Montana Health and Economic Livelihood Partnership (HELP) Plan

Evidence of Coverage

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Effective January 1, 2016

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The Montana Health and Economic Livelihood Partnership (HELP) Plan agrees to make payment for the medical, Behavioral Health, surgical, Hospital and Pharmacy services named in this Evidence of Coverage (EOC) subject to the following conditions:

1. All statements made in the HELP Plan Application for eligibility must be true and correct.

2. Payments by the HELP Plan will be subject to the terms, conditions, and limitations of this EOC.

3. Payment will only be made for Medically Necessary services that are provided to the Participant after the Effective Date of this EOC and before the date on which this EOC terminates.

ARTICLE ONE – DEFINITIONS

This Article defines certain words used throughout this EOC. These words will be capitalized whenever they are used as defined.

ACCIDENT

An unexpected traumatic incident or unusual strain which is:

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

Some examples are:

- Fracture or dislocation;
- Sprain or strain;
- Abrasion or laceration;
- Contusion;
- Embedded foreign body;
- Burns; and
- Concussion.

ADMISSION CERTIFICATION FOR EMERGENCY CARE AND MATERNITY CARE

Notification to the Claim Administrator by the Participant, or Participant's authorized representative, of an emergency Inpatient admission or an Inpatient admission related to pregnancy, including pre-term labor, complications of pregnancy, or delivery.

ADVANCE BENEFIT NOTIFICATION (ABN)

Refers to the process in which a provider informs the Participant that a service is not Medically Necessary in accordance with the Claim Administrator's Medical Policy prior to having the service performed, and requests the Participant sign an ABN to accept responsibility for payment if the Participant wishes to proceed with the service. The Participant is only responsible for services which are not Medically Necessary, non-covered, Experimental, Investigational, or Unproven, require Preauthorization and are not preauthorized, or not performed in an appropriate setting, if an ABN has been signed by the Participant or the Participant's authorized representative.

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 (BCBSMT) 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

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same level of hospital resources for the given DRG regardless of the actual hospital resources used. Therefore, the amount paid by BCBSMT 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 BCBSMT 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 BCBSMT 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 BCBSMT to nonparticipating providers under the flat fee per category of service system can be considerably less than the nonparticipating providers' billed charge; or
7. Flat fee per unit of service fixed payment amount for a unit of service. For instance, a unit of service could be the amount of "work units" customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by BCBSMT 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 from 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 BCBSMT to nonparticipating providers under the system can be considerably less than the nonparticipating providers' billed charge.

AMBULANCE

A privately or publicly owned motor vehicle or aircraft that is maintained and used for the emergency transport of patients that is licensed and further defined in 50-6-302, MCA.

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

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- 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.

BEHAVIORAL HEALTH

The blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services.

BENEFIT

Services, supplies, and medications that a Participant is eligible to receive, if Medically Necessary, as a Covered Medical Expense. The HELP Plan Benefits are stated in the Evidence of Coverage (EOC).

BENEFIT PERIOD

The Benefit Period for medical services is January 1 through December 31. If a Participant's Effective Date is after January 1, the Participant's Benefit Period begins with the Effective Date and ends December 31. The Benefit Period for dental services is July 1 through June 30. If a Participant's Effective Date is after July 1, the Participant's Benefit Period begins with the Effective Date and ends June 30.

BLUE CROSS AND BLUE SHIELD OF MONTANA (BCBSMT)

BCBSMT, a Division of Health Care Services Corporation, a mutual legal reserve company, is a Claim Administrator for the Department.

CARDIAC REHABILITATION THERAPY

Medically supervised program that helps improve the health and well-being of people who have heart problems.

CARE MANAGEMENT

A process that assesses and evaluates options and services required to meet the Participant's health care needs. Care Management may involve a team of health care professionals, including covered providers, BCBSMT, and other resources to work with Participants to promote quality, cost-effective care.

CHEMICAL DEPENDENCY

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

CHEMICAL DEPENDENCY TREATMENT CENTER

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

CLAIM ADMINISTRATOR(S)

Claim Administrator means a Department contractor that provides consulting services to the Department and other administrative functions, including the processing and payment of claims. The Claim Administrator provides administrative duties only.

COMPLAINT

A verbal or written communication by the Participant or his or her authorized representative that identifies an adverse action by the Department or BCBSMT.

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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.

CONTINUED STAY REVIEW

BCBSMT's review of an Inpatient stay beyond what was initially certified to assure that the setting and the level of care continues to be the most appropriate for the Participant's condition.

CONVALESCENT HOME

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

- a skilled nursing facility;
- an extended care facility;
- an extended care unit; or
- a transitional care unit.

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

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

COPAYMENT

A predetermined portion of the cost for a health care service or item that is owed by the Participant directly to a provider for a covered health care service.

COST SHARE

The total of premium and copayment costs in relation to the delivery of health care services to the Participant that is the responsibility of the Participant to pay.

COVERED MEDICAL EXPENSE

Expenses incurred for Medically Necessary medical and behavioral health services and supplies that are:

- Covered under this EOC; and
- In accordance with Medical Policy; and
- Provided to Participants by and/or ordered by a Participating Provider for the diagnosis or treatment of active Illness or injury or in providing maternity care.

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.).

DENTAL

Covered Dental services delivered by enrolled Dental providers in the Medicaid Program.

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DEPARTMENT (DPHHS)

The Department of Public Health and Human Services, State of Montana (DPHHS).

DISENROLLMENT

The process of ending the Participant's enrollments in the HELP Plan due to a determination of ineligibility made by the Department or by voluntary withdrawal by the Participant.

DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

Durable Medical Equipment is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of an illness or injury, and is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be Durable Medical Equipment. Durable Medical Equipment and supplies are items that are reasonable and necessary in amount, duration, and scope to achieve their purpose. Equipment and supplies must be Medically Necessary, prescribed, delivered in the most appropriate and cost effective manner, and may not be excluded by state or federal rules or regulations.

EARLY AND PERIODIC SCREENING, DIAGNOSITIC, AND TREATMENT SERVICES (EPSDT)

EPSDT services are comprehensive and preventive health care services for Participants under age 21, as defined in ARM Title 37, chapter 86, subchapter 22. EPSDT services include:

- Comprehensive health and developmental history, physical exam, immunizations, lab tests and health education;
- Vision services including diagnosis and treatment, and eyeglasses;
- Dental services; and
- Hearing services.

EFFECTIVE DATE

The Effective Date of the Participant's coverage is the date the Participant is determined eligible for Benefits by the Department.

EMERGENCY SERVICES

Emergency Services are covered Inpatient and Outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services.
- Needed to evaluate or stabilize an Emergency Medical Condition.

EMERGENCY MEDICAL CONDITION

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

- Placing the health of the individuals (or, for a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

EVIDENCE OF COVERAGE (EOC)

This document that explains covered services, service limits, defines the plan's obligations, and explains the rights and responsibilities of the Participant.

EXCLUSION

Services not included in the HELP Plan benefit plan.

EXPERIMENTAL, INVESTIGATIONAL, AND UNPROVEN

Any drug, device, treatment, or procedure that meets any of the following criteria:

- Prescription drugs not approved by the Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, and it is not identified in the American Hospital Formulary Service, the AMA Drug Evaluation, or the Pharmacopoeia as an appropriate use;
- It is subject to review or approval by an institutional review board (meaning that a Hospital considered it experimental and put it under review to meet federal regulations, or review is

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required and defined by federal regulations, particularly those of the FDA or U.S. Department of Health and Human Services);

- It is the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in FDA regulations, regardless of whether it is an FDA trial;
- It has not been demonstrated through prevailing, peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed;
- The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, and effectiveness (or effectiveness compared with conventional alternatives), or that usage should be substantially confined to research settings;
- It is not a covered benefit under Medicare, as determined by the Centers for Medicare and Medicaid Services (CMS), because it is considered experimental, investigational or unproven;
- It is experimental, investigational, unproven, or not a generally acceptable medical practice in the predominate opinion of independent experts utilized by the administrator of each plan; or
- It is not experimental or investigational in itself pursuant to the above and would not be medically necessary, but it being provided in conjunction with the provision of a treatment, procedure, device, or drug which is experimental, investigational or unproven.

FAMILY

Means one or more children residing in the same household with a parent, adoptive parent, guardian, or caretaker relative. A Family may also be an emancipated child or a child living independently. The Department may determine if a household is a "Family" for purposes of HELP Plan eligibility.

FEDERAL POVERTY LEVEL

The federal government's working definition of poverty that is used as the reference point for the income level for Medicaid eligibility for certain categories of beneficiaries.

FREESTANDING INPATIENT FACILITY

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

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

HABILITATIVE CARE

Coverage will be provided for Habilitative Care services when the individual requires help to keep, learn or improve skills and functioning for daily living or to prevent deterioration, if making reasonable progress, determined by DPHHS. These services include, but are not limited to:

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology; and
4. Behavioral health treatment.

Applied behavior analysis for adults is excluded.

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

HOSPITAL

A short-term, acute-care, general Hospital licensed by the state where it is located and which:

- Primarily provides facilities for diagnosis and therapy for medical/surgical treatment under the supervision of a staff of Physicians; and
- Provides 24-hour-a-day nursing services under the supervision of registered graduate nurses.

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The term "Hospital" does not include the following, even if such facilities are associated with a Hospital:

- A nursing home;
- A rest home;
- Hospice;
- A rehabilitation facility;
- A skilled nursing facility;
- A convalescent home;
- A place for care and treatment of Chemical Dependency;
- A place for treatment of Mental Illness; or
- A long-term, chronic-care institution or facility providing the type of care listed above.

IDENTIFICATION (ID) CARD

A document issued to each HELP Plan Participant that identifies that Participant as eligible for the HELP Plan.

ILLNESS

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

INCLUSIVE SERVICES/PROCEDURES

- A portion of a service or procedure which is Medically 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.

INSTITUTE FOR MENTAL DISEASE (IMD)

An institution for the treatment and care of persons suffering from mental diseases under Medicaid regulations (42 CFR § 440.160).

INPATIENT (OR HOSPITAL INPATIENT)

Services or supplies provided to the Participant who has been admitted to a Hospital as a registered bed patient and who is receiving services under the direction of a Participating Provider with staff privileges at that Hospital.

INPATIENT BENEFITS (FOR CHEMICAL DEPENDENCY OR MENTAL ILLNESS)

The payment to a Provider for services for Medically Necessary care and treatment of Chemical Dependency or Mental Illness, which are provided in a setting that is medically appropriate. Such services must be provided:

- By a Hospital, Freestanding Inpatient Facility, or Physician; and
- While Participants are in a Hospital Inpatient; or
- While Participants are confined as an Inpatient in a Freestanding Inpatient Facility.

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 POLICY

The policy of the BCBSMT, which is used to determine if health care services including medical procedures, medication, medical equipment, processes and technology meet nationally accepted criteria, such as:

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- Services must have final approval from the appropriate governmental regulatory agencies;
- Scientific studies have conclusive evidence of improved net health outcome; and
- Must be in accordance with any established standards of good medical practice.

MEDICALLY NECESSARY (MEDICAL NECESSITY)

Services or items reimbursable under the HELP Plan, and that are:

1. Reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a Participant, which:
    - Endanger life;
    - Cause suffering or pain;
    - Result in illness or infirmity;
    - Threaten to cause or aggravate a handicap; or
    - Cause physical deformity or malfunction.

2. A service or item is not Medically Necessary if there is another service or item for the Participant that is equally safe and effective and substantially less costly including, when appropriate, no treatment at all.

3. Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not Medically Necessary for purposes of the HELP Plan. Experimental services are procedures and items, including prescribed drugs, considered experimental or investigational by the U.S. Department of Health and Human Services, including the Medicare program, or the Department's designated review organization or procedures and items approved by the U.S. Department of Health and Human Services for use only in controlled studies to determine the effectiveness of such services.

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 HELP Plan. The HELP Plan may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MENTAL HEALTH TREATMENT CENTER

A facility which provides treatment for Mental Illness through multiple modalities or techniques following a written treatment plan approved and monitored by an interdisciplinary team, including a licensed Physician, psychiatric social worker, and psychologist. The facility must also be:

- Licensed as a Mental Health Treatment Center by the state;
- Funded or eligible for funding under federal or state law; or
- Affiliated with a Hospital 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:

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

Mental Illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person. Mental Illness does not include:

- Developmental disorders;
- Speech disorders;
- Psychoactive chemical dependency disorders;
- Eating disorders;
- Impulse control disorders (except for intermittent explosive disorder and trichotillomania); and
- Severe Mental Illness.

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MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP (HELP) PLAN COVERAGE GROUP

The coverage group is a benefit program for eligible Montanans administered by the Department through the Montana Health and Economic Livelihood Partnership HELP Plan.

MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP (HELP) PLAN NETWORK

A provider or group of providers who have contracted with BCBSMT to provide medical and Mental Illness services to Participants covered under the HELP Plan.

MONTH

For the purposes of this EOC, a Month is the actual calendar Month.

MULTIDISCIPLINARY TEAM

When used in the Rehabilitative Care portion of the EOC, a Multidisciplinary Team is a group of health service providers who must be either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided.

NON-COVERED (OR NON-PARTICIPATING PROVIDER)

Medical and Behavioral Health

Any Provider who is not under contract with the Claim Administrator to provide HELP Plan Benefits. Non-Participating Providers are not included in the HELP Plan Network. Services received from a Non-Participating Provider:

- May not be covered;
- May be covered by the HELP Plan but the non-participating provider may refuse payment from the HELP Plan;
- May be subject to Preauthorization; or
- May not be paid by the HELP Plan; and
- Payment may be the Participant's responsibility.

Pharmacy (Non-Covered or Non-Participating)

Any Provider who is not enrolled as a Montana Medicaid Provider. In addition, any provider that is under any sanctions, suspensions, exclusions or civil monetary penalties imposed by the Medicare program is a Non-Covered Provider. Services received from a Non-Participating or Non-Covered Provider will not be covered.

NURSE ADVICE LINE

All HELP Plan Participants are eligible to use the 24 hour 7 day Nurse Advice Line called Nurse Advice. Nurse Advice is free and can be accessed by calling 1-877-213-2568.

OBSERVATION BEDS/ROOM

Outpatient beds, which are used to:

- Provide active short-term medical/surgical nursing services; or
- Monitor the stabilization of the patient's condition.

OCCUPATIONAL THERAPY

Treatment of the physically disabled due to disease, injury, or loss of bodily part by means of constructive activities designed and adapted to promote the restoration of an individual's ability to perform required daily living tasks.

OUT OF POCKET AMOUNT

The combined dollar amount of Copayments and premiums are out of pocket costs and are the responsibility of the Participant.

OUTPATIENT

Services or supplies provided to Participants by Participating Providers while Participants are not Inpatient.

PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS AND CHEMICAL DEPENDENCY

A time-limited ambulatory (Outpatient) program offering active treatment, which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The

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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 offers 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 Participant.

PARTICIPANT

A Participant who has been approved and notified by the Department as eligible for the HELP Plan. To be eligible to participate, an individual must be:

- A childless adult between 19 and 65 years of age, with an income at or below 138 percent of the Federal Poverty Level (FPL) or a parent between 19 and 65 years of age, with an income between 0-138 percent of the FPL;
- Not enrolled in Medicare;
- A United States citizen or a documented, qualified alien; and
- A resident of Montana.

PARTICIPATING PROVIDER

A provider that provides services administered by DPHHS must be enrolled as a Montana Medicaid provider. A provider that provides services administered by BCBSMT must be enrolled in the Help Plan Network.

PHARMACY

Every site properly licensed by the Montana Board of Pharmacy, in which the practice of Pharmacy is conducted.

PHYSICAL THERAPY

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

PHYSICIAN

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

PLAN ADMINISTRATOR

State of Montana, Department of Public Health and Human Services.

POSTSTABILIZATION CARE SERVICES

Poststabilization Care Services are covered services, related to an Emergency Medical Condition, that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in STC 10.2, to improve or resolve the enrollee's condition.

PREAUTHORIZATION

Approval in advance to obtain services. **Failure to obtain Preauthorization may result in Participants paying out of pocket for the services provided, if an ABN has been signed.** Some services are covered only if Participants' doctors or other Participating Providers obtain "Preauthorization." This process is used to inform HELP Plan Participants whether or not a proposed service, medication, supply, or ongoing treatment is a Covered Medical Expense under this EOC.

- For Preauthorization of Medical, Behavioral Health and Inpatient Hospital services, contact BCBSMT at 1-877-296-8206.
- For Preauthorization of Pharmacy services contact DPHHS's Drug Preauthorization Unit, Mountain-Pacific Quality Health at 1-800-395-7961.
- For Preauthorization of Dental Services contact Xerox Provider Relations at 1-800-624-3958.
- For Preauthorization of Eyeglasses contact Vision Program Officer at (406)444-4066.
- For Preauthorization of services provided by a Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC), and Community Based Psychiatric Rehabilitation Services (CBPRS) contact DPHHS at 1-800-624-3958.

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PREMIUM

The amount of money which must be paid by the Participant monthly to continue enrollment in the HELP Plan.

PRIMARY CARE PROVIDER

1. A physician, including general practitioners, family practitioners, internists, pediatricians, obstetricians and gynecologists who are participating in the HELP Plan Network;
2. Selected by a Participant to be the Personal Care Physician; 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

A personal interview between Participants and HELP Plan Participating Providers. HELP Plan Participating Providers must examine Participants and provide or prescribe medical treatment. "Professional Call" does not include telephone calls or any other communication where Participants are not examined by HELP Plan Participating Providers, except as included in Section XII, Medical Services (Non-Surgical), for Telemedicine.

QUALIFIED INDIVIDUAL (For an Approved Clinical Trial)

An individual 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.

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.

REHABILITATIVE CARE

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

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology; and
4. Behavioral Health treatment.

Applied behavior analysis for adults is excluded.

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

REHABILITATION UNIT

- Inpatient licensed general Hospital which provides services by a Multidisciplinary Team under the direction of a qualified Physician; or
- Physician's office.

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, supervisions, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, 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 Chemical Dependency disorders. Requirements: BCBSMT requires that any Mental Illness and/or Chemical Dependency Residential

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Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by BCBSMT as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

RETROSPECTIVE REVIEW

The Claim Administrator's review of services, supplies, or treatment after they have been provided, and the claim has been submitted, to determine whether or not the services, supplies, or treatment were Medically Necessary.

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 the HELP Plan when the items or services are typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. The term does not include:

1. An investigational item, device, or service that is part of the trial;
2. An item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis.

SEVERE MENTAL ILLNESS

The following disorders as defined by the American Psychiatric Association:

- Schizophrenia;
- Schizoaffective disorder;
- Bipolar disorder;
- Major depression;
- Panic disorder;
- Obsessive-compulsive disorder; and
- Autism

SPEECH THERAPY

Treatment for the correction of a speech impairment resulting from disease or trauma.

TELEMEDICINE

The use of a secure interactive audio and video, or other telecommunications technology by a health care provider to deliver health care services at a site other than the site where the patient is located. Does not include audio only (phone call), e-mail, and/or facsimile transmission.

URGENT CARE

Medically Necessary care for a condition that is not life threatening but that requires treatment that cannot wait for a regularly scheduled clinical appointment because of the potential of the condition worsening without timely medical intervention.

ARTICLE TWO – PARTICIPATING PROVIDERS

This EOC allows benefits for Covered Medical Expenses, which are provided by a Participating Provider. A Participating Provider is a provider which has satisfied the necessary qualifications to practice medical care within the state of Montana or another state and, which has been recognized by BCBSMT as a Montana Health and Economic Livelihood Partnership (HELP) Plan Provider for medical or Behavioral Health services or is enrolled as a Montana Medicaid Provider for services administered by DPHHS for benefits described in this EOC. Some providers may be "participating" only for certain specific services because of a limited scope of practice. To determine if a provider is "participating," the HELP Plan looks to the nature of the services rendered, the extent of licensure, and the HELP Plan's recognition of the provider.

HELP Plan Participants may obtain a list of HELP Plan Providers for medical and Behavioral Health services from BCBSMT upon request or download it from the BCBSMT website at www.BCBSMT.com.

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HELP Plan Participants may obtain a list of enrolled Montana Medicaid for services administered by DPHHS through a search on the Montana Healthcare Provider website at https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do.

ARTICLE THREE – MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP (HELP PLAN) NETWORK

HELP Plan Participants are encouraged to choose a Primary Care Provider from the list of HELP Plan Providers. A Primary Care Provider will be better able to know Participants and their medical history, determine Participants' health care needs, and help Participants use the Medically Necessary Benefits available under the HELP Plan.

Section I: Use of the HELP Plan Network

HELP Plan Participants are encouraged to have their care directed by the Primary Care Providers they select. Generally, Participants need to make an appointment with their HELP Plan Providers. Participants' Primary Care Providers will provide health care, or if Participants' Primary Care Providers determine it is Medically Necessary to do so, may refer Participants to another care provider or recommend a specialist in the HELP Plan Network. They will also help Participants arrange or coordinate Medically Necessary hospitalization. Benefits for certain Medically Necessary services, including obstetrical and gynecological services, are available without a recommendation from Participants' Primary Care Providers when Participants use the HELP Plan Network.

If HELP Plan Participants have not chosen a Primary Care Provider, they still need to use the HELP Plan Network to obtain Benefits.

Covered medical and Behavioral Health Benefits are only available if Participants use the HELP Plan Network, except:

1. If the Medically Necessary services are not available in the HELP Plan Network; AND
2. Preauthorization has been approved by BCBSMT on behalf of the HELP Plan.

Covered pharmacy, vision, dental, hearing aid, audiology, transportation, ambulance, Indian Health Services, FQHC, RHC and diabetes prevention services must be obtained through an enrolled Montana Medicaid Provider.

In the situations listed above, Participants must receive Preauthorization from the Claim Administrator. If Participants do not obtain Preauthorization, then such services are not a Benefit of this EOC and Participants will be responsible for payment of the costs of the services provided, if the Participant has signed an ABN.

Section II: Private Pay Agreement or Advance Benefit Notification (ABN)

The Claim Administrator will review claims to determine if the services were Medically Necessary. The HELP Plan does not pay for services that are determined to not be Medically Necessary.

When a service is denied as non-covered, not Medically Necessary, Experimental, Investigational, or Unproven, or not performed in an appropriate setting, Participating Providers may not bill the Participant for the services, unless the Participant or the Participant's authorized representative has signed an ABN.

Section III: Emergency Care and Urgent Care

Emergency Care

If Participants need Emergency Care, go to the nearest doctor or Hospital. Participants may need Emergency Care if their medical condition manifests itself by sudden symptoms of enough severity (including severe pain) 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 the following:

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- Placing the health of the Participant (or, for a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Participants should notify their Primary Care Provider as soon as possible that they have received Emergency Care and plan to receive follow-up care from their Primary Care Provider.

Urgent Care

Some situations require prompt medical attention although they are not emergencies. In these situations, it is recommended that Participants call their Primary Care Provider and describe the situation. He or she will then direct Participants' care.

Unless Participants get approval from the Claim Administrator, they must receive Urgent Care from a HELP Plan Provider. If Participants receive services from a provider who is not a HELP Plan Provider, they may have to pay for these services.

Before receiving Emergency Care or Urgent Care, Participants can call Nurse Advice, the 24 hour 7 day Nurse Advice Line. Nurse Advice is free and can be accessed by calling 1-877-213-2568.

Section IV: Out-of-State Services

HELP Plan Participants cannot get routine, non-emergency or non-urgent care without the HELP Plan's approval when Participants are out-of-state. Participants who spend time away from home will have care paid for if the HELP Plan approves the service. The HELP Plan must give Preauthorization approval in these instances.

Covered Medically Necessary Services for a Participant receiving care from a HELP Plan provider outside of Montana, but in a county bordering Montana, may be covered.

Preauthorization does not guarantee that the care and services a Participant receives are eligible for Benefits.

Section V: Prohibition on Payment Outside of the United States

No payment for items or services of medical assistance can be made to any provider located outside of the United States.

ARTICLE FOUR – PREAUTHORIZATION

Preauthorization is required in order to receive some Benefits provided under this EOC. Listed covered Benefits in this EOC that require Preauthorization are noted under each covered Benefit. The appropriate Claim Administrator is identified for claim processing purposes under each covered Benefit.

BCBSMT Administered Claims

BCBSMT has designated certain covered services which require Preauthorization in order for the Participant to receive the maximum Benefits possible.

If the Participant utilizes a Participating Provider for covered services, the Participating Provider is responsible for satisfying the requirement for Preauthorization.

If the Participant utilizes a Non-Participating Provider for covered services, the Participant is responsible for satisfying the requirement for Preauthorization.

To request Preauthorization, the Participant or his/her Physician must call the Preauthorization number shown on the Participant's Identification Card before receiving treatment. BCBSMT 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.

Preauthorization does not guarantee that the care and services a Participant receives are eligible for Benefits.

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Section I: Preauthorization Process for Inpatient Services

Preauthorization must be requested before the Participant's scheduled Inpatient admission. BCBSMT 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. BCBSMT 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 BCBSMT 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 approval, the Participant may be responsible to pay the full cost of the services received, if an ABN has been signed.

If Preauthorization is not requested by the Participant or Participating Provider, the claim will be denied on the basis of no Preauthorization. The Participant may appeal the denial of the claim as outlined in the Article entitled "Complaints, Appeals, and Confidential Information." 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 EOC, the Participant may be responsible for the full cost of the services, if an ABN has been signed.

Section II: Preauthorization Process for Mental Illness, Severe Mental Illness and Chemical Dependency Services

All Inpatient and partial hospitalization services related to treatment of Mental Illness, Severe Mental Illness, and Chemical Dependency must be Preauthorized. Preauthorization is also required for the following Outpatient Services:

- Psychological Testing;
- Neuropsychological Testing;
- Electroconvulsive Therapy; and
- Intensive Outpatient Treatment.

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

If Preauthorization is not requested by the Participant or Participating Provider, the claim will be denied on the basis of no Preauthorization. The Participant may appeal the denial of the claim as outlined in the Article entitled "Complaints, Appeals, and Confidential Information." 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 EOC, the Participant may be responsible for the full cost of the services, if an ABN has been signed.

Section III: Preauthorization Process for Other Outpatient Services

In addition to the Preauthorization requirements outlined above, BCBSMT also requires Preauthorization for certain Outpatient services. The following services and items require Preauthorization:

1. Home Health Care and Hospice services, including Private Duty Nursing and Personal Care Services for EPSDT;
2. Outpatient Therapies;
3. Potentially experimental, investigational or cosmetic procedures;
4. Transplant evaluations for the following transplant surgeries: heart, lung, heart/lung, liver, pancreas, kidney, bone marrow, corneal, and small bowel;
5. Outpatient surgeries for dental anesthesia, dental trauma, termination of pregnancy, cochlear implants and uvulopalatopharyngoplasty (UPPP);
6. Laminectomy;

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7. Genetic testing and/or counseling;
8. DME, medical supplies, orthotics and prosthetics over $2,500 and including the following: diabetic shoes, power wheelchairs, diapers, underpads and incontinent supplies, specialty beds, and cochlear implant devices.
9. Cardiac rehabilitation;
10. MRIs, PET scans, GI radiology, and CT scans; and
11. All services provided by a non-covered or non-participating provider, with the exception of Emergency Services.

For additional information on Preauthorization, the Participant or the Provider may call the Participant Services number on the Participant's identification card.

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

If BCBSMT 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 approval, the Participant may be responsible to pay the full cost of the services received, if an ABN has been signed.

If Preauthorization is not requested by the Participant or Participating Provider, the claim will be denied on the basis of no Preauthorization. The Participant may appeal the denial of the claim as outlined in the Article entitled "Complaints, Appeals, and Confidential Information." 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 EOC, the Participant may be responsible for the full cost of the services, if an ABN has been signed.

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

Section IV: 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 BCBSMT within two working days following the Participant's emergency admission.

Section V: Preauthorization Required For Certain Prescription Drug Products and Other Medications

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

1. Prescription Drugs – Covered Under the Prescription Drug Program Benefit

Certain prescription drugs, which are self-administered, require Preauthorization. Please refer to the Prescription Drug Program section for complete information about the Prescription Drug Products that are subject to Preauthorization 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 EOC. Certain medications administered by a Covered Provider require Preauthorization. The medications that require Preauthorization are subject to change by BCBSMT.

To determine which medications are subject to Preauthorization, please refer to the Prescription Drug Program section for complete information.

Section VI: General Provisions Applicable to All Required Preauthorizations

1. No Guarantee of Payment

Preauthorization does not guarantee payment of Benefits. Even if the Benefit has been Preauthorized,

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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 BCBSMT to make a determination of coverage pursuant to the terms and conditions of this EOC.

3. Failure to Obtain Preauthorization

If Preauthorization is not requested by the Participant or Participating Provider, the claim will be denied on the basis of no Preauthorization. The Participant may appeal the denial of the claim as outlined in the Article entitled "Complaints, Appeals, and Confidential Information." 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 EOC, the Participant may be responsible for the full cost of the services, if an ABN has been signed.

Any treatment the Participant receives which is not a covered service under this EOC, or is not determined to be Medically Necessary, was Experimental, Investigational, Unproven 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. When a service is denied as non-covered, Participating Providers may not balance bill the Participant for the services, unless the Participant or the Participant's authorized representative has signed an ABN. For non-covered services, providers may bill Participants only when providers and Participants have agreed in writing prior to the services being provided.

DPHHS Administered Claims

A request for Preauthorization must be submitted for consideration in the following manner:

1. A written request for Preauthorization must be submitted to DPHHS in writing by the Participating Provider.

2. The written request should explain the proposed services being sought, the functional aspects of the service, and why it is being done.

3. Any additional documentation such as study molds, x-rays, or photographs necessary for a determination should be mailed to the address listed on the Participant's ID card. HELP Plan Participant's names, addresses, and Participant numbers must be included.

DPHHS will review the request and all necessary supporting documentation to determine if the services are Medically Necessary. The decision will be made in accordance with the terms of this EOC. In no event shall a coverage determination be made more than 14 days following receipt of all documents.

A request for Preauthorization does not guarantee that Benefits are payable. Attending an appointment prior to receiving Preauthorization approval may result in the HELP Plan Participant paying costs of a service determined to not be Medically Necessary, not covered, Experimental, Investigational, Unproven, or performed in an inappropriate setting under this EOC.

Pharmacy Claims

Many drug products require Preauthorization before the pharmacist provides them to the Participant.

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For the Pharmacy drug Preauthorization process, please refer to the Pharmacy provider manual located at the following website: http://medicaidprovider.mt.gov/.

Section VII: Concurrent Review

Whenever it is determined by BCBSMT that Inpatient care or an ongoing course of treatment may no longer meet Medical Necessity criteria or is considered Experimental, Investigational, or Unproven, the Participant, Participant's Provider or the Participant's authorized representative may submit a request to BCBSMT for continued services.

Section VIII: Healthy Behavior Plan

The HELP Plan includes a comprehensive Healthy Behavior Plan for Participants with a focus on engaging Participants, their families, and providers. The components of this program have been designed to:

- Improve Participants' knowledge of lifestyles that are healthy and promote wellness;
- Improve Participants' understanding of chronic health conditions;
- Provide easy access to validated, accurate health information; and
- Inform Participants of health and self-care, and how to access plan benefits.

BCBSMT's Health Education Program for health and wellness promotion for the HELP Plan is a comprehensive program comprised of three separate components including:

- Annual Participant communication,
- Condition (disease) management, and
- Physician education.

Additional information regarding DPHHS administered wellness programs can be found on the Department's website at http://dphhs.mt.gov/publichealth/chronicdisease/CommunityBasedPrograms.

Section IX: On-Line Education Tools

HELP Plan Participants have access to on-line tools and mailed materials upon request. The following topics are available:

- Availability of and benefits for preventive health care;
- Targeted disease management education;
- Healthy pregnancy;
- Appropriate ER utilization;
- Injury prevention;
- Importance of and schedules for screenings for cancer, high blood pressure, and diabetes;
- Risks associated with the use of alcohol, tobacco, and other substances;
- Healthy lifestyle choices such as exercise, balanced diet, maintaining an appropriate weight, stress reduction, and the importance of sleep;
- The use of the Primary Care Provider (PCP) or a Patient Centered Medical Home (PCMH) as the primary source of medical care; and
- Ask Me3 – educational information regarding how to ask your doctor questions during a medical appointment.

Annual Participant Materials:

- Primary prevention and health education;
- BCBSMT Participant newsletters with a variety of articles of general health interest and primary prevention for this population;
- Reminder post-cards about immunizations and preventive services; and
- Exercise and physical activity pamphlet.

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Web-Based Education:

Web-based education is offered through Well onTarget℠, a dynamic new condition management tool that Participants can use to learn about and manage their condition. It also provides an opportunity to increase engagement by giving Participants alternative means to enroll in Care Management programs. Well onTarget complements the robust catalog of health and wellness tools already available to all Participants. Participants have access to the following:

- **Health Assessments (HA):** Online HAs allow Participants to answer basic questions about their health with their answers stored in one, secure place. They can take Care Activities (CAs) for asthma, coronary artery disease, diabetes, depression, and substance abuse.
- **Online Health Tutorials:** Based on answers to the HA, Well onTarget will suggest online tutorials to help Participants better understand their care needs and offer ways for them to take a more active role in their care.
- **Health Resources:** This section allows Participants to obtain useful health information from well-known and recognized groups such as the National Institutes of Health (NIH) and Centers for Disease Control and Prevention.

Participants can log on to Well onTarget by choosing the link in the My Health tab in their Blue Access for Members℠ (BAM) account. BAM is the web-based Participant portal available to Participants.

Section X: Condition Management

Condition management provided by BCBSMT clinical staff is the most important one-on-one vehicle for health education. Identified Participants are stratified by his/her risk into one of three levels depending upon his/her use of services, co-morbidities, and/or gaps in care. All Participants with “care gaps” are flagged in the Care Management system and used in the Participant risk stratification. The stratification is continuously updated based on data analysis of cost and prevalence, referral from BCBSMT medical management staff, contracted providers, registry development, stratification by severity criteria, interventions by stratification, and outcomes measurement.

BCBSMT provides the following condition and lifestyle management programs:

- Diabetes;
- Asthma;
- Hypertension;
- Special Beginnings Maternity Management;
- Weight Management; and
- Smoking Cessation.

Interventions are designed to afford Participants the opportunity to acquire self-care information that will enhance the Participant’s knowledge about risk factors and to improve the Participant’s ability to work with his/her physician to identify treatment regimens appropriate to prevent complications and to improve the Participant’s quality of life.

Additional information regarding DPHHS administered wellness programs can be found on the Department’s website at http://dphhs.mt.gov/publichealth/chronicdisease/CommunityBasedPrograms.

Special Beginnings Maternity Management

The Special Beginnings® Program is a comprehensive maternity program designed to help expectant Participants better understand and manage their pregnancy. The program focuses on providing Participants with educational resources and additional support throughout their pregnancy and postpartum care.

Participants can access a new online resource tool for expectant mothers located on Blue Access® for Members. The online tool provides the following resources:

- Pregnancy calendar to help keep track of the pregnancy and what to expect in each trimester;

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- A pregnancy due date calculator;
- Videos about pregnancy and childbirth with professionals such as clinical psychologists and registered nurses; and
- Educational articles.

Upon enrollment into Special Beginnings, Participants are screened for risk stratification, low, moderate or high. Low risk Participants receive outreach every trimester and at two (2) weeks post-partum but are followed through six (6) weeks post-partum. They are continually screened for a change in risk stratification during their pregnancy.

Participants receive an informational packet which includes:

- Prenatal care book;
- Infant care information;
- Back to Sleep – safe sleep information; and
- Breastfeeding information.

Participants screened as moderate are managed by a maternal/child health nurse and receive monthly outreach. Participants identified as high risk OB are referred to a complex case manager who specializes in maternal/child health.

ARTICLE FIVE – COVERED BENEFITS

The HELP Plan will make payment for certain professional provider and Hospital services based on the Allowable Fee for Covered Medical Expenses provided by Participating Providers during the Benefit Period and while this EOC in force. (Please read Article Two entitled "Participating Providers.")

Section I: Inpatient Hospital Services

BCBSMT administers claims for Inpatient Hospital Services and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

1. Room and Board Accommodations include:

    a. Room and board, which includes special diets and nursing services; and
    b. Intensive care and cardiac care units only when such service is Medically Necessary. Intensive care and cardiac care units include:
        1) Special equipment; and
        2) Concentrated nursing services provided by nurses who are Hospital employees.

2. Miscellaneous Inpatient Hospital Benefits include:

    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; and
    k. Drugs and medicines which:
        1) Are approved for use in humans by the U.S. Food and Drug Administration.
        2) Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons.
        3) Require a Physician's written order.

3. Transplant Benefits include:

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a. Heart, heart/lung, single lung, double lung, liver, pancreas, kidney, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea, and renal transplants.
b. For organ and tissue transplants involving a living donor, transplant organ/tissue procurement and transplant-related medical care for the living donor are covered.
c. Transplants of a nonhuman organ or artificial organ implant are not covered.
d. Donor searches are not covered.

For certain transplants, BCBSMT contracts with a number of Centers of Excellence that provide transplant services. BCBSMT 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 BCBSMT Participant Services to discuss the possible benefits of utilizing the Centers of Excellence.

Section II: Observation and Recovery Care Beds/Rooms

BCBSMT administers claims for Observation/Recovery Beds/Rooms and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Payment will be made for Observation Beds/Rooms and Recovery Care Beds/Rooms when necessary, and in accordance with BCBSMT Medical Policy guidelines. Observation Beds/Room and Recovery Care Beds/Rooms services are subject to the following limitations:

1. The HELP Plan will pay Observation Beds/Room and Recovery Care Beds/Rooms benefits when provided for less than 24 hours.
2. Benefits for Observation Beds/Rooms and Recovery Care Beds/Rooms will not exceed the semiprivate room rate that would be billed for an Inpatient stay.

Section III: Outpatient Hospital Services

BCBSMT administers claims for Outpatient Hospital Services and Preauthorization may be required for some services. Please refer to the Preauthorization section. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Outpatient services include:

1. Emergency room care for accidental injury;
2. Emergency room care for an Emergency Medical Condition;
3. Emergency room care for sudden illness;
4. Use of the Hospital's facilities and equipment for surgery; and
5. Use of the Hospital's facilities and equipment for respiratory therapy, chemotherapy, radiation therapy, and dialysis therapy.

Section IV: Outpatient Therapies – Please refer to Section XI: Rehabilitative Care Benefits

Section V: Outpatient Diagnostic Services

Claims for Outpatient Diagnostic Services provided by FQHCs and RHCs are administered by DPHHS. Participating Providers may contact Provider Relations at 1-800-624-3958. Applicable guidance for claims submission for services provided by these specific types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov.

Claims for all other Outpatient Diagnostic Services are administered by BCBSMT and Preauthorization may be required for some services. Please refer to the Preauthorization section. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Covered Outpatient Diagnostic Services include:

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1. Diagnostic x-ray examinations;
2. Laboratory and tissue diagnostic examinations; and
3. Medical diagnostic procedures (machine tests such as EKG, EEG).

Section VI: Freestanding Surgical Facilities (Surgery Centers)

Freestanding Surgical Facility claims are administered by BCBSMT and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Surgery center services are available if:

1. The center is licensed by the state in which it is located or certified for Medicare;
2. The center has an effective peer review program to assure quality and appropriate patient care; and
3. The surgical procedure performed is:
   a. Recognized as a procedure, which can be safely and effectively performed in an Outpatient setting; and
   b. One which cannot be appropriately performed in a doctor's office.

Section VII: Mammograms

Claims for mammograms provided by FQHCs and RHCs are administered by DPHHS. Participating Providers may contact Provider Relations at 1-800-624-3958. Applicable guidance for claims submission for services provided by these specific types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

All other claims for mammograms are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

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.

Section VIII: Preventive Health Care

Claims for preventive health care services provided by FQHCs and RHCs are administered by DPHHS. Participating Providers may contact Provider Relations at 1-800-624-3958. Applicable guidance for claims submission for services provided by these specific types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

All other claims for preventive health care are administered by BCBSMT administers. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Covered preventive services include, but are not limited to:

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

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

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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, BCBSMT will reimburse the Participant the actual cost for the purchase of a breast pump once per birth event. Hospital-grade pumps can be rented, per Medical Policy criteria. For additional information, access www.bcbsmt.com and click on "New Mothers."

b. Contraceptives

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

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

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

For more detailed information on all covered services, contact Participant Services at 1-877-233-7055 or access www.bcbsmt.com.

Section IX: Post-mastectomy Care

BCBSMT administers claims for Post-mastectomy care and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer. Covered services include, but are not limited to:

1. Inpatient care for the period of time as determined by the attending Physician, in consultation with the Participant, to be necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer. Preauthorization is required for Inpatient Hospital services;
2. All stages of reconstructive breast surgery after a mastectomy are covered;
3. The cost of the breast prosthesis as the result of the mastectomy is covered;
4. All stages of one reconstructive breast surgery on the non-diseased breast to establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed;
5. Chemotherapy; and
6. Prosthesis and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Section X: Surgical Services

Surgical Services Billed by a Professional Provider

BCBSMT administers claims for surgical services billed by a professional provider and Preauthorization may be required for some services. Please refer to the Preauthorization section. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

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

BCBSMT administers claims for surgical services billed by an Outpatient surgical facility or

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freestanding surgery center and Preauthorization may be required for some services. Please refer to the Preauthorization section. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

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.

BCBSMT will pay for a Recovery Care Beds/Room 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)

BCBSMT administers claims for surgical services billed by a Hospital and Preauthorization may be required for some services. Please refer to the Preauthorization section. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

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.

Section XI: Anesthesia Services

BCBSMT administers anesthesia services and Preauthorization may be required for some services. Please refer to the Preauthorization section. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Anesthesia services provided by a Physician (other than the attending Physician or assistant), or nurse anesthetist are generally Covered Medical Expense if the services are determined to be Medically Necessary to provide care for a condition covered by this EOC.

Anesthesia services include:

1. Administration of spinal anesthesia;
2. The injection or inhalation of a drug or other anesthetic agent used to cause muscles to relax, or a loss of sensation or consciousness; and
3. Supervision of the individual administering anesthesia.

The Allowable Fee for the anesthesia performed during the surgery includes the pre-surgery anesthesia consultation.

Exclusions to Anesthesia Benefit coverage under the HELP Plan are:

1. Hypnosis;
2. Local anesthesia that is considered to be an Inclusive Service/Procedure;
3. Anesthesia consultations before surgery that are considered to be Inclusive Services/Procedures; and
4. Anesthesia for Dental services or extraction of teeth, except as included in the Dental Treatment section of this EOC.

Section XII: Rehabilitative Care Benefits

Outpatient Rehabilitative Care Covered Medical Expense claims from FQHCs and RHCs are administered by DPHHS. Participating Providers may contact DPHHS Provider Relations at 1-800-624-3958. Applicable guidance for claims submission for services provided by these specific types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

All other Outpatient Rehabilitative Care Covered Medical Expense are administered by BCBSMT and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206.

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Participants may contact BCBSMT at 1-877-233-7055.

Outpatient Rehabilitation Therapy Benefits are described below:

1. Therapy service provided to Participants by a Multidisciplinary Team under the direction of a qualified Physician.
2. Members of the Multidisciplinary Team may include but are not limited to a licensed psychologist, licensed Speech Therapist, licensed Physical Therapist, or licensed Occupational Therapist.
3. Services must be Medically Necessary to improve or restore bodily function and the Participant must continue to show measurable progress.
4. Outpatient Rehabilitative Care does require Preauthorization.

Inpatient Rehabilitative Care Covered Medical Expenses are administered by BCBSMT and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206.

Inpatient Rehabilitative Care Benefits are described below:

1. Therapy service provided to Participants by a Multidisciplinary Team under the direction of a qualified Physician.
2. Participants of the Multidisciplinary Team may include but are not limited to a licensed psychologist, licensed speech therapist, licensed physical therapist, or licensed occupational therapist.
3. Services must be Medically Necessary to improve or restore bodily function and the Participant must continue to show reasonable progress.

Rehabilitative Care Benefit Exclusions:

1. Rehabilitative Care is not covered when the primary reason for the therapy is one of the following:
   a. Custodial care;
   b. Diagnostic admissions;
   c. Maintenance, nonmedical self-help, or vocational educational therapy;
   d. Learning and developmental disabilities;
   e. Social or cultural rehabilitation; and
   f. Visual, speech, or auditory disorders.

Section XIII: Medical Services (Non-Surgical)

Medical services are those non-surgical Covered Medical Expenses provided by Participating Providers during office, home, or Hospital visits, which do not include surgical or maternity services. Outpatient medical service claims from FQHCs and RHCs are administered by DPHHS. Participating Providers may contact DPHHS at 1-800-624-3958. Applicable guidance for claims submission for services provided by these specific types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov.

All other Outpatient medical services (non-surgical) Covered Medical Expenses are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Outpatient medical services (non-surgical) include the following:

1. Outpatient medical services include physical examinations and immunizations provided for home, office, and Outpatient Hospital Professional Calls.
2. Services provided via Telemedicine are allowed.

Inpatient claims for services are processed through BCBSMT. Preauthorization may be required for certain non-surgical medical services administered by BCBSMT. It is recommended Participating Providers contact BCBSMT at 1-877-296-8206 if they are uncertain whether a Covered Medical Expense needs Preauthorization. Participants may contact BCBSMT at 1-877-233-7055.

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Inpatient medical services (non-surgical) include the following:

1. Inpatient medical services are covered for eligible Hospital admissions.
2. Medical care visits, limited to one visit per day per Participating Provider.
3. Intensive medical care rendered to Participants whose condition requires a Physician's constant attendance and treatment for a prolonged period of time.
4. Concurrent Care services.
5. Consultation services are services of a consulting Physician requested by the attending Physician. These services include:
   a. Evaluation and management service provided at the request of another Participating Provider;
   b. The consultant's opinion and any services ordered or performed must be documented in the Participant's medical record and communicated by written report to the requesting Participating Provider; and
   c. Evaluation and management consultation services requested by a Participating Provider from a non-Participating Provider and subsequent referrals or treatment services must be Prior Authorized by BCBSMT.

Benefit coverage will not be provided under the HELP Plan for:

a. Staff consultations required by Hospital rules; and
b. Family consultations.

Section XIV: Maternity Services

BCBSMT administers claims for maternity services and Preauthorization is required for Hospital admissions. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Payment for any maternity services is limited to the Allowable Fee for total maternity care, which includes:

1. Prenatal and postpartum care delivery of one or more newborn;
2. In Hospital medical services for conditions related directly to pregnancy; and
3. Prenatal vitamins.

Inpatient Hospital care following delivery will be covered for the length of time determined to be Medically Necessary. At a minimum, Inpatient care coverage 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 Inpatient stay to less than that stated above must be made by the attending Participating Provider and the mother.

Section XV: Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

BCBSMT administers claims for EPSDT. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

EPSDT services are comprehensive and preventive health care services for Participants between the ages of 19 and 20. EPSDT services include:

- Comprehensive health and developmental history, physical exam, immunizations, lab tests, and health education;
- Vision services including diagnosis and treatment, including eyeglasses;
- Dental services;
- Hearing services; and
- Requests for Medically Necessary services.

Section XVI: Vision Benefits and Medical Eye Care

Vision claims from FQHCs and RHCs are administered by DPHHS. Participating Providers may contact DPHHS Provider Relations at 1-800-624-3958. Applicable guidance for claims submission for services provided by these types of providers is explained in the Montana Medicaid Provider Manuals found at the

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following website: http://medicaidprovider.mt.gov.

BCBSMT administers vision claims for all other types of providers. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

BCBSMT administered Vision Benefits include:

1. Services for the medical treatment of diseases or injury to the eye by a licensed Physician or optometrist working within the scope of his/her license; and
2. Vision exams.

DPHHS administers claims for eyeglasses. Providers may contact DPHHS Provider Relations at 1-800-624-3958. Providers must complete the Montana Medicaid Rx Form to order eyeglasses from the Department's contractor. See the Forms page of the Provider Information website at: http://medicaidprovider.mt.gov/.

DPHHS administered Eyeglasses Benefits include:

a. Eyeglasses are available through the Department through a contractor;
b. Glasses are limited to one pair every 365 days; and
c. Contact lenses are not covered.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov.

Section XVII: Dental Services

Dental claims (non-medical) are administered by DPHHS. Participating Providers may contact DPHHS Provider Relations at 1-800-624-3958.

Dental Benefits include:

1. Dental treatment services are limited to $1,125 each July through June;
2. Dental preventive and diagnostic services; and
3. Dental dentures services.

The $1,125 annual cap for dental treatment does not include dentures, preventive/diagnostic services or anesthesia.

Additional information can be found on the DPHHS' website at: http://medicaidprovider.mt.gov/.

The HELP Plan may pay for Medically Necessary services provided by dentists and oral surgeons for the initial repair or replacement of sound natural teeth damaged as a result of an Accident. Dental Accidents should be reported immediately to BCBSMT at 1-877-233-7055.

Inpatient Dental Services include:

1. Services and supplies provided by a Hospital in conjunction with Dental treatment will be covered only when a non-dental physical Illness or injury exists, which makes Hospital care Medically Necessary to safeguard the Participant's health. Things such as complexity of Dental treatment and length of anesthesia are not considered non-dental physical Illness or injury.
2. Other conditions are subject to medical review and Preauthorization.

Exclusions to Outpatient and Inpatient Dental Services include:

1. Orthodontics;
2. Dentofacial orthopedics;
3. Related appliances; and
4. Dental implants.

Section XVIII: Dental Fluoride

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Claims for Dental fluoride provided by a Dentist are administered by DPHHS. Participating Providers may contact DPHHS Provider Relations at 1-800-624-3958.

BCBSMT administers claims for Dental fluoride provided by Physicians. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Dental varnish fluoride applications are covered when provided by a Physician or Dentist. Prescribed oral fluoride preparations are a covered Pharmacy benefit.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/.

Section XIX: Audiological Services

Audiology services claims are administered by DPHHS and Preauthorization required. Participating Providers may contact DPHHS Provider Relations at 1-800-624-3958.

Audiology services are hearing aid evaluations and basic audio assessments provided to Participants with hearing disorders within the scope of service permitted by state law.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/.

Section XX: Hearing Aid Services

Hearing aid services claims are administered by DPHHS and Preauthorization is required. Participating Providers may contact DPHHS Provider Relations at 1-800-624-3958.

For a hearing aid to be covered, the Participant must be referred by a Physician or mid-level practitioner for an audiological exam, and the Physician or mid-level practitioner must have determined that a hearing evaluation would be medically appropriate to evaluate the patient's hearing loss.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/.

Section XXI: Radiation Therapy Services

BCBSMT administers claims for radiation therapy services. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

The use of x-ray, radium, or radioactive isotopes ordered by the attending Physician for the treatment of disease is covered.

Section XXII: Chemotherapy

BCBSMT administers claims for chemotherapy. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

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

Section XXIII: Diabetes Education

BCBSMT administers diabetes education claims for Covered Medical Expenses. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

The HELP Plan covers Outpatient diabetes education services. Covered services include programs for self-management training and education as prescribed by a licensed health care professional with expertise in diabetes.

Please see Section XXXIV: Durable Medical Equipment (DME) and Medical Supplies for important information regarding diabetes equipment and supplies covered by the HELP Plan.

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Section XXIV: Montana Diabetes Prevention Program

The Montana Diabetes Prevention Program offers an intensive, ten month, lifestyle management intervention focusing on; behavior change, healthy eating strategies, and ways to become more active. The program is facilitated by trained lifestyle coaches that encourage, coach, and motivate participants to adopt sustainable lifestyle changes.

Additional information can be found on the Department's website at: http://dphhs.mt.gov/publichealth/Diabetes/DPP.aspx.

Section XXV: Diagnostic Services – Please refer to Section V: Outpatient Diagnostic Services

Section XXVI: Mental Illness Inpatient and Outpatient Benefits

BCBSMT administers Mental Illness claims for Covered Medical Expenses and Preauthorization is required for Inpatient services and several Outpatient services. Please refer to the Article entitled "Preauthorization." Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

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

Outpatient Services

Care and treatment for Mental Illness when the Participant is not an Inpatient Participant and provided by a (an):

1. Hospital;
2. Physician or prescribed by a Physician;
3. Mental Illness Treatment Center;
4. Chemical Dependency Treatment Center;
5. Psychologist;
6. Licensed social worker;
7. Licensed professional counselor;
8. Addiction counselor licensed by the state; or
9. Licensed psychiatrist.

Outpatient services are subject to the following conditions:

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

Inpatient Care Services

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

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

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

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

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Partial Hospitalization

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

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

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

Mental Illness Outpatient Benefits

Mental Illness Outpatient claims from FQHCs and RHCs are administered by DPHHS. Participating Providers may contact DPHHS Provider Relations at 1-800-624-3958. Applicable guidance for claims submission for services provided by these types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

BCBSMT administers Mental Illness Outpatient benefit claims for all other types of Participating Providers. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

1. The HELP Plan will pay for Outpatient Mental Illness services that are Covered Medical Expenses if provided by a Participating Provider. Outpatient Mental Illness services may be furnished in a variety of settings:
   a. Community based settings; or a
   b. Mental Illness Hospital.

2. Mental Illness Outpatient Benefits include individual, family, and/or group psychotherapy office visits.

3. Services provided via Telemedicine are allowed.

Section XXVII: Severe Mental Illness

Claims for Severe Mental Illness services provided by FQHCs and RHCs are administered by DPHHS. Participating Providers may contact Provider Relations at 1-800-624-3958. Applicable guidance for claims submission for services provided by these specific types of providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

BCBSMT administers Severe Mental Illness claims for all other types of Participating Providers. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

The HELP Plan will pay the Allowable Fee for Medically Necessary services provided by a licensed Physician, licensed advanced practice registered nurse with prescriptive authority and specializing in Mental Illness, licensed advanced practice registered nurse with a specialty in Mental Illness, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed Physician.

Section XXVIII: Chemical Dependency

BCBSMT administers claims for Chemical Dependency Inpatient and Outpatient services and Preauthorization is required for Inpatient services. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

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

Outpatient Services

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Care and treatment for Chemical Dependency when the Participant is not an Inpatient Participant and provided by a (an):

1. Hospital;
2. Mental Illness Treatment Center;
3. Chemical Dependency Treatment Center;
4. Physician or prescribed by a Physician;
5. Psychologist;
6. Licensed social worker;
7. Licensed professional counselor;
8. Addiction counselor licensed by the state; or
9. Licensed psychiatrist.

Outpatient services are subject to the following conditions:

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

Inpatient Care Services

Care and treatment of Chemical Dependency, while the Participant is an Inpatient Participant, and which are provided in or by a:

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

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

Partial Hospitalization

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

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

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

Section XXIX: Ambulance Services

DPHHS administers claims for Ambulance services. Providers may contact DPHHS at 1-800-624-3958.

Licensed ground and air Ambulance services are covered to the nearest Hospital equipped to provide the necessary treatment, when the service is for a life-endangering medical condition or injury. Ambulance transport must be Medically Necessary meaning other forms of transportation would endanger the health of the Participant.

Additional information can found on the DPHHS website at: http://medicaid provider.mt.gov/.

Section XXX: Specialized Non-Emergency Transportation

DPHHS administers claims for specialized non-emergency transportation services and Preauthorization is required. Providers may contact the Montana Medicaid Transportation Center at 1-800-292-7114.

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Specialized non-emergency transportation is for Participants who are wheelchair bound or must be transported by stretcher and Prior Authorization must be received before travel takes place. Call the Montana Medicaid Transportation Center at 1-800-292-7114.

Additional information can found on the Department's website at: http://medicaid provider.mt.gov/.

Section XXXI: Personal and Commercial Transportation

DPHHS administers claims for personal and commercial transportation. Providers may contact the Montana Medicaid Transportation Center at 1-800-292-7114.

Commercial transportation is for Participants who do not have special transportation requirements. Commercial transportation services are provided by air or ground commercial carrier, taxicab, or bus for a Participant to receive medical care. Commercial transportation is covered only when it is the least costly form of transportation. Participants must obtain Preauthorization from the Montana Medicaid Transportation Center for this service. The Participant or his/her designee must call in or fax all non-emergent transportation requests to the Montana Medicaid Transportation Center before the services are provided.

The Montana Medicaid Transportation Center completes the following procedures for each transportation request:

- Verifies current eligibility
- Confirms Team Care provider approval, if necessary
- Confirms individual appointments
- Confirms that the service is covered
- Determines the least expensive and most appropriate mode of travel
- Determines the closest site of service

Montana Medicaid Transportation Center
MPQH
P.O. Box 6488
Helena, MT 59604-6488
Phone
1-800-292-7114 In/Out of state
406-443-6100 Helena
Fax
1-800-291-7791 In/Out of state

Section XXXII: Personal Transportation

DPHHS administers claims for personal transportation benefits. Preauthorization must be obtained from the Montana Medicaid Transportation Center at 1-800-292-7114.

The HELP Plan will provide financial assistance towards expenses for HELP Plan Participants' mileage, meals and lodging while receiving Medicaid covered medical care outside a Participants' community. It is important to have Participants' Participating Providers submit requests for Preauthorization to the Claim Administrator and receive approval for Medically Necessary medical care before submitting Preauthorization for travel and per diem. The Montana Medicaid Transportation Center must approve all travel assistance requests before the trip.

Additional information can be found on the Department's website at: http://medicaid provider.mt.gov.

Section XXXIII: Prescription Drugs

DPHHS administers claims for prescription drugs. Providers may contact DPHHS Provider Relations at 1-800-624-3958.

Drug coverage is limited to those products where the pharmaceutical manufacturer has signed a rebate agreement with the Federal government. Federal regulations further allow states to impose restrictions on payment of prescription drugs through Preauthorization (PA) and preferred drug lists (PDL).

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Prescription drugs purchased at a nonparticipating Pharmacy are not a benefit of this EOC. Participants will be responsible for payment of drugs purchased at a non-participating Pharmacy.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov.

Preauthorization
Certain Prescription Drug Products require Preauthorization to be covered by the Department at the time of purchase. Preauthorization procedures require the Participant's Physician to provide documentation to the Department that the prescription drug is Medically Necessary. Preauthorization may be initiated by the Participant's Physician or the dispensing pharmacist. If these products are not preauthorized before being dispensed the claim will deny. The Department may delegate the Preauthorization function, but it retains the final discretionary authority regarding coverage under the HELP Plan.

For all questions regarding drug prior authorization, please call 1-800-395-7961 or (406) 443-6002 in Helena. Mail or fax backup documentation to:

Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602
1-800-294-1350 Fax
406-513-1928 Fax Helena

Section XXXIV: Durable Medical Equipment (DME) and Medical Supplies

BCBSMT administers claims for DME and Medical Supplies and Preauthorization may be required services greater than $2,500. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

The HELP Plan will pay for the most economical equipment or supplies that are Medically Necessary to treat a problem or physical condition; must be appropriate for use in the Participant's home, residence, school, or workplace.

1. DME does not include equipment or supplies that are useful or convenient, but are not Medically Necessary. DME includes oxygen equipment, wheelchairs, prosthetic limbs, and orthotics.
2. Diabetes equipment and supplies include: insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for the warranty period, and accessories to insulin pumps. (Please also see Section XXIII regarding Diabetes Education and Section XXXVIII: Nutrition Services.)

The following items are not covered:
4. Exercise equipment;
5. Lifts;
6. Hot tubs
7. Computerized equipment;
8. Athletic equipment;
9. Replacement of lost or stolen items;
10. Repair to rental equipment; and
11. Convenience items.

Section XXXV: Home Health Services

BCBSMT administers home health service claims for Covered Medical Expenses and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

The HELP Plan will pay for home health services provided by a licensed home health agency to Participants considered homebound in Participants' place of residence for the purposes of postponing or preventing institutionalization.

1. Home health services include:

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a. Nursing services;
b. Home health aide services;
c. Hospice services;
d. Physical Therapy services;
e. Occupational Therapy services;
f. Speech Therapy services;
g. Medical social worker;
h. Medically Necessary personal hygiene, grooming and dietary assistance; and
i. Medical supplies and equipment suitable for use in the home.

2. Home health services not covered:
   a. Respite care;
   b. Maintenance or custodial care visits;
   c. Domestic or housekeeping services;
   d. "Meals-on-Wheels" or similar food arrangements;
   e. Visits, services, medical equipment or supplies not approved or included as part of the Participant's treatment plan;
   f. Services provided in a nursing home or skilled nursing facility;
   g. Participating home health agencies will be required to use a participating home infusion therapy provider who will bill the Claim Administrator directly;
   h. Compensation for daily prescriptions and oral medications will not be allowed through the home health agency; and
   i. Compensation for Ambulance services will not be allowed through the home health agency.

Home health services are limited to 180 visits per Benefit Period.

Section XXXVI: Home Infusion Therapy Services

DPHHS administers claims for home infusion therapy services for Covered Medical Expenses. Participating Providers may contact DPHHS at 1-800-624-3958.

Home infusion therapy is a comprehensive treatment program of pharmaceutical products and clinical support services provided to Participants who are living in their home, a nursing facility, or any setting other than a hospital. A physician's authorization (prescription) for home infusion therapy allows Participants to avoid or leave the hospital care setting and receive medical care at home. Under the guidance of the Participant's physician, the licensed home infusion therapy provider develops and implements a treatment program to meet the particular requirements of the Participant.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/.

Section XXXVII: Hospice Services

BCBSMT administers claims for hospice services and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

The HELP Plan will cover Medically Necessary hospice services from licensed providers. Medically Necessary curative services are allowed while receiving hospice services.

1. A plan of care must be submitted to the Claim Administrator prior to providing services.
2. Hospice services must be Preauthorized before services are provided.
3. Volunteer services are not a Covered Medical Expense.

Section XXXVIII: Nutrition Services

BCBSMT administers claims for nutrition services that are Covered Medical Expenses. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

The HELP Plan will cover nutrition counseling.

Section XXXIX: Approved Clinical Trials

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BCBSMT administers claims for Approved Clinical Trials that are Covered Medical Expenses. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Routine Patient Costs provided in connection with an Approved Clinical Trial are Covered Medical Expenses.

Section XL: Indian Health Services (IHS) and Tribal Health

DPHHS administers claims for Indian Health Services (IHS) and Tribal Health and Preauthorization may be required. Members of federally recognized Indian tribes and their descendants are eligible for services provided by the IHS, an agency of the U.S. Public Health Service, Department of Health and Human Services. Participating Providers may contact DPHHS Provider Relations at 1-800-624-3958.

Additional information can be found on the Department's website at: http://medicaidprovider.mt.gov/.

Section XLI: Cultural and Language Services

The HELP Plan will pay for Cultural and Language Services provided to eligible HELP Plan Participants if:

- The service is a Medically Necessary service;
- The service is a HELP Plan Covered Medical Expense;
- Reimbursement is to the provider of the service (the Interpreter), not a third party;
- Another payer is not responsible for payment;
- Services were performed in a prompt, efficient fashion; and
- A complete request for payment is received within 365 days of the service provided. This means that the request for payment will include all information necessary to successfully pay the claim.

Section XLII: Prostheses

BCBSMT administers claims for prostheses that are Covered Medical Expenses and Preauthorization may be required for services greater than $2,500. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

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

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

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

The Help Plan will not pay for the following items:

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

Section XLIII: Convalescent Home Services

BCBSMT administers claims for Convalescent Home services that are Covered Medical Expenses and Preauthorization is required. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

Services of a Convalescent Home as an alternative to Hospital Inpatient care are Covered Medical Expenses. BCBSMT will not pay for Custodial Care.

NOTE: BCBSMT 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.

Convalescent Home services are limited to 60 days per Benefit Period.

Section XLIV: Education Services

BCBSMT administers claims for education services that are Covered Medical Expenses. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

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

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Medical Expenses.

Section XLV: Other Services

BCBSMT is the Claims Administrator for the Covered Medical Expenses listed below. Participating Providers may contact BCBSMT at 1-877-296-8206. Participants may contact BCBSMT at 1-877-233-7055.

1. Blood transfusions, including cost of blood, blood plasma, blood plasma expanders, and packed cells. Storage charges for blood are covered when Participants have blood drawn and stored for their own use for a planned surgery.
2. Supplies used outside of a Hospital are covered ONLY if the supplies are prescribed by a Participating Provider and Medically Necessary to treat a condition that is covered by HELP Plan.

ARTICLE SIX– GENERAL EXCLUSIONS AND LIMITATIONS

All Benefits provided under this EOC are subject to the Exclusions and limitations stated below. Except as specifically provided in this EOC, the HELP Plan will not be required to provide Benefits for the following services, supplies, situations, and any related expenses:

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

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

2. Worker's Compensation: All services and supplies which would be provided to treat Illness or Injury arising out of employment when Participants' employers are required by law to obtain coverage or have elected to be covered 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 employment related government legislation provides Benefits for only a portion of the services incurred.
    b. Participants' employers have failed to obtain such coverage as required by law.
    c. Participants have waived their rights to such coverage or Benefits.
    d. Participants fail to file claims within the filing period allowed by law for such Benefits.
    e. Participants fail to comply with any other provision of the law to obtain such coverage or Benefits.
    f. Participants have elected to not be covered by the Workers' Compensation Act but failed to properly make such election effective.

    This Exclusion will not apply if Participants are permitted by statute to not be covered and they effectively elect not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws (example: Independent Contractor holding a valid Independent Contractor Exemption Certificate).

    This Exclusion will not apply if Participants' employers were 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.

3. Other government services and supplies: Services and supplies that are paid for by the United States or any city, county, or state. This Exclusion applies to any programs of any agency or department of any government.

    Note: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to Participants from the HELP Plan. An example of this would be vaccines

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administered to HELP Plan Participants by a county health provider. When such a circumstance occurs, Participants will receive an Explanation of Benefits.

4. Comprehensive School and Community Treatment (CSCT) services.

5. Third Party Automobile Liability. Services, supplies, and medications provided to treat any injury to the extent the Participant receives, or would be entitled to receive, Benefits under an automobile insurance policy. Note: Any services, supplies, and medications provided by the HELP Plan to treat the Participants for Accident related injuries which may be covered by third party liability are subject to the lien and subrogation rights of the State of Montana.

6. Third-Party Premises Liability: Services, supplies, and medications provided to treat any injury to the extent Participants receive, or would be entitled to receive Benefits from a premises liability policy. Examples of such policies are a homeowners or business liability policy. Note: Any services, supplies and medications provided by the HELP Plan to treat Participants for Accident related injuries, which may be covered by third party liability are subject to the lien and subrogation rights of the State of Montana.

7. Injury or Illness resulting from war, declared or undeclared, insurrection, rebellion, or armed invasion.

8. Benefits for Participants incarcerated in a criminal justice institution. Participants are excluded from coverage only if they meet the definition of an inmate of a public institution as defined at 42 CFR 435.1009.

9. Any loss for which a contributing cause was commission by Participants of criminal acts, or attempts by Participants to commit felonies, or engaging in an illegal occupation.

10. Non-surgical treatment for malocculusion of the jaw, including services for Temporomandibular Joint Dysfunction (TMJ), anterior or internal dislocations, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances.

11. Services and supplies related to ridge augmentation or vestibuloplasty.

12. Dental Services, except as specifically included in this EOC.

13. Visual augmentation services including:

    a. Contact lenses; or
    b. Radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism).

    See Article Five, Section XVII: Vision Benefits and Medical Eye Care for important information on vision Benefits, including eye glasses, provided by the HELP Plan.

14. Service animals, including purchase, training, and maintenance costs.

15. Services or supplies related to cosmetic surgery, except as specifically included in this EOC.

16. Services, supplies or drugs used for cosmetic purposes or cosmetic treatment.

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

18. Private Duty Nursing, for Participants 21 and older.

19. Services for which Participants are not legally required to pay or charges that are made only because Benefits are available under this EOC.

20. Any services or supplies related to the treatment of infertility, including, artificial insemination, in

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vitro fertilization, gamete or zygote intrafallopian transfer, and fertility enhancing treatment.

21. Reversal of an elective sterilization.

22. Abortion (except an abortion which is Medically Necessary to save the life of the mother or to terminate a pregnancy which is the result of rape or incest or if provider certifies other rare reason for service).

23. Foot care including but not limited to:

    a. Routine foot care for Participants without co-morbidities, except Routine foot care is covered if a Participant has co-morbidities such as diabetes;
    b. Treatment or removal of corns or callosities;
    c. Hypertrophy, hyperplasia of the skin or subcutaneous tissues;
    d. Cutting or trimming of nails;
    e. Treatment of flat foot conditions and prescription of supportive devices for such conditions;
    f. Treatment of subluxations of the foot; and
    g. Foot orthotics.

24. Services provided for Participants before their Effective Date of coverage or after Participants' coverage terminates.

25. Services and supplies related to sexual inadequacies or dysfunctions or sexual reassignment and reversal of such procedures.

26. Services or supplies relating to any of the following treatments or related procedures:

    a. Acupuncture;
    b. Acupressure;
    c. Biofeedback and Neurofeedback;
    d. Naturopathy and naturopathic physician services;
    e. Homeopathy;
    f. Hypnosis;
    g. Hypnotherapy;
    h. Rolfing;
    i. Holistic medicine;
    j. Marriage counseling;
    k. Religious counseling;
    l. Self-help programs; and
    m. Stress management.

27. Any services or supplies not furnished in treatment of an actual Illness or injury such as, but not limited to, insurance physicals and premarital physicals. Note: Preventive checkups, immunizations, and sport or employment physicals are covered.

28. Sanitarium care, custodial care, rest cures, or convalescent care to help Participants with daily living tasks. Examples of such care would include, but are not limited to:

    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:
        1. Is usually self-administered; and
        2. Does not require the continuous attention of medical personnel.

29. No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, rest home, nursing home, rehabilitation facility, convalescent home, or extended care facility for the

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types of care outlined in this Exclusion.

30. Supplements.

31. Food supplements (except for those for inborn errors of metabolism and treatment of other Medically Necessary conditions).

32. All invasive medical procedures undertaken for the purpose of weight reduction such as gastric bypass, gastric banding, or bariatric surgery (including all revisions).

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

34. Benefits shall not be paid for services or items provided by an entity, institute, or provider located outside of the United States.

35. Education or tutoring services, except as specifically included as a Benefit of this EOC.

36. Any services or supplies not provided by a Participating Provider or that were provided by a Non-Participating Provider following referral from a Participating Provider, but for which Preauthorization was not obtained before the services were received.

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

38. Services and supplies related to Applied Behavioral Analysis (ABA).

39. Professional or courtesy discounts.

40. For travel by a Participant or provider, unless specifically included in this EOC.

41. 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 II 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 dosages(s) toxicity, safety, efficacy or efficacy as compared with standard treatment, or for the diagnosis of the condition in question.

42. Services provided by a massage therapist.

43. Services provided by a chiropractor.

44. Any services and supplies, which are not listed as a Benefit of this EOC.

ARTICLE SEVEN – CLAIMS FOR BENEFITS

Section I: Claims Processing

Medical and Behavioral Health

In order to have Participant Benefit claims processed through the HELP Plan, Participants' providers must submit clean claims for services no later than 365 days after the date on which Participants received the services, in accordance with ARM 37.85.406. All claims must give enough information about the services to determine whether they are covered under the EOC.

For BCBSMT administered claims, providers should submit claims to BCBSMT, PO Box 3387, Scranton, PA, 18505.

For DPHHS administered claims, providers should submit claims to Xerox, PO Box 8000, Helena, MT 59604.

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Pharmacy

For Pharmacy claims processing information please see the manual found at the following website: http://medicaidprovider.mt.gov/.

In addition, please refer to the National Council for Prescription Drug Programs (NCPDP) Payer Sheet located under Provider Notices on the following website: http://medicaidprovider.mt.gov/.

Section II: Payment for Professional and Hospital Services

1. Payment for Covered Medical Expenses Participants receive from Participating Providers will be made by the Claim Administrator directly to the Provider.

2. No payment can be made by the Claim Administrator to the following:

   a. Participants, even if the payment is requested for reimbursement for services Participants paid directly to a provider or Hospital. Reimbursement may be made to Participants for personal transportation services according to the provision of this EOC.
   b. Participants and Providers jointly.
   c. Any person, firm, or corporation who paid for the services on Participants' behalf.

3. Non-Participating Providers may refuse payment for a covered service under the HELP Plan. In the event a Non-Participating Provider does refuse to accept payment for a covered service under the HELP Plan, the expenses will be the responsibility of Participants.

4. Benefits payable under this EOC are not assignable by Participants to any third party.

ARTICLE EIGHT – COMPLAINTS, APPEALS, AND CONFIDENTIAL INFORMATION

Section I: Complaints

HELP Plan Participants may file verbal or written Complaints about any aspect of service delivery provided or paid for by the HELP Plan.

Section II: Appeals for claims administered by BCBSMT
(For example, medical, Mental Illness, Chemical Dependency, and Rehabilitative Care claims. Please refer to the specific Benefit section for claims administered by BCBSMT).

1. First Level Appeal:

   If Participants do not agree with a denial or partial denial of a claim, Participants have 90 days from receipt of the denial to appeal the decision on the claim. Participants must write to BCBSMT and ask for a review of the claim denial. BCBSMT will acknowledge Participants' requests for appeals within 10 days of receipt of requests.

   To file a written appeal, Participants must state their issue and ask for a review of the denied claim and send it to:

   Blue Cross and Blue Shield of Montana
   Attn: Appeals and Grievances Department
   P.O. Box 27838
   Albuquerque, NM 87105-9705

   Participants will receive a written response to their appeal within 45 days of receipt. If Participants do not agree with the First Level determination, Participants may choose to make a Second Level Appeal with the Department of Public Health and Human Services.

2. Second Level Appeal:

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If Participants do not agree with the First Level determination by BCBSMT, Participants may fax a Second Level appeal request to (406) 444-3980 within 90 days of receiving the First Level determination or mail it to the address below:

Office of Fair Hearings
Montana Department of Public Health and Human Services
P.O. Box 202953
Helena, MT 59620-2953

The Office of Fair Hearings will contact Participants to conduct an impartial Administrative Review and/or a Fair Hearing. The Hearing Officer will research statutes, rules, regulations, policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, they issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district court.

Section II: Appeals for claims administered by DPHHS
(Pharmacy, dental, ambulance, transportation claims, hearing aids and audiology, IHS and Tribal health services, eyeglasses and FQHC and RHC visits. Please refer to the specific Benefit section for claims administered by DPHHS).

1. First Level Appeal:

   If Participants do not agree with a denial or partial denial of a claim, Participants have 90 days from receipt of the denial to appeal the determination made. To request an Administrative Review, the request must be in writing, must state in detail all objections, and must include any substantiating documents and information which Participants wish the Department to consider in the Administrative Review. The request must be mailed or delivered to:

   Montana DPHHS
   Attn: Program Officer
   1400 Broadway, Room A206
   Helena, MT 59601
   FAX: (406) 444-1861

   Once the Administrative Review has been completed Participants will receive a letter outlining the Department's First Level decision. Participants may choose to make a Second Level Appeal with the Department of Public Health and Human Services Office of Fair Hearings.

2. Second Level Appeal:

   If Participants do not agree with the First Level determination, Participants may fax their Second Level appeal request to (406) 444-3980 within 90 days of receiving the First Level determination or mail it to the address below:

   Office of Fair Hearings
   Montana Department of Public Health and Human Services
   P.O. Box 202953 Helena, MT
   59620-2953

   The Office of Fair Hearings will contact Participants to conduct an impartial Fair Hearing. The Hearing Officer will research statutes, rules, regulations, policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, the Office of Fair Hearings issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district court.

Section III: Confidential Information and Records

1. Disclosure of a Participant's Medical Information – Medical documentation obtained by the Department regarding a Participant's health history, condition, or treatment is strictly confidential and may not be released without Participants' written authorization; however, the Department reserves the

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right to release such information without Participants' written authorization in the following instances:

a. When such information is requested by Peer and Utilization Review Board, or by the HELP Plan's Medical and/or Dental consultants as required for accurate Benefit determination.
b. Information is required under a judicial or administrative subpoena.
c. The Office of the Insurance Commissioner of the State of Montana requests such information.
d. Information is required for Workers' Compensation proceedings.

Additional information may be found in the Notice of Privacy Practices for HELP Plan Participants brochure which is provided in the enrollment package for all new eligible Participants. A copy may be requested by calling the Claim Administrator at 1-877-233-7055.

2. Release of medically related information -- Participants accept this EOC under the following conditions:

a. Participants authorize all Providers of health care services or supplies, including medical, Hospital, Dental, and vision, to furnish to the HELP Plan any medically related information pertaining to any Illness, Injury, service, or supply for which Benefits are claimed under this EOC for the purposes of Benefit determination.

b. Participants waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies, including medical, Hospital, Dental, and/or vision, from disclosing or testifying such information.

ARTICLE NINE – OUT-OF-AREA SERVICES – THE BLUECARD® PROGRAM

Section I: Out-of-Area Services

BCBSMT has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Participant obtains healthcare services outside of the BCBSMT 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 BCBSMT service area, the 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 Participant may obtain care from non-participating healthcare providers. BCBSMT payment practices in both instances are described below.

Section II: BlueCard® Program

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

Whenever the Participant incurs Covered Medical Expenses outside the BCBSMT service area and the claim is processed through the BlueCard Program, the amount the Participant pays for Covered Medical Expenses is calculated based on the lower of:

- The billed covered charges for the Participant's covered services; or
- The negotiated price that the Host Blue makes available to BCBSMT.

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

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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 BCBSMT uses for the Participant's claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the Participant's calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSMT would then calculate the Participant's liability for any Covered Medical Expenses according to applicable law.

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

1. Participant Liability Calculation

   When the Participant incurs Covered Medical Expenses outside of the BCBSMT service area for services provided by non-participating healthcare providers, the amount the 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 Participant may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment BCBSMT will make for the covered services as set forth in this paragraph.

2. Exceptions

   In certain situations, BCBSMT may use other payment bases, such as billed covered charges, the payment BCBSMT would make if the healthcare services had been obtained within the BCBSMT service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount BCBSMT will pay for services rendered by non-participating healthcare providers. In these situations, the Participant may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment BCBSMT will make for the covered services as set forth in this paragraph.

Section III: Participant Responsibility

Before a Participant receives services outside the geographic area that BCBSMT serves:

- Contact BCBSMT and determine whether the provider the Participant requests to see is a Host Plan Participating Provider. The Participant may be responsible for payment of Benefits received by a Non-Participating Provider.
- Contact BCBSMT and arrange for Preauthorization with the HELP Plan Participating Provider before scheduling and receiving out-of-state services.

HELP Plan Participants who have copayments are responsible for paying applicable copayments to BlueCard Program Participating Providers.

ARTICLE TEN – EVIDENCE OF COVERAGE – GENERAL PROVISIONS

Section I: Department Powers and Duties

The Department shall have total and exclusive responsibility to control, operate, manage, and administer the HELP Plan in accordance with its terms. The Department shall have all the authority that may be necessary or helpful to discharge those responsibilities with respect to the HELP Plan. Without limiting the generality of the preceding sentence, the Department shall have the exclusive right: to interpret the HELP Plan; to determine eligibility for coverage under the HELP Plan; to construe any ambiguous provisions of the HELP 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 HELP Plan.

The Department shall have full discretionary authority in all matters related to the discharge of its

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

The Department may delegate some or all of its authority under the HELP Plan, or revoke such delegation given to any person, persons, or agents provided that any such delegation or revocation of delegation is in writing.

Section II: Entire Evidence of Coverage; Changes

This EOC, including the Endorsements and attached or referenced papers, if any, constitutes the entire EOC. No change in the EOC is valid until made pursuant to the Section of this Article entitled "Modification of EOC."

Section III: Modification of Evidence of Coverage

The Department may modify this EOC upon the effective date of the codification of Montana Administrative Rule 37.79.304.

Section IV: 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 EOC. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits may be made. Clerical errors shall not prevent administration of this EOC in strict accordance with its terms.

Section V: Notices Under Evidence of Coverage

Any notice required by this EOC shall be in writing and 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 Claim Administrator. Notice to the medical and Behavioral Health Claim Administrator should be sent to BCBSMT. Notices for claims administered by DPHHS should be sent to Xerox, P.O. Box 8000, Helena MT 59604. Notices are effective on the date mailed.

Section VI: Benefits Not Transferable

No person, other than a Participant is entitled to the Benefits identified under this EOC. This means that Participants are not allowed to transfer or assign their coverage under the HELP Plan to another person.

Section VII: Validity of Evidence of Coverage

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

Section VIII: Execution of Papers

Participants agree to execute and deliver any documents requested by the Department, which are Necessary to administer the terms of this EOC.

Section IX: Participants' Rights

Participants have no rights or privileges except as specifically provided in the EOC.

Section X: Alternate Care

The HELP Plan may, at its sole discretion, make payment for medical, vision or Dental services, which are not listed as a Benefit of this EOC. Such payments may be made only when it is determined by the

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Department that it is in the best interest of the HELP Plan and/or Participants to make payment for alternate care.

Section XI: Statement of Representations

Any HELP Plan Participant who, with intent to defraud or knowing that he or she is facilitating a fraud against the Department, submits an application or files a claim containing a false, incomplete, or misleading statement is guilty of fraud. Any HELP Plan Participant who submits bad faith claims, or facilitates bad faith claims to be submitted, misrepresents facts or attempts to perpetrate a fraud upon the Department may be subject to criminal charge or a civil action brought by the Department or the HELP Plan as permitted under State or Federal laws. The Department reserves the right to take appropriate action in any instance where fraud is at issue.

Section XII: Recovery, Reimbursement, and Subrogation

By enrollment in the HELP Plan, Participants agree to the provisions of this section as a condition precedent to receiving Benefits under the HELP Plan.

1. **Right to Recover Benefits Paid in Error.** If a payment in excess of the HELP Plan Benefits is made in error on behalf of Participants to which Participants are not entitled, or if a claim for a non-covered service is paid, the Department and/or the Claim Administrator has the right to recover the payment from any one or more of the following:

   a. Any person to whom such payments were made for, or on behalf of Participants;
   b. Any insurance company; and
   c. Any other individuals or entities that received payment on behalf of Participants.

   By receipt of Benefits by Participants under the HELP Plan, Participants authorize the recovery of amounts paid in error.

   The amount of Benefits paid in error may be recovered by any method that the Department and/or the Claim Administrator, in its sole discretion, will determine is appropriate.

2. **Reimbursement.** The HELP Plan's right to reimbursement is separate from and in addition to the HELP Plan's right of subrogation. Subrogation is explained in paragraph 3, below. Reimbursement means to repay a party who has paid something on another's behalf, generally under Third Party Liability. If the HELP Plan pays Benefits for medical expenses on Participants' behalf, and another party was actually responsible or liable to pay those medical expenses, the HELP Plan has the right to be reimbursed.

   Accordingly, if Participants settle, are reimbursed, or recover 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 HELP Plan, Participants agree to reimburse the HELP Plan for the Benefits paid on behalf of Participants. The HELP Plan shall be reimbursed, in first priority, from any money recovered from a liable third party, as a result of said Accident, Injury, condition, or Illness, to the extent that the money recovered represents payment for medical expenses.

3. **Subrogation.** The HELP Plan's right to subrogation is separate from and in addition to the HELP Plan's right to reimbursement. Subrogation is the right of the HELP Plan to exercise Participants': rights and remedies in order to recover from third parties who are legally responsible to Participants for a loss paid by the HELP Plan. This means the Department, on behalf of the HELP Plan can proceed through litigation or settlement in the name of Participants, to recover the money paid under the HELP Plan. In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to Participants' Accidents, injuries, conditions, or Illnesses, which the HELP Plan has paid, then the HELP Plan is entitled to recover, by legal action or otherwise, the money paid; in effect the Department has the right to "stand in the shoes" of Participants for whom Benefits were paid, and to take any action the Participants could have undertaken to recover the money paid.

   Participants agree to subrogate to the HELP Plan any and all claims, causes of action, or rights that

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Participants have 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 HELP Plan Coverage Group has paid Benefits, and to subrogate any claims, causes of action, or rights Participants 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 Participants decide not to pursue a claim against any third party or insurer, Participants will notify the Department and specifically authorize the Department, in its sole discretion, to sue for, compromise, or settle any such claims in Participants' names, to cooperate fully with the Department 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 the HELP Plan, the Department **is not** required to pay any claims where there is evidence of liability of a third party. However, the Department, in its discretion, may instruct the Claim Administrator to pay Benefits while the liability of a party other than the Participant is being legally determined.

b. Participants will cooperate fully with the Department, its agents, attorneys, and assigns, regarding the recovery of any monies paid by the HELP Plan from any party other than Participants who are liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Department or the Claims 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 Department or the Claims Administrator with any and all documents, papers, reports, and the like regarding demands, litigation or settlements involving recovery of monies paid by the HELP Plan; and notifying the Department or the Claims Administrator of the amount and source of any monies received from third parties as compensation or damages for any event from which the HELP Plan may have a reimbursement or subrogation claim.

c. Participants will respond within ten (10) days to all inquiries of the Department or the Claims Administrator regarding the status of any claim Participants may have against any third parties or insurers, including but not limited to, liability, no-fault, uninsured and underinsured insurance coverage.

d. Participants will notify the Department or the Claims Administrator of the name and address of any attorney engaged to pursue any personal injury claim on behalf of Participants.

e. Participants 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 HELP Plan, the result of which may prejudice or interfere with the HELP Plan's rights to recovery hereunder. Participants will not conceal or attempt to conceal the fact that recovery occurred or will occur.

f. The HELP Plan will not pay or be responsible, without its written consent, for any fees or costs associated with Participants pursuing claims against any third party or coverage, including, but not limited to, attorney fees or costs of litigation.

g. Monies paid by the HELP Plan will be repaid to the extent the HELP Plan paid medical assistance on behalf of the Participant due to the Accident, Injury, condition, or Illness for which monies were recovered from a liable third party, 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.

Section: XII: Relationship Between HELP Plan and Professional Providers

HELP Plan Participating Providers are Providers who contract with the Claim Administrator to provide medical care and health services to HELP Plan Participants. HELP Plan Participating Providers furnishing care to Participants do so as independent contractors with the Claim Administrator. The relationship between a Participating Provider and a patient is personal, private, and confidential; the choice of a provider

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within the HELP Plan Network is solely the Participants'.

Under the laws of Montana, the Claim Administrator cannot be licensed to practice medicine or surgery, and the Claim Administrator does not assume to do so.

Neither the Department nor the Claim Administrator are responsible or liable for the negligence, wrongful acts, or omissions of any Participating Provider, employee, or Participant providing or receiving services. Neither the HELP Plan nor the Claim Administrator is liable for services or facilities which are not available to Participants for any reason.

Neither the Department or the Claim Administrator are liable for cost of services received by Participants that are not covered by this EOC, are not provided by a Participating Provider, are received without Preauthorization approval, or are specifically excluded under any provision of this EOC.

Section XIV: When Participants Move Out of State

If Participants move from Montana, they will no longer be eligible for coverage under the HELP Plan. Participants will be responsible for any services received from out-of-state medical Providers. Returned mail with out-of-state forwarding addresses shall be considered conclusive evidence that Participants have moved out of state and Participants will be disenrolled from the HELP Plan.

Section XV: Authority of the Department

The Department has the authority to interpret uncertain terms and to determine all questions arising in the administration, interpretation, and application of the HELP Plan, giving full consideration to all evidence reasonably available to it. All such determinations are final, conclusive, and binding except to the extent they are appealed under the claims procedure.

Section XVI: Blue Cross and Blue Shield of Montana is an Independent Corporation

BCBSMT 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 BCBSMT to use the Blue Cross and Blue Shield Service Mark in the state of Montana, and that BCBSMT is not contracting as the agent of the Association.

The Participant further acknowledges and agrees that the Participant has not entered into this EOC based upon representations by any person other than BCBSMT and that no person, entity, or organization other than BCBSMT shall be held accountable or liable to the Participant for any of BCBSMT's obligations to the Participant created under this EOC. This paragraph shall not create any additional obligations whatsoever on the part of BCBSMT other than those obligations created under other provisions of this EOC.

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KEY CONTACTS

HELP Plan Eligibility
For questions regarding eligibility:
Montana Public Assistance Help Line
1-888-706-1535 or covermt.org

Blue Cross Blue Shield of Montana (BCBSMT)
1-877-233-7055 – Participant Line
1-877296-8206 – Provider Line
8 a.m. to 6 p.m. Monday – Friday (Mountain Time)

Drug Prior Authorization
For all questions regarding drug prior authorization:
1-800-395-7961
406-443-6002 (Helena)
8 a.m. to 5 p.m., Monday – Friday (Mountain Time)

Mail or fax backup documentation to:
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602
1-800-294-1350 Fax
406-513-1928 Fax Helena

Montana Relay Services
Telecommunications assistance for the hearing impaired
1-800-833-8503 Voice, TTY
406-444-1335 Voice, TTY
relay@mt.gov

Cultural and Language Services
For forms and information on cultural and language or translator services:
1-877-233-7055
http://medicaidprovider.mt.gov/forms#240933496-forms-a--c

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For additional resources on the HELP Plan:

HELPPlan.mt.gov

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