Healthy Montana Kids

Evidence of Coverage

Effective ~~January~~August 1, ~~2016~~2017

Contents

The HMK Coverage Group agrees to make payment for the medical, ~~mental~~Behavioral ~~H~~health, surgical, Hospital, and Pharmacy services named in this Evidence of Coverage subject to the following conditions:

1. All statements made in the ~~Healthy Montana Kids~~HMK Program Application for eligibility must be true and correct.

2. Payments by the HMK Coverage Group will be subject to the terms, conditions, and limitations of this Evidence of Coverage.

3. Payment will only be made for services that are provided to the Members after the Effective Date of this Evidence of Coverage and before the date on which this Evidence of Coverage terminates.

ARTICLE ONE – DEFINITIONS

This ~~Article~~ article defines certain words used throughout this Evidence of Coverage. 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 Member 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, laceration;
- Contusion;
- Embedded foreign body;
- Burns; and
- Concussion.

ADMISSION CERTIFICATION FOR EMERGENCY CARE AND MATERNITY CARE

Notification to the Claim Administrator by the Member, ~~or~~ Family Member, or Hospital of an emergency Inpatient admission or an Inpatient admission related to pregnancy, including pre-term labor, complications of pregnancy, or delivery.

ALLOWABLE FEE

The provider's actual charge or any amount determined by the Claim Administrator~~s~~ to be an appropriate fee for a specific service, whichever is less.

ADVANCE MEMBER NOTIFICATION (AMN)

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

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.

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.

BENEFITS OR COVERED BENEFITS

The payment to the Participating Provider for services covered under this Evidence of Coverage which are provided to Members.

BENEFIT MANAGEMENT

A program designed to involve Members, Members' ~~health care~~healthcare providers, and the Claim Administrators' (Blue Cross and Blue Shield of Montana and ~~Xerox~~Conduent) professional staff manage ~~health care~~healthcare Benefits while maintaining the quality of care.

BENEFIT PERIOD

MEDICAL AND ~~MENTAL~~BEHAVIORAL HEALTH BENEFIT

The Benefit Period is October 1 through September 30. If a Member's Effective Date is after October 1, the Member's Benefit Period begins with the Effective Date and ends September 30.

DENTAL BENEFIT

The Benefit Period for Dental is July 1 through June 30. If a Member's Effective Date is after July 1, the Member'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 Member's ~~health care~~healthcare needs. Care Management may involve a team of ~~health care~~healthcare professionals, including covered providers, BCBSMT, and other resources to work with Members to promote quality, cost-effective care.

CHEMICAL DEPENDENCY

Addiction to drugs or alcohol. Refer to Substance Use Disorder.

CHEMICAL DEPENDENCY OR SUBSTANCE USE DISORDER TREATMENT CENTER

A facility that provides treatment for Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Physician or a licensed addiction counselor. The facility must be state approved as a Substance Use Disorder Treatment Center by the Department or an equivalent facility licensed by the state where the facility is located.

CHILD/CHILDREN

For purposes of coverage under the HMK Program the term "child" means an individual 18 years old or younger.

CLAIM ADMINISTRATORS

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 Administrators provide administrative duties only.

COMPLAINT

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

COMMUNITY BASED PSYCHIATRIC REHABILITATION and SUPPORT (CBPRS)

Rehabilitation services provided in home, school, and community settings for youth with serious emotional disturbance (SED) who are at risk of out of home or residential placement, or risk removal from current setting for youth under six years of age.

CONDUENT

The fiscal agent for the ~~State of~~ Montana~~,~~ Department of Public Health and Human Services, who processes claims at the Department's direction and in accordance with ARM 37.86 *et seq* found at http://www.mtrules.org/.

CONTINUED STAY REVIEW

The 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 Member's condition.

COPAYMENT

The percentage or specific dollar amount of Covered Medical Expenses and Allowable Fees for services payable by the Member.

COVERED MEDICAL EXPENSE

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

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

DENTAL

Covered Dental services delivered by Dental providers in the ~~Healthy Montana Kids~~HMK Dental Network.

DEPARTMENT

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

DISENROLLMENT

The process of ending the Member's membership in the HMK Coverage Group by a determination of ineligibility made by the Department or by voluntary withdrawal by the Member.

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 D~~d~~urable M~~m~~edical E~~e~~quipment. 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.

EFFECTIVE DATE

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

EMERGENCY CARE

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

EMERGENCY MEDICAL CONDITION

An Emergency Medical Condition is a condition manifesting itself by symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably expected to result in any of the following:

- The Member's health would be in serious jeopardy;
- The Member's bodily functions would be seriously impaired; or
- A bodily organ or part would be seriously damaged.

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 Member.~~This document.~~

EXCLUSION

Services not paid for with state and federal funds by the HMK Coverage Group.

EXTENDED MENTAL HEALTH BENEFITS

Benefits provided to a ~~Healthy Montana Kids~~HMK Member who~~m the Department~~ is determine~~ds~~ to have a Serious Emotional Disturbance (SED).

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 HMK eligibility.

HABILITATIVE CARE

Coverage is provided for habilitative care services when the individual requires help to maintain, learn, or improve skills and functioning for daily living or to prevent deterioration. These services include, but are not limited to: (1) physical therapy; (2) occupational therapy; (3) speech-language pathology; and (4) Behavioral Health professional treatment. Applied behavioral analysis is not a covered service. Habilitative services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. Services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician or mid-level practitioner.

HEALTHY MONTANA KIDS (HMK) COVERAGE GROUP

The ~~Healthy Montana Kids~~HMK Coverage Group is a benefit program for eligible Montana children administered by the Department through the ~~Healthy Montana Kids~~HMK Plan. Montana Administrative Rule 37.79.101 provides HMK Coverage Group information.

HEALTHY MONTANA KIDS (HMK) NETWORK

A provider or group of providers who have contracted with Blue Cross and Blue Shield of Montana (BCBSMT) to provide medical and ~~mental~~Behavioral H~~h~~ealth services to Members covered under the HMK Coverage Group.

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..

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 Substance Use Disorder;
- 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 ~~Healthy Montana Kids~~HMK Member that identifies that Member i~~a~~s eligible for the ~~Healthy Montana Kids~~HMK Coverage Group.

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.

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).

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.

INPATIENT OR HOSPITAL INPATIENT

Services or supplies provided to a Member 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 SUBSTANCE USE DISORDER OR MENTAL ILLNESS)

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

- By a Hospital, ~~Freestanding~~ freestanding Inpatient f~~F~~acility, or Physician; and
- While Members are in a Hospital as an Inpatient; or
- While Members are confined as an Inpatient in a Freestanding Inpatient Facility.

INTERPRETER SERVICES

HMK will pay for Interpreter Services provided to eligible HMK Members if:

- The service is a Medically Necessary service;
- The service is a HMK covered service;

- 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.

INVESTIGATIONAL/EXPERIMENTAL/UNPROVEN SERVICE OR CLINICAL TRIAL

Surgical procedures or medical procedures, supplies, devices, or drugs which at the time provided, or sought to be provided, are in the judgment of the Department not recognized as conforming to accepted medical practice, or:

The procedure, drug, or device:

- Has not received required final approval to market from appropriate government bodies; or
- Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes as described by BCBSMT Medical Policy; or
- Is not demonstrated to be as beneficial as established alternatives; or
- Has not been demonstrated to improve the net health outcomes; or
- Is one in which the improvement claimed is not demonstrated to be obtainable outside the Investigational or Experimental setting.

MAXIMUM FAMILY LIABILITY

When the Copayments for services incurred during the Benefit Period for one or more Members in a Family total more than $215, Members will not be required to pay any additional Copayments for Covered Medical Expenses for the remainder of the current Benefit Period.

MEDICAL POLICY

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

- 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

Services or items reimbursable under the HMK Coverage Group, and that are:

1. Reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a Member, 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 Member 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 HMK 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 DPHHS' 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.

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

~~1. In accordance with generally accepted standards of medical practice;~~
~~2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, injury or disease; and~~
~~3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, injury or disease; and~~
~~4. In accordance with the BCBSMT Medical Policy.~~

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

The fact that services were recommended or performed by a Participating 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~~ Member receives the services, supplies, or medications and a claim is submitted to the HMK Coverage Group. The HMK Coverage Group may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary.

MEMBER OR ENROLLED CHILD OR HEALTHY MONTANA KIDS (HMK) MEMBER

A Child who has been certified and notified by the Department as eligible for the HMK Coverage Group. An enrolled Member or Family member. For purposes of this document the term "Member" includes a parent, guardian, or caretaker who is responsible for decisions and notification for the Child enrolled in the HMK Coverage Group.

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.

The following conditions are paid as any other medical condition.

- Developmental disorders;
- Speech disorders;

- Psychoactive Substance Use Disorders;
- Eating disorders;
- Impulse control disorders (except for intermittent explosive disorder and trichotillomania); and
- Severe Mental Illness.

MONTH

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

MULTIDISCIPLINARY TEAM

When used in the Rehabilitation Therapy portion of the Evidence of Coverage, 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 Mental Health (non-covered or non-participating)**~~

Any Provider who is not under contract with the Claim Administrator to provide HMK Coverage Group Benefits. Non-Participating Providers are not included in the ~~Healthy Montana Kids~~HMK Network. Services received from a Non-Participating Provider:

- M~~m~~ay not be covered;
- M~~m~~ay be covered by the HMK Coverage Group but the provider may refuse payment from the HMK Coverage Group;
- M~~m~~ay be subject to Prior Authorization; or
- M~~m~~ay not be paid by the HMK Coverage Group.

Pharmacy (non-covered or non-participating)

Any Provider who is not enrolled as a Montana Health~~c C~~are Programs 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 FIRST

All ~~Healthy Montana Kids~~HMK Members are eligible to use the 24 hour 7 day nurse advice line called Nurse First. Nurse First is free and can be accessed by calling 1-800-330-7847.

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.~~Therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of specific tasks or goal-oriented activities; designed to address the functional performance of an individual. These services emphasize useful and purposeful activities related to neuromusculoskeletal functions and to provide training in activities of daily living (ADL). (See Habilitative Care and Rehabilitative Care.)

OUTPATIENT

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

OUTPATIENT BENEFITS FOR SUBSTANCE USE DISORDER OR MENTAL ILLNESS

The payment for services Medically Necessary for care and treatment of Substance Use Disorder or Mental Illness provided by:

- A Hospital, if Members are not confined as a Hospital Inpatient;
- A Physician, if Members are not confined as a Hospital Inpatient;
- A Mental Health Treatment Center;
- A Substance Use Disorder Treatment Center if Members are not confined as an Inpatient;
- A licensed psychologist;
- A licensed social worker;
- A licensed professional counselor; or
- A licensed addiction counselor.

Outpatient Benefits are subject to the following additional conditions:

- The services must be given to diagnose and treat recognized Substance Use Disorder or recognized Mental Illness;
- The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Substance Use Disorder or Mental Illness;
- No Benefits will be provided for marriage counseling, hypnotherapy, or for services given by a staff member of a school or halfway house.

PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS

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

A Partial Hospitalization program 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 individual.

PARTICIPATING PROVIDER

Medical and ~~Mental~~Behavioral Health

A provider in the ~~Healthy Montana Kids~~HMK network who will provide medical, Dental, and Behavioral H~~h~~ealth services covered in the Evidence of Coverage.

Pharmacy

A provider who is enrolled as a Montana Health~~c C~~are Programs Provider and who will provide prescription drug services covered under this Evidence of Coverage. (See: https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do)

PHARMACY

Every site properly licensed by the Montana Board of Pharmacy in which 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.~~Treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living, and pain relief. Treatment may include active and passive modalities using a variety of means and techniques based upon biomechanical and neurophysiological principles. (See Habilitative Care and Rehabilitative Care.)

PHYSICIAN

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

PLAN ADMINISTRATOR

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

PREADMISSION CERTIFICATION

Prior to a scheduled Inpatient admission, the facility, provider, Member or a Family Member must notify the Claim Administrator of the proposed admission. The Claim Administrator's professional staff certifies that the admission is Medically Necessary, that the setting is the most appropriate for the Member's condition, and that Benefits are available for the proposed Inpatient stay.

PRIOR AUTHORIZATION

Approval in advance to obtain services. ~~**Failure to obtain Prior Authorization may result in Members paying out of pocket for the services provided.**~~ Some services are covered only if Members' doctors or other Participating Providers get "Prior Authorization". This process is used to inform HMK Members whether or not a proposed service, medication, supply, or ongoing treatment is Medically Necessary, based on the Medical Policy, and is a covered Benefit under this Evidence of Coverage. This also includes the Retrospective Review and Preadmission Certification process.

- ~~For Prior Authorization of Medical mental health and Inpatient Federally Qualified Health Center (FQHC) services contact BCBSMT at 1-855-313-8914.~~
- ~~For Prior Authorization of Pharmacy services contact DPHHS's Drug Prior Authorization Unit, Mountain Pacific Quality Health at 1-800-395-7961.~~
- ~~For Prior Authorization of Dental Services and Eyeglasses contact the HMK Dental and Vision Program Officer at 1-877-543-7669.~~
- ~~For Prior Authorization of Outpatient Services provided by a Federally Qualified Health Clinic or Rural Health Clinic, and Community Based Psychiatric Rehabilitation Services (CBPRS) contact Xerox at 1-800-624-3958.~~

PROFESSIONAL CALL

A personal interview between Members and ~~Healthy Montana Kids~~HMK Participating Providers. HMK Participating Providers must examine Members and provide or prescribe medical treatment. "Professional Call" does not include telephone calls or any other communication where Members are not examined by HMK Participating Providers.

PSYCHIATRIC RESIDENTIAL TREATMENT CENTER (PRTF)

Inpatient psychiatric Hospital services for individuals under 21 years of age.

RECOVERY CARE BED

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

~~REHABILITATION THERAPY~~REHABILITATIVE CARE

~~Specialized treatment, for an injury or physical deficit, which is:~~

- ~~Provided in an Inpatient or Outpatient setting;~~
- ~~An intense, comprehensive program of therapies (e.g., Physical Therapy, Occupational Therapy, and Speech Therapy) provided by a Multidisciplinary Team, and also includes associated general and medical services incidental to rehabilitation care;~~
- ~~Designed to restore the patient's maximum function and independence; and~~
- ~~Under the direction of a qualified Physician and includes a formal written treatment plan with specific goals.~~

Coverage is 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. Rehabilitative services include, but are not limited to: (1) physical therapy; (2) occupational therapy; (3) speech-language pathology; and (4) Behavioral

~~Health~~ professional treatment. Applied behavioral analysis is not a covered service. Rehabilitative services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician or mid-level practitioner.

REHABILITATION UNIT

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

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.

~~SEVERE~~ SERIOUS EMOTIONAL DISTURBANCE (SED)

~~SED means with respect to a youth from the age of six through 17 years of age that the youth~~ A behavioral health condition that meets the SED requirements found in the Children's Mental Health Bureau Medicaid Services Provider Manual found at http://dphhs.mt.gov/dsd/CMB.

~~requirements of Administrative Rules of Montana (ARM) 37.87.903 found at http://www.mtrules.org/.~~

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

SCHEDULE OF BENEFITS

Included with this Evidence of Coverage, the Schedule of Benefits lists coverage Benefit Periods, co-payments payable for services, and maximum liability for coverage periods for services provided under this Evidence of Coverage.

SPEECH THERAPY

~~Treatment for the correction of a speech impairment resulting from disease or trauma.~~Treatment of communication impairment and swallowing disorders. (See Habilitative Care and Rehabilitative Care.)

SUBSTANCE USE DISORDER

Alcoholism, drug addiction, or substance abuse. Inpatient and Outpatient services are available for treatment of Substance Use Disorder.

TELEMEDICINE

The use of a secure interactive audio and video, or other telecommunications technology by a ~~health care~~healthcare provider to deliver ~~health care~~healthcare 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.

TREATMENT FACILITY

1. For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorders in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment Center that is approved by the Montana Department of Public Health and Human Services under Montana Code Annotated (MCA) § 53-24-208 and found at http://leg.mt.gov/bills/mca_toc/.

   Services include medical evaluation and health supervision; Substance Use Disorder education; organized individual, group, and Family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up Program after discharge.

2. For treatment of Mental Illness, it means a facility licensed by the state specializing in the treatment of Mental Illness for persons requiring 24-hour supervision which is:
   a. A psychiatric residential Treatment Facility (PRTF); or
   b. A Therapeutic Group Home.

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.

~~**XEROX**~~

~~The fiscal agent for the State of Montana, Department of Public Health and Human Services, who processes claims at the Department's direction and in accordance with ARM 37.86 *et seq* found at http://www.mtrules.org/.~~

ARTICLE TWO – PARTICIPATING PROVIDER

This Evidence of Coverage (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 Healthy Montana Kids (HMK) Provider for medical or ~~mental~~Behavioral ~~H~~health services or is enrolled as a Montana Health~~c C~~are Programs Provider for Pharmacy services for benefits described in this ~~Evidence of Coverage~~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 HMK Coverage Group looks to the nature of the services rendered, the extent of licensure, and the HMK Coverage Group's recognition of the provider.

HMK Members may obtain a list of ~~Healthy Montana Kids~~ Providers for medical and ~~mental~~Behavioral ~~H~~health services from BCBSMT upon request or download it from the BCBSMT website at www.BCBSMT.com. Contact BCBSMT at 1-855-258-3489 to request a list of HMK Participating Providers.

HMK Members may obtain a list of enrolled Montana Healthcare Providers for Pharmacy services, FQHCs, and RHCs through a search on the Montana Healthcare Provider website at https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do.

HMK Members may obtain a list of HMK dental and eyeglass providers through a search on the HMK website at http://hmk.mt.gov or by calling the HMK Dental and Optometric Program Officer at 406-444-7045.

ARTICLE THREE – HEALTHY MONTANA KIDS (HMK) NETWORK

HMK Members are encouraged to choose a primary care provider from the list of ~~Healthy Montana Kids~~HMK Providers. A primary care provider will be better able to know Members and their medical history, determine Members' ~~health care~~healthcare needs, and help Members use the Medically Necessary Benefits available under the HMK Coverage Group.

Section I: Use of the Healthy Montana Kids (HMK) Network

HMK Members are encouraged to have their care directed by the primary care providers they select. Generally, Members need to make an appointment with their ~~Healthy Montana Kids~~HMK Providers. Members' primary care providers will provide ~~health care~~healthcare, or if Members' primary care providers determine it is Medically Necessary to do so, may refer Members to another ~~care~~ provider or recommend a specialist in the HMK Network. They will also help Members arrange or coordinate Medically Necessary hospitalization.

Benefits for certain Medically Necessary services, including obstetrical and gynecological services, are available without a recommendation from Members' primary care providers when Members use the HMK Network.

If HMK Members have not chosen a primary care provider, they still need to use the HMK Network to obtain Benefits.

Covered medical and ~~mental~~Behavioral H~~h~~ealth Benefits are only available if Members use the ~~Healthy Montana Kids~~HMK Network, except:

1. If the Medically Necessary services are not available in the HMK Network; **AND**
2. Prior A~~a~~uthorization has been approved by BCBSMT on behalf of HMK.

Covered Pharmacy services must be obtained through an enrolled Montana Health~~c C~~are Programs Provider.

In the situations listed above, Members' healthcare providers must obtain~~receive~~ Prior Authorization from the Claim Administrator. ~~If Members do not obtain Prior Authorization, then such services are not a Benefit of this Evidence of Coverage and Members will be responsible for payment of the costs of the services provided.~~

Section II: Private Pay Agreement or Advance Member Notification (AMN)

The Claim Administrator will review claims to determine if the services were Medically Necessary. The HMK Coverage Group does not pay for services that are determined to not be Medically Necessary, non-covered, Investigational, Experimental, Unproven, require Prior Authorization and are not preauthorized, or not performed in an appropriate setting~~.~~ When a service is denied as not Medically Necessary, Participating Providers may not balance bill the Member for the services, unless the Member or the Member's authorized representative has signed an AMN.

For services not Medically Necessary, providers may bill Members only when providers and Members have agreed in writing prior to the services being provided.

The AMN process does not apply to services that are ~~denied as experimental, investigational, unproven, or otherwise~~ not covered by the HMK Coverage Group and Members may be billed for these services.

Section III: Emergency Care and Urgent Care

Emergency Care
If Members need Emergency Care, go to the nearest doctor or Hospital. Members may need Emergency Care if their condition is severe, if they have severe pain, or if they need immediate medical attention to prevent any of the following:

- Serious jeopardy of the Member's health;
- Serious damage to the Member's bodily functions; or
- Serious damage to a bodily organ or part.

Members 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 Members call their primary care provider and describe the situation. He or she will then direct Members' care.

Unless Members get approval from the Claim Administrator, they must receive Urgent Care from a ~~Healthy Montana Kids~~HMK Provider. If Members receive services from a provider who is not a ~~Healthy Montana Kids~~HMK Provider~~s~~, they may have to pay for these services.

Before receiving Emergency Care or Urgent Care, Members can call Nurse First, the 24 hour 7 day nurse advice line. Nurse First is free and can be accessed by calling 1-800-330-7847.

Section IV: Out-of-State Services

HMK Members cannot get routine or non-emergency or non-urgent care without the HMK Coverage Group's approval when Members are out of state. Children who spend time away from home with a parent or relative will have care paid for if the HMK Coverage Group approves the service. The HMK Coverage Group must give Prior Authorization approval in these instances.

Medically Necessary Services for a Child receiving care from a ~~Healthy Montana Kids~~HMK provider outside of Montana, but in a county bordering Montana, are covered.

Out-of-state Pharmacy benefits may only be paid if the provider is enrolled as a Montana Health~~c C~~are Programs Provider.

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 – BENEFIT MANAGEMENT

The advantages of Benefit Management are to:

- Assure Members of coverage before they receive treatment, services, or supplies;
- Provide information regarding proposed procedures or alternate treatment plans;
- Direct Members to the provider networks, including participating out-of-state networks; and
- Assist Members in determining out-of-pocket expenses and identifying possible ways to reduce them.

Section I: Healthy Montana Kids (HMK) Claim Administrators

The ~~Healthy Montana Kids~~HMK Coverage Group provides Covered Benefits through the following Claim Administrators:

- ~~Xerox~~Conduent
  The following Covered Benefit claims are processed by ~~Xerox~~Conduent:
  1. Pharmacy;
  2. Dental;
  3. Eyeglasses;
  4. Outpatient benefits provided by ~~Federally Qualified Health Center~~FQHCs and ~~Rural Health Clinic~~RHCs; and
  5. Community Based Psychiatric and Rehabilitation Services (CBPRS).

- Blue Cross Blue Shield of Montana (BCBSMT) All other Covered Benefit claims not listed under Covered Benefit claims processed by ~~Xerox~~ Conduent are administered by BCBSMT.

Section II: Inpatient Admissions

This section applies to facilities that provide licensed Inpatient care including Hospitals and Free-Standing Inpatient Facilities.

Inpatient admissions are reviewed through the Admission Certification process, the Continued Stay Review process, or through Retrospective Review upon receipt of the claims for the Inpatient stay. Use the BCBSMT Benefit Management program for Member Inpatient admissions to avoid unexpected out-of-pocket expenses, benefit reductions, or claim denials.

1. Admission Certification or Prior Authorization
   When Members have scheduled Inpatient admissions, the Hospital or provider contacts the Claim Administrator~~,r,~~ BCBSMT at 1-855-313-8914. ~~Members may also have the Hospital or provider make the contact.~~ BCBSMT will review the Inpatient admission to certify:
   a. The service is Medically Necessary;
   b. The length of stay and level of care are appropriate; and
   c. The service setting is appropriate (Inpatient vs. Outpatient).

   NOTE: Inpatient admissions for diagnostic tests prior to surgery will be approved only if services cannot be provided on an Outpatient basis.

   The Claim Administrator will certify the admission for the appropriate length of stay and level of care based on the information provided by the Provider and Hospital. Members will receive, in writing, an approval for the appropriate length of stay or a denial of the admission. Members will be covered for days and services that have been certified under the HMK Coverage Group. If the admission is determined by the Claim Administrator to not be appropriate, the Member will be notified by mail.

2. Admission Certification for Emergency Care Unscheduled Inpatient Admission

   In the event of an unscheduled Inpatient admission, the Claim Administrator, BCBSMT requires Admission Certification within 24 hours, or the next working day, after the admission. Unscheduled admissions are emergency admissions or pregnancy-related admissions for pre-term labor, complications of pregnancy or delivery. Admission Certification will alert the Claim Administrator's professional staff of opportunities to work with Members and their ~~health care~~healthcare providers to avoid additional unexpected out-of-pocket expenses while continuing to maintain the quality of care.

3. Continued Stay Review

If an Inpatient admission extends beyond the approved length of stay that was certified, the Claim Administrator, BCBSMT, in consultation with Members' healthcare providers, will review the stay to ensure that the length of stay and level of care are Medically Necessary. Additional Medically Necessary Inpatient days may be certified following the Continued Stay Review. The Claim Administrator will send letters to Members once the decision to disallow additional days has been made. The Claim Administrator will make a phone call to the facility where the additional days are denied.

Section III: Prior Authorization

~~Use the Prior Authorization process to avoid unexpected out-of-pocket expenses, benefit reductions, or claim denials.~~ Members' ~~health care~~healthcare providers are responsible for obtaining Prior Authorization for referrals to other providers or to specialists, out-~~-~~of-~~-~~state services, and Covered Benefits that require Prior Authorization listed in Article Five – Covered Benefits. Coverage for certain services, supplies, or treatment will be determined through the Prior Authorization process.

The Prior Authorization process may require additional documentation from Members' ~~health care~~healthcare providers for some services. In these cases, a written request must be submitted to the Claim Administrator by Members' ~~health care~~healthcare providers and should 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, photographs, x-rays, etc.

For Prior Authorization on medical health services, contact BCBSMT at 1-855-313-8914 or on the number on the back of Members' ID cards.

For Prior Authorization on ~~mental~~Behavioral H~~h~~ealth services, contact BCBSMT at 1-855-313-8909 or on the number on the back of Members' ID cards.

For Prior Authorization on Pharmacy claims Members' prescribers or dispensing Pharmacy will call the Drug Prior Authorization Unit, Mountain-~~-~~Pacific Quality Health, at 1-800-395-7961.

~~Failure to obtain Prior Authorization could result in unexpected out-of-pocket expenses if the services, supplies, medications, or ongoing treatments are determined to not be Medically Necessary, or are not a Covered Benefit under the HMK Coverage Group.~~ If Prior Authorization is not obtained, a Retrospective Review of medical and ~~mental~~Behavioral H~~h~~ealth claims will be performed after the claims have been submitted to determine whether or not the services, supplies, or treatment were Medically Necessary.

~~For some services, Prior Authorization is highly recommended in order to avoid paying out-of-pocket expenses. Members will be responsible for paying the charges for any experimental, investigational, unproven, non-covered services, or services provided in inappropriate settings.~~

Section IV: Benefit Reductions

1. Inpatient Care:

For a planned Inpatient stay, Members' providers will need to obtain approval for Admission Certification prior to the I~~i~~npatient stay. Members' providers must submit requests for approval for Admission Certification within 48 hours after the admission for unplanned Inpatient stays. The Claim Administrator will review the admission to verify that:

a. The service is Medically Necessary.
b. The length of stay and the setting are appropriate.
c. The level of care is appropriate.

2. If ~~Members do not obtain~~ Preadmission Certification and Admission Certification is not obtained prior to an Inpatient stay, a Retrospective Review may be completed to determine whether or not the services, supplies, or treatment were Medically Necessary. ~~If upon review, a determination is made that the services were not Medically Necessary or appropriate, Members may be responsible for paying the room and board charges associated with any uncertified days.~~

Section V: Care Management

The goal of Care Management is to help the Member receive the most appropriate care that is also cost effective. If the Member has an ongoing medical condition or a catastrophic illness, the Member should contact BCBSMT. If appropriate, a care manager will be assigned to work with the Member and the Member's providers to facilitate a treatment plan. Care Management includes Member Education, referral coordination, utilization review and individual care planning. Involvement in Care Management does not guarantee payment by the HMK Coverage Group.

A care manager may identify a problem or need and work with the provider to develop and recommend viable alternatives to assist, maintain or enhance the quality of treatment, which provide cost controls through implementation of the agreed upon treatment plan.

A written treatment plan may be developed by the case manager in conjunction with Members, the attending physician, and the Claim Administrator. The treatment plan includes:

1. Treatment plan objectives;
2. Courses of treatment identified to accomplish care objectives;
3. Responsibility for obtaining objectives;
4. Signatures of each party (case manager, attending physician, and the Member or parent or guardian); and
5. Estimated costs and savings.

This treatment plan may include both covered services and non-covered services. The HMK Coverage Group must approve any treatment plan which includes non-covered services. Once the treatment plan is agreed upon by all parties, Benefits for non-covered services or supplies shall be paid on the same basis as if they were Covered Services under the terms and provisions of this ~~Evidence of Coverage~~EOC. Non-covered s~~S~~ervices provided outside the ~~alternate~~ treatment plan will not be paid.

Section VI: Copayments

GENERAL

Dental Services Benefit Period……..……July 1 through June 30
All other HMK Services Benefit Period ..... October 1 through September 30

The Benefits of this Schedule are subject to this Benefit Period unless otherwise specified.

Copayment..... Varies by Covered Services

There is no Copayment for Covered services ~~for Members whose Family income is at or below 100 percent of the federal poverty level or~~ for families with at least one enrollee who is a Native American or Native Alaskan. This determination will be made by the Montana Department of Public Health and Human Services at the time of enrollment.

Maximum Family Copayment liability.....$215 per Benefit Year

PRIOR AUTHORIZATION

Certain services require Prior Authorization. ~~Please read~~See Article Four of this Evidence of

Coverage entitled “Benefit Management” and Article Five entitled “Covered Benefits” for details.

COPAYMENTS

PROFESSIONAL PROVIDER BENEFITS

Outpatient Professional Call (including Office and Home Visits) ..... $3 Copayment Per Visit
Surgical Services ..... No Copayment
Diagnostic X-ray and Laboratory Services ..... No Copayment
Well-baby/Well-child Visit ..... No Copayment
Home Health Services…… ..... $3 Copayment Per Visit
Chiropractic Services…….. ..... $3 Copayment Per Visit

OUTPATIENT THERAPY

Professional and Facility-Based Services – Outpatient ..... $5 Copayment Per Visit

HOSPITAL AND OTHER SERVICES

Inpatient

Semi Private Room and Board Charges, per admission .....$25 Copayment

All Inpatient admissions require Preadmission Certification for full benefits to be paid. ~~Please read~~See Article Four of this ~~Evidence of Coverage~~EOC entitled “Benefit Management” for details.

Outpatient Hospital and Facility Benefits

Nonemergency Care

Covered Facility Services and Supplies ..... $5 Copayment Per Visit
Visit for Diagnostic X-ray and Laboratory Services Only ..... No Copayment

Urgent and Emergency Services

Urgent Care Office Visit ..... $3 Copayment Per Visit
Outpatient Emergency Room ..... $5 Copayment Per Visit
Ambulance ..... ~~$25~~ No Copayment ~~per incident~~

Inpatient Hospital Copayment applies if the Emergency Room visit results in an Inpatient stay. If Members are admitted for an Inpatient stay, the Emergency Room Copayment will be waived.

SUBSTANCE USE DISORDER AND MENTAL ILLNESS

All Inpatient admissions require Admission Certification in order for full Benefits to be paid.

Substance Use Disorder

Outpatient and Inpatient (professional provider and facility)

~~Copayment (~~Outpatient~~)~~.....$3 Copayment
~~Copayment (~~Inpatient~~)~~.....$25 Copayment

Mental Illness

Outpatient

Mental Health Counseling (professional provider office visit) .....$3 Copayment
Mental Health Professional Visit at a Facility .....$5 Copayment

~~*Inpatient*~~
~~Copayment~~Inpatient .....$25 Copayment

Extended Mental Health ..... No Copayment

Pharmacy Benefit

Copayment (Generic) ..... No Copayment
Copayment (Brand-Name) ..... No Copayment

OTHER

Laboratory (in the Doctor's Office) ..... No Copayment
Visits at Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) No Copayment
Well Child ..... No Copayment
Well Baby ..... No Copayment
Immunizations ..... No Copayment
Dental Services..... No Copayment

ARTICLE FIVE – COVERED BENEFITS

NOTE: Other sections of this Evidence of CoverageEOC may limit the availability of the Benefits listed in this Article.

The HMK Coverage Group 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 Evidence of CoverageEOC is in force. (Please readSee Article Two entitled "Participating Provider.") Payment by the HMK Coverage Group will be subject to the Copayments shown in the Schedule of Benefits.

Section I: Inpatient Hospital Services

BCBSMT administers claims for Inpatient Hospital Services and Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-313-8914.

1. The number of allowable Inpatient days of care shall be determined by the Claim Administrator in accordance with the Milliman CareGuidelines, HCSC Medical Policies Criteria, Medical Director Directive.

    a. Days of care guidelines:

        1. The day a Member enters a Hospital is the day of admission.
        2. The day a Member leaves a Hospital is the day of discharge.
        3. The number of Inpatient care days available under the HMK Coverage Group will be computed as follows:
            - Days will be counted according to the standard midnight census procedure used in most Hospitals.
            - The day a Member is admitted to a Hospital is counted.
            - The day of discharge is not counted.
            - If a Member is discharged on the day of admission, one day will be counted.

2. Room and Board Accommodations include:

    a. Bed and board, which includes special diets and nursing services.
    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.

    NOTE: Members will be responsible to Hospitals for payment of charges if Members remain as Inpatient when Inpatient care is not Medically Necessary and if Members' representatives signed a private pay agreement specific to a service and date. No Benefits will be paid for Inpatient care provided primarily for diagnostic or therapy services.

3. 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. Respiratory therapy, chemotherapy, radiation therapy, dialysis therapy;
   i. Physical Therapy, Speech Therapy, and Occupational Therapy; and
   j. 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.

4. Transplant Benefits include:

   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.

5. Nursery Care Benefits include:

   a. Hospital nursery care of a newborn infant of an HMK Member is a covered service during the infant's eligibility period.
   b. Nursery care for newborns born into an HMK Family may be covered if the Department is notified in the Month of the birth or within ten (10) days following the birth if the baby is born at the end of the Month. (~~SPlease s~~ee Article Five, Section XIV: Newborn Care – Care of newborn of non-covered Family member for important notification requirements.)

Section II: Observation and Recovery Beds/Rooms

BCBSMT administers claims for Observation/Recovery Beds/Rooms and Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-258-3489.

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

1. The HMK Coverage Group will pay Observation Beds/Room and Recovery Care Bed 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. Participating Providers may contact BCBSMT at 1-855-313-8914.

1. Emergency room care for accidental injury.

2. Emergency room care for an Emergency Medical Condition.

3. Use of the Hospital's facilities and equipment for surgery.

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

Section IV: Outpatient Therapies – ~~Please refer to~~See Section XI: Rehabilitation/Habilitation Therapy Benefits

Section V: Outpatient Diagnostic Services

1. Outpatient Diagnostic Services provided by ~~Federally Qualified Health Center~~FQHCs and ~~Rural Health Clinic~~RHC claims are administered by ~~Xerox~~Conduent. Participating Providers may contact ~~Xerox~~ Conduent at 1-800-362-8312. 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/

2. Outpatient Diagnostic Service claims from all other types of Participating Providers are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-313-8914.

The following Outpatient Diagnostic Services are provided:

1. Diagnostic x-ray examinations;

2. Laboratory and tissue diagnostic examinations; and

3. Medical diagnostic procedures.

Section VI: Freestanding Surgical Facilities (Surgicenters)

Freestanding Surgical Facility claims are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-313-8914. Prior Authorization is required.

The following surgicenter 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 are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-313-8914.

The Department will pay the HMK Coverage Group allowable charge for routine mammograms.

Section VIII: Post-mastectomy Care

Post-mastectomy Care claims are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-313-8914.

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 Member, to be necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer. Prior Authorization 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.

6. Prosthesis and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Section IX: Surgical Services

BCBSMT administers Covered Benefits for surgical services and Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-313-8914.

Surgical services include cutting procedures and care of fractures and dislocations. Such services include usual care before and after surgery. Payment for these services is subject to the following conditions:

1. If more than one surgical procedure is performed during one operating session, The HMK Coverage Group will pay only the Allowable Fee for one procedure plus one-half of the Allowable Fee for any other procedures. When two surgeons of different specialties perform distinctly different procedures in one session, all claims will be reviewed before any determination on payment is made. No additional payment will be made for incidental surgery. "Incidental surgery" is a procedure which is an integral part of, or incidental to, the primary surgical service and performed during the same operative session. Surgery is not incidental if:

    a. It involves a major body system different from the primary surgical services.
    b. It adds significant time or complexity to the operating sessions and patient care.

2. If an operation or procedure is performed in two or more steps, total payment will be limited to the Allowable Fee for the initial procedure.

3. If two or more surgeons acting as co-surgeons perform the same operations or procedures other than as an assistant at surgery, the Allowable Fee will be divided among them. If a surgeon is acting as an assistant at surgery, payment for the services will be subject to the limitations listed below.

4. An assistant at surgery is a Physician or non-physician assistant who actively assists the operating Physician in the performance of covered surgery. The services of an assistant at surgery shall be considered for payment under the following conditions:

    a. Benefit payments are not available when the assistant at surgery is present only because the facility provider requires such services.
    b. Benefit payments for the assistant at surgery will be paid only if such services are determined to be Medically Necessary.
    c. If the assistant at surgery is a Physician, payment will be made at 20 percent (20%) of the Allowable Fee for the surgical procedure or the assistant's charge, whichever is less.
    d. If the assistant at surgery is a non-physician assistant or surgical technician, payment will be 10 percent (10%) of the Allowable Fee for the surgical procedure or the assistant's charge, whichever is less.
    e. If two surgeons are paid as primary surgeons or co-surgeons for their multiple surgeries, no allowance as an assistant at surgery will be made to either of the surgeons. Any charges for an additional assistant at surgery will be subject to review.

    The charge for a surgical suite outside of the Hospital is included in the Allowable Fee for the surgery.

Section X: Anesthesia Services

BCBSMT administers anesthesia services and Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-313-8914.

Anesthesia services provided by a Physician (other than the attending Physician or assistant), or nurse anesthetist are generally Covered Benefits if the services are determined to be Medically Necessary to provide care for a condition covered by this ~~Evidence of Coverage~~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.
4. Coverage is available for Dental anesthesia in the Hospital for Children age 5 and under. Prior authorization is needed for children age 6 and over.

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

Exclusions to Anesthesia Benefit coverage under the HMK Coverage Group 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 ~~Evidence of Coverage~~EOC.

Section XI: Rehabilitation/Habilitation Therapy Benefits

Outpatient Rehabilitation/Habilitation Therapy Covered Benefit claims from FQHCs and RHCs are administered by ~~Xerox~~Conduent. Participating Providers may contact ~~Xerox~~ Conduent at 1-800-362-8312. 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/.

All other Outpatient Rehabilitation/Habilitation Therapy Covered Benefit claims are administered by BCBSMT and Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-313-8914.

Payment by the HMK Coverage Group for Rehabilitation/Habilitation Therapy is based on the Allowable Fee and is subject to the Copayments identified in the Schedule of Benefits. These services must be Medically Necessary and provided by Participating Providers. (Please read Article Two entitled "Participating Providers.")

Outpatient Rehabilitation/Habilitation Therapy Benefits are described below:

1. Therapy service provided to Members 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 Member must continue to show measurable progress.
4. Outpatient R~~r~~ehabilitation/Habilitation therapy ~~does~~ requires Prior Authorization.

Inpatient Rehabilitation/Habilitation Therapy Benefits are described below:

1. Therapy service provided to Members 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 Member must continue to show reasonable progress.

Rehabilitation/Habilitation Therapy Benefit Exclusions:

1. Rehabilitation/Habilitation Therapy 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 XII: Medical Services (Non-Surgical)

Medical services are those non-surgical covered services 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 ~~Xerox~~Conduent. Participating Providers may contact ~~Xerox~~ Conduent at 1-800-362-8312. 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/ Outpatient medical service claims from all other types of providers are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-~~877-258-3489~~855-313-8914.

BCBSMT administers claims for all Inpatient medical services. BCBSMT administers claims for Outpatient medical services provided by all other types of Participating Providers. Participating Providers may contact BCBSMT at 1-855-~~258-3489~~313-8914.

Outpatient m~~M~~edical 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, effective October 1, 2014.

Inpatient claims for services provided by ~~Federally Qualified Health Center~~FQHCs and all other ~~i~~inpatient claims are processed through BCBSMT. Prior Authorization may be required for certain non-surgical medical services administered by BCBSMT. It is recommended Participating Providers contact BCBSMT at 1-855-313-8914 if they are uncertain whether a Covered Benefit needs Prior Authorization.

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 Members whose condition requires a Physician's constant attendance and treatment for a prolonged period of time.
4. Concurrent Care services.

   Concurrent Care is:
   a. 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
   b. Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Member's condition requires the skills of separate Physicians.
5. Consultation Services are services of a consulting Physician requested by the attending Physician. These services include:
   a. Evaluation and management service~~s~~ provided at the request of another Participating Provider;

b. The consultant's opinion and any services ordered or performed must be documented in the Member'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 HMK Coverage Group for:
a. Staff consultations required by Hospital rules, and
b. Family consultations.

Section XIII: Maternity Services

BCBSMT administers claims for maternity services and Admission Certification is required for Hospital admissions~~ts~~. For Admission Certification contact BCBSMT at 1-855-313-8914.

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 newborns.
2. In Hospital medical services for conditions related directly to pregnancy.
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 ~~health care~~healthcare provider and the mother.

Section XIV: Newborn Care

Newborn care claims from FQHCs and RHCs are administered by ~~Xerox~~Conduent. Participating Providers may contact ~~Xerox~~ Conduent at 1-800-362-8312. 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 newborn care claims for all other types of providers. Participating Providers may contact BCBSMT at 1-855-313-8914.

Newborn of **Covered Member**:

Benefits are provided for the newborn baby of eligible Members. Covered Benefits must be provided by Participating Providers and can include:

1. The initial care of a newborn at birth provided by Participating Providers,
2. Standby care provided by a pediatrician during a Cesarean section, and
3. Covered Benefits for 31 days following the birth.
   a. The newborn services will be provided under the eligible Member's coverage.
   b. Coverage for the newborn will terminate at the end of the 31-day period.
   c. In order to avoid interruption in coverage for the newborn, an HMK application for eligibility for the newborn must be received prior to the end of the 31-day period.

Continued HMK coverage after birth for the newborn is subject to meeting eligibility requirements as determined by the Department.

Newborn of a **non-covered Family Member** (example – mother of Member is pregnant): Benefits are provided for a newborn baby of a non-covered Family Member if the services are provided by a Participating Provider and the Family has provided information listed below to the Department:

1. The initial care of a newborn eligible Family Member begins on the date of birth **IF** notification is received by the Department in the Month of birth or within ten (10) calendar days following the birth if the baby is born at the end of the Month.

2. If notification of birth is not received in the Month of birth, or within ten (10) days following the birth if the baby is born at the end of the Month, Benefits for the newborn eligible Family Member will begin effective the first of the Month in which notification is actually received.
   NOTE: Declaring a date of delivery on an application, prior to the birth of a baby, is not notification of birth.

Section XV: Well-Baby/Well-Child Care

Well-Baby/Well-Child care claims from FQHCs and RHCs are administered by ~~Xerox~~Conduent. Participating Providers may contact ~~Xerox~~ Conduent at 1-800-362-8312. 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 well-baby/well-child care claims for all other types of providers. Participating Providers may contact BCBSMT at 1-855-313-8914.

Well-baby/well-child care Benefits are available for eligible and enrolled HMK Children and newborn Children of HMK Members from the moment of birth through their first 31 days from birth.

Covered Benefits include:

1. A well-baby/well-child examination by a Participating Provider following the recommended guidelines of the American Association of Pediatrics (AAP), which shall include a medical history, physical examination, developmental assessment, and anticipatory guidance.

2. Laboratory tests according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in MCA § 53-6-101.

3. Routine immunizations according to the schedule of immunizations which is recommended by the Immunization Practices Advisory Committee of the United States Department of Health and Human Services.

4. Sport and employment physicals.

Payment will be made based on the Allowable Fee. No payment will be made for duplicate services with respect to any scheduled visit.

Section XVI: Vision Benefits and Medical Eye Care

Vision claims from FQHCs and RHCs are administered by ~~Xerox~~Conduent. Participating Providers may contact ~~Xerox~~ Conduent at 1-800-362-8312. 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~~.hhs.~~.mt.gov/~~providerpages/providertype/providertype.shtml.~~

BCBSMT administers vision claims for all other types of providers. Participating Providers may contact BCBSMT at 1-855-313-8914.

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.

2. Vision exams.

3. Eyeglasses are covered by the Department and claims are administered by ~~Xerox~~Conduent.

    a. Eyeglasses are available through the Department by the HMK Dental and Vision Program.
    b. HMK will pay for one pair of glasses within a 365-day period.
    c. Contact lenses are not covered.
    d. Information about eyeglasses can be found at: http://medicaidprovider.mt.gov/ or call the HMK Dental and Optometric Program Officer at ~~877-543-7669~~1-406-444-7045~~ or email hmk@mt.gov.~~.

Section XVII: Dental Services

Dental claims from Dentists, FQHCs and RHCs are administered by ~~Xerox~~Conduent. Participating Providers may contact ~~Xerox~~ Conduent at 1-800-362-8312.

HMK Dental Benefits are administered by the Department's Dental and Vision Program Officer.

Outpatient Dental services include:

1. A Child may receive up to $1,900 in reimbursable Dental services per Benefit Year (July 1 through June 30).
2. Implant services are Covered Benefits if the Participating Provider receives Prior Authorization from the HMK Dental and Optometric Program Officer. Participating Providers may contact the HMK Dental and Optometric Program Officer at 1-~~877-543-7669~~406-444-7045.
    a. Implant services have a lifetime limit of $1,500 per person.

3. Dentists may charge families for services over $1,900 per Member per Benefit Year. Families can make payment arrangements with dentists.

4. ~~-~~Information about Dental services can be found at http://medicaidprovider.mt.gov/ or call HMK at ~~877-543-7669~~1-406-444-7045~~ or email hmk@mt.gov~~.

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 Member's health. Things such as complexity of Dental treatment and length of anesthesia are not considered non-dental physical Illness or injury.

2. Coverage is available for Dental anesthesia in the Hospital for Children age 5 and under.

3. Other conditions are subject to medical review and Prior Authorization.

The HMK Coverage Group 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 the Dental and Optometric Program Officer at 1-~~877-543-7669~~406-444-7045 or BCBSMT at 1-855-313-8914.

Exclusions to Outpatient and Inpatient Dental Services include:

a. o~~O~~rthodontics,
b. dentofacial orthopedics, or
c. related appliances.

Section XVIII: Dental Fluoride

Claims for Dental fluoride provided by a Dentist are administered by ~~Xerox~~Conduent. Participating Providers may contact ~~Xerox~~ Conduent at 1-800-362-8312.

BCBSMT administers claims for Dental fluoride provided by all other types of Participating Providers. Participating Providers may contact BCBSMT at 1-855-313-8914.

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

Section XIX: Audiological Benefits

BCBSMT administers audiological claims for Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

Audiological Benefits include:

1. Hearing exams, including newborn hearing screens in a Hospital or Outpatient setting, are covered. Coverage includes assessment and diagnosis.

2. Hearing aids, hearing aid supplies, including batteries, and hearing aid repairs are covered.
   a. Hearing aids must be provided by HMK Participating Providers.
   b. The HMK Coverage Group will pay for a single or one set of hearing aids within a 5-year period.

3. Participating Providers must submit Prior Authorization request forms for hearing aids to BCBSMT.
   a. HMK Participating Providers may contact HMK Customer Service at 1-855-313-8914 to receive the HMK Hearing Aid Prior Authorization form or download it at the following web site: ~~https://www.bcbsmt.com/BlueDocs/PriorAuthFormHMKHearingAids.pdf.~~https://www.bcbsmt.com/provider/education-and-reference/forms-and-documents.
   b. HMK Members must be enrolled on the date of the Prior Authorization request and on the date of service, including the date hearing aids are provided to HMK Members.

4. Cochlear implants and associated components are Covered Benefits.
   a. Prior Authorization is required for cochlear implants and associated components. Participating Providers may contact HMK Customer Service at 1-855-313-8914 to receive the HMK Prior Authorization request form or download it at the following web site: https://www.bcbsmt.com/provider/education-and-reference/forms-and-documents.~~https://www.bcbsmt.com/BlueDocs/PriorAuthFormHMKGeneral.pdf.~~
   b. HMK Members must be enrolled on the date of the Prior Authorization request and on the date of service.

~~***Section XX: Outpatient Therapies – Please refer to Section XI: Rehabilitation Therapy Benefits***~~

Section XX~~I~~: Radiation Therapy Service

BCBSMT administers claims for radiation therapy Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

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

Section XXII: Chemotherapy

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: Diabetic Education

BCBSMT administers diabetic education claims for Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

The HMK Coverage Group covers Outpatient diabetic education services. Covered services include programs for self-management training and education as prescribed by a licensed health carehealthcare professional with expertise in diabetes.

SPlease see Section XXXIV: Durable Medical Equipment (DME) and Medical Supplies for important information regarding diabetic equipment and supplies covered by the HMK Coverage Group.

Section XXIIIV: Diagnostic Services – Please refer toSee Section V: Outpatient Diagnostic Services

Section XXIV: MentalBehavioral Health Inpatient Benefits

BCBSMT administers Inpatient MentalBehavioral Health claims for Covered Benefits. Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-313-8909.

1. The HMK Coverage Group will pay for Inpatient mentalBehavioral Hhealth services that are Covered Benefits if provided by a Participating Provider. Covered Benefits must be provided by one of the following types of providers:
   a. Hospital;
   b. Psychiatric Residential Treatment Facility; or a
   c. Therapeutic Group Home.

2. Therapeutic Group Home Leave is allowed, but limited to 14 paid days per benefit year, effective July 1, 2015.

3. Inpatient admission to a 24-hour therapeutically structured service location must receive Prior Authorization.

4. Specific limitations apply to HMK Coverage Group eligibility for Children who are patients in an Institution for Mental Diseases (IMD). Federal Law prohibits coverage of Children in a facility which would be termed an IMD under Medicaid regulations (42 CFR 435.1009(2)) and HMK regulations (42 CFR 457.310(2)(ii)). Children must not be patients in an IMD at the time of initial application or any redetermination of eligibility. Members who are enrolled in the HMK Coverage Group prior to becoming patients in an IMD will be covered.

Section XXVI: MentalBehavioral Health Outpatient Benefits

MentalBehavioral Hhealth Outpatient claims from FQHCs and RHCs are administered by XeroxConduent. Participating Providers may contact Xerox Conduent at 1-800-362-8312. 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~~Behavioral Health Outpatient benefit claims for all other types of Participating Providers. Participating Providers may contact BCBSMT at 1-855-313-8909.

1. The HMK Coverage Group will pay for Outpatient ~~mental~~Behavioral ~~H~~health services that are Covered Benefits if provided by a Participating Provider. Outpatient ~~mental~~Behavioral ~~H~~health services may be furnished in a variety of settings:
   a. community based settings; or in a
   b. mental health Hospital.

2. ~~Mental~~Behavioral Health Outpatient Benefits include individual, Family and/or group psychotherapy office visits.

3. Services provided via telemedicine are allowed, effective October 1, 2014.

Section XXVI~~I~~: Extended Mental Health Benefits

1. The HMK Coverage Group will provide Covered Benefits which include community based mental health services available for Children who have been diagnosed as having a Serious Emotional ~~Disease~~ Disturbance (SED).

2. Extended Mental Health Benefits are in addition to the ~~Mental~~Behavioral Health Outpatient Benefits and must be applied for by a Covered mental health Provider.

3. Extended Mental Health services are available for Children who are determined by the Department to have a SED. Extended Mental Health Benefits include the following community-based services:
   a. Therapeutic Family Care/Home Supports (moderate level);
   b. Day Treatment;
   c. Respite Care; and
   d. Community Based Psychiatric Rehabilitation and Support (CBPRS).

The following Extended Mental Health Covered Benefit claims are administered by BCBSMT and the following Benefit Year limits apply:

- Therapeutic Family Care/Home Supports, maximum of 90 days, effective July 1, 2015;
- Day Treatment, maximum 120 hours; and
- Respite Care, maximum of 144 hours.

The following Extended Mental Health claims are administered by Xerox and the following Benefit Year limits apply:

- Community Based Psychiatric Rehabilitation and Support, 120 hours.

~~Please refer to~~See the chart of HMK Extended Mental Health Benefits in Section XXVIII: Severe Mental Illness.

Section XXVII~~I~~: Severe Mental Illness

The HMK Coverage Group 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 health, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed Physician.

HMK Coverage Group Extended Mental Health Benefits
Benefit Year October 1 – September 30
All services must be Medically Necessary

Therapeutic Family Care or Home Support Services (Moderate level in Child's home) Submit Claims to BCBSMT	**Day Treatment Submit Claims to BCBSMT**	**Respite Care Submit Claims to BCBSMT**	**CBPRS Community Based Psychiatric Rehabilitation and Support Submit Claims to ~~Xerox~~Conduent**
COVERED 90 days	**COVERED** 120 hours	**COVERED** 144 hours	**COVERED** ~~(~~120 hours~~)~~
H 2020	H 2012 With Modifier HA	S 5150 With Modifier HA	H 2019

Section XXII~~IX~~: Substance Use Disorder

Payment by the Department for Substance Use Disorder services of Participating Providers will be based on the Allowable Fee and is subject to the copayments identified in the Schedule of Benefits. These services must be Medically Necessary and provided by a Participating Provider. (~~Please read~~See Article Three entitled "Participating Providers.")

BCBSMT administers Substance Use Disorder Inpatient and Outpatient claims for Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914. Prior Authorization is required for Inpatient ~~Bb~~enefits.

Inpatient Benefits:

1. Inpatient treatment for alcoholism and drug addiction services are Covered Benefits. Inpatient Services are provided as medical benefits.

Outpatient Benefits:

1. Outpatient treatments for alcoholism and drug addiction services are Covered Benefits.

2. BCBSMT administers claims for Outpatient Substance Use Disorder services.

3. These services must be Medically Necessary and provided by a Participating Provider.

Section XXIX: Ambulance Services

~~BCBSMT~~ DPHHS administers claims for Ambulance services. Providers may contact ~~BCBSMT~~ the Montana Healthcare Programs Transportation Center at 1-~~855-313-8914~~877-362-5861.

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 Member. HMK only pays for loaded miles when the patient is on-board the Ambulance.

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

Section XXX~~I~~: Transportation and Per Diem

BCBSMT administers claims for transportation and per diem Covered Benefits. Members or Family Members may contact BCBSMT at 1-855-258-3489.

The HMK Coverage Group will provide financial assistance towards expenses for HMK Members' transport, meals and lodging while enroute to Medically Necessary medical care. It is important to have Members' Participating Providers submit requests for Prior Authorization to the Claim Administrator and receive approval for Medically Necessary medical care before submitting Prior Authorization for travel and per diem.

1. Prior Authorization is required for all transportation and per diem reimbursement. Members' Participating Providers must sign and submit Prior Authorization forms to the Claim Administrator before Members travel to receive medical care.

2. Members must schedule an appointment and attend the appointment prior to receiving transportation and per diem reimbursement.

3. Coverage of per diem and transportation is available for an adult companion to accompany a minor who must travel to receive care.

4. HMK will only pay per diem and transportation to the nearest provider that can provide the needed services, regardless of where the member chooses to receive care.

Section XXXII~~I~~: Chiropractic Services: Benefit Effective January 1, 2013

BCBSMT administers claims for chiropractic Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

The HMK Coverage Group will pay the Allowable Fee for evaluation and management office visits with licensed chiropractors.

1. Members may receive manual manipulation of the spine, and x-rays to support the diagnosis of subluxation of the spine.

Section XXXIII~~I~~: 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 ~~prior authorization (PA) and preferred drug lists (PDL).~~Preauthorization and Preferred Drug Lists.

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

The prescription drug benefit administered by DPHHS is set forth in ARM Title 37, chapter 86, part 11.

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

~~**DEFINITIONS**~~

~~**BRAND-NAME**~~

~~The proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging.~~

~~**DRUG EFFICACY STUDY INDEX (DESI) OR "LESS-THAN-EFFECTIVE-DRUGS"**~~

~~An index that measures one drug against a clinical response criteria. If the index is low, the drug is classified as less-than-effective.~~

~~**DRUG UTILIZATION REVIEW (DUR) PROGRAM**~~

~~A quality assurance program for covered outpatient drugs which assures that prescriptions are appropriate, Medically Necessary, and not likely to result in adverse medical outcomes.~~

~~**GENERIC EQUIVALENTS**~~

~~Drug products are considered pharmaceutical equivalents if they contain the same active ingredients, are of the same dosage form, route of administration, and are identical in strength or concentration. Pharmaceutically equivalent drug products are formulated to contain the same amount of active ingredient in the same dosage form and to meet the same or compendial or other applicable standards, but they may differ in characteristics such as shape, scoring configuration, release mechanisms, packaging, excipients (including colors, flavors, preservatives), expiration time, and, within certain limits, labeling (FDA *Approved Drug Products with Therapeutic Equivalence Evaluations,* 23rd Edition, March 2003).~~

~~**LEGEND OR PRESCRIPTION DRUGS**~~

~~Any drug(s) required by any applicable Federal or state law or regulation to be dispensed by prescription only or which are restricted to use by practitioners only.~~

~~**NATIONAL DRUG CODE (NDC)**~~

~~An 11-digit number the manufacturer assigns to a pharmaceutical product and attaches to the product container at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.~~

~~**NONREBATE DRUGS**~~

~~Drugs manufactured or distributed by manufactures/labelers who have not signed a drug rebate agreement with the Federal Department of Health and Human Services (DHHS) or the state Department of Public Health and Human Services (DPHHS).~~

~~**OBSOLETE DRUG**~~

~~A drug that has been identified as obsolete by the manufacturer and is no longer available.~~

~~**OBSOLETE NDC**~~

~~A national drug code replaced or discontinued by the manufacturer or labeler.~~

~~**OVER-THE-COUNTER (OTC) DRUG**~~

~~Drugs (non-legend) that do not require a prescription before they can be dispensed.~~

PARTICIPATING PHARMACY

A Pharmacy which is enrolled as a Montana Health CareHealthcare Programs Provider to provide Legend or Prescription Drugs to Members and has agreed to accept specified reimbursement rates.

POINT-OF-SALE (POS)

A Pharmacy claims processing system capable of adjudicating claims online.

PREFERRED DRUG LIST (PDL)

A list of clinically effective medications from selected classes for which the Department will allow payment without restriction.

PRESCRIPTION ORDER OR REFILL

The directive to dispense a Legend or Prescription Drug issued by a duly licensed health carehealthcare provider whose scope of practice permits issuing such a directive.

PRIOR AUTHORIZATION

Approval in advance to obtain certain prescribed medications, prior to dispensing, using guidelines approved by the Department.

TERMINATED DRUG PRODUCT

A product whose shelf life expiration date has been met, per manufacturer or CMS notification.

BENEFITS

The Department provides coverage for Prescription Drug Products if all of the following conditions are met:

1. It is Medically Necessary;
2. If it is obtained through a Participating Pharmacy;
3. It is provided while the person is a Member; and
4. It is considered an eligible Prescription Drug Product.
5. It is prescribed by a physician or other licensed practitioner who is authorized by law to prescribe drugs and is recognized by the Medicaid program

COVERED DRUGS

1. Legend and covered outpatient drugs as described in 42 USC 1396r-8, subject to the PDL and PA requirements.

2. The following **prescribed** over-the-counter (OTC) products manufactured by companies who have signed a Federal rebate agreement:
   - Aspirin
   - Insulin
   - Laxatives
   - Antacids
   - Head lice treatment
   - H2 antagonist GI products
   - Non-sedating antihistamines
   - Diphenhydramine
   - Proton pump inhibitors

- OTC nicotine patches with prior authorization
- OTC contraceptive drugs
- Ketotifin ophthalmic solution
- Pyridoxine
- Doxylamine
- Steroid nasal sprays
- Benzoyl peroxide
- Folic acid

3. Compounded prescriptions

4. Contraceptive supplies and devices

5. Federal law allows states the discretion to cover certain medications listed in 42 USC 1396r-8, it has been determined that the following medications are covered:
   - Barbiturates only when used for specific conditions.
   - Prescription cough and cold medications

6. Prescription vitamins and minerals will be granted prior authorization when indicated for the treatment of an appropriate diagnosis

NONCOVERED DRUGS

1. Drugs supplied by drug manufacturers who have **not** entered into a Federal drug rebate agreement.

2. Drugs supplied by other public agencies such as the United States Veterans Administration, United States Department of Health and Human Services, local health departments, etc.

3. Drugs prescribed:
   - To promote fertility
   - For erectile dysfunction
   - For weight reduction
   - For cosmetic purposes or hair growth

4. For an indication that is not medically accepted as determined by the Department in consultation with federal guidelines, DUR Board, or the Department medical and Pharmacy consultants.

5. Drugs designated as “less-than-effective” (DESI drugs), or which are identical, similar, or related to such drugs.

6. Drugs that are Experimental, Investigational, or of unproven efficacy or safety.

7. Free pharmaceutical samples.

8. Obsolete National Drug Code (NDC).

9. Terminated drug products.

10. Any drug, biological product, or insulin provided as part of, or incident to and in the same setting as, any of the following:

- Inpatient Hospital setting
- Hospice services
- Outpatient Hospital services emergency room visit
- Other laboratory and x-ray services
- Renal dialysis
- Incarceration

11. Any of the following drugs:
    - Outpatient nonprescription drugs (except those OTC products previously listed)
    - Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

12. Medical supplies (non-drug items) are not covered under the prescription drug program.
    Exception:
    - Contraceptive supplies and devices

PRIOR AUTHORIZATION

Certain Prescription Drug Products require Prior Authorization to be covered by the Department at the time of purchase. Prior Authorization procedures require the Member's physician to provide documentation to the Department that the prescription drug is Medically Necessary. Prior Authorization may be initiated by the Member's physician or the dispensing pharmacist. If these products are not prior authorized before being dispensed the claim will deny. The Department may delegate the Prior Authorization function, but it retains the final discretionary authority regarding coverage under the HMK Coverage Group.

DISPENSING LIMITATIONS

1. Drugs are limited to a 34-day supply except for the following specific package sizes:
    - Seasonale® 91-day supply
    - Poly-vi-Flor® (and generics with or without iron) 50- to 100-day supply
    - Depo-Provera® 90-day supply
    - Vitamin B-12 injections 90-day supply
    - Maintenance supplies

The Drug Utilization Review Board has recommended the following drug classes be considered for **maintenance supplies** (examples in parentheses):

Drug Classes Considered for Maintenance Supplies

Heart Disease	**Diabetes Medications**	**Blood Pressure**	**Women's Health**	**Thyroid**
Digitalis glycosides (digoxin, lanoxin)	Insulin release stimulant type (glipizide)	Hypotensive, vasodilators (prasozin)	Folic acid preparations	Thyroid hormones (levothyroxine)
Antiarrythmics (quinidine)	Biguanides (metformin)	Hypotensive, sympatholytic (clonidine)	Prenatal vitamins	
Potassium replacement	Alpha-glucosidase inhibitors (acarbose)	ACE inhibitors (lisinopril)	Oral contraceptives	

Thiazide and related diuretics (HCTZ)	Insulin release stimulant/biguanide combo	ACE inhibitors/ diuretic combos		
Potassium sparing diuretics and combinations (spironolactone)		ACE inhibitor/ Calcium channel blocker combos		
Loop diuretics (furosemide)		Calcium Channel Blockers (diltiazem)		
		Alpha/beta adrenergic blocking agents (carvedilol)		
		Alpha adrenergic blocking agents and thiazide combos		
		Beta-adrenergic blocking agents (propranolol)		

2. No more than two prescriptions of the same drug may be dispensed in a calendar Month, except for the following:
   - Antibiotics
   - Schedule II and V drugs
   - Antineoplastic agents
   - Compounded prescriptions
   - Prescriptions for suicidal patients or patients at risk for drug abuse
   - Topical preparations

Other medications may not be dispensed in quantities greater than a 34-day supply, except where manufacturer packing cannot be reduced to a smaller quantity.

The DUR Board has set monthly limits on certain drugs. Use over these amounts requires prior authorization.

PRESCRIPTION REFILLS

Prescriptions for non-controlled substances may be refilled after 75% of the estimated therapy days have elapsed. Prescriptions for controlled substances (CII-CV), Ultram (tramadol), Ultracet (tramadol/acetaminophen), carisoprodol, and gabapentin may be refilled after 90% of the estimated therapy days have elapsed. The POS system will deny a claim for "refill-to-soon" based on prescriptions dispensed on month-to-month usage.

A prescription may be refilled early only if the prescriber changes the dosage. The pharmacist must document any dosage change. Early refills are not granted for lost or stolen medication nor are they granted for vacation and/or travel. In any circumstance, the provider must contact the Drug Prior Authorization Unit at 1-800-395-7961 to receive approval.

Section XXXIIIV: Durable Medical Equipment (DME) and Medical Supplies (Benefit effective January 1, 2013)

BCBSMT administers claims for DME and Medical ~~Supply~~ Supplies Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914. Prior Authorization is required for DME and medical supplies that cost more than $500.

The HMK Coverage Group 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 Member'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 things like oxygen equipment, wheelchairs, prosthetic limbs, and orthotics.

2. Diabetic equipment and supplies include things like: 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~~See Section XXIII regarding Diabetic Education and Section XXXVII: Nutrition Services.)

Section XXX~~I~~V: Home Health Services

BCBSMT administers home health service claims for Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914. The ordering provider must submit Prior Authorization to BCBSMT prior to providing services.

The HMK Coverage Group will pay for home health services provided by a licensed home health agency to Members considered homebound in Members' place of residence for the purposes of postponing or preventing institutionalization.

1. Home health services include:
   a. Skilled nursing services;
   b. Home health aide services;
   c. Physical Therapy services;
   d. Occupational Therapy services;
   e. Speech Therapy services; and
   f. Medical supplies and equipment suitable for use in the home.

2. Home health services not covered:
   a. Respite care;
   b. Participating home health agencies will be required to use a participating home infusion therapy provider who will bill the Claim Administrator directly;
   c. Compensation for daily prescriptions and oral medications will not be allowed through the home health agency; and
   d. Compensation for ~~A~~ambulance services will not be allowed through the home health agency.

Section XXXV~~I~~: Hospice Services

BCBSMT administers claims for hospice services. Participating Providers may contact BCBSMT at 1-855-313-8914.

The HMK Coverage Group will cover Medically Necessary hospice services from licensed providers.

1. A plan of care must be submitted to the Claim Administrator prior to providing services.

2. Hospice services must be Prior Authorized before services are provided.

3. Volunteer services are not a Covered Benefit.

Section XXXVII~~I~~: Nutrition Services

BCBSMT administers claims for nutrition services that are Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

The HMK Coverage Group will cover nutrition counseling directly with Members or with Members' parents or guardians for treatment of diabetes and obesity.

Section XXXVIII~~I~~: Children's Special Health Services Clinics

The HMK Coverage Group participates in three clinics which are managed through the Department's Children's Special Health Services (CSHS) Program.

1. Cleft/craniofacial Clinic:

   Provides comprehensive evaluation and treatment for Members with cleft/craniofacial conditions. These may include cleft lip and/or palate, Apert's, Crouzon's disease, or syndromes affecting facial growth and speech and language development.

2. Metabolic Interdisciplinary Clinic:

   Provides comprehensive evaluation and treatment for Members with metabolic diseases. These may include phenylketonuria (PKU), galactosemia, urea cycle disorders, mitochondrial diseases, and fatty acid oxidation disorders.

3. Cystic Fibrosis Interdisciplinary Clinic:

   Provides comprehensive evaluation and treatment for Members with ~~the understanding that a comprehensive assessment of the Member's physical and emotional status is necessary to promote wellness and minimize the disease process. Longitudinal follow-up by the interdisciplinary team promotes the early recognition and treatment of symptoms, the development of positive coping mechanisms, and ensures access to available resources including those in the community and nationally through the CF Foundation.~~cystic fibrosis. The Member is evaluated and treatment recommendations are made by a team of healthcare professionals in accordance with his/her individual needs based on guidelines developed by the Cystic Fibrosis Foundation.

Participation in CSHS clinics is available to Members who have one of the above mentioned conditions. Claims for this HMK Coverage Group Benefit are administered by BCBSMT.

Section XXXIII~~X~~: Other Services

BCBSMT is the Claims Administrator for Covered Benefits listed below. Participating Providers may contact BCBSMT at 1-855-313-8914.

1. Blood transfusions, including cost of blood, blood plasma, blood plasma expanders, and packed cells. Storage charges for blood are covered when Members have blood drawn and stored for their own use for a planned surgery.

2. Medically Necessary nutrition formula for Medically Necessary treatment of conditions in addition to inborn errors of metabolism.

3. Licensed professional medical services provided under the supervision of a Physician for inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage includes the

diagnosis, monitoring, and control of the disorder by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

4. 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 the HMK Coverage Group.

ARTICLE SIX– GENERAL EXCLUSIONS AND LIMITATIONS

All Benefits provided under this ~~Evidence of Coverage~~EOC are subject to the Exclusions and limitations stated hereunder. Except as specifically provided in this ~~Evidence of Coverage~~EOC, the HMK Coverage Group will not be required to provide Benefits for the following services, supplies, situations, and any related expenses:

1. Any service ~~or supply~~ s, supplies, drugs, and devices, which ~~is~~are:

   a. Not Medically Necessary to treat active Illness or injury;
   b. Not an accepted medical practice. (The HMK Coverage Group may consult with the Physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice); ~~and/or~~
   c. Not a covered service;
   ~~c.~~d. An Investigational/Experimental/Unproven Service or Clinical Trial; and/or
   ~~d.~~e. Not provided in the appropriate setting.

2. Worker's Compensation: All services and supplies which would be provided to treat Illness or injury arising out of employment when Members' 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. Members' employers have failed to obtain such coverage as required by law.
   c. Members have waived their rights to such coverage or Benefits.
   d. Members fail to file claims within the filing period allowed by law for such Benefits.
   e. Members fail to comply with any other provision of the law to obtain such coverage or Benefits.
   f. Members 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 Members 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 Members' 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 Members from the HMK Coverage Group. An example of this would be vaccines administered to HMK Members by a county health provider. When such a circumstance occurs, Members 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 Member receives, or would be entitled to receive, Benefits under an automobile insurance policy. **Note:** Any services, supplies and medications provided by the HMK Coverage Group to treat the Members 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 Members 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 HMK Coverage Group to treat Members 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 Members incarcerated in a criminal justice institution. Members 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 Members of criminal acts, or attempts by Members to commit felonies, or engaging in an illegal occupation.

10. Treatment for Temporomandibular Joint Dysfunction (TMJ).

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

12. Dental Services except as specifically included in this ~~Evidence of Coverage~~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 XVI: Vision Benefits and Medical Eye Care for important information on vision Benefits, including eye-glasses, provided by the HMK Coverage Group.

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

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

16. Any drugs or supplies 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.

19. Services for which Members are not legally required to pay or charges that are made only because Benefits are available under this ~~Evidence of Coverage~~EOC.

20. Any services or supplies related to in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, and fertility enhancing treatment.

21. Sterilization or the 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).

23. Foot care including but not limited to:
    a. Routine foot care;
    b. Treatment or removal of corns or callosities;
    c. Hypertrophy, hyperplasia of the skin or subcutaneous tissues; and/or
    d. Cutting or trimming of nails.

24. Services provided for Members before their Effective Date of coverage or after Members' 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 (effective October 1, 2015);
    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: Well-child checkups, immunizations, and sport or employment physicals are covered.

28. Sanitarium care, custodial care, rest cures, or convalescent care to help Members 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; and
    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 types of care outlined in this Exclusion.

~~29~~30. Supplements.

30~~1~~. Food supplements (except for those for inborn errors of metabolism and treatment of other Medically Necessary conditions).

31~~2~~. All invasive medical procedures undertaken for the purpose of weight reduction such as gastric bypass, gastric banding or bariatric surgery (including all revisions).

32~~3~~. Charges associated with health or weight loss clubs, or clinics.

33~~4~~. Benefits shall not be paid for services or items provided by an entity, institute, or provider located outside of the United States.

34~~5~~. Education or tutoring services, except as specifically included as a Benefit of this Evidence of Coverage.

35~~6~~. 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 Prior Authorization was not obtained before the services were received.

36~~7~~. Services and supplies primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature.

37~~8~~. Any services and supplies which are not listed as a Benefit of this ~~Evidence of Coverage~~EOC.

ARTICLE SEVEN – CLAIMS FOR BENEFITS

Section I: Claims Processing

Medical and ~~Mental~~Behavioral Health

In order to have Member Benefit claims processed through the HMK Coverage Group, Members' Participating Providers must submit all claims for services no later than 12 months after the date on which Members received the services. All claims must give enough information about the services for the Claim Administrator to determine whether they are covered under the ~~Evidence of Coverage~~EOC. The ~~Healthy Montana Kids~~HMK Provider must submit all non-Pharmacy claims to the address listed on the back of Members' ID cards. ~~Federally Qualified Health Center~~FQHCs, ~~Rural Health Clinic~~RHCs, Community Based Psychiatric Rehabilitation and Support facilities, and dentists must submit claims to ~~Xerox~~Conduent, PO Box 8000, Helena, MT 59604.

~~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 NCPDP Payer Sheet located under Provider Notices on the following website: http://medicaidprovider.mt.gov/.~~

~~.~~

Section II: Prior Authorization

Medical and ~~Mental~~Behavioral Health Claims

Prior Authorization is required in order to receive some Benefits provided under this ~~Evidence of Coverage~~EOC. Listed Covered Benefits in this ~~Evidence of Coverage~~EOC that require Prior Authorization are noted under each Covered Benefit. The appropriate Claim Administrator is identified for claim processing purposes under each Covered Benefit. A request for Prior Authorization must be submitted for consideration to the Claim Administrator in the following manner:

1. A written request for Prior Authorization must be submitted to the applicable Claim Administrator 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 attention of the applicable Claim Administrator at the address listed on the back cover of this document. HMK Member's names, addresses, and Member numbers must be included.

The applicable Claim Administrator 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 ~~Evidence of Coverage~~EOC. In no event shall a coverage determination be made more than 14 days following receipt of all documents.

A request for Prior Authorization does not guarantee that Benefits are payable. ~~Attending an appointment prior to receiving Prior Authorization approval may result in the HMK Member paying costs of a service determined to not be Medically Necessary, not covered, investigational, experimental, unproven, or performed in an inappropriate setting under this Evidence of Coverage.~~

~~**Pharmacy Claims**~~

~~Many drug products require Prior Authorization (PA) **before** the pharmacist provides them to the client. For the Pharmacy drug Prior Authorization process, please refer to the Pharmacy provider manual located at the following website: http://medicaidprovider.mt.gov/.~~

Section III: Payment for Professional and Hospital Services

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

3. Non-Participating Providers may refuse payment for a covered service under the HMK Coverage Group. In the event a Non-Participating Provider does refuse to accept payment for a covered service under the HMK Coverage Group, the expenses will be the responsibility of Members.

4. Benefits payable under this ~~Evidence of Coverage~~EOC are not assignable by Members to any third party.

ARTICLE EIGHT – COMPLAINTS, APPEALS AND CONFIDENTIAL INFORMATION

Section I: Complaints

HMK Members may file verbal or written Complaints about any aspect of service delivery provided or paid for by the HMK Coverage Group.

Section II: Appeals

Medical and ~~Mental~~Behavioral Health

1. First Level Appeal:
   If Members do not agree with a denial or partial denial of a claim, Members have 180 days from receipt of the denial to appeal the decision on the claim. Members must write to BCBSMT and ask for a review of the claim denial. BCBSMT will acknowledge Members' requests for appeals within 10 days of receipt of requests.

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

   ~~Healthy Montana Kids~~HMK Customer Service Department
   Blue Cross and Blue Shield of Montana
   P.O. Box 4309
   Helena, MT 59604

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

2. Second Level Appeal:
   If Members do not agree with the First Level determination, Members may fax their Second Level appeal request to 1-~~(~~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 Members to conduct an impartial administrative hearing 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.

Pharmacy, Dental, Vision, FQHC, RHC, CBPRS

1. First Level Appeal:
   If Members do not agree with a denial or partial denial of a claim, Members have 180 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 Members wish the Department to consider in the Administrative Review. The request must be mailed or delivered to:

Montana DPHHS
~~Attn: Pharmacy Program Officer~~
111 N. Sanders
PO Box 4210
Helena, MT 59620-4210

Once the Administrative Review has been completed Members will receive a letter outlining the Department's decision. Members 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 Members do not agree with the First Level determination, Members may fax their Second Level appeal request to 1-~~(~~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 Members 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, they 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 Member's Medical Information – Medical documentation obtained by the Department regarding a Member's health history, condition, or treatment is strictly confidential and may not be released without Members' written authorization; however, the Department reserves the right to release such information without Members' written authorization in the following instances:

   a. When such information is requested by Peer and Utilization Review Board, or by the HMK Coverage Group'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 HMK Members brochure which is provided in the enrollment package for all new eligible Members. A copy may be requested by calling the Claim Administrator at 1-855-258-3489.

2. Release of medically related information -- Members accept this ~~Evidence of Coverage~~EOC under the following conditions:

   a. Members authorize all Providers of ~~health care~~healthcare services or supplies, including medical, Hospital, Dental, and vision, to furnish to the HMK Coverage Group any medically related information pertaining to any Illness, injury, service, or supply for which Benefits are claimed under this ~~Evidence of Coverage~~EOC for the purposes of Benefit determination.

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

ARTICLE NINE – BLUECard® PROGRAM

OUT-OF-AREA – THE BLUECARD PROGRAM

Section 1: Out-of-Area Services

Blue Cross and Blue Shield of Montana has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Member obtains healthcare services outside of the Blue Cross and Blue Shield of Montana service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

Typically, when accessing care outside the Blue Cross and Blue Shield of Montana service area, the Member 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 Member may obtain care from non-participating healthcare providers. Blue Cross and Blue Shield of Montana payment practices in both instances are described below.

Section II: BlueCard® Program

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

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield of Montana uses for the Member'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 Member's calculation. If any state laws mandate other liability calculation methods, including a surcharge, Blue Cross and Blue Shield of Montana would then calculate the Member'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

Member Liability Calculation

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

Exceptions

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

Section III: Member Responsibility

Before You receive ~~Healthy Montana Kids~~HMK Program Benefits outside the geographic area that Blue Cross and Blue Shield of Montana serves:

- Contact Blue Cross and Blue Shield of Montana and determine whether the provider You request to see is a Host Plan Participating Provider. You may be responsible for payment of Benefits received by a Non-Participating Provider.
- Contact Blue Cross and Blue Shield of Montana and arrange for Prior Authorization with your HMK Participating Provider before scheduling and receiving out-of-state services.

HMK Members who have copayments are responsible for paying applicable copayments to BlueCard Program Participating Providers.

ARTICLE TEN – EVIDENCE OF COVERAGE (EOC) – GENERAL PROVISIONS

Section I: Department Powers and Duties

The Department shall have total and exclusive responsibility to control, operate, manage, and administer the HMK Coverage Group 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 HMK Coverage Group. Without limiting the generality of the preceding sentence, the Department shall have the exclusive right: to interpret the HMK Coverage Group; to determine eligibility for coverage under the HMK Coverage Group; to construe any ambiguous provisions of the HMK Coverage Group; 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 HMK Coverage Group.

The Department shall have full discretionary authority in all matters related to the discharge of its responsibilities and the exercise of authority under the HMK Coverage Group, including, without limitation, the construction of the terms of the HMK Coverage Group, 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 HMK Coverage Group 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 HMK Coverage Group, 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 (EOC); Changes

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

Section III: Modification of Evidence of Coverage (EOC)

The Department may modify this ~~Evidence of Coverage~~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 Member covered under this ~~Evidence of Coverage~~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 ~~Evidence of Coverage~~EOC in strict accordance with its terms.

Section V: Notices Under Evidence of Coverage (EOC)

Any notice required by this ~~Evidence of Coverage~~EOC shall be in writing and may be given by United States mail, postage paid. Notice to the Member will be mailed to the address appearing on the records of the Claim Administrator. Notice to the medical and ~~mental~~Behavioral H~~h~~ealth Claim Administrator should be sent to Blue Cross and Blue Shield of Montana at the address listed on the back cover of this document. Notices to the Pharmacy, Dental, Vision, FQHC, and RHC Claim Administrator should be sent to ~~Xerox~~ Conduent at PO Box 8000, Helena MT 59604. Notices are effective on the date mailed.

Section VI: Benefits Not Transferable

No person, other than Members, are entitled to the Benefits identified under this ~~Evidence of Coverage~~EOC. This means that Members are not allowed to transfer or assign their coverage under the ~~Healthy Montana Kids~~HMK Coverage Group to another person.

Section VII: Validity of Evidence of Coverage (EOC)

If any part, term, or provision of this ~~Evidence of Coverage~~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 ~~Evidence of Coverage~~EOC did not contain the particular part, term, or provision held to be invalid.

Section VIII: Execution of Papers

Members agree to execute and deliver any documents requested by the Department which are Necessary to administer the terms of this ~~Evidence of Coverage~~EOC.

Section IX: Members' Rights

Members have no rights or privileges except as specifically provided in the ~~Evidence of Coverage~~EOC.

Section X: Alternate Care

The HMK Coverage Group may, at its sole discretion, make payment for medical, vision or Dental services which are not listed as a Benefit of this ~~Evidence of Coverage~~EOC. Such payments may be made only when it is determined by the Department that it is in the best interest of the HMK Coverage Group and/or Members to make payment for alternate care.

Section XI: Civil Rights Protection for Children

Children enrolled in the HMK Coverage Group have a right to:

1. Equal Access to Services without regard to race, color, national origin, disability, age, or sexual orientation;
2. A bilingual interpreter, where necessary for effective communication;
3. Auxiliary aids to accommodate a disability; and
4. File a Complaint if the Member believes they were treated in a discriminatory fashion.

If Members need additional information regarding these protections, please contact:

Office of Civil Rights
Departments of Health & Human Services
Federal Office Building, Room 1426
1961 Stout Street
Denver, CO 80294
Telephone: (303) 844-2024
FAX: (303) 844-2025
TDD: (303) 844-3439

Section XII: Statement of Representations

Any HMK Member 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 HMK Member 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 HMK Coverage Group 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 XIII: Recovery, Reimbursement, and Subrogation

By enrollment in the HMK Coverage Group, Members agree to the provisions of this section as a condition precedent to receiving Benefits under the HMK Coverage Group.

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

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

   By receipt of Benefits by Members under the HMK Coverage Group, Members authorize the recovery of amounts paid in error.

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

2. Reimbursement. The HMK Coverage Group's right to reimbursement is separate from and in addition to the HMK Coverage Group's right of subrogation. Reimbursement means to repay a party who has paid something on another's behalf, generally under Third Party Liability. If the HMK Coverage Group pays Benefits for medical expenses on Members' behalf, and another party was actually responsible or liable to pay those medical expenses, the HMK Coverage Group has the right to be reimbursed.

   Accordingly, if Members settle, are reimbursed, or recover money by or on behalf of Members, 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 HMK Coverage Group, Members agree to reimburse the HMK Coverage Group for the Benefits paid on behalf of Members. The HMK Coverage Group 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. Reimbursement to the HMK Coverage Group will be paid first, even if Members are not paid for all damage claims and regardless of whether the settlement, judgment or payment received is for or specifically designates the recovery, or a portion thereof, as including ~~health care~~healthcare, medical, disability, or other expenses or damages.

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

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

   b. If the HMK Coverage Group makes payments which Members, or any other party on Members' behalf, is or may be entitled to recover against any third party responsible for an Accident, injury,

condition or Illness, the HMK Coverage Group has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. Members or someone acting on behalf of Members will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the HMK Coverage Group's right of recovery.

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

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

e. Members will notify the Department of the name and address of any attorney engaged to pursue any personal injury claim on behalf of Members.

f. Members 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 HMK Coverage Group, the result of which may prejudice or interfere with the HMK Coverage Group's rights to recovery hereunder. Members will not conceal or attempt to conceal the fact that recovery occurred or will occur.

g. The HMK Coverage Group will not pay or be responsible, without its written consent, for any fees or costs associated with Members pursuing claims against any third party or coverage, including, but not limited to, attorney fees or costs of litigation.

h. Monies paid by the HMK Coverage Group will be repaid in first priority, notwithstanding any anti-subrogation, "made whole," "common fund," or similar statute, regulation, prior court decision, or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

Section XIV Relationship Between HMK Coverage Group and Professional Providers

~~Healthy Montana Kids~~HMK Participating Providers are Providers who contract with the Claim Administrator to provide medical care and health services to HMK Members. HMK Participating Providers furnishing care to Members 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 within the ~~Healthy Montana Kids~~HMK Network is solely the Members'.

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 Member providing or receiving services. Neither the HMK Coverage Group nor the Claim Administrator is liable for services or facilities which are not available to Members for any reason.

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

Section XV: When Members Move Out of State

If Members move from Montana, they will no longer be eligible for coverage under the ~~Healthy Montana Kids~~HMK Coverage Group. Members 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 Members have moved out of state and Members will be disenrolled from the HMK Coverage Group.

Section XVI: 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 ~~Healthy Montana Kids~~HMK Coverage Group, 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 XVII: Blue Cross and Blue Shield of Montana is an Independent Corporation

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

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

Section XVIII: ~~XEROX~~ Conduent is the Fiscal Agent for the Department

~~Xerox~~ Conduent is the Fiscal Agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.