



Evidence of Coverage

Effective October 1, 2013

Contents

ARTICLE ONE – DEFINITIONS	1
ACCIDENT	1
ADMISSION NOTIFICATION FOR EMERGENCY CARE AND MATERNITY CARE	1
ALLOWABLE FEE	1
ADVANCED MEMBER NOTIFICATION (AMN).....	1
AMBULANCE	1
BENEFITS	1
BENEFIT MANAGEMENT	2
BENEFIT PERIOD.....	2
BLUE CROSS AND BLUE SHIELD OF MONTANA (BCBSMT).....	2
CASE MANAGEMENT	2
CHEMICAL DEPENDENCY TREATMENT CENTER	2
CHILD/CHILDREN.....	2
CLAIM ADMINISTRATORS.....	2
COMPLAINT	2
CONTINUED STAY REVIEW.....	2
COPAYMENT	3
COVERED MEDICAL EXPENSE	3
COVERED PROVIDER	3
DENTAL.....	3
DEPARTMENT	3
DISENROLLMENT	3
EFFECTIVE DATE	3
EMERGENCY CARE.....	3
EMERGENCY MEDICAL CONDITION	3
EVIDENCE OF COVERAGE	3
EXCLUSION	4
EXTENDED MENTAL HEALTH BENEFITS.....	4
FAMILY	4
HEALTHY MONTANA KIDS (HMK)	4
HEALTHY MONTANA KIDS NETWORK	4
HEALTHY MONTANA KIDS PROVIDER (HMK PROVIDER)	4
HOSPITAL	4
IDENTIFICATION (ID) CARD	4
ILLNESS	5
INSTITUTE FOR MENTAL DISEASE (IMD)	5
INCLUSIVE SERVICES/PROCEDURES	5
INPATIENT	5
INPATIENT BENEFITS (FOR SUBSTANCE USE DISORDER OR MENTAL ILLNESS)	5
INTERPRETER SERVICES	5
INVESTIGATIONAL/EXPERIMENTAL SERVICE OR CLINICAL TRIAL.....	5
MAXIMUM FAMILY LIABILITY	6
MEDICAL POLICY.....	6
MEDICALLY NECESSARY	6
MEMBER OR ENROLLED CHILD	6
MENTAL HEALTH TREATMENT CENTER.....	6
MENTAL ILLNESS	7
MONTH.....	7
MULTIDISCIPLINARY TEAM.....	7
NURSE FIRST	7
OBSERVATION BEDS/ROOM.....	7
OCCUPATIONAL THERAPY	8
ORTHOTICS.....	8
OUTPATIENT	8
OUTPATIENT BENEFITS (FOR SUBSTANCE USE DISORDER OR MENTAL ILLNESS)	8
PARTIAL HOSPITALIZATION (FOR MENTAL ILLNESS)	8
PHARMACY	8

PHYSICAL THERAPY	8
PHYSICIAN	8
PLAN – THE PLAN.....	9
PLAN ADMINISTRATOR.....	9
PREADMISSION CERTIFICATION	9
PRIOR AUTHORIZATION	9
PROFESSIONAL CALL.....	9
PSYCHIATRIC RESIDENTIAL TREATMENT CENTER (PRTF)	9
RECOVERY CARE BED	9
REHABILITATION THERAPY	9
REHABILITATION UNIT.....	9
RETROSPECTIVE REVIEW	10
SEVERE EMOTIONAL DISTURBANCE (SED)	10
SEVERE MENTAL ILLNESS.....	10
SCHEDULE OF BENEFITS.....	10
SPEECH THERAPY	10
SUBSTANCE USE DISORDER	10
TREATMENT FACILITY	10
URGENT CARE.....	10
YOU – YOUR.....	11
XEROX	11
ARTICLE TWO – COVERED PROVIDER	11
ARTICLE THREE – HEALTHY MONTANA KIDS NETWORK	11
SECTION I: USE OF THE HEALTHY MONTANA KIDS NETWORK	11
SECTION II: PRIVATE PAY AGREEMENT OR ADVANCED MEMBER NOTIFICATION (AMN).....	12
SECTION III: EMERGENCY CARE AND URGENT CARE	12
SECTION IV: OUT-OF-STATE SERVICES	12
SECTION V: PROHIBITION ON PAYMENT OUTSIDE OF THE UNITED STATES	13
ARTICLE FOUR – BENEFIT MANAGEMENT.....	13
SECTION I: INPATIENT ADMISSIONS	13
SECTION II: PRIOR AUTHORIZATION.....	14
SECTION III: BENEFIT REDUCTIONS.....	15
SECTION IV: CASE MANAGEMENT	15
SECTION V: PRESCRIPTION DRUGS	16
SECTION VI: COPAYMENTS	20
ARTICLE FIVE – PROFESSIONAL PROVIDER SERVICES.....	22
SECTION I: SURGICAL SERVICES	22
SECTION II: ANESTHESIA SERVICES.....	23
SECTION III: MEDICAL SERVICES (NON-SURGICAL)	23
SECTION IV: MATERNITY SERVICES	24
SECTION V: NEWBORN CARE.....	24
SECTION VI: WELL-BABY/WELL-CHILD CARE	25
SECTION VII: VISION BENEFITS AND MEDICAL EYE CARE	25
SECTION VIII: DENTAL SERVICES.....	25
SECTION IX: DENTAL FLUORIDE	26
SECTION X: AUDIOLOGICAL BENEFITS.....	26
SECTION XI: OUTPATIENT THERAPIES	26
SECTION XII: RADIATION THERAPY SERVICE.....	26
SECTION XIII: CHEMOTHERAPY	26
SECTION XIV: DIABETIC EDUCATION	26
SECTION XV: DIAGNOSTIC SERVICES	27
SECTION XVI: SEVERE MENTAL ILLNESS.....	27
SECTION XVII: AMBULANCE SERVICES	27
SECTION XVIII: TRANSPORTATION AND PER DIEM.....	27
SECTION XIX: CHIROPRACTIC SERVICES: BENEFIT EFFECTIVE JANUARY 1, 2013.....	27
SECTION XX: DURABLE MEDICAL EQUIPMENT: BENEFIT EFFECTIVE JANUARY 1, 2013	27
SECTION XXI: HOME HEALTH SERVICES.....	28
SECTION XXII: HOSPICE SERVICES	28

SECTION XXIII: NUTRITION SERVICES	28
ARTICLE SIX – HOSPITAL AND OTHER SERVICES.....	28
SECTION I: INPATIENT HOSPITAL SERVICES.....	29
SECTION II: OBSERVATION BEDS/ROOMS	30
SECTION III: OUTPATIENT CARE	30
SECTION IV: OUTPATIENT THERAPIES	30
SECTION VI: FREESTANDING SURGICAL FACILITIES (SURGICENTERS)	30
SECTION VII: MAMMOGRAMS	30
SECTION VIII: POST-MASTECTOMY CARE	31
SECTION IX: SEVERE MENTAL ILLNESS	31
SECTION X: DENTAL TREATMENT	31
SECTION XI: OTHER SERVICES.....	31
ARTICLE SEVEN – SUBSTANCE USE DISORDER AND MENTAL ILLNESS	32
SECTION I: SUBSTANCE USE DISORDER	32
SECTION II: MENTAL ILLNESS	32
SECTION III: INSTITUTION FOR MENTAL DISEASES (IMD).....	32
ARTICLE EIGHT – REHABILITATION THERAPY	32
SECTION I: BENEFITS	33
SECTION II: EXCLUSIONS.....	33
ARTICLE NINE – GENERAL EXCLUSIONS AND LIMITATIONS.....	33
ARTICLE TEN – CLAIMS FOR BENEFITS	36
SECTION I: CLAIMS PROCESSING	36
SECTION II: PRIOR AUTHORIZATION.....	37
SECTION III: PAYMENT FOR PROFESSIONAL AND HOSPITAL SERVICES.....	37
SECTION IV: COMPLAINTS	38
SECTION V: APPEALS	38
SECTION VI: CONFIDENTIAL INFORMATION AND RECORDS.....	39
ARTICLE ELEVEN – BLUECARD® PROGRAM	40
ARTICLE TWELVE – EVIDENCE OF COVERAGE – GENERAL PROVISIONS	41
SECTION I: PLAN ADMINISTRATOR POWERS AND DUTIES	41
SECTION II: ENTIRE EVIDENCE OF COVERAGE; CHANGES.....	42
SECTION III: MODIFICATION OF EVIDENCE OF COVERAGE	42
SECTION IV: CLERICAL ERRORS	42
SECTION V: NOTICES UNDER EVIDENCE OF COVERAGE	42
SECTION VI: BENEFITS NOT TRANSFERABLE	42
SECTION VII: VALIDITY OF EVIDENCE OF COVERAGE	42
SECTION VIII: EXECUTION OF PAPERS.....	43
SECTION IX: MEMBERS’ RIGHTS.....	43
SECTION X: ALTERNATE CARE	43
SECTION XI: BENEFIT MAXIMUMS	43
SECTION XII: CIVIL RIGHTS PROTECTION FOR CHILDREN.....	43
SECTION XIII: STATEMENT OF REPRESENTATIONS.....	43
SECTION XIV: RECOVERY, REIMBURSEMENT, AND SUBROGATION	44
SECTION XV RELATIONSHIP BETWEEN HMK PROGRAM AND PROFESSIONAL PROVIDERS...	46
SECTION XVI: WHEN YOU MOVE OUT OF STATE	46
SECTION XVII: AUTHORITY OF THE PLAN ADMINISTRATOR	46
SECTION XVIII: BLUE CROSS AND BLUE SHIELD OF MONTANA IS AN INDEPENDENT CORPORATION.....	46
SECTION XIX: XEROX IS THE FISCAL AGENT FOR THE DEPARTMENT.....	47

The Plan agrees to make payment for the medical, mental 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 Program Application for eligibility must be true and correct.
2. Payments by the Plan 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 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
- Concussion

ADMISSION NOTIFICATION FOR EMERGENCY CARE AND MATERNITY CARE

Notification to the Claim Administrator by the Member, or Family Member, 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 to be an appropriate fee for a specific service, whichever is less.

ADVANCED MEMBER NOTIFICATION (AMN)

Refers to the process in which the Provider informs a Member that a service, supply, device, or drug is not likely to be a covered Benefit prior to the service being performed.

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.

BENEFITS

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

BENEFIT MANAGEMENT

A program designed to involve You, Your health care providers, and the Claim Administrator's (Blue Cross and Blue Shield of Montana and Xerox) professional staff in assisting You with the management of Your health care benefits while maintaining the quality of care. Please see Article Four entitled "Benefit Management" for a complete description of the program.

BENEFIT PERIOD

The Benefit Period is October 1 through September 30. If Your Effective Date is after October 1, Your Benefit Period begins with Your Effective Date and ends September 30.

BLUE CROSS AND BLUE SHIELD OF MONTANA (BCBSMT)

A non-profit health service corporation, organized and existing under the laws of the State of Montana.

CASE MANAGEMENT

A program designed to help You manage health care Benefits and costs. The Member and Physician consider alternative treatment options with input from the Plan's professional staff. Please see Article ~~Five~~ Four entitled "Benefit Management" for a complete description of the program.

CHEMICAL DEPENDENCY TREATMENT CENTER

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

CHILD/CHILDREN

For purposes of coverage under the HMK Program an individual is considered to be a child, potentially eligible for coverage through the month of the child's 19th birthday.

CLAIM ADMINISTRATORS

Claim Administrator means the person(s) or firm(s) employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. At the time of entering into this Evidence of Coverage, the Claim Administrator for medical and mental health claims is Blue Cross and Blue Shield of Montana (BCBSMT) and the Claim Administrator for pharmacy, Federal Qualified Health Centers, Rural Health Centers, Community Based Psychiatric Rehabilitation and Support services, and dental claims is Xerox. The Claim Administrators provides administrative duties only, exercises no discretion over Plan assets, and will not be considered a fiduciary under any state or federal law or regulation.

COMPLAINT

A verbal or written communication which a Member or his or her authorized representative presents regarding what the Member or his or her authorized representative perceives to be an inappropriate or lack of appropriate action by the Claim Administrator or its agents or providers.

CONTINUED STAY REVIEW

The Claim Administrator'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. The services and applicable Copayments are listed in the Schedule of Benefits.

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 You by and/or ordered by a Covered Provider for the diagnosis or treatment of active illness or injury or in providing maternity care.

COVERED PROVIDER

Medical and Mental Health

A provider in the Healthy Montana Kids Network who will provide medical, dental, and health services covered under this Evidence of Coverage. (See also: Healthy Montana Kids Provider)

Pharmacy

A provider who is enrolled as a Montana Health Care 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>)

DENTAL

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

DEPARTMENT

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

DISENROLLMENT

The process of ending your membership in the Plan. Discontinuance of the Member's participation in the Healthy Montana Kids Program by a determination of ineligibility made by HMK or voluntary withdrawal by the Member.

EFFECTIVE DATE

The Effective Date of a Member's coverage means the date the Member is shown on the records of the Plan to be eligible for Benefits.

EMERGENCY CARE

Health care items and services furnished or required to evaluate and treat an emergency medical condition.

EMERGENCY MEDICAL CONDITION

An emergency medical condition for purposes of the HMK Evidence of Coverage shall be specifically defined as a condition manifesting itself by symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably be 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

This document, and any other attachments, which explains your coverage, rights and responsibilities as a Member of the Plan and the HMK Program obligations.

EXCLUSION

A provision which states that the Plan has no obligation under this Evidence of Coverage to provide any payment for services that have been received by a Member.

EXTENDED MENTAL HEALTH BENEFITS

Benefits provided to a Healthy Montana Kids Member whom the Plan Administrator determines 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.

HEALTHY MONTANA KIDS (HMK)

The Healthy Montana Kids Program administered by the Department under Title XXI of the Social Security Act.

HEALTHY MONTANA KIDS NETWORK

A provider or group of providers who have contracted with Blue Cross and Blue Shield of Montana (BCBSMT) to provide medical and mental health services to Members covered under HMK.

HEALTHY MONTANA KIDS PROVIDER (HMK PROVIDER)**Medical and Mental Health**

A provider in the Healthy Montana Kids Network who will provide medical and health services covered under this Evidence of Coverage. (See also: Covered Provider)

Pharmacy

A provider who is enrolled as a Montana Health Care Programs Provider and who will provide prescription drug services covered under this Evidence of Coverage.

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;
- 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 Member that identifies that Member as eligible for the Healthy Montana Kids Program.

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

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 Covered 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 Inpatient Facility, or Physician; and
- While You are a Hospital Inpatient; or
- While You 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 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 Plan 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; 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, You 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 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

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

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

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

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

MEMBER OR ENROLLED CHILD

A child who has been certified and notified by the Department as eligible for HMK, and whose name appears on the Plan enrollment information which the Department or Department's agent will transmit to the Plan every business day (excluding holidays) in accordance with an established notification schedule.

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);
- Severe Mental Illness.

MONTH

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

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

Any Provider who is not under contract with the Claim Administrator to provide HMK Benefits. Non-participating providers are not included in the Healthy Montana Kids Network. Services received from a non-participating provider:

- may not be covered;
- may be covered by HMK but the provider may refuse payment from HMK;
- may be subject to Prior Authorization; or
- may not be paid by HMK.

Pharmacy (non-covered or non-participating)

Any Provider who is not enrolled as a Montana Health Care 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 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.

ORTHOTICS

Orthotic appliances and related items are covered under the Durable Medical Equipment benefit (effective January 1, 2013). Prior authorization requirements may apply.

OUTPATIENT

Services or supplies provided to You by a Covered Provider while You are not an Inpatient.

OUTPATIENT BENEFITS (for Substance use disorder or Mental Illness)

The payment for services Medically Necessary for care and treatment of Chemical Dependency or Mental Illness provided by:

- A Hospital, if You are not confined as a Hospital Inpatient;
- A Physician, if You are not confined as a Hospital Inpatient;
- A Mental Health Treatment Center;
- A Chemical Dependency Treatment Center if You 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.

PHARMACY

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

PHYSICAL THERAPY

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

PHYSICIAN

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

PLAN – THE PLAN

The publically funded health coverage for Montana children, identified as Healthy Montana Kids which is administered by the State of Montana, Department of Public Health and Human Services through the Healthy Montana Kids Program.

PLAN ADMINISTRATOR

State of 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 Plan'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 your paying out of pocket for the services provided.** Some services are covered only if your doctor or other plan provider get "prior authorization" from BCBSMT for medical and mental health claims or from the Drug Prior Authorization Unit for pharmacy claims. This process is used to inform You 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.

PROFESSIONAL CALL

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

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

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.

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 EMOTIONAL DISTURBANCE (SED)

SED means with respect to a youth from the age of six through 17 years of age that the youth meets the requirements of ARM 37.87.303.

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.

SUBSTANCE USE DISORDER

Alcoholism, drug addiction, or substance abuse.

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 Chemical Dependency Treatment Center that is approved by the Montana Department of Public Health and Human Services under MCA § 53-24-208.

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

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).
 - 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.

YOU – YOUR

An enrolled Member or a Family member under this Evidence of Coverage. For purposes of this Evidence of Coverage this term may be inclusive of the parent, guardian, or caretaker who is responsible for decisions and notification for the Member.

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.*

ARTICLE TWO – COVERED PROVIDER

This Evidence of Coverage allows benefits for Covered Medical Expenses which are provided by a Covered Provider. A Covered 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 Provider for medical or mental health services or is enrolled as a Montana Health Care Programs Provider for pharmacy services for benefits described in this Evidence of Coverage. Some providers may be “covered” only for certain specific services because of a limited scope of practice. To determine if a provider is “covered,” the Plan looks to the nature of the services rendered, the extent of licensure, and the Plan's recognition of the provider.

You may obtain a list of Healthy Montana Kids Providers for medical and mental health services from BCBSMT upon request or download it from the BCBSMT website at www.BCBSMT.com.

You may obtain a list of enrolled Montana Healthcare Providers for pharmacy services through a search on the Montana Healthcare Provider website at <https://mtaccesstohealth.acshc.com/mt/general/providerLocator.do>.

ARTICLE THREE – HEALTHY MONTANA KIDS NETWORK

You are encouraged to choose a primary care provider from the list of Healthy Montana Kids Providers. A primary care provider will be better able to know You and Your medical history, determine Your health care needs, and help You use the Medically Necessary Benefits available under the Plan.

Section I: Use of the Healthy Montana Kids Network

You are encouraged to have Your care directed by the primary care provider You select. Generally, You need to make an appointment with Your Healthy Montana Kids Provider. Your primary care provider will provide Your health care, or if Your primary care provider determines it is Medically Necessary to do so, may refer you to another care provider or recommend a specialist in the HMK Network. They will also help You arrange or coordinate Medically Necessary hospitalization.

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

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

Covered medical and mental health Benefits are only available if You use the Healthy Montana Kids Network, except:

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

Covered pharmacy services must be obtained through an enrolled Montana Health Care Programs Provider.

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

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

The Claim Administrator will review claims to determine if the services were Medically Necessary. HMK does not pay for services that are determined to not be Medically Necessary. When a service is denied as not Medically Necessary, a Participating Provider 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 or services not covered by HMK, a provider may bill a Member only when the provider and the Member have agreed in writing prior to the services being provided. The Member must agree to pay for specific services on a specific date and must understand the services will not be covered by HMK.

Section III: Emergency Care and Urgent Care

Emergency Care

If You need Emergency Care, go to the nearest doctor or hospital. You may need Emergency Care if Your condition is severe, if You have severe pain, or if You need immediate medical attention to prevent any of the following:

- Serious jeopardy of Your health
- Serious damage to Your bodily functions
- Serious damage to a bodily organ or part

You should notify Your primary care provider as soon as possible that You have received Emergency Care and plan to receive follow-up care from Your primary care provider..

Urgent Care

Some situations require prompt medical attention although they are not emergencies. In these situations, it is recommended that You call Your primary care provider and describe the situation. He or she will then direct Your care.

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

Before receiving emergency care or urgent, 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

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

Medically Necessary Services for a child receiving care from a Healthy Montana Kids 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 Care 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 the Benefit Management program, defined above, are to:

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

Section I: 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 Preadmission Certification process, the Continued Stay Review process, or through Retrospective Review upon receipt of the claims for the Inpatient stay. Use the Benefit Management program for Your Inpatient admissions to avoid unexpected out-of-pocket expenses, benefit reductions, or claim denials.

1. Preadmission Certification

When You have a scheduled Inpatient admission, contact the Claim Administrator at the number listed on the first page (i) of Your Member Handbook. You may also have the Hospital or provider make the contact. The Claim Administrator will review the Inpatient admission to certify:

- a. The service is Medically Necessary.
- b. The length of stay and level of care are appropriate.
- 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. You will receive, in writing, an approval for the appropriate length of stay or a denial of the admission. You will be covered for days and services that have been certified under the Plan. If the admission is determined by the Claim Administrator to not be appropriate, the Member will be notified by mail.

2. Admission Notification for Emergency Care Unscheduled Inpatient Admission

In the event of an unscheduled Inpatient admission, the Claim Administrator requires Admission Notification 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 Notification will alert the Claim Administrator's professional staff of opportunities to work with You and Your health care 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, in consultation with Your health care 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 a letter to You 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 II: Prior Authorization

Use the Prior Authorization process to avoid unexpected out-of-pocket expenses, benefit reductions, or claim denials. Your health care provider is responsible for obtaining Prior Authorization for referrals to other providers or to specialists. Coverage for certain services, supplies, or treatment will be determined through the Prior Authorization process. Prior Authorization **is required** for:

- Physical therapy
- Speech therapy
- Occupational therapy
- Maxillofacial and oral surgery, and
- Cardiac rehabilitation therapy
- Services provided by Non-Participating Providers
- Referrals to non-covered or out-of-network providers by the primary care provider
- Durable medical equipment in excess of \$500 (benefit available effective January 1, 2013)
- Home health services
- Hospice services
- Travel and per diem reimbursement
- Cochlear implants and associated components
- Certain prescription drugs (Check with your provider)

Your provider must obtain Prior Authorization for Services for which Prior Authorization is required, You will be responsible for paying the charges for any non-covered services if you have signed a specific Private Pay Agreement before receiving the services.

The Prior Authorization process may require additional documentation from Your health care provider for some services. In these cases, a written request must be submitted to the Claim Administrator by Your health care provider 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 and mental health services, contact the Claim Administrator at the number listed on the first page (i) of Your Member Handbook or on Your ID card. For pharmacy claims your prescriber or dispensing pharmacy will call the Drug Prior Authorization Unit.

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 Plan. If You do not obtain Prior Authorization, a Retrospective Review of medical and mental health 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 other services, Prior Authorization is highly recommended in order to avoid paying out-of-pocket expenses. Examples of services for which Prior Authorization is recommended include, but are not limited to:

- Pulmonary therapy; and
- Hearing aids

Section III: Benefit Reductions

1. Inpatient Care:

Your provider will need to obtain Preadmission Certification and receive Admission Notification prior to an Inpatient stay. 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 You do not obtain Preadmission Certification and Admission Notification prior to an Inpatient stay, a post admission review may be completed. If upon review, a determination is made that the services were not Medically Necessary or appropriate, You may be responsible for paying the room and board charges associated with any uncertified days if You signed a private pay agreement for the specific inpatient stay.

Section IV: Case Management

Case Management is a program conducted by a case manager who:

1. Identifies cases involving a Member's medical condition that present either the potential for catastrophic claims or atypical use of services.
2. Evaluates for the appropriateness of the level of patient care and the setting in which it is received.
3. Develops and recommends viable alternate treatment plans for such cases in order to assist, maintain or enhance the quality of treatment.
4. Provides cost controls through implementation of the agreed-upon treatment plan.

A written treatment plan may be developed by the case manager in conjunction with the Member, 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. HMK Plan Administrator 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. Services provided outside the alternate treatment plan will not be paid.

Section V: Prescription Drugs

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).

Prescription drugs purchased at a nonparticipating pharmacy are not a benefit of this Evidence of Coverage. You will be responsible for payment of drugs purchased at a non-participating pharmacy.

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 Care 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 Plan Administrator will allow payment without restriction.

PRESCRIPTION ORDER OR REFILL

The directive to dispense a Legend or Prescription Drug issued by a duly licensed health care 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 Plan.

TERMINATED DRUG PRODUCT

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

BENEFITS

The Plan 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
 - Ketotifen ophthalmic solution
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 Plan at the time of purchase. Prior Authorization procedures require the Member's physician to provide documentation to the Plan 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 Plan may delegate the Prior Authorization function, but it retains the final discretionary authority regarding coverage under the Plan.

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 (prazosin)	Folic acid preparations	Thyroid hormones (levothyroxine)
Antiarrhythmics (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 to receive approval.

Section VI: Copayments

GENERAL

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 Liability \$215 per benefit year

PRIOR AUTHORIZATION

Certain services require Prior Authorization. Please read Article ~~Five~~ Four of this Evidence of Coverage entitled “Benefit Management” 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
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HOSPITAL AND OTHER SERVICES

Inpatient

Semi Private Room and Board Charges, Per Admission	\$25 Copayment
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All Inpatient admissions require Preadmission Certification in for full benefits to be paid. Please read Article Four of this Evidence of Coverage 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 Copayment per incident

Inpatient Hospital and Facility Benefits will apply if the Emergency Room visit results in an Inpatient stay. If You are admitted for an Inpatient stay, the Emergency Room Copayment will be waived.

SUBSTANCE USE DISORDER AND MENTAL ILLNESS

All Inpatient admissions require Preadmission 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.....	\$25 Copayment
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DRUG CARD PROGRAM

Pharmacy Benefit

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

OTHER

Laboratory (in the Doctor’s Office)	\$0 Copayment
Visits at Federally Qualified Health Centers (FQHC) or Rural Health Centers (RHC).....	\$0 Copayment
Well Child	\$0 Copayment
Well Baby	\$0 Copayment
Immunizations	\$0 Copayment

ARTICLE FIVE – PROFESSIONAL PROVIDER SERVICES

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

The Plan will make payment for certain professional Provider services based on the Allowable Fee for Medically Necessary Covered Medical Expenses provided by a Covered Provider during the Benefit Period and while this Evidence of Coverage is in force. (Please read Article ~~Three~~ Two entitled “Covered Provider.”) Payment by the Plan will be subject to the Copayments shown in the attached Schedule of Benefits.

Section I: Surgical Services

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

Section II: Anesthesia Services

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.

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.

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

Benefit coverage is not provided under this Plan for:

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.
4. Anesthesia for dental services or extraction of teeth, except as included in the Dental Treatment section of the "Hospital and Other Services" portion of this Evidence of Coverage.

Section III: Medical Services (Non-Surgical)

Medical services are those non-surgical covered services provided by a Covered Provider during office, home, or Hospital visits which do not include surgical or maternity services. Medical services include the following:

1. Inpatient medical services – Inpatient medical services are covered for eligible Hospital admissions.
2. Medical care visits, limited to one visit per day per Covered Provider.
3. Intensive medical care rendered to a Member 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;
- 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. Discussion with the attending Physician
 - b. A written report by the consultant based on an examination of the Member.

Benefit coverage will not be provided under this Plan for:

- a. Staff consultations required by Hospital rules
 - b. Family consultations.
6. Outpatient medical services, including physical examinations and immunizations, will be provided for home, office and outpatient hospital professional calls.

Section IV: Maternity Services

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 health care provider and the mother.

Section V: Newborn Care

Newborn of **Covered Member**:

Benefits are provided for the newborn baby of a Covered Member. The services must be provided by a Covered Provider and can include:

1. The initial care of a newborn at birth provided by a Covered Provider
2. Standby care provided by a pediatrician during a Cesarean section
3. Regular covered services for 31 days following the birth.
 - a. The newborn services will be provided under the Covered 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 for the newborn is subject to meeting eligibility requirements as determined by the Plan Administrator.

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 Covered Provider and the family has provided information listed below to HMK:

1. The initial care of a newborn eligible family member will begin on the date of birth **IF** notification is received by HMK 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 VI: Well-Baby/Well-Child Care

Well-baby/well-child care Benefits, for eligible and enrolled HMK Children and newborn children of HMK members from the moment of birth through their first 31 days from birth, include:

1. A well-baby/well-child examination by a Covered 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 VII: Vision Benefits and Medical Eye Care

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 Plan but are not administered by BCBSMT.
 - a. Eyeglasses are available through the Plan Administrator.
 - b. HMK will pay for one pair of glasses within a 365-day period.
 - c. Contact lenses are not covered.
 - d. For more information about eyeglasses call HMK at 877-543-7669 or email hmk@mt.gov

Section VIII: Dental Services

HMK Dental benefits are administered by the HMK Dental and Vision Program.

- a. A child may receive up to \$1,412 in reimbursable dental services per Benefit Year (October 1 through September 30)
- b. Implant services are covered with prior approval, up to a lifetime limit of \$1,500 per person.
- c. Dentists may charge families for services over \$1,412 per Member per Benefit Year. Families can make payment arrangements with dentists.
- d. For more information about Dental services call HMK at 877-543-7669 or email hmk@mt.gov.

Coverage is available for dental anesthesia in the hospital for children age 5 and under.

The Plan may pay for Medically Necessary services provided by Dentists and oral surgeons for the initial repair or replacement of sound natural teeth damaged as a result of an Accident and You continue to be covered by the Plan. Prior Authorization is required for these services.

Dental implants are a Benefit subject to the following conditions:

- a. The Benefits are administered through the Claim Administrator.
- b. Prior Authorization is required.
- c. This Benefit is limited to a lifetime maximum of \$1,500. The \$1,500 lifetime maximum for dental implants is included, not in addition to the annual maximums for the HMK Basic Dental and Extended Dental Programs.

Orthodontics, dentofacial orthopedics, or related appliances **are not** covered. Please see Article Six, Section X: Dental Treatment for additional information.

Section IX: Dental Fluoride

Dental varnish fluoride applications are covered when provided by a physician or other Covered Provider. Prescribed oral fluoride preparations are a covered pharmacy benefit.

Section X: Audiological Benefits

1. Hearing exams, including newborn hearing screens in a hospital or outpatient setting, are covered. Coverage includes assessment and diagnosis.
3. Hearing aids, hearing aid supplies, including batteries, and hearing aid repairs are covered.
 - a. Hearing aids must be provided by an HMK Provider.
 - b. HMK will pay for a single or one set of hearing aids within a 5-year period.
3. Prior Authorization is required for hearing aids. The HMK Provider must request Prior Authorization for hearing aids.
 - a. The HMK Provider must contact HMK Customer Service at 1-855-258-3489 to receive the HMK Hearing Aid Prior Authorization form.
 - b. The HMK Member must be enrolled on the date of the Prior Authorization request and on the date of service, including the date the hearing aid is provided to the HMK Member.
4. Cochlear implants and associated components are covered.
 - a. Prior authorization is required for cochlear implants and associated components.
 - b. The HMK Member must be enrolled on the date of the Prior Authorization request and on the date of service.

Section XI: Outpatient Therapies

The Plan will pay the Allowable Fee for the Medically Necessary services of a physical therapist, speech therapist, occupational therapist, and a cardiac rehabilitation therapist. Such services are subject to medical review and Prior Authorization.

Section XII: Radiation Therapy Service

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

Section XIII: 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 XIV: Diabetic Education

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

Please see Article Seven, Section XI: Other Services - for important information regarding diabetic equipment and supplies covered by HMK.

Section XV: Diagnostic Services

1. Diagnostic x-ray examinations.
2. Laboratory and tissue diagnostic examinations.

Section XVI: Severe Mental Illness

The Plan will pay the Allowable Fee for Medically Necessary services provided by a licensed physician, licensed advanced practice registered nurse with prescriptive authority and specializing in mental 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.

Please see Article Seven, *Substance Use Disorder and Mental Illness* for important information regarding mental illness Benefits.

Section XVII: Ambulance Services

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.

Section XVIII: Transportation and Per Diem

The Plan will provide financial assistance towards expenses for HMK Member transport, meals and lodging while enroute to medically necessary medical care. It is important to have Your Covered Provider submit a request 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. Your Covered Provider must sign and submit a Prior Authorization form to the Claim Administrator before You travel to receive medical care.
2. The Member 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 a responsible adult to accompany a minor for whom the responsible adult is necessary to provide legal consent for medical procedures.

Section XIX: Chiropractic Services: Benefit effective January 1, 2013

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

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

Section XX: Durable Medical Equipment: Benefit effective January 1, 2013

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

1. Equipment or supplies that are useful or convenient, but are not medically necessary, do not qualify.

2. Prior Authorization is required for durable medical equipment and supplies that cost more than \$500.

Section XXI: Home Health Services

The Plan will pay for home health services provided by a licensed home health agency to a Member considered homebound in the Member's 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 ambulance services will not be allowed through the home health agency.
3. The ordering provider must submit Prior Authorization to the Claim Administrator prior to providing services.

Section XXII: Hospice Services

The Plan 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 XXIII: Nutrition Services

The Plan will cover nutrition counseling directly with Members or with the Member's parent or guardian for treatment of diabetes and obesity.

ARTICLE SIX – HOSPITAL AND OTHER SERVICES

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

The Plan will make payment for Hospital and other services under this Article based on the Allowable Fee for Medically Necessary Covered Medical Expenses provided by a Covered Provider during the Benefit Period and **while this Evidence of Coverage is in force**. (Please read Article ~~Three~~ Two entitled "Covered Provider") Payment by the Plan will be subject to the Copayment shown in the attached Schedule of Benefits.

Section I: Inpatient Hospital Services

1. The number of allowable Inpatient days of care shall be determined by the Claim Administrator in accordance with the Medical Policy.
 - 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 Plan 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
 - 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
 2. Concentrated nursing services provided by nurses who are Hospital employees

NOTE: The Member will be responsible to the Hospital for payment of its charges if the Member remains as an Inpatient when Inpatient care is not Medically Necessary and if the Member's representative has 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 Hospital Service
 - 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
 - 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 prescription.
4. Nursery Care
 - 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 HMK 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. (Please see Article Five, Section V: Newborn Care – Care of newborn of non-covered family member for important notification requirements.)

Section II: Observation Beds/Rooms

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

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

Section III: Outpatient Care

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

When ordered by a Covered Provider, the following Outpatient Therapy services are covered:

1. Physical Therapy
2. Speech Therapy
3. Cardiac Rehabilitation Therapy
4. Occupational Therapy

These services must be Medically Necessary and Prior Authorization **is required**. Payment by the Plan will be subject to the Copayments shown in the attached Schedule of Benefits.

Section V: Outpatient Diagnostic Services

When ordered by a Covered Provider, the following Outpatient diagnostic services are provided:

1. Diagnostic x-ray examinations
2. Laboratory and tissue diagnostic examinations
3. Medical diagnostic procedures

Section VI: Freestanding Surgical Facilities (Surgicenters)

Medically Necessary services of a surgicenter 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;
3. The surgical procedure performed is:
 - a. Recognized as a procedure which can be safely and effectively performed in an Outpatient setting;
 - b. One which cannot be appropriately performed in a doctor's office.

Section VII: Mammograms

The Plan will pay the HMK allowable charge for routine mammograms.

Section VIII: Post-mastectomy Care

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

Section IX: Severe Mental Illness

Payment will be based on the Allowable Fee for Medically Necessary services provided for the treatment of Severe Mental Illness. Benefits for Severe Mental Illness will be paid as any other Illness and are subject to the provisions outlined in Article Four entitled "Benefit Management."

Section X: Dental Treatment

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. Coverage is available for dental anesthesia in the hospital for children age 5 and under. Other conditions are subject to medical review and Prior Authorization. Craniofacial anomalies are not a direct service of the HMK Program and are referred to the Department's Children's Special Health Services Program.

Section XI: Other Services

1. Blood transfusions, including cost of blood, blood plasma, blood plasma expanders, and packed cells. Storage charges for blood are covered when You have blood drawn and stored for Your own use for a planned surgery.
2. 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.
3. Supplies used outside of a hospital are covered ONLY if the supplies are prescribed by a Covered Provider and Medically Necessary to treat a condition that is covered by Healthy Montana Kids.
4. Diabetic equipment and supplies. The following equipment and supplies are covered: 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, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States Food and Drug Administration, and glucagon emergency kits. (Please also see Article Five, Section XIV regarding Diabetic Education and Section XXIII Nutrition Services.)

ARTICLE SEVEN – SUBSTANCE USE DISORDER AND MENTAL ILLNESS

Payment by the Plan for Substance Use Disorder and Mental Illness services of Covered 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 Covered Provider. (Please read Article Three entitled “Covered Providers.”)

Section I: Substance Use Disorder

Inpatient and Outpatient Benefits:

1. Inpatient and Outpatient treatment for alcoholism and drug addiction are covered benefits.
2. These services must be medically necessary and provided by a Covered Provider. (Please read Article Three entitled “Covered Providers.”)

Section II: Mental Illness

1. *Basic Plan Inpatient Benefits:*
The Plan will cover Inpatient Mental Health Benefits for services furnished in a Hospital, a psychiatric residential treatment facility or Therapeutic group home, if provided by a Covered Provider. Inpatient admission to a 24-hour therapeutically structured service location must follow pre-certification requirements found in this Evidence of Coverage.
2. *Basic Plan Outpatient Benefits:*
Outpatient mental health services may be furnished in a variety of community based settings or in a mental health hospital. Basic Outpatient mental health benefits include individual, family and/or group psychotherapy office visits.
3. *Extended Mental Health Benefits for Children with a Serious Emotional Disturbance (SED):*
Extended Mental Health Benefits are in addition to the “Basic Plan” Outpatient benefits and must be applied for by a Covered mental health Provider.

Additional mental health services are available for children who are determined by the Plan to have a SED. These benefits include community-based services, not covered under the “Basic Plan” for Outpatient mental health services. Other services include: therapeutic family care (moderate level); day treatment; community based psychiatric rehabilitation and support (CBPRS), and respite care.

Section III: Institution for Mental Diseases (IMD)

Specific limitations apply to HMK 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 HMK prior to becoming patients in an IMD will be covered.

ARTICLE EIGHT – REHABILITATION THERAPY

Payment by the Plan for rehabilitation therapy 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 Covered Provider. (Please read Article Two entitled “Covered Providers.”)

Section I: Benefits

Outpatient and Inpatient Rehabilitation Therapy Benefits are described below.

1. Therapy service provided to You 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.

NOTE: Payment by the Plan will be subject to the Copayments shown in the attached Schedule of Benefits.

Section II: Exclusions

1. Rehabilitation 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.

ARTICLE NINE – GENERAL EXCLUSIONS AND LIMITATIONS

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

1. Any service or supply which is:
 - a. Not Medically Necessary to treat active Illness or injury;
 - b. Not an accepted medical practice. (The Plan may consult with the Physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice);
 - c. An Investigational/Experimental Service or Clinical Trial
2. Worker's Compensation: All services and supplies which would be provided to treat Illness or injury arising out of employment when Your employer is required by law to obtain coverage or has 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. Your employer has failed to obtain such coverage as required by law.
 - c. The Member has waived his or her rights to such coverage or benefits.
 - d. The Member fails to file a claim within the filing period allowed by law for such benefits.
 - e. The Member fails to comply with any other provision of the law to obtain such coverage or benefits.
 - f. The Member has elected to not be covered by the Workers' Compensation Act but failed to properly make such election effective.

This exclusion will not apply if You are permitted by statute to not be covered and You 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 Your employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws or employer's liability acts of any state, country, or the United States.

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 You from the Plan. An example of this would be vaccines administered to HMK Members by a county health provider. When such a circumstance occurs, You 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 HMK to treat the Member 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 the Member receives, 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 HMK to treat the Member 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 a Member incarcerated in a criminal justice institution. The Member is excluded from coverage only if he/she meets 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 the Member of a criminal act, or attempt by the Member to commit a felony, or being engaged in an illegal occupation.
10. Treatment for Temporomandibular Joint Dysfunction (TMJ).
11. Services and supplies related to ridge augmentation, implantology, or vestibuloplasty.
12. Dental Services except as specifically included in this Evidence of Coverage.
13. Visual augmentation services including:
 - a. Contact lenses.
 - b. Radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism)

See Article Five, Section VII: Vision Benefits and Medical Eye Care for important information on vision benefits, including eye glasses, provided by HMK.

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.
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 a Member is not legally required to pay or charges that are made only because Benefits are available under this Evidence of Coverage.
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;
 - d. Cutting or trimming of nails.
24. Services provided You before Your Effective Date of coverage or after Your coverage terminates
25. Services and supplies related to sexual inadequacies or dysfunctions or sexual transformation 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, except as specifically included in this Evidence of Coverage
 - e. Homeopathy
 - f. Hypnosis
 - g. Hypnotherapy
 - h. Rolfing
 - i. Holistic medicine
 - j. Marriage counseling
 - k. Religious counseling
 - l. Self-help programs
 - 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 You with daily living tasks. Examples of such care would include, but are not limited to:
 - a. Walking
 - b. Getting in and out of bed
 - c. Bathing
 - d. Dressing
 - e. Feeding
 - f. Using the toilet
 - g. Preparing special diets
 - h. Supervision of medication which:
 1. Is usually self-administered; and
 2. Does not require the continuous attention of medical personnel
29. No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, rest home, nursing home, rehabilitation facility, convalescent home or extended care facility for the types of care outlined in this exclusion.
30. Supplements
31. Food supplements (except for those for inborn errors of metabolism)
32. All invasive medical procedures undertaken for the purpose of weight reduction such as gastric bypass, gastric banding or bariatric surgery (including all revisions)
33. Charges associated with health or weight loss clubs, or clinics
34. Benefits shall not be paid for services or items provided by an entity, institute, or provider located outside of the United States.
35. Education or tutoring services, except as specifically included as a Benefit of this Evidence of Coverage.
36. Any services or supplies not provided by a Covered Provider or that were provided by a Non Covered Provider following referral from a Covered Provider, but for which Prior Authorization was not obtained before the services were received.
37. Services and supplies primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature
38. Any services and supplies which are not listed as a Benefit of this Evidence of Coverage

ARTICLE TEN – CLAIMS FOR BENEFITS

Section I: Claims Processing

Medical and Mental Health

In order to have your benefit claims processed through HMK, your Covered Provider must submit all claims for services no later than 12 months after the date on which You 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. The Healthy Montana Kids Provider must submit all non-pharmacy claims to the address listed on the back of members' ID cards. Federally Qualified Health Centers, Rural Health Centers, Community Based Psychiatric Rehabilitation and Support facilities, and dentists must submit claims to Xerox, PO Box 8000, Helena MT 59604.

Pharmacy

For pharmacy claims processing information please see the manual found at the following website: <http://medicaidprovider.hhs.mt.gov/pdf/manuals/pharmacy.pdf>.

In addition, please refer to the NCPDP Payer Sheet located under Provider Notices on the following website: <http://medicaidprovider.hhs.mt.gov/providerpages/providertype/19.shtml>.

Section II: Prior Authorization

Medical and Mental Health Claims

Prior Authorization is required in order to receive some Benefits provided under this Evidence of Coverage. 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 Claim Administrator in writing by the 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 Claim Administrator at the address listed on the back cover of this document. The HMK Member's name, address, and member number must be included.

The 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. In no event shall a coverage determination be made more than 14 days following receipt of all documents. A copy of the Claim Administrator's written approval of available Benefits must be attached to all related claims at the time of submittal.

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 under this Evidence of Coverage if the Member's representative signs a private pay agreement specific to that service and date.

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.hhs.mt.gov/pdf/manuals/pharmacy.pdf>.

Section III: Payment for Professional and Hospital Services

1. Payment for services You receive from a Healthy Montana Kids Provider 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. You, even if the payment is requested for reimbursement for services You paid directly to a provider or hospital. Reimbursement may be made to you for transportation services according to the provision of this Evidence of Coverage.
 - b. You and the Provider jointly
 - c. Any person, firm, or corporation who paid for the services on Your behalf

3. Non-Participating Providers may refuse payment for a covered service under the Plan. In the event a Non-Participating Provider does refuse to accept payment for a covered service under the Plan, the expenses will be the responsibility of the Member if the Member's representative signs a private pay agreement specific to that service and date..
4. Benefits payable under this Evidence of Coverage are not assignable by the Member to any third party.

Section IV: Complaints

HMK Members may file verbal or written complaints about any aspect of service delivery provided or paid for by the Plan.

Section V: Appeals

Medical and Mental Health

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

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

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

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

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

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

The Office of Fair Hearings will contact You 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

1. **First Level Appeal:**

If You do not agree with a denial or partial denial of a claim, You 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 your objections, and must include any substantiating documents and information which you 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 You will receive a letter outlining the Departments decision. You 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 you do not agree with the First Level determination, You may fax Your Second Level appeal request to (406)-444-3980 within 90 days of receiving the First Level determination or mail it to the address below:

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

The Office of Fair Hearings will contact You 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 VI: Confidential Information and Records

1. **Disclosure of a Member's Medical Information** – Medical documentation obtained by the Plan regarding a Member's health history, condition, or treatment is strictly confidential and may not be released without the Member's written authorization; however, the Plan reserves the right to release such information without the Member's written authorization in the following instances:

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

Additional information may be found in the Notice of Privacy Practices for HMK Members brochure which is provided in the enrollment package. A copy may be requested by calling the Claim Administrator at 1-855-258-3489.

2. Release of medically related information -- A Member accepts this Evidence of Coverage under the following conditions:
 - a. Each Member authorizes all Providers of health care services or supplies, including medical, hospital, dental, and vision, to furnish to the Plan any medically related information pertaining to any illness, injury, service, or supply for which Benefits are claimed under this Evidence of Coverage for the purposes of Benefit determination.
 - b. A Member waives all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies, including medical, hospital, dental, and/or vision, from disclosing or testifying such information.

ARTICLE ELEVEN – 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 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 TWELVE – EVIDENCE OF COVERAGE – GENERAL PROVISIONS

Section I: Plan Administrator Powers and Duties

The Plan Administrator shall have total and exclusive responsibility to control, operate, manage, and administer the Plan in accordance with its terms. The Plan Administrator shall have all the authority that may be necessary or helpful to discharge those responsibilities with respect to the Plan. Without limiting the generality of the preceding sentence, the Plan Administrator shall have the exclusive right: to interpret the Plan; to determine eligibility for coverage under the Plan; to construe any ambiguous provisions of the Plan; to correct any default; to supply any omission; to reconcile any inconsistency; and to decide any and all questions arising in administration, interpretation, and application of the Plan.

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

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

Section II: Entire Evidence of Coverage; Changes

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

Section III: Modification of Evidence of Coverage

The Plan Administrator may modify this Evidence of Coverage at any time. Any changes to this Evidence of Coverage shall be in writing and may be identified through Endorsements or Amendments, and shall become incorporated into this document when signed by the Plan Administrator on behalf of the HMK Program.

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. 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 in strict accordance with its terms.

Section V: Notices Under Evidence of Coverage

Any notice required by this Evidence of Coverage 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 health 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 Claim Administrator should be sent to Xerox at PO Box 8000, Helena MT 59604. Notices are effective on the date mailed.

Section VI: Benefits Not Transferable

No person, other than the Member, is entitled to the Benefits identified under this Evidence of Coverage. This means that You are not allowed to transfer or assign Your coverage under the Healthy Montana Kids Program to another person.

Section VII: Validity of Evidence of Coverage

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

Section VIII: Execution of Papers

A Member agrees to execute and deliver any documents requested by the Plan Administrator which are Necessary to administer the terms of this Evidence of Coverage.

Section IX: Members' Rights

A Member has no rights or privileges except as specifically provided in the Evidence of Coverage.

Section X: Alternate Care

The Plan Administrator 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. Such payments may be made only when it is determined by the Plan Administrator that it is in the best interest of the Plan and/or the Member to make payment for alternate care.

Section XI: Benefit Maximums

1. If a member receives services under the Extended Mental Health benefit identified in Article Seven, benefit maximums apply.
2. If the member receives services under the Extended Dental Plan for dental implants, Benefit maximums apply.
3. There is a Benefit Maximum of a 34-day supply for prescription drugs with exceptions that are noted in Article Four Section V of this document.

Section XII: Civil Rights Protection for Children

Children enrolled in the Healthy Montana Kids Program (HMK) have a right to:

1. Equal Access to Services without regard to race, color, national origin, disability, or age;
2. A bilingual interpreter, where necessary for effective communication;
3. Auxiliary aids to accommodate a disability;
4. File a complaint if You believe You were treated in a discriminatory fashion.

If You 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 XIII: Statement of Representations

Any HMK Member who, with intent to defraud or knowing that he or she is facilitating a fraud against the Plan, 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 Plan may be subject to criminal charge or a civil action brought by the Plan Administrator or the HMK Program as permitted under State or Federal laws. The Plan Administrator reserves the right to take appropriate action in any instance where fraud is at issue.

Section XIV: Recovery, Reimbursement, and Subrogation

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

1. Right to Recover Benefits Paid in Error. If a payment in excess of the Plan Benefits is made in error on behalf of a Member to which the Member is 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 the Member;
- b. any insurance company; and
- c. any other individuals or entities that received payment on behalf of the Member.

By receipt of Benefits by a Member under this Plan, You 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 Plan's right to reimbursement is separate from and in addition to the Plan's right of subrogation. Reimbursement means to repay a party who has paid something on another's behalf, generally under Third Party Liability. If the Plan pays Benefits for medical expenses on a Member's behalf, and another party was actually responsible or liable to pay those medical expenses, the Plan has the right to be reimbursed.

Accordingly, if You settle, are reimbursed, or recover money by or on behalf of the Member, from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any Accident, injury, condition, or Illness for which Benefits were provided by the Plan, You agree to reimburse the Plan for the Benefits paid on behalf of the Member. The Plan shall be reimbursed, in first priority, from any money recovered from a liable third party, as a result of said Accident, injury, condition, or Illness. Reimbursement to the Plan will be paid first, even if the Member is 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, medical, disability, or other expenses or damages.

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

You agree to subrogate to the Plan any and all claims, causes of action, or rights that the Member has or that may arise against any entity who has or may have caused, contributed to, or aggravated the Accident, injury, condition, or Illness for which the Plan has paid Benefits, and to subrogate any claims, causes of action, or rights the Member 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 You decide not to pursue a claim against any third party or insurer, by or on behalf of the Member, You will notify the Plan, and specifically authorize the Plan in its sole discretion, to sue for, compromise, or settle any such claims in the Member's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

4. The Following Paragraphs Apply to Both Reimbursement and Subrogation

- a. Under the terms of this Plan, the Plan Administrator **is not** required to pay any claims where there is evidence of liability of a third party. However, the Plan, in its discretion, may instruct the Claim Administrator to pay Benefits while the liability of a party other than the Member is being legally determined.
- b. If the Plan makes a payment which the Member, or any other party on the Member's behalf, is or may be entitled to recover against any third party responsible for an Accident, injury, condition or illness, the Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. The Member or someone acting on behalf of the Member will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the Plan's right of recovery.
- c. You will cooperate fully with the Plan Administrator, its agents, attorneys, and assigns, regarding the recovery of any monies paid by the Plan from any party other than the Member who is liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Plan Administrator, upon request and in a timely manner, of all material facts regarding the Accident, injury, condition, or illness; all efforts by any person to recover any such monies; provide the Plan Administrator with any and all documents, papers, reports, and the like regarding demands, litigation or settlements involving recovery of monies paid by the Plan; and notifying the Plan Administrator of the amount and source of any monies received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.
- d. You will respond within ten (10) days to all inquiries of the Plan Administrator regarding the status of any claim You may have against any third parties or insurers, including but not limited to, liability, no-fault, uninsured and underinsured insurance coverage.
- e. You will notify the Plan Administrator of the name and address of any attorney engaged to pursue any personal injury claim on behalf of the Member.
- f. You will not act, fail to act, or engage in any conduct directly, indirectly, personally, or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. You will not conceal or attempt to conceal the fact that recovery occurred or will occur.
- g. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Member pursuing a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation.
- h. Monies paid by the Plan 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 XV Relationship Between HMK Program and Professional Providers

Healthy Montana Kids Providers are Providers who contract with the Claim Administrator to provide medical care and health services to HMK Members. HMK Providers furnishing care to a Member do so as independent contractors with the Claim Administrator. The relationship between a Provider and a patient is personal, private, and confidential; the choice of a provider within the Healthy Montana Kids Network is solely the Member's.

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

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

Section XVI: When You Move Out of State

If You move from Montana, You will no longer be eligible for coverage under the Healthy Montana Kids Program. You will be responsible for any services received from out-of-state medical Providers. Returned mail with an out-of-state forwarding address shall be considered conclusive evidence that a Member has moved out of state and the Member will be disenrolled from HMK.

Section XVII: Authority of the Plan Administrator

The Plan Administrator has the authority to interpret uncertain terms and to determine all questions arising in the administration, interpretation, and application of the Healthy Montana Kids Program, 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 XVIII: 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 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. 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.

SECTION XIX: XEROX IS THE FISCAL AGENT FOR THE DEPARTMENT

Xerox 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.