrator.

44. Any services, supplies, drugs and devices that are required as a result of unreasonable provider error.

45. Any services, supplies, drugs and devices for an Illness, Injury or sickness not payable by virtue of the Plan’s subrogation, reimbursement, and/or third-party responsibility.

46. Any services, supplies, drugs and devices that are not reasonable in nature or in charge, or are required to treat Illness or Injury arising from and due to a provider’s error, wherein such Illness, Injury, infection or complication is not reasonable expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professional practicing in the same or similar type(s) of medicine as the treating provider whose error caused the loss(es).

47. Occupational Injury. Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies even though the Plan Participant:

    a. Has waived his/her rights to Workers’ Compensation benefits;
    b. Was eligible for Workers’ Compensation benefits and failed to properly file a claim for such benefits;
    c. The Plan Participant is permitted to elect not to be covered under Workers’ Compensation and has failed to properly file for such election;
    d. The Plan Participant is permitted to elect not to be covered under Workers’ Compensation and has made such election; or
    e. Executed a disputed liability settlement with Workers’ Compensation.

48. Services, supplies, drugs and devices which are not listed as a Benefit as described in this Plan Document.

CLAIMS INFORMATION

How to Obtain Benefits for Covered Medical Expenses

When a Participant obtains services from a covered health care provider, the Participant must present the Participant’s identification card to the provider of care. Billing and payments for Physician, Hospital, and other other providers usually will be handled directly by the provider’s office. Normally, there are no claim forms for the Participant to file. A Participating Professional or Facility Provider will always file claims directly with the Claim Administrator.

How to File a Claim

If it is necessary for the Participant to file a claim, the Participant should obtain an itemized bill from the provider which includes all information about the services so the Claim Administrator can determine whether or not they are Covered Medical Expenses. The itemized bill must contain the following information:

- Employee's name
- Employee Plan Identification Number from the ID card
- Name of patient
- Patient's date of birth
- Employee's address
- Provider name, address, telephone number
- Provider number
- Type of service
- Procedure code for each service
- Date of each service
- Diagnosis
- Charge for each service

Send this itemized bill to:

Blue Cross and Blue Shield of Montana
P.O. Box 7982
Helena, MT 59604-7982

In certain instances, the Claim Administrator may require that additional documents or information be submitted, including, but not limited to, accident reports and medical records. This information must be submitted within the time frame requested when the additional documentation is requested, before payment can be made for the services.

Claims must be submitted no later than 12 months from the date of service.

Out-of-State Services – Claims for Family Members Who Live Out of State and All Other Claims for Out-of-State Services

Family Members who live out of state or Participants who have health care services out of state should use Participating Blue Cross and Blue Shield Providers in that state. In most cases providers will file claims directly with the Claim Administrator. Please refer to the BlueCard Program section. If the provider does not file the claim, the Participant should use the same procedures outlined in the section entitled Claims Information.

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 Participant ID cards. To find a Prime Therapeutics Participating Pharmacy or a Participating Pharmacy nearest the Participant, 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 Participant's ID card to the pharmacist.
3. Make sure that the pharmacist has complete and correct information about the Participant for whom the prescription is written, including sex and date of birth.
4. When the Participant receives a prescription, he or she should sign the pharmacy log and pay his or her share of the cost.
5. If a Participant purchases prescription drugs from a participating outpatient pharmacy, an extended supply pharmacy or mail-service pharmacy approved by the Plan, the Participant must pay for the Prescription Drug Product and the pharmacy will submit the prescription drug claims to Pharmacy Benefit Manager.
6. The Participant must pay the difference between a Brand-Name Drug and the Generic equivalent if the Participant purchases a Brand-Name Prescription drug when a Generic Prescription drug substitute is available.

7. The Plan makes use of a Drug List, which is a list of preferred prescription drugs for dispensing to Participants as appropriate.
8. For prescriptions filled at a pharmacy that is not part of the network, the Participant will need to pay the pharmacist the entire cost of the prescription at the time the prescription is filled and dispensed and submit a paper claim to Pharmacy Benefit Manager for reimbursement. If a Participant does not present his or her ID card at a Participating Pharmacy, a paper claim must be submitted by the Participant to Pharmacy Benefit Manager for reimbursement. The Participant will be reimbursed at the contracted rate minus Copayment, Coinsurance and Deductible, if applicable, in both situations. The Participant 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 Claim Administrator at the telephone number on the inside cover of this document.

Mail-Service Pharmacy

The Participant may obtain maintenance prescriptions through the mail. Maintenance prescriptions are those that the Participant 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 Claim Administrator 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 Participant's current pharmacy telephone number, prescription numbers to be transferred; and
   c. the Participant's telephone number.
3. Mail the form to the mail service pharmacy at the address listed on the form.

PRIVACY OF PROTECTED HEALTH INFORMATION

Protected Health Information about a Plan Participant will not be disclosed to the Plan Sponsor by the Health Plan or any Business Associate servicing the Health Plan, unless the Plan Sponsor certifies that the Plan Documents have been amended to include this section and the Plan Sponsor agrees to abide by this section. Any disclosure to and use by the Plan Sponsor will comply with all provisions of this section.

Definitions

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

1. Business Associate.

   A person or entity who performs, or assists in performing or provides a function or activity that involves the use or disclosure of Protected Health Information on behalf of the Health Plan. Such functions or activities include, but are not limited to, claims processing, claims administration, data analysis, data processing, data administration, utilization review, quality assurance, billing, benefit management, legal services, marketing services, accounting services, and administration services.

2. Federal Regulations.

   Those regulations entitled Standards for Privacy of Individually Identifiable Health Information, 45 CFR §160 and §164.

3. Group Health Plan.

   A self-insured employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act (ERISA) that provides coverage for medical care.

4. Health Plan or Plan.

   The Group Health Plan, provided to the Plan Participants by or through the Plan Sponsor. The Group Health Plan may be administered by a third-party health insurance carrier or other third-party administrator. The health insurance issuer or third-party administrator is the Business Associate of the Group Health Plan.

5. Plan Participant.

   A person covered under the Group Health Plan.

6. Plan Sponsor.

   The Employer or other entity that sponsors the Group Health Plan, as defined in Section 3(16)(B) of ERISA.

7. Protected Health Information (PHI).

   Individually identifiable health information transmitted, including electronic transmission, or maintained in any form or medium.

Purpose of Disclosure to Plan Sponsor

A Plan Participant's PHI will only be disclosed to the Plan Sponsor by the Health Plan, or a Business Associate servicing the Health Plan, subject to the following:

1. To permit the Plan Sponsor to carry out Plan administration functions that are in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. Disclosures to the Plan Sponsor of a Plan Participant's PHI will be explained in the Notice of Privacy Practices issued to Plan Participants by the Health Plan.
3. No Plan Participant's PHI will be disclosed to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other Benefit or employee benefit plan of the Plan Sponsor. 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 Participant's explanation of benefits (EOB) or in a letter from the Plan, whether adverse or not. There are five types of claims:

Restrictions on Plan Sponsor's Use and Disclosure of PHI

The Plan Sponsor will:

1. Not use or further disclose PHI except as permitted or required by the Plan Documents, as amended by this section, or required by law.
2. Ensure that any agent, including subcontractors, to whom it provides PHI agrees to the restrictions and provisions of the Plan Documents, including this section.
3. Not use or disclose PHI for the purpose of employment-related actions or decisions or in connection with any other Benefit or Employee Benefit plan of the Plan Sponsor.
4. Promptly report to the Health Plan any use or disclosure of PHI that does not comply with the provisions of this section upon learning of such noncompliance.
5. Make PHI, located in a Plan Participant's designated record set, available to the Plan Participant who is the subject of the information, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for their information.
6. Make PHI, located in a Plan Participant's designated record set, available for amendment, and amend PHI, in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for amendment.
7. Provide an accounting of disclosure to Plan Participants in accordance with Federal Regulations. Plan Participants must provide a written request to the Health Plan for an accounting of disclosures.

8. Make its internal practices, books, and records, relating to its use and disclosure of PHI, available to the Health Plan and the United States Department of Health and Human Services to determine compliance with Federal Regulations.
9. If feasible, and subject to 9b below:
    a. Return or destroy all PHI, and retain no copies, when the PHI is no longer needed for the Plan administration functions for which the disclosure was made. This includes:
        1. PHI, in whatever form or medium (including any electronic medium under the Plan Sponsor's custody or control), received from the Health Plan or a Business Associate; and
        2. Any data or compilations derived from and allowing identification of any Plan Participant who is the subject of the PHI.
    b. If it is not feasible to return or destroy all PHI, the Plan Sponsor will limit the use or disclosure of any PHI that it cannot return or destroy to those purposes that make it unfeasible to return or destroy the PHI.

Adequate Separation Between the Plan Sponsor and the Plan

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to PHI received from the Health Plan or the Business Associate servicing the Plan. This includes those Employees who may receive PHI relating to payment under, health care operations of, or other matters pertaining to the Health Plan in the ordinary course of business:

Melissa Moore, Director of Human Resources
Angela Austin, Human Resource Assistant
Emily Isaacson, Accountant
Ron Wiens, Chief Financial Officer
Mary Kay Puckett, Senior Consultant, Leavitt Great West Insurance
Heather Brewer, Account Executive, Leavitt Great West Insurance
Clarity Benefits – for COBRA purposes
DataSmart – Claims and Eligibility

Access to PHI will be given to the Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, only to perform the Plan administration functions that the Plan Sponsor provides for the Health Plan.

The Employees, classes of Employees or other workforce members under the control of the Plan Sponsor, as identified above, will be subject to disciplinary action and sanctions, up to and including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of PHI in breach or violation of, or noncompliance with the provisions of this section.

The Plan Sponsor will promptly report any breach or violation of, or noncompliance as required in the section entitled "Restrictions on Plan Sponsor's use of Disclosure of PHI," Item 4 of this section. The Plan Sponsor will cooperate with the Health Plan to:

1. Correct the breach or violation of or noncompliance.
2. Impose appropriate disciplinary action or sanctions on the person(s) responsible for causing the breach or violation of or noncompliance.
3. Mitigate any detrimental effect of the breach or violation of or noncompliance on any Plan Participant who may have had the privacy of PHI compromised by the breach or violation of or noncompliance.

GENERAL PROVISIONS

Plan Administrator Powers and Duties

The Plan Administrator shall have total and exclusive responsibility to control, operate, manage, and administer the Plan in accordance with its terms. The Plan Administrator shall have all the authority that may be necessary or helpful to enable it to discharge its responsibilities with respect to the Plan. Without limiting the generality of

the preceding sentence, the Plan Administrator shall have the exclusive right: to interpret the Plan; to determine eligibility for coverage under the Plan; to determine eligibility for Benefits under the Plan; to construe any ambiguous provisions of the Plan; to correct any default; to supply any omission; to reconcile any inconsistency; and to decide any and all questions arising in administration, interpretation, and application of the Plan.

The Plan Administrator shall have full discretionary authority in all matters related to the discharge of its responsibilities and the exercise of authority under the Plan, including, without limitation, the construction of the terms of the Plan, and the determination of eligibility for coverage and Benefits. The decisions of the Plan Administrator, as Plan Administrator, shall be conclusive, binding and final upon all persons having or claiming to have any right or interest in or under the Plan and no such decision shall be modified under judicial review unless such decision is proven to be arbitrary or capricious.

The Plan Administrator may delegate some or all of its authority under the Plan, or revoke such delegation to any person or persons provided that any such delegation or revocation of delegation is in writing. The Plan Administrator may delegate its authority to determine eligibility for Benefits to the Claim Administrator.

Entire Plan; Changes

This Plan supersedes any previous plan. This Plan, including the amendments and attached papers, if any, constitutes the entire Plan. No change in this Plan is valid until made pursuant to the section entitled Modification of Plan.

Modification of Plan

The Plan Sponsor and Plan Administrator reserve the right to amend the Plan in whole or in part at any time, including the right to make any amendments to a contract with an insurance company, and the right to amend any rules adopted for the administration of the Plan. Expenses incurred prior to the Effective Date of any amendment are based on the provisions in effect at the time the expenses were incurred. The Employer reserves the right to change or cancel any Benefits under the Plan, at any time. Any such change in Benefits will be based solely on the decisions of the Employer and may apply to active Employees, future retirees and current retirees as either separate groups or as one group. If the Employer cancels any Benefits under the Plan, participation in the canceled Benefits terminates on the date of the cancellation, unless otherwise specified.

The Employer may terminate the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate, unless the Plan is continued by a successor to the Employer. Any such termination in Benefits will be based solely on the decision of the Employer and may apply to current Employees and their Dependents, future retirees and current retirees as either separate groups or as one group.

Notice of Change

All changes or amendments to this Plan that directly or indirectly relate to any Benefit or coverage under the Plan including any increase in contribution for coverage required from a Participant, will be reported to all eligible Participants in accordance with federal law after the date such change or amendment is adopted.

Clerical Errors

No clerical error on the part of the Claim Administrator shall operate to defeat any of the rights, privileges, or Benefits of any Participant covered under this Plan. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits will be made. Clerical errors shall not prevent administration of this Plan in strict accordance with its terms.

Notice of Annual Meeting

The Policyholder is hereby notified that it is a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative or by proxy at all meetings of Members of said Company. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

For purposes of the aforementioned paragraph the term "Member" means the group, trust, association or other entity to which this Plan Document has been issued. It does not include Family Members covered under the Plan

Document. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Plan Document to "premium(s) (dues)" shall mean "charge(s)."

Notices Under Plan

Any notice required by this Plan may be given by United States mail, postage paid. Notice to the Participant will be mailed to the address appearing on the records of the Plan. Notice to the Plan should be sent to the Plan Sponsor. Any time periods included in a notice shall be measured from the date the notice was mailed.

Rescission of Plan Document

This Plan Document is subject to rescission if the Participant commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, concerning a Participant's health, claims history, or current receipt of health care services. Blue Cross and Blue Shield of Montana will provide at least 30 days advance written notice to the Participant before coverage may be rescinded.

Payment of Claims and Assignment of Benefits

Claim Payment Assignment

All payments by the Claim Administrator for the benefit of any Participant may be made directly to any Provider furnishing Covered Medical Expenses for which such payment is due, and the Claim Administrator is authorized by such Participant to make such payments directly to such providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Participant or provider furnishing Covered Medical Expenses. All benefits payable to the Participant which remain unpaid at the time of the death of the Participant will be paid to the estate of the Participant.

Claim Dispute

Once Covered Medical Expenses are rendered by a provider, the Participant has no right to request the Claim Administrator not to pay the Claim submitted by such provider and no such request by a Participant or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Participant or any other person because of its rejection of such request.

Plan Coverage Assignment

Neither the Plan nor a Participant's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non-assignable or non-transferable and will be forfeited if a Participant attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the Claim Administrator makes payment because of a person's wrongful use of the identification card of a Participant, such payment will be considered a proper payment and the Claim Administrator will have no obligation to pursue recovery of such payment.

Validity of Plan

If any part, term, or provision of this Plan is held by the courts to be illegal or in conflict with any law of the state of Montana, 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 Plan did not contain the particular part, term, or provision held to be invalid.

Participants Rights

A Participant has no rights or privileges except as specifically provided in this Plan. Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any Participant, or as the right of any Participant to continue in the employment of the Employer or as a limitation of the right of the Employer to discharge any of its Employees with or without cause.

Alternate Care

This Plan may, at its sole discretion, make payment for services that are not listed as a Benefit of this Plan. Such payment will be made only upon mutual agreement by the Participant, the Plan Administrator, and/or the Claim Administrator. Such payment does not act as a waiver of the terms of this Plan.

Benefit Maximums

If a Participant receives services payable under any section of this Plan and exhausts all Benefits available under that section, no Benefits are available under any other section for that same condition.

Pilot Programs

The Plan reserves the right to develop and enter into pilot programs to test the success of providing Benefits for care not normally covered under this Plan. The existence of a pilot program does not guarantee that all Participants are eligible for the pilot program Benefits or that such Benefits will be permanent.

Research Fees

The Plan reserves the right to charge a reasonable fee when extensive research is necessary to reconstruct information or documents which were previously provided in writing to the Participant by the Plan. Fees may be charged for the costs of copying labor, supplies and postage. Fees will not be charged for searching for and retrieving the requested information.

Cooperation of Participant

The Participant must cooperate fully with the Plan, and any person or entity administering this Plan Document on behalf of the Plan, in providing documents and information requested to determine whether the Participant is or remains eligible for membership; to determine whether services are Covered Medical Expenses; to determine whether any term or exclusion of this Plan Document applies; and to make any other determination necessary to administer this Plan Document. Required cooperation by a Participant includes executing such consents, releases, disclosure authorizations and other documents as may be requested by the Plan in order to obtain documents or information from a third party necessary to make such determinations.

Required cooperation of a Participant includes but is not limited to providing or authorizing the provision of the following to the Plan:

1. All medical, hospital, dental, vision and other health care records relating to the diagnosis or treatment of or services or items provided to the Participant;
2. All information and documents regarding coverage, policy limits, claim payments, demands, litigation, settlement (including disputed and undisputed liability settlements) under any applicable or potentially applicable insurance, health plan, government benefit program or other health or medical payor plan or program, including but not limited to:
    a. Workers' compensation, FELA or other similar plan or program providing benefits for injury or illness arising out of employment;
    b. Personal, commercial or other automobile insurance, including but not limited to no-fault medical payment, liability or other coverages; and
    c. Personal, homeowners, commercial, or other premises insurance, including but not limited to no-fault medical payment, liability or other coverages.

Statements are Representations

In the absence of fraud, all statements by applicants or the Participant shall be deemed to be representations and not warranties.

Any representations or statements made to a Participant by the Plan Administrator, their representatives or agent, about being covered for Benefits under the Plan, which conflict with the provisions of the Plan shall:

1. Not be considered as representations or statements made by, or on behalf of, the Plan Administrator;
2. Not bind the Plan Administrator for Benefits under the Plan.

Any Participant who, with intent to defraud of knowing that he or she is facilitating a fraud against the Employer, submits an application or files a claim containing a false, incomplete, or misleading statement is guilty of fraud. The Employer reserves the right to take appropriate action in any instance where fraud is at issue.

Plan Audit

The Plan reserves the right to review bills and identify claims that are not Medically Necessary.

Participant/Provider Relationship

Choosing a Provider

The choice of a Provider is solely the choice of the Participant and the Claim Administrator will not interfere with the Participant's relationship with any provider.

Claim Administrator's Role

It is expressly understood that the Claim Administrator does not itself undertake to furnish hospital, medical or dental services, but solely to make payment to a provider for the Covered Medical Expenses received by Participants. The Claim Administrator is not in any event liable for any act or omission of any provider or the agent or employee of such provider, including, but not limited to, the failure or refusal to render services to a Participant. Professional services which can only be legally performed by a provider are not provided by the Claim Administrator. Any contractual relationship between a provider and the Claim Administrator shall not be construed to mean that the Claim Administrator is providing professional services.

Intent of Terminology

The use of an adjective such as approved, administrator, participating, in-network or network in modifying a provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such provider. In addition, the omission, non-use or non-designation of approved, administrator, participating, in-network, network or any similar modifier or the use of a term such as non-approved, non-administrator, non-participating, out-of-network or non-network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such provider.

Provider's Role

Each provider provides Covered Medical Expenses only to covered Participants and does not deal with or provide any services to the Employer (other than as an individual Participant) or the Plan.

Recovery, Reimbursement, and Subrogation

By enrollment in this Plan, Participants agree to the provisions of this section as a condition precedent to receiving Benefits under this Plan. Failure of a Participant to comply with the requirements of this section may result in the pending of the payment of Benefits.

1. Right to Recover Benefits Paid in Error

If the Plan makes a payment in error on behalf of a Participant or an assignee of a Participant to which the Participant is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefited from the payment. The Plan can deduct the amount paid from the Participant's future Benefits or from the Benefits of any covered Family Member even if the erroneous payment was not made on that Family Member's behalf.

Payment of Benefits by the Plan for Participants' spouses, ex-spouses, or children, who are not eligible for coverage under this Plan, but for whom Benefits were paid based upon inaccurate, erroneous, false information or omissions of information provided or omitted by the Employee, will be reimbursed to the Plan by the Employee. The Employee's failure to reimburse the Plan after demand is made may result in an interruption in or loss of Benefits to the Employee, and could be reported to the appropriate governmental authorities for investigation of criminal fraud and abuse.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine. By receipt of Benefits under this Plan, each Participant authorizes the deduction of any excess payment of such Benefits or other present or future compensation payments.

The provisions of this subsection apply to any licensed health care provider who receives an assignment of Benefits or payment of Benefits under this Plan. If a licensed health care provider refuses to refund improperly paid claims, the Plan may refuse to recognize future assignments of Benefits to that provider.

2. Reimbursement

The Plan's right to reimbursement is separate from and in addition to the Plan's right of subrogation. Reimbursement means to repay a party who has paid something on another's behalf. If the Plan pays Benefits for medical expenses on a Participant's behalf, and another party was actually responsible or liable to pay those medical expenses, the Plan has the right to be reimbursed for the amounts the Plan paid.

Accordingly, if a Participant, or anyone on his or her behalf, settles, is reimbursed, or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any Accident, injury, condition, or Illness for which Benefits were provided by the Plan, the Participant or whoever received the money, agrees to hold the money received in trust for the Benefit of the Plan. The Plan shall be reimbursed, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Participant or on his or her behalf or that will be paid as a result of said Accident, injury, condition, or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Participant is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability, or other expenses or damages.

3. Subrogation

The Plan's right to subrogation is separate from and in addition to the Plan's right to reimbursement. Subrogation is the right of the Plan to exercise the Participant's rights and remedies in order to recover from third parties who are legally responsible to the Participant for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Participant, with or without his or her consent, to recover the money paid under the Plan. In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to the Participant's Accident, injury, condition, or Illness, which the Plan has paid, then the Plan is entitled to recover, by legal action or otherwise, the money paid; in effect the Plan has the right to "stand in the shoes" of the Participant for whom Benefits were paid, and to take any action the Participant could have undertaken to recover the money paid.

The Participant agrees to subrogate to the Plan any and all claims, causes of action, or rights that he or she has or that may arise against any entity who has or may have caused, contributed to, or aggravated the Accident, injury, condition, or Illness for which the Plan has paid Benefits, and to subrogate any claims, causes of action, or rights the Participant may have against any other coverage, including but not limited to liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event that a Participant decides not to pursue a claim against any third party or insurer, the Participant will notify the Plan, and specifically authorize the Plan in its sole discretion, to sue for, compromise, or settle any such claims in the Participant's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

4. The Following Paragraphs Apply to Both Reimbursement and Subrogation:

- **a.** Under the terms of this Plan, the Plan Administrator is not required to pay any claims where there is evidence of liability of a third party. However, the Plan, in its discretion, may instruct the Claim Administrator not to withhold payment of Benefits while the liability of a party other than the Participant is being legally determined.
- **b.** If the Plan makes a payment which the Participant, or any other party of the Participant's behalf, is or may be entitled to recover against any third party responsible for an Accident, injury, condition or Illness, the Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. The Participant receiving payment from this Plan will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the Plan's right of recovery.
- **c.** The Participant will cooperate fully with the Plan Administrator, its agents, attorneys, and assigns, regarding the recovery of any monies paid by the Plan for any party other than the Participant who is liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Plan Administrator, upon request and in a timely manner, of all material facts regarding the Accident, injury, condition, or Illness; all efforts by any person to recover any such monies; provide the Plan Administrator with any and all documents, papers, reports, and the like regarding demands, litigation or settlements involving recovery of monies paid by the Plan; and notifying the Plan Administrator of the amount and source

of any monies received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.

d. Participants will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers, including but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Participant will notify the Plan immediately of the name and address of any attorney whom the Participant engages to pursue any personal injury claim on his or her behalf.

e. The Participant will not act, fail to act, or engage in any conduct directly, indirectly, personally, or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Participant will not conceal or attempt to conceal the fact that recovery occurred or will occur.

f. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Participant pursuing a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund," or similar statute, regulation, prior court decision, or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

5. Right of Offset

The Plan has a right of offset to satisfy reimbursement claims against Participants for money received by the Participant from a third party, including any insurer. If the Participant fails or refuses to reimburse the Plan for funds paid for claims, the Plan may deny payment of future claims of the Participant, up to the full amount paid by the Plan and subject to reimbursement for such claims. The right of offset applies to all reimbursement claims owing to the Plan whether or not formal demand is made by the Plan, and not withstanding any anti-subrogation, "common fund," "made whole," or similar statutes, regulations, prior court decisions, or common law theories.

DEFINITIONS

This section defines certain words used throughout this Plan Document. These words are capitalized whenever they are used as defined.

ACCIDENT

An unexpected traumatic incident or unusual strain which is:

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

Some examples include:

1. Fracture or dislocation.
2. Sprain or strain.
3. Abrasion, laceration.
4. Contusion.
5. Embedded foreign body.
6. Burns.
7. Concussion.

ADVANCED PRACTICE REGISTERED NURSE

Nurses who have additional professional education beyond the basic nursing degree required of a registered nurse and are considered Advanced Practice Registered Nurses by applicable state law. Advanced Practice Registered Nurses include nurse practitioners, nurse-midwives, nurse-anesthetists and clinical nurse specialists.

ALLOWABLE FEE

The Allowable Fee is based on, but not limited to, the following:

1. Medicare RBRVS based is a system established by Medicare to pay physicians for a "work unit." The RBRVS value is determined by multiplying a "relative value" of the service by a "converter" to determine the

value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers' billed charge; or

2. Diagnosis-related group (DRG) methodology is a system used to classify hospital cases into one of approximately 500 to 900 groups that are expected to have similar hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of hospital resources for the given DRG regardless of the actual hospital resources used. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating provider under the DRG system can be considerably less than the nonparticipating providers' billed charge; or
3. Billed charge is the amount billed by the provider; or
4. Case rate methodology is an all inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the case rate system can be considerably less than the nonparticipating providers' billed charge; or
5. Per diem methodology is an all inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the per diem system can be considerably less than the nonparticipating providers' billed charge; or
6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating provider under the flat fee per category of service system can be considerably less than the nonparticipating providers' billed charge; or
7. Flat fee per unit of service fixed payment amount for a unit of service. For instance, a unit of service could be the amount of "work units" customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the flat fee per unit system can be considerably less than the nonparticipating providers' billed charge; or
8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or
9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or
10. The amount negotiated with the pharmacy benefit manager or manufacturer or the actual price for prescription or drugs; or
11. The American Society of Anesthesiologists' Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a "work unit." The payment value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the system can be considerably less than the nonparticipating providers' billed charge.
12. For nonparticipating providers in Montana, the Allowable Fee is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for nonparticipating providers will represent an average contract rate for Participating Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. Blue Cross and Blue Shield of Montana will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by nonparticipating providers which may also alter the Allowable Fee for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

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

13. For non-participating providers outside Montana, 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 Participant 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, Participants may call the customer service number shown on the back of their Identification Card.

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

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

1. increase desired behaviors or social interaction skills;
2. teach new functional life, communication, or social, skills;
3. maintain desired behaviors, such as teaching self control and self-monitoring procedures;
4. appropriate transfer of behavior from one situation or response to another;
5. restrict or narrow conditions under which interfering behaviors occur;
6. reduce interfering behaviors such as self injury.

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

Services must be provided by an appropriately certified provider.

APPROVED CLINICAL TRIAL

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

1. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
2. Exempt from an investigational new drug application; or
3. Approved or funded by:

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

BENEFIT

The payment for services of a Covered Provider to a Participant for Covered Medical Expenses under this Plan.

BENEFIT PERIOD

For the Plan, the Benefit Period is the period set forth in the Schedule of Benefits.

For the Participant the Benefit Period is the same as that described for the Plan except that if the Participant's Effective Date is after the Effective Date of the Plan, the Participant's Benefit Period begins with his or her Effective Date and ends on the same date the Plan Benefit Period ends. Thus, the Participant's Benefit Period may be less than 12 months.

BEST EVIDENCE

Means evidence based on

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

BLUE CROSS AND BLUE SHIELD OF MONTANA

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, is the Claim Administrator for this Plan.

BLUE OPTIONS PARTICIPATING FACILITY PROVIDER

A facility which has a contract with Blue Cross and Blue Shield of Montana for the Blue Options Network 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 Participants.

BLUE OPTIONS PARTICIPATING PROFESSIONAL PROVIDER

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

BLUE OPTIONS PROVIDER NETWORK

A professional provider, group of professional providers, or a facility provider in the Geographic Service Area, that has contracted with Blue Cross and Blue Shield of Montana to provide services to Participants covered under this Plan Document and that is listed in the current provider directory.

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

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.

CLAIM ADMINISTRATOR

Claim Administrator means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Claim Administrator is Blue Cross and Blue Shield of Montana. The Claim Administrator provides ministerial duties only, exercises no discretion over Plan assets, and will not be considered a fiduciary as defined by ERISA (Employee Retirement Income Security Act) or any other state or federal law or regulation.

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.

CODE

The Internal Revenue Code of 1986, as amended.

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 Participant for Covered Medical Expenses. The applicable Coinsurance is stated in the Schedule of Benefits.

COMPOUND DRUGS

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

CONCURRENT CARE

Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or

Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Participant'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 Participant.

CONVALESCENT HOME

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

1. skilled nursing facility;
2. extended care facility;
3. extended care unit; or
4. 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: In no event, shall this term 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 Participant for Covered Medical Expenses. The applicable Copayments are stated in the Schedule of Benefits.

COVERED MEDICAL EXPENSE

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

1. Covered under the Plan;
2. In accordance with Medical Policy; and
3. Provided to the Participant 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 Participant must be responsible for such services, supplies and medications.

COVERED PROVIDER

A provider that has satisfied the necessary qualifications to practice within the state of Montana or another state and that has been recognized by the Claim Administrator as a provider of services for Benefits described in the Plan Document. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine whether a provider is covered, the Claim Administrator looks to the nature of the services rendered and the extent of licensure.

CREDITABLE COVERAGE

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

1. a group health plan
2. health insurance coverage
3. Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1935c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4 (Medicare)
4. Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s (Medicaid)
5. Title 10, chapter 55, United States Code (TRICARE)
6. a medical care program of the Indian Health Service or of a tribal organization
7. the Montana Comprehensive Health Association provided for in 33-22-1503 (MCHA)
8. a health plan offered under Title 5, chapter 89, of the United States Code (Federal Employee Health Benefits Program)
9. a public health plan
10. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e)
11. a high risk pool in any state

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

CUSTODIAL CARE

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

DEDUCTIBLE

The dollar amount each Participant must pay for Covered Medical Expenses incurred during the Benefit Period before the Plan will make payment for any Covered Medical Expense to which the Deductible applies.

Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. Thus, Coinsurance, Copayment, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Participant's responsibility.

If two or more Participants covered under the same family satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Participant of the family.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, only one Deductible will be applied to that Hospital stay (facility charges only). If the Participant satisfied the Participant's Deductible prior to that Hospital stay, no Deductible will be applied to that stay.

DEPENDENT

A Participant who has been enrolled by an enrolled Employee and who is one of the following:

1. His or her legal Spouse.

2. His or her Domestic Partner.
3. His or her unmarried or married biological child, adopted child, or child placed for adoption and who is under the age of 26 years.
4. Children for who the Employee becomes legally responsible by reason of placement for adoption, as defined in Montana law.
5. An unmarried or married child of the Employee and/or Spouse who is 26 years of age or older may qualify as a Family Member if the child:

    a. Has been covered under the Plan before age 26; and
    b. Cannot support himself/herself because of intellectual disability or physical handicap; and
    c. Is legally dependent on the enrolled Employee for support.

Proof of those qualifications must be supplied to the Plan within 31 days of the child's 26th birthday. Although there is no limiting age for handicapped children, the Plan reserves the right to require periodic certification from the enrolled Employee of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child's 26th birthday.

Notwithstanding any other restrictions or criteria in this definition of Dependent of the section entitled Eligibility and Coverage, as provided in ERISA 609(a), the Plan shall provide coverage to any "alternate recipient" with respect to a "qualified medical child support order."

DOMESTIC PARTNER

A person that meets the following definition:

1. Neither partner is or has been for the past 6 months, married, legally separated, a cohabiter or a Domestic Partner to another;
2. The partners have cohabitated for at least 6 months and continue to cohabitate;
3. The partners are at least 18 years of age and mentally competent to consent to contract and mentally competent to execute this Affidavit;
4. The partners are not related by blood to a degree that would bar marriage in the State of Montana;
5. The partners are each other's sole Domestic Partner and intend to remain so indefinitely; and
6. The partners are responsible for each other's common welfare and have a financial interdependent relationship evidenced by any of the following:

    a. Mutually granted financial or health care powers of attorney;
    b. Designation of each other as primary beneficiary in wills, life insurance policies or retirement plans;
    c. Executed a joint lease, mortgage or deed; or
    d. Have joint ownership of a banking account

DRUG LIST

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

EFFECTIVE DATE

For a Participant, the Effective Date is the date the Participant has met the requirements of the Plan and is shown on the records of the Plan to be eligible for Benefits. For the Plan, the Effective Date is the date shown on the Schedule of Benefits. However, certain provisions shall be effective as of the dates specified within those provisions. The Effective Date of any amendment to the Plan is the Effective Date set forth on such 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

Services, medicines or supplies provided in a Hospital emergency department (emergency room) to evaluate and treat an Emergency Medical Condition.

EMPLOYEE

Any person (other than a nonresident alien who receives no U.S. income from the Employer) who is employed by the Employer. Notwithstanding the foregoing, the term “Employee” shall also include any officer, or former officer of the Employer for whom the Employer is contractually bound by written agreement to provide health Benefits. Employee shall not include any person who is classified by the Employer as an independent contractor or as a leased Employee.

EMPLOYER

Shodair Children's Hospital

ERISA

The Employee Retirement Income Security Act of 1974, as amended and all regulations applicable thereto.

EVIDENCE-BASED STANDARD

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

EXCLUSION

A provision which states that the Plan has no obligation to make payment for specific services.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

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

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

EXPERT OPINION

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

FAMILY MEMBER

A Dependent who has been enrolled by an enrolled Employee into the Plan and has been accepted as a Participant of the Plan.

FREESTANDING INPATIENT FACILITY

For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorder in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment Center and is approved as a Freestanding Inpatient Facility by the alcohol authority of the state.

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. 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. The Participant may also contact Customer Service for more information.

GEOGRAPHIC SERVICE AREA

The geographic area of Montana in which a health carrier has a network that has been deemed adequate by the Montana department of health and human services. A list of Primary Care Providers and other Participating Providers and the communities they serve within the Geographic Service area is available to the Participant free of charge.

HABILITATIVE CARE

Coverage will be provided for Habilitative Care services when the Participant 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 the Participant in the Participant'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 HEALTH SERVICE

The services provided by a Home Health Agency that must be:

1. Prescribed and supervised by the Participant's attending Physician;
2. Provided through a licensed Home Health Agency; and
3. Provided to the Participant in the Participant's home.

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 diagnoses, treatment, rehabilitation, and care of injured, disabled, or sick individuals. A Hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week and provides 24-hour nursing care by licensed registered nurses.

ILLNESS

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

IN-NETWORK

Providers who are:

1. Blue Options Participating Professional Providers and Blue Options Participating Facility Providers;
2. Participating Blue Cross and Blue Shield of Montana Professional and Facility Providers; or
3. Blue Cross and/or Blue Shield participating 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 Participant 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 Participant might be admitted include:

1. Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent homes;
5. Freestanding inpatient facilities.

INPATIENT PARTICIPANT

A Participant who has been admitted to a facility as a registered bed patient for Inpatient Care.

LATE ENROLLEE

An eligible Employee or Dependent, other than a special enrollee under the special enrollment provisions who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 31 days. However, an eligible Employee or Dependent is not considered a Late Enrollee if a court has ordered that coverage be provided for a Spouse, minor, or dependent child under a covered Employee's health benefit plan and request for enrollment is made within 31 days after issuance of the court order. If an individual is employed by an employer that offers multiple health benefit plans, and the individual elects a different plan during an open enrollment period, that individual is not a Late Enrollee.

LIFE-THREATENING CONDITION

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MEDICAL FOODS

Nutritional substances in any form that are:

1. formulated to be consumed or administered enterally under supervision of a Physician;
2. specifically processed or formulated to be distinct in one or more nutrients present in natural food;
3. intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
4. essential to optimize growth, health, and metabolic homeostasis.

MEDICAL OR SCIENTIFIC EVIDENCE

Evidence found in the following sources:

1. peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's library of medicine for indexing in Index Medicus and Excerpta Medica, published by the Reed Elsevier group;
3. medical journals recognized by the Secretary of Health and Human Services under 42 U.S.C. 1395x(t)(2)(B) of the federal Social Security Act;
4. the following standard reference compendia:
   a. the American Hospital Formulary Service Drug Information;
   b. Drug Facts and Comparisons;
   c. the American Dental Association Guide to Dental Therapeutics; and
   d. the United States Pharmacopeia;
5. findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
   a. the federal Agency for Healthcare Research and Quality;
   b. the national Institutes of Health;

c. the National Cancer Institute;
d. the National Academy of Sciences;
e. the Centers for Medicare and Medicaid Services;
f. the Food and Drug Administration; and
g. any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

6. any other medical or scientific evidence that is comparable to the sources listed in subsection 4 or 5.

MEDICAL POLICY

The Claim Administrator's policy which is used to determine whether 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. are in accordance with any established standards of good medical practice.

Medical Policy is reviewed and modified periodically as is necessary.

MEDICALLY NECESSARY (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 Participant receives the services, supplies, or medications and a claim is submitted to the Plan. The Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

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

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

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

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).

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. For the purposes of Rehabilitation Therapy, 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 which is subject to the Non-Preferred Brand-Name Drug payment level on the Drug List for this Plan. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com.

NON-PREFERRED GENERIC DRUG

A Generic Drug which is subject to the Non-Preferred Generic Drug payment level on the Drug List for this Plan. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com.

NON-PREFERRED SPECIALTY MEDICATION

A Specialty Medication which is subject to the Non-Preferred Specialty Medication payment level on the Drug List for this Plan. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com.

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.

OUT-OF-NETWORK

Providers who are:

1. Non-participating professional providers;
2. Non-participating 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 Participant:

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

If a Participant is in the Hospital on the last day of the Participant'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 Participant 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 Participant pays for the difference between a Brand-Name Drug and the Generic equivalent and amounts over the allowed amount billed by a non-participating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

For the Family:

The total amounts of Deductible, Copayment and Coinsurance for Covered Medical Expenses a family must pay for services incurred during that Benefit Period. Once the Deductible and Coinsurance paid by the Participant during the Benefit Period for two or more Family Members covered under the same family total the Out of Pocket Amount for the family, the Participants covered under the same family will not be required to pay the Deductible and Coinsurance for Covered Medical Expenses the remainder of that Benefit Period. The Out of Pocket Amount for the family is listed on the Schedule of Benefits.

Non-covered services, the amount the Participant pays for the difference between a Brand-Name Drug and the Generic equivalent and amounts over the allowed amount billed by a non-participating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

OUTPATIENT

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

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.

PARTICIPANT

An eligible Employee or Eligible Family Member who has applied for participation in accordance with the section entitled Eligibility and Coverage, has been accepted as a participant of the Plan, and maintains participation in the Plan.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA FACILITY PROVIDER

A facility which has a contract with the Claim Administrator, 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 Participants.

PARTICIPATING BLUE CROSS AND BLUE SHIELD OF MONTANA PROFESSIONAL PROVIDER

A provider who has a contract with the Claim Administrator, 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 Participants.

PARTICIPATING PHARMACY

A pharmacy that has entered into an agreement with the Pharmacy Benefit Manager to provide Prescription Drug Products to Participants and has agreed to accept specified reimbursement rates.

PARTICIPATING PROVIDER

A provider who has a contract with the Claim Administrator, Blue Cross and Blue Shield of Montana.

PHARMACY BENEFIT MANAGER

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

PHYSICAL THERAPY

The treatment of a disease or injury by physical means (e.g., hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices) to relieve pain, restore maximum function and prevent disability following disease, injury, or a loss of a bodily part.

PHYSICIAN

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

PLAN

Plan means the health benefit plan for Employees of the company, the Plan Document, or any other relevant documents pertinent to the operation and maintenance of the Plan.

PLAN ADMINISTRATOR

Plan Administrator means the company and/or its designee who is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purpose of the Employee Retirement Income Security Act of 1974, as amended, and any applicable state legislation of a similar nature, the company will be deemed to be the Plan Administrator of the Plan unless by action of the board of directors, the company designates an individual or committee to act as Plan Administrator of the Plan.

PLAN BENEFIT YEAR

The period specified as the Benefit Period in the Schedule of Benefits.

PLAN DOCUMENT

This document which sets forth and governs the rights and duties of the Plan Sponsor, Plan Administrator, Claim Administrator, and Participants under the Plan and modified by any policies, interpretations, rules, practices, and procedures made by the Sponsor.

POLICYHOLDER

The (1) employing entity corporation, partnership, sole proprietor or other employer, or (2) association, or (3) trust which has executed the Group Application for the Plan Document. An ERISA Health Benefit Program may not be a Policyholder hereunder, but a sponsor of or trust implementing an ERISA Health Benefit Program may be a Policyholder hereunder.

PPO-A PREFERRED PROVIDER ORGANIZATION

A provider or group of providers which have contracted with the Plan to provide services to Participants covered under PPO Benefit Contracts.

PPO NETWORK

A provider or group of providers which have a PPO contract with Blue Cross Blue Shield of Montana. The Participant may obtain a list of PPO providers from Blue Cross Blue Shield of Montana upon request. Payment to a non-PPO Network provider is subject to the non-PPO Network provider reduction shown in the Schedule of Benefits and the Special Provisions section of this document.

PREAUTHORIZATION

A process to inform the Participant whether or not a proposed service, medication, supply, or on-going treatment is Medically Necessary and is a Covered Medical Expense of this Plan.

PREFERRED BRAND-NAME DRUG

A Brand-Name Drug which is subject to the Preferred Brand-Name Drug payment level on the Drug List for this Plan. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com.

PREFERRED GENERIC DRUG

A Generic Drug which is subject to the Preferred Generic Drug payment level on the Drug List for this Plan. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com.

PREFERRED SPECIALTY MEDICATION

A Specialty Medication which is subject to the Preferred Specialty Medication payment level on the Drug List for this Plan. The Drug List is available by accessing the Blue Cross and Blue Shield of Montana website at www.bcbsmt.com.

PRESCRIPTION DRUG PRODUCT

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

PRIMARY CARE PROVIDER

is:

1. a physician, including general practitioners, family practitioners, internists, naturopaths, physician assistants, nurse practitioners who are in a Family Practice, pediatricians, obstetricians and gynecologists who are Blue Options Participating Professional Providers;
2. selected by a Participant to be the Primary Care Provider; and
3. responsible for providing initial and primary care to Participants, providing, supervising, and coordinating the continuity of a Participant's care including specialty care.

PROFESSIONAL CALL

An interview between the Participant and the professional provider in attendance. The professional provider must examine the Participant and provide or prescribe medical treatment and/or advice. "Professional Call" does not include telephone calls or any other communication where the Participant is not examined by the professional provider, except as included in the Benefit section entitled Telemedicine.

PROOF OF LOSS

The documentation accepted by the Claim Administrator 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.

RECONSTRUCTIVE BREAST SURGERY

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

RECOVERY CARE BED

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

REHABILITATION FACILITY

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

1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or a facility associated or co-located with a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital;
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Participant, 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 Participant must continue to show measurable progress.

RESIDENTIAL TREATMENT CENTER

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or a 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

Medications used to treat serious or chronic conditions. Examples include hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis. These drugs are typically given by injection, but may be topical or taken by mouth. They often require careful adherence to treatment plans, have special handling or storage requirements, and may not be stocked by retail pharmacies.

SPECIALTY PHARMACY

A pharmacy which has entered into an agreement with the Claim Administrator to provide Specialty Medications to Participants and which has agreed to accept specified reimbursement rates.

SPEECH THERAPY

Speech Therapy is the treatment of communication impairment and swallowing disorders.

SPOUSE

The opposite sex or the same sex person to whom the Employee is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

SUBSTANCE USE DISORDER

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

SUBSTANCE USE DISORDER TREATMENT CENTER

A facility which provides treatment for Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Qualified Health Care Provider or an addiction counselor licensed by the state. The facility must also be licensed or approved as a Substance Use Disorder Treatment Center by the Department of Public Health and Human Services or must be licensed or approved by the state where the facility is located.

TELEMEDICINE

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

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

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

VALUE PARTICIPATING PHARMACY

A Participating Pharmacy which has a written agreement with Blue Cross and Blue Shield of Montana to provide pharmaceutical services to the Member or an entity chosen by Blue Cross and Blue Shield of Montana to administer its prescription drug program that has been designated as a Value Participating Pharmacy.

VIRTUAL VISIT

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

IN WITNESS WHEREOF, the Employer has caused this Plan to be duly executed, effective as of the Plan's Effective Date.

Shodair Children's Hospital

By: _____

Its: _____

Date: _____

BlueCross BlueShield
of Montana

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