

Montana University System's Flexible Benefits Program

**2006 – 2007**

**Blue Cross Blue Shield  
Managed Care Plan Amendment**

# **BLUE CROSS BLUE SHIELD OF MONTANA MANAGED CARE PLAN DESCRIPTION**

## **AN AMENDMENT TO THE MONTANA UNIVERSITY SYSTEM GROUP BENEFITS PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION**

This Amendment replaces corresponding medical benefit sections of the Montana University System Group Benefits Plan Document/ Summary Plan Description for Members Enrolled in the BCBSMT Managed Care Plan.

For purposes of this Amendment:

“Employer” or “Plan” means the Montana University System

“Health Plan” or “Plan Administrator” means Blue Cross Blue Shield of Montana

“BCBSMT Managed Care Plan” means the plan of benefits defined by this Amendment

Other capitalized terms are defined in Section C, Definitions.

**Employer Contact:**

Your campus Human Resource Office

**Health Plan Contact:**

Blue Cross and Blue Shield of Montana at 1-800-447-7828 or visit their web site at

[www.bluecrossmontana.com](http://www.bluecrossmontana.com).

# CONTENTS

<b>HOW TO OBTAIN BENEFITS</b>	
A.1	STEPS TO TAKE IN ADVANCE OF RECEIVING SERVICES .....2
A.2	STEPS TO TAKE TO RECEIVE BENEFITS AND PAYMENT .....3
A.3	CLAIMS ASSISTANCE.....4
<b>MEDICAL BENEFITS</b> .....	
B.1	COVERED MEDICAL EXPENSES AND SERVICES.....5
B.2	(PROVISION RESERVED) .....6
B.3	INPATIENT HOSPITAL CARE .....6
B.4	INPATIENT PROVIDER CARE .....6
B.5	OUTPATIENT HOSPITAL SERVICES .....6
B.6	OUTPATIENT OFFICE VISIT SERVICES .....6
B.7	AMBULANCE TRANSPORTATION.....6
B.8	AMBULATORY SURGICAL CENTER SERVICES AND SUPPLIES .....6
B.9	CONGENITAL ANOMALY.....6
B.10	EMERGENCY CARE .....6
B.11	DIALYSIS.....7
B.12	HOME INFUSION THERAPY .....7
B.13	INJECTIBLE BENEFIT .....7
B.14	MASTECTOMY .....7
B.15	RECONSTRUCTIVE BREAST SURGERY.....7
B.16	OBSTETRICS AND GYNECOLOGY/GYN .....7
B.17	OBSTETRICAL DELIVERY CARE AND SERVICES.....8
B.18	ROUTINE NEWBORN CARE.....8
B.19	INBORN ERRORS OF METABOLISM (INCLUDING PKU).....8
B.20	ORAL SURGERY .....8
B.21	ADULT PREVENTIVE SERVICES .....8
B.22	RECONSTRUCTIVE SURGERY .....9
B.23	(PROVISION RESERVED) .....9
B.24	SEVERE MENTAL ILLNESS .....9
B.25	URGENT CARE.....9
B.26	WELL CHILD BENEFITS .....9
B.27	DIAGNOSTIC /LABORATORY SERVICES .....9
B.28	SERVICES WITH LIMITED COVERAGE.....10
B.29	HEALTH PLAN EXCLUSIONS.....14
C	<b>DEFINITIONS</b> .....19

# HOW TO OBTAIN BENEFITS

Payment of benefits by your Employer’s Employee Benefit Plan will be made on the basis of your submission of required information to the Blue Cross Blue Shield of Montana Health Plan.

## SECTION A. OBTAINING BCBSMT MANAGED CARE PLAN BENEFITS

### A.1 STEPS TO TAKE IN ADVANCE OF RECEIVING SERVICES

.....

1. Make sure you have a current Identification Card from the Health Plan. Make sure it contains the correct Identification Number, name(s), Dependent coverage information, and date(s) of birth. If you need services before you receive your card or have lost it, ask your provider to verify your coverage by calling the Health Plan or your Employer at the numbers or location on the Cover Page. Replacement cards can also be ordered by calling the Health Plan.
2. Make sure there is an available BCBSMT Network (In-Network) Personal Care Physician (PCP) in your area that you and any Enrolled Dependents feel comfortable using for your typical health care needs, and for referral to a specialist, if needed. Each plan Member must select and maintain a PCP, but may change PCPs under some circumstances by contacting the Health Plan. You may also want to determine if there are specialists in the BCBSMT Network that will meet your (and Member Dependents’) medical needs.

For a full list of In-Network Providers and updates to the PCP list, see the BCBSMT website at [www.bluecrossmontana.com](http://www.bluecrossmontana.com). The BCBSMT website allows you to search for Network Providers statewide or in your area. Specify “Montana University System Managed Care” or “Blue Choice” as the plan to access the right Network .

You may also identify Participating (BCBSMT member) Providers. These are Covered Providers on the “All Plans” list, but not on the “Montana University System Managed Care” or “Blue Choice” list. These Participating (BCBSMT

member) Providers are not recognized as In-Network Providers (to whom you may self-refer and obtain the In-Network Level of Benefits), but they have agreed to accept Allowable Fees as payment in full, and thus will not balance bill Health Plan Members for charges in excess of these fees.

3. In advance of receiving any non-emergency services, know and optimize your benefits:
  - a. Obtain Pre-Certification for inpatient Hospital stays. All non-emergency inpatient Hospital stays should be Pre-Certified (prior to admission) by calling the Health Plan to make sure the stay meets Medical Necessity requirements for inpatient benefits. All emergency admissions should be Certified within 24 hours after admission, or at the first opportunity, to make sure any continued stay meets Medical Necessity criteria for inpatient benefits. The Hospital will typically make this call to assure payment, but since you are responsible for any charges that are not benefits of the BCBSMT Managed Care Plan, you should call for your own protection. *Pre-Certification is especially critical for any inpatient facility admissions/stays for: organ transplants, treatment of Mental Illness or Chemical Dependency, and Rehabilitation Services or recovery, as stated in Section B.*
  - b. Determine if you need Prior Authorization by the Health Plan for specific proposed medical procedures, equipment, or supplies. You must call the Health Plan and obtain Prior Authorization to receive benefits for:
    - 1) durable medical equipment expenses in excess of \$500;
    - 2) infertility treatments;
    - 3) obesity management (nonsurgical).
  - c. Identify services for which Prior Authorization is recommended. These include, but are not limited to the following (a retrospective review will be done if services are not Prior Authorized):
    - 1) cardiac and/or pulmonary rehabilitation;
    - 2) chronic pain programs;
    - 3) dietary and nutritional counseling;

- 4) home health services;
- 5) inpatient Hospital and Professional Provider care;
- 6) Hospice;
- 7) Magnetic Resonance Imaging (MRI), Computer Axis Tomography (CAT scan, CT scan), and Positron Emission Tomography (PET Scans);
- 8) reconstructive surgery;
- 9) TMJ surgery;
- 10) transplants.

emergency has ended) if the above Pre-Certification requirements are met.

Non-emergency care received from a provider who is a Covered Provider but not a BCBSMT Network Provider will be covered at the Out-of-Network Level of Benefits also described in the Schedule of Benefits. However, note that the medical services identified in B.1 4 are not available as an Out-of-Network benefit.

Call and obtain Prior Authorization for any services that are new or outside the standard medical practice (and which may be excluded as experimental), or that are only covered under some circumstances (as described in Section B) to assure coverage.

d. Obtain the In-Network Level of Benefits (the highest level of benefits described in this Amendment and the Schedule of Benefits) by:

- 1) obtaining Covered Medical Services from a BCBSMT Network Provider listed on the BCBSMT web site for the “Montana University System Managed Care” or “Blue Choice” plan; (While a PCP referral to an In-Network specialist is not required, consulting with and obtaining a PCP referral for non-emergency specialty care is always advisable) or
- 2) obtaining Covered Medical Services from an Out-of-Network Provider under the following circumstances:
  - a) For treatment of an Emergency Medical Condition. In the case of a medical emergency, BCBSMT Managed Care Plan Members are encouraged to obtain services from the closest appropriate provider. You will receive the In-Network Level of Benefits for immediate treatment of an Emergency Medical Condition by any Covered Provider, including an Out-of-Network Provider. However, you will only receive the In-Network Level of Benefits for any Out-of-Network follow up care (after the medical

e. Determine if there are frequency, duration, or dollar limits on services you plan to receive so you can consider alternatives, if needed (see Section B and the Schedule of Benefits)

f. If you must use an Out-of-Network Provider, try to use a Participating (BCBSMT member) Provider. This will protect you against charges in excess of the Health Plan’s Allowable Fee. You are responsible for paying these charges (in addition to any Deductible, Coinsurance, or Copayment for applicable Out-of-Network Benefits), unless the Out-of-Network Provider has agreed to accept the Allowable Fee as full payment. See A.1 for instructions on identifying BCBSMT Participating Providers.

**A.2 STEPS TO TAKE TO RECEIVE BENEFITS AND PAYMENT**

- .....
- 1. Present your Identification Card to the Physician, Hospital, or other health care provider when you or any covered Dependents receive services, and pay any required Co-payments.
  - 2. Make sure the provider has your current Identification Number and address. If you change your address, notify the Health Plan and your Employer at the number or location on the Cover Page.
  - 3. You may need to complete a standard claim form if you use a provider who is neither an In-Network Provider, nor a Participating (BCBS member) Provider. A standard claim form should be available from the provider. Have the

provider complete his/her portion, and send the completed form, with all itemized bills attached, to the Health Plan at the address on your Identification Card.

- 4. Payment will automatically be sent directly to BCBSMT Network Providers and Participating (BCBSMT member) Providers who have agreed to accept Allowable Fees, as well as to Out-of-Network Providers whose bills include an assignment of benefits from you. You will receive payment directly for services for which no assignment of benefits has been made. For both In-Network and Participating (BCBSMT member) Providers, you will not be responsible for paying charges for Covered Medical Services above Allowable Fees.
- 5. Respond to requests for information about accidents, other insurance coverage, or any other information requests from the Health Plan. Your claim will not be paid until the required information is received.

**CLAIMS FILING DEADLINE**

Claims must be filed within one year from the date the expenses were first incurred to receive benefits, unless you show that it was not reasonably possible to file a claim within this time limit.

**EXPLANATION OF BENEFITS (EOB)**

Check EOBs from the Health Plan to determine if you have received the benefits described in this BCBSMT Managed Care Plan Amendment, and to determine what fees you owe the provider. This includes any Deductible, Copayments not paid at the time of service, Coinsurance, charges for Un-Covered Medical Services, and charges in excess of Allowable Fees when using providers who are not BCBSMT Network or Participating (BCBSMT member) Providers.

**A.3 CLAIMS ASSISTANCE**

.....

If you need assistance with a claim or an explanation of how a claim was paid, call BCBSMT at the customer service number on your Identification Card. If you are not satisfied with the Health Plan’s explanation of a denial or partial denial of benefits, you may file an appeal as described in your Employer’s Plan Document/

# MEDICAL BENEFITS

## SECTION B. BCBSMT MANAGED CARE PLAN BENEFITS

### B.1 COVERED MEDICAL EXPENSES AND SERVICES

.....

#### 1. COVERED MEDICAL EXPENSES

Covered Medical Expenses of the BCBSMT Managed Care Plan are:

- a. expenses within Allowable Fees (you are responsible for amounts over Allowable Fees if you use a provider other than a BCBSMT Network Provider or a Participating (BCBSMT member) Provider;
- b. expenses within the specified benefit limitations contained in this Amendment and the current Schedule of Benefits, and which meet other requirements of your Employer's Plan Document /Summary Plan Description (such as applicable waiting periods); and
- c. expenses for Covered Medical Services, defined next.

#### 2. COVERED MEDICAL SERVICES

Covered Medical Services are services, procedures, and supplies:

- a. listed in this Amendment as Covered Medical Services, and not specified as exclusions in this Amendment or in the Schedule of Benefits;
- b. determined by the Health Plan to be Medically Necessary for the diagnosis or treatment of:
  - 1) injury;
  - 2) illness;
  - 3) maternity care; or
  - 4) are preventive services specified in this section;
- c. provided to a Member by a Covered Provider; and
- d. provided and coded in accordance with applicable medical policy.

Covered Medical Expenses are paid or credited to the Member's Deductible, Copayment and Co-insurance obligations for the applicable level of benefits as described below.

#### 3. IN-NETWORK LEVEL OF BENEFITS

You receive the In-Network Level of Benefits (described in this Amendment and the Schedule of Benefits) for Covered Medical Services that are:

- a. services provided by an In-Network Provider;
- b. treatment of an Emergency Medical Condition (by any Covered Providers);

You will be responsible for any Deductible, Copayment and Coinsurance amounts, which the current Schedule of Benefits specifies for the In-Network Level of Benefits. See B.2 and B.28 for any special requirements for receiving the In-Network Level of Benefits for particular Covered Medical Services or services with limited coverage.

#### 4. OUT-OF-NETWORK LEVEL OF BENEFITS

You will receive the reduced Out-of-Network Level of Benefits (described in the Schedule of Benefits) for all other Covered Medical Services with some exceptions. There are no benefits for the following services and, in the case of hospital admission, Pre-Certification, permitting the In-Network Level of Benefits:

- a. organ transplant services;
  - b. infertility treatment; and
  - c. obesity management (nonsurgical).
- (Note that b. and c. above also require Prior Authorization.)

For Covered Medical Services eligible for the Out-of-Network Level of Benefits, you will be responsible for any applicable Copayment, Deductible, and Coinsurance amounts described in the current Schedule of Benefits. You will also be responsible for any charges in excess of the Health Plan's Allowable Fee by non-Participating Providers who do not accept the Health Plan's Allowable Fees as full compensation as well as any applicable Out-of-Network differential.

**B.2 (Provision Reserved.)**  
.....

**B.3 INPATIENT HOSPITAL CARE**  
.....

*Pre-Certification of all Hospital admissions is strongly recommended.*

Inpatient Hospital care is covered and includes, but is not limited to: room and board; general nursing care; special diets; use of operating room and related facilities; use of intensive care units and services; x-ray, laboratory, and other diagnostic tests; drugs, medications, biologicals, anesthesia, and oxygen services; physical, radiation, and inhalation therapy; psychotherapy; administration of whole blood and blood plasma; short-term rehabilitation therapy services; and medical detoxification when the inpatient stay is Certified as Medically Necessary by the Health Plan.

**B.4 INPATIENT PROVIDER CARE**  
.....

*Pre-Certification of all Hospital admissions is strongly recommended.*

Coverage includes health care services performed, prescribed, or supervised by a Covered Provider, including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services.

**B.5 OUTPATIENT HOSPITAL SERVICES**  
.....

Hospital services and supplies described in B.3 are covered if a Member is treated at a licensed Hospital, but not admitted for bed patient care. Charges for Observation Beds/Rooms are covered when Medically Necessary and in accordance with medical policy for services of less than 24 hours and for charges not exceeding the room rate that would be charged for an inpatient stay of one day.

**B.6 OUTPATIENT OFFICE VISIT SERVICES**  
.....

Coverage includes health care services

provided by a Physician or Mid-Level Practitioner working in a Physician’s office or clinic, or by other office/clinic staff members under Physician direction.

The office visit Copayment only covers the office visit Allowable Fee. Any laboratory, x-ray, radiation or other tests or procedures are subject to Deductible and Coinsurance.

**B.7 AMBULANCE TRANSPORTATION**  
.....

Coverage only includes emergency ground or emergency air transportation to the nearest Hospital or medical facility that is equipped to furnish the services, unless otherwise approved by the Health Plan. The emergency transportation must be Medically Necessary. The Medical Necessity is established when the patient’s condition is such that other means of transportation would endanger the health of the Member. Transportation is not covered if not Medically Necessary. Please see the current Schedule of Benefits for ambulance transportation Copayments.

**B.8 AMBULATORY SURGICAL CENTER SERVICES AND SUPPLIES**  
.....

*Prior Authorization of non-emergency surgery is strongly recommended.*

Coverage includes ambulatory surgical center or outpatient Hospital services and supplies furnished in connection with a covered surgical procedure performed in the center, provided the center is licensed or certified for Medicare by the state in which it is located.

**B.9 CONGENITAL ANOMALY**  
.....

Coverage includes the treatment only of medically diagnosed congenital defects and birth abnormalities.

**B.10 EMERGENCY CARE**  
.....

Coverage includes health care for an Emergency Medical Condition with acute symptoms that would reasonably cause a Member to believe that the absence of medical attention would place the Member's health in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of a bodily organ or part.

The emergency room Copayment (as identified in the Schedule of Benefits) only includes the facility charges. Any professional charges and/or any lab or diagnostic fees are subject to Deductible and Coinsurance.

**SPECIAL REQUIREMENT TO RECEIVE THE IN-NETWORK LEVEL OF BENEFITS FOR OUT-OF-NETWORK SERVICES**

The In-Network Level of Benefits is provided for Out-of-Network emergency services immediately required to diagnose and treat an Emergency Medical Condition at the nearest appropriate medical facility.

If an Emergency Medical Condition is determined to exist that requires Hospital admission or any follow-up services, you must notify the Health Plan within 24 hours of (or the next working day after) the initial emergency care so the Health Plan can coordinate the subsequent follow-up care and assure continued In-Network Benefits. If you are incapable of calling or having a representative call the Health Plan within 24 hours (or on the next working day), you should contact the Health Plan as soon as medically possible. Once medical stabilization is achieved, BCBSMT may require transfer to a BCBSMT Network Hospital for the In-Network Level of Benefits to continue.

**B.11 DIALYSIS**

.....  
Coverage is provided for renal disease, including the equipment, training, and medical supplies required for effective home dialysis.

**B.12 HOME INFUSION THERAPY**

.....  
Coverage is provided in lieu of hospitalization. Infusion therapy includes, but is not limited to: antibiotic therapy, enteral nutrition, total parenteral nutrition, pain management, and

specialized disease state therapy.

**B.13 INJECTIBLE BENEFIT**

.....  
Coverage includes injectible medications administered at the Covered Provider's office or facility including, but not limited to: allergy shots, contraception, pain control, and administration of antibiotics.

Injectibles billed without an office visit are exempt from Deductible and only subject to appropriate Coinsurance.

**B.14 MASTECTOMY**

.....  
Coverage is provided for mastectomies due to malignancy, and as a result of disease, illness, or injury.

**B.15 RECONSTRUCTIVE BREAST SURGERY**

.....  
*Prior Authorization of non-emergency surgery is strongly recommended.*

Coverage provides reconstructive surgery after a mastectomy, which resulted from disease, illness, or injury.

Coverage is provided for:

- a. reconstruction of the breast on which the mastectomy was performed;
- b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. prostheses and treatment of any physical complications resulting from the mastectomy, including lymphedemas.

**B.16 OBSTETRICS AND GYNECOLOGY/GYN**

.....  
Coverage includes Medically Necessary obstetrical and gynecological services. The global Copayment as identified in the Schedule of Benefits includes professional office visit Allowable Fees only. One global Copayment is applied per pregnancy regardless of Benefit Year.

**B.17 OBSTETRICAL DELIVERY CARE AND SERVICES**

Coverage includes Hospital obstetrical delivery care and services for covered female Members. Coverage allows a minimum 48-hour inpatient Hospital stay for a normal delivery, and a minimum 96-hour inpatient Hospital stay for a cesarean section delivery, unless otherwise agreed and deemed appropriate by the Member and attending Professional Provider.

**B.18 ROUTINE NEWBORN CARE**

Coverage includes the initial routine care of a newborn at birth provided by a Physician, standby care provided by a pediatrician at cesarean section, and Hospital nursery care of newborn infants, born in the Hospital while the mother is receiving inpatient care services for the deliver.

**B.19 INBORN ERRORS OF METABOLISM (INCLUDING PKU)**

Coverage includes the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist. Treatment includes diagnosing, monitoring, and controlling the disorders 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.

**B.20 ORAL SURGERY**

*Prior Authorization of non-emergency surgery (especially temporal mandibular joint (TMJ)-related surgery) is strongly recommended.*

Coverage includes non-cosmetic surgical treatment for the excision of lesions of the oral cavity, tongue, cheek, and maxillary/mandibular fracture,

or for the treatment of degenerative joint disease that is associated with rheumatoid arthritis or osteoarthritis of the TMJ. Non-surgical treatment of TMJ pain, dysfunction, or disease is not covered.

**ORTHOGNATHIC SURGERY (RECONSTRUCTIVE JAW SURGERY)**

*Prior Authorization is strongly recommended.*

Coverage is provided only for the treatment of congenital conditions of the jaw that may be demonstrated to cause actual significant deterioration of the Member’s physical condition because of inadequate nutrition.

Dental appliances, splints, orthodontia, or other services associated with an approved jaw surgery are considered dental services and are not covered under the medical benefit.

**B.21 ADULT PREVENTIVE SERVICES**

Coverage includes an age and gender appropriate annual routine physical examination including the following periodic tests and services:

- a. routine gynecological exams, Pap tests, and related lab charges;
- b. colonoscopies, proctoscopies, sigmoidoscopies, or hemocults;
- c. immunoassays for tumor antigen or prostate specific antigen (PSA)s; and
- d. routine diagnostic x-rays and laboratory services including chemistry screens, bone density scans, cholesterol and other blood fats tests, and T4 thyroid tests.

2. Adult immunizations recommended by the Centers for Disease Control Immunization Guidelines, excluding immunizations recommended because of increased risk due to type of employment or travel, such as, but not limited to: malaria, yellow fever, hepatitis B, and tuberculosis. *Immunizations billed without an office visit are exempt from Deductible and only subject to appropriate Co-insurance.*

3. Periodic routine mammograms, defined as:
  - a. one baseline mammogram for women ages 35 - 39;
  - b. one mammogram each year for women beginning at age 40.

**B.22 RECONSTRUCTIVE SURGERY**  
 .....

*Prior Authorization of non-emergency surgery is strongly recommended.*

Coverage is provided in order to restore bodily function or correct deformity resulting from a disease, trauma, or congenital or developmental abnormality. Coverage includes any consequences or complications that may arise from a covered surgery or related service.

**B.23 PROVISION RESERVED**

**B.24 SEVERE MENTAL ILLNESS**  
 .....

*Pre-Certification of all Hospital admissions is strongly recommended.*

Coverage includes Medically Necessary care and treatment of Severe Mental Illness as defined in 33-22-706 MCA and this Amendment Section C Definitions.

1. Schizophrenia.
2. Shizo-affective disorder.
3. Bipolar disorder.
4. Major depression.
5. Panic disorder.
6. Obsessive-compulsive disorder.
7. Autism.

**B.25 URGENT CARE**  
 .....

Coverage includes care for an acute illness or injury that requires immediate treatment (such as high fever; ear, nose, and throat infections; and minor sprains and lacerations).

The urgent care Copayment (as identified in the Schedule of Benefits) only includes the office

visit. Any lab and/or diagnostic fees are subject to Deductible and Coinsurance.

**B.26 WELL CHILD BENEFITS**  
 .....

1. Coverage includes well-child examinations by Physician from birth through puberty. Such exams shall include a medical history, routine physical examination, and routine development assessment at the following approximate ages:

- a. Physician's visit for any newborn discharged from a Hospital in less than 36 hours;
- b. one month;
- c. two months;
- d. four months;
- e. six months;
- f. nine months;
- g. 12 months;
- h. 15 months;
- i. 18 months;
- j. 24 months; and
- k. one per year thereafter, until the child reaches the appropriate age for adult preventive services.

2. Laboratory tests are covered 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 are covered according to the schedule of immunizations recommended by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services.

**B.27 DIAGNOSTIC / LABORATORY SERVICES**  
 .....

*Prior Authorization is strongly recommended for MRIs, CT Scans, CAT Scans and PET Scans.*

1. Coverage includes x-ray, laboratory and tissue diagnostic examinations, and diagnostic machine tests (such as EKGs) made for the purpose of diagnosing accident or illness when Hospital confinement is not required and benefits are not provided elsewhere in this Amendment.

2. X-ray and laboratory benefits shall not be provided for the following:

- a. dental examinations or treatments, except for dental x-rays resulting from injuries sustained in an accident (covered under B.28, provision 2);
- b. visual examinations; and
- c. premarital examinations and routine physical checkups, including examinations made as a requirement of employment or governmental authority, except as provided in B.21.

**B.28 SERVICES WITH LIMITED COVERAGE**

.....  
The following are health care services and supplies that are covered as described in B.1, but with special limitations.

Some of these services have no Out-of-Network Level of Benefits, as specified next (and as listed in B.1, provision 4). They are only covered when provided by a BCBSMT PCP (or a designated stand-in Physician or Mid-Level Practitioner). Some services require Prior Authorization by the Health Plan (in advance of the service) for any benefits (either In-Network or Out-of-Network). Some have dollar or service limits, or require a Physician's order.

**1. CHEMICAL DEPENDENCY TREATMENT**

*Pre-Certification of all Hospital admissions is strongly recommended.*

Coverage is provided for inpatient and outpatient treatment for alcoholism and drug addiction (excluding costs for medical detoxification, which is covered under B.3). Coverage is limited to a maximum combined benefit of \$6,000 for a 12-month period, until a lifetime maximum inpatient benefit of \$12,000 is met. After that, an annual benefit for inpatient and outpatient treatment of \$2,000 may be available.

**2. DENTAL SERVICES FOR ACCIDENTAL INJURY**

Coverage is provided for the treatment of accidental dental injury only, and is limited to the restorative services and supplies necessary for the treatment of a fractured jaw or other accidental injury to sound natural teeth, provided that the following criteria are met:

- a. the dental injury occurs while the Member is Enrolled in the Employer's Employee Benefit Plan unless the individual has a certificate of creditable coverage; and
- b. the treatment is completed within 12 months after the date of the accidental injury.

Services for the treatment of accidental injury to teeth caused by biting or chewing are exclusions of this provision (but may be covered by an Employer Dental Plan).

**3. DIETARY AND NUTRITIONAL COUNSELING**

*Prior Authorization is strongly recommended.*

Dietary and Nutritional coverage is provided when Medically Necessary and with a Physician's referral.

**4. EDUCATION PROGRAMS**

*See the current Schedule of Benefits for maximum limits.*

Coverage is provided when referred by a BCBSMT PCP (or designated stand-in Physician or Mid-Level Practitioner). The program must be a certified educational program administered by an In-Network facility or Professional Provider. Covered programs/clinics include, but are not limited to: diabetes, multiple sclerosis, respiratory, polio, and cardiac clinics. Educational services are otherwise excluded.

**5. DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS**

*Prior Authorization is required for DME expenses in excess of \$500. Coinsurance does not apply to annual Out of Pocket Maximum/Coinsurance Maximum.*

Coverage is provided for medical purposes only

and in lieu of hospitalization, or for therapeutic use in a Member's home. Coverage includes rentals, purchases, and repairs (on purchased equipment). The Health Plan will be responsible for determining rental versus purchase agreements. Requests for computerized and "deluxe" equipment, like motor-driven wheelchairs, are reviewed on an individual basis. The Health Plan will have the right to decide when standard equipment is adequate. Coverage does not include maintenance, replacement due to loss, or duplication. Replacement can occur when equipment or prosthetics are no longer repairable.

DME and prosthetic items include, but are not limited to:

- a. hospital beds;
- b. wheelchairs and walkers;
- c. foot orthotics (with a \$100 per foot per year limit, and coverage is not provided for the sole purpose of treating sports-related activities);
- d. breast prostheses;
- e. oxygen services and supplies; and
- f. prosthetic appliances. Coverage includes the purchase and fitting of artificial limbs, larynx, eyes, other prosthetic appliances or permanent internally implanted devices that are not experimental. Repair, maintenance, replacement due to loss, and duplication are not covered. Replacement can occur when the item is no longer repairable.

## **6. HOME HEALTH SERVICES**

*Prior Authorization is strongly recommended.*

Coverage includes the following services and supplies furnished by a licensed Home Health Agency for the care of a Member in accordance with a Physician's written Home Health Care Plan:

- a. part time or intermittent skilled care provided by a registered nurse or licensed practical/vocational nurse;
- b. Physical, Occupational, respiratory, and Home Infusion therapies (up to the maximum benefit) for the therapies as described in other provisions of this Amendment and the current Schedule of Benefits;

- c. medical supplies, prescribed medications, and lab services provided at home; and
- d. part time or intermittent home health aid services required to allow the Member to be treated at home.

Home health services are limited to 30 visits per Benefit Year, where a day with any home health service is counted toward the maximum, and a day with more than four hours of home health services is counted as two visits.

The following services are non-covered home health services:

- a. services and supplies not part of the Home Health Care Plan;
- b. domestic or housekeeping services such as Meals on Wheels;
- c. services for mental or nervous conditions;
- d. transportation; and
- e. disposable supplies self-administered in the home (gauze, bandages, etc.) and DME and prostheses, which are covered elsewhere.

## **7. HOSPICE SERVICES**

*Prior Authorization is strongly recommended.*

Members who are diagnosed as having a terminal illness with a life expectancy of six months or less may elect Hospice care when ordered by a Physician. The following Hospice services are covered:

- a. Facility expenses of a Hospice facility, Hospital, or Skilled Nursing Facility for board, room, and other services and supplies furnished to a person while inpatient for pain control and other acute and chronic symptom management. Expenses for a private room are covered only up to the regular daily expense for a semi-private room, unless Medically Necessary.
- b. Hospice expenses for:
  - 1) nursing care provided by a registered nurse or licensed practical nurse, and services of a home health aide;

- 2) medical social services provided under the direction of a Physician;
- 3) psychological and dietary counseling;
- 4) consultation or Case Management services;
- 5) Medically Necessary Physical and Occupational Therapy;
- 6) medical supplies, drugs, and medicines prescribed by a Physician; and
- 7) expenses for consultant or Case Management services, or Physical or Occupational Therapy by health care providers who are not employees of the Hospice - but only when the Hospice retains responsibility for the care.

### **8. INFERTILITY TREATMENT**

*Prior Authorization is required. No Out-of-Network Level of Benefits is available.*

Benefits include diagnostic and evaluation services to determine if treatment for infertility is necessary. Follow-up treatment is limited to Members who have been diagnosed as biologically infertile in accordance with accepted medical practice. Artificial insemination attempts are limited to three per Member per lifetime. Infertility services do not include in-vitro fertilization, and are not covered for Members who have undergone a voluntary sterilization procedure.

### **9. MENTAL ILLNESS**

*Prior Authorization of all Hospital admissions is strongly recommended.*

Coverage is provided for Medically Necessary inpatient and outpatient treatment of Mental Illness. Inpatient services are limited to a maximum of 21 days; no maximum for Severe Mental Illness defined in 33-22-706, MCA. See Section C Definitions. Please also refer to the Schedule of Benefits, for visit limits; no maximum for Severe Mental Illness as defined in 33-22-706, MCA. Covered Medical Services do not include treatment of the following conditions:

- a. developmental and learning disorders;
- b. speech disorders;
- c. psychoactive substance abuse disorders;
- d. eating disorders (except bulimia and anorexia nervosa);
- e. impulse control conduct disorders (except intermittent explosive disorder and trichotillomania);

- f. mental retardation; or
- g. inpatient confinement for environmental change.

### **10. CHIROPRACTIC SERVICES**

*Please refer to the Schedule of Benefits for visit limitations. Deductibles and Coinsurance apply to x-rays and ultrasounds.*

### **11. OBESITY MANAGEMENT**

*Prior Authorization is required for benefits. No Out-of-Network Level of Benefits is available.*

Coverage includes non-surgical treatment for reducing or controlling weight under a Prior-Authorized treatment plan. The Member must meet the definition of Morbid Obesity in Section C Definitions of this Amendment, and make timely progressive weight loss for benefit continuation. Bariatric and other surgeries to reduce weight, dietary supplements, and exercise programs are not included in this benefit.

### **12. REHABILITATIVE SERVICES**

*Prior Authorization is strongly recommended. Please refer to your Schedule of Benefits for inpatient and outpatient maximums.*

Coverage includes respiratory, pulmonary, cardiac, Physical, Occupational, and Speech Therapy that is ordered by a covered Physician and determined to show proven gain in function. For services to be eligible for coverage, the Member must meet one or more of the following criteria:

- a. Has suffered an acute injury or serious illness which debilitates muscles or speech, or hinders the activities of daily living; or
- b. Is receiving treatment for medically diagnosed congenital defects or birth abnormalities; or
- c. Is suffering an exacerbation of an illness/injury, causing further debilitation.

### **13. ORGAN TRANSPLANTS**

*Benefits are only available through the designated Transplant Network. Prior Authorization of outpatient services and Pre-Certification of the Hospital stay is strongly recommended.*

The Health Plan has designated certain Hospitals

to perform covered transplants. These Hospitals have been selected for their experience in performing transplants and no benefits are available from other Hospitals (except under rare circumstances approved in advance by the Health Plan) In some instances, the designated Hospital may not be located in the Health Plan's service area, therefore requiring travel. Contact the Health Plan for a list of designated organ transplant facilities. Covered transplant services and supplies (defined next) for all covered transplant procedures have limits. Please refer to the current Summary of Benefits for limits.

**a. Covered Transplant Services**

Coverage includes the following services for covered transplants:

- 1) evaluation;
- 2) pre-transplant care;
- 3) transplant and certain specific donor-related services; and
- 4) follow-up treatment.

**b. Covered Transplants**

The following human organ/ tissue transplants are covered:

- 1) corneal
- 2) heart
- 3) heart/lung
- 4) kidney
- 5) liver
- 6) lung
- 7) pancreas

Bone marrow transplants are covered, when Medically Necessary, under the following circumstances:

**1) Allogenic and Syngeneic Bone Marrow Transplants (Requires HLA Typing Match on at Least Five Out of Six Loci)**

- a) acute lymphocytic leukemia and non-acute lymphocytic leukemia
- b) chronic melogenous leukemia
- c) aplastic anemia
- d) Franconi's Anemia
- e) infantile malignant osteopetrosis
- f) large-cell lymphoma
- g) lymphoma
- h) Severe Combined Immundeficiency Disease (SCIDS)

- i) Wiscott Aldrich Syndrome

**2). Autologous Bone Marrow Transplants**

- a) acute lymphocytic leukemia and non-acute lymphocytic
- b) leukemia
- c) Burkitts Lymphoma
- d) large-cell lymphoma
- e) non-Hodgkin's lymphoma
- f) Hodgkin's Disease
- g) neuroblastoma

- 3).** Stem cell transplants in conjunction with high-dose chemotherapy are covered, when medically necessary. Prior authorization is recommended (a retrospective review will be done if services are not prior authorized). The Plan Administrator will consider high-dose chemotherapy with either allogenic or autologous stem-cell transplant on an individual case basis

**c. Donor Benefits**

Donor services and supplies will not be covered if provided to an Enrolled donor when the recipient is not Enrolled in the BCBSMT Managed Care Plan or is not eligible for transplant benefits. The exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.

**d. No Coverage for the Following:**

- 1) Services or expenses related to the transplantation of animal or artificial organs.
- 2) Transplants that are not currently approved under Medicare transplant guidelines.
- 3) Charges that are not routinely made to all patients receiving similar human organ transplants.
- 4) Benefits for a human organ transplant donor who has coverage for services related to the organ donation elsewhere. If the donor does not have coverage elsewhere, and the recipient is a Member, then the donor will be covered under this BCBSMT Managed Care Plan, but only

for health services related to the organ donation.

- 5) Kidney transplants that are first covered by Medicare.
- 6) Experimental or investigational Procedures.

**14. SKILLED NURSING FACILITY CARE**

*Please refer to Schedule of Benefits for maximums.*

Coverage is provided for Medically Necessary care by a licensed institution, or part of an institution that offers skilled nursing services (as defined in Section C Definitions of this Amendment).

**B.29 HEALTH PLAN EXCLUSIONS**

.....

The following exclusions are considered non-Covered Medical Services and supplies:

**1. NON-COVERED SERVICES**

Exclusions include health care services and supplies that are not listed as Covered Medical Services even if provided by a Covered Provider.

**2 SERVICES WHICH ARE NOT MEDICALLY NECESSARY**

**3. NON-AUTHORIZED SERVICES**

Exclusions include services not performed, arranged, authorized, or approved as specified in this Amendment.

**4. PRESCRIPTION DRUGS**

Exclusions include outpatient prescription drugs, which are covered by a separate Prescription Drug Plan (see Section C Definitions of this Amendment).

**5. PRE-EXISTING CONDITIONS**

Pre-Existing Conditions are excluded for up to one year from a Member’s coverage Effective Date. However, the period of exclusion may be reduced by Creditable Coverage as described in Section C Definitions of this Amendment.

**6. HEARING AID SERVICES**

Exclusions include all services and supplies related to the purchase, examination, or fitting of hearing aids; supplies; and tinnitus maskers.

**7. COMPLICATIONS FROM INELIGIBLE PROCEDURE**

Exclusions include surgery and other services and supplies related to (or required to treat) complications arising from any procedure ineligible for coverage under this Amendment.

**8. ELECTIVE, COSMETIC, AND VOLUNTARY HEALTH SERVICES**

Except as specifically provided in this Amendment, exclusions include all services related to voluntary personal health improvement, cosmetic, or other elective health care including, but not limited to:

- a. Surgery and any related services for the sole intent to improve appearance.
- b. Services and supplies for cosmetic purposes, including the restoration of hair, appearance of skin, and/or body shape.
- c. Personal hygiene and convenience items including, but not limited to: air conditioners, humidifiers, or physical fitness equipment.
- d. Lifestyle improvements, such as physical fitness programs.
- e. Services and/or memberships provided through facilities including, but not limited to: health clubs, fitness centers, or spas.
- f. Dietary regimen supplements and/or exercise programs for the controlling or reduction of weight, except the limited obesity treatment benefit (described in B.28, provision 11).
- g. Dietary supplements, except medical foods required for the treatment of inborn errors of metabolism (described in B.19).
- h. Procedures, services, drugs, and supplies related to elective abortions, except when the

- pregnancy is the result of an act of rape or incest.
- i. Treatment leading to (or in connection with) sexual reassignment including, but not limited to: surgery and mental health counseling.
  - j. Services and supplies for (or related to) conception by artificial means, except as provided in B.28, provision 8.
  - k. Services and supplies needed to reverse a sterilization procedure, including tubal ligations and vasectomies.
  - l. Treatment of non-organic sexual dysfunction.
  - m. Pastoral, financial, or legal counseling.
  - n. Counseling services for adolescent behavior problems, learning delays, self discovery and improvement, and family and marital problems, except as provided by the Employee Assistance Program.
  - o. All services related to routine, non-Medically Necessary foot care including, but not limited to: the treatment or removal of corns, calluses, or nails; hypertrophy; hyperplasia of skin or subcutaneous tissues; cutting or trimming of nails; treatment of weak, strained, or flat feet; fallen arches; orthotic appliances, lifts, and orthopedic shoes (except the foot orthotic benefit provided in B.28, provision 5); padding and strapping; and fabrication.
  - p. Physical examinations and other services required for obtaining or maintaining employment, insurance, or government licensing, unless they are a portion of an annual physical assessment covered as an adult preventive service (as defined in B.21 or B.26).
  - q. School, sports, and camp physicals, unless they are part of an annual physical assessment covered as a preventive services (as defined in B.21 or B.26).

- r. Over-the-counter supplies including, but not limited to: bandages, splints, and medications.
- s. Any device for the sole purpose of enhancing sports-related activities.
- t. Immunizations for foreign travel.
- u. Education or tutoring services, except as provided in B.28, provision 4.

## **9. NURSING HOME AND RELATED CONVALESCENT CARE**

Except as specifically provided in this Amendment, exclusions include:

- a. Confinement in a skilled nursing facility or convalescent Hospital, or that part of such facility used for:
  - 1) convalescent, custodial, or rest care;
  - 2) Mental Illness or Chemical Dependency care; or
  - 3) training or schooling.
- b. Services or articles for custodial, convalescent, or maintenance care; domiciliary care; rest care; or care designed primarily to assist in the activities of daily living.
- c. Long-term care services.

## **10. EXPERIMENTAL PROCEDURES**

Exclusions include Experimental Procedures (as defined in Section C Definitions of this Amendment) and/or medical treatments, procedures, drugs, devices, or biologics that are experimental, investigational, or used for research.

## **11. NON-STANDARD, OR SELF PRESCRIBED SERVICES AND SUPPLIES**

Except as specifically provided in this Amendment, plan exclusions include all services for non-standard, or self-prescribed therapies including, but not limited to:

- a. orthomolecular therapy, including nutrients, vitamins, and food supplements;

- b. hypnotism, hypnotherapy, or hypnotic anesthesia;
- c. acupuncture or acupressure;
- d. stress management;
- e. biofeedback;
- f. naturopathy;
- g. homeopathy;
- h. chelation therapy (except for mineral or metal poisoning);
- i. massage or massage therapy; and
- j. rolfing

**12. INJURY OR SICKNESS RELATED TO ILLEGAL ACTIVITIES**

Exclusions include the care and treatment of injuries or sickness due to the commission of (or attempt to commit) a felony act, or engaging in an illegal act or occupation.

**13. INJURY OR SICKNESS RELATED TO A RIOT**

Exclusions include the care and treatment of injuries or sickness due to voluntary participation in a riot.

**14. LEGALLY-ORDERED SERVICES**

Exclusions include services which are not deemed Medically Necessary regardless of whether required by a court order, or as a condition of parole or probation.

**15. ADMINISTRATIVE CHARGES**

Exclusions include charges for missed appointments or other administrative sanctions.

**16. INJURIES OR SICKNESS RELATED TO MILITARY SERVICE**

Exclusions include services for (or related to) any sickness or injury suffered as a result of (or while in) military service.

**17. SERVICES INCURRED OUTSIDE THE COVERAGE PERIOD**

Exclusions include services incurred outside the coverage period including:

- a. while the Member is not covered;

- b. prior to the Effective Date of coverage for a Member; and
- c. after a Member's termination of coverage and after any extension of benefits or continuation of coverage as specified in your Employer's Plan Document/Summary Plan Description.

**18. TRAVEL**

Travel is excluded, except transportation of the patient in an emergency to the nearest facility qualified to treat the injury or disease, or as otherwise provided in the ambulance benefit (B.7) or transplant benefit (B.28, provision 13), and approved by the Health Plan.

**19. CERTAIN PRIVATE ROOM CHARGES**

Exclusions include private room accommodations to the extent charges are in excess of the institution's most common semi-private room charge, unless a private room is deemed Medically Necessary by the Health Plan.

**20. DUPLICATE SERVICES OR SERVICES COVERED UNDER ANOTHER BENEFIT PLAN**

Except as specifically provided in this Amendment, and subject to the Coordination of Benefits Section of your Employer's Plan Document/ Summary Plan Description, all services covered by another benefit plan are excluded including, but not limited to:

**a. Government-Covered Services and Supplies**

Exclusions include services and supplies to the extent they are covered by any governmental law, regulation, or program (such as Medicare, Medicaid, and Champus), subject to federal and state laws or regulations.

Under certain circumstances, the law allows certain governmental agencies to recover expenses for services rendered to you from your BCBSMT Managed Care Plan. When such a circumstance occurs, you will receive an EOB.

**b. Workers' Compensation-Covered**

## Services

Exclusions include services for injuries or diseases for which benefits are (or should be) provided pursuant to state workers' compensation laws.

This exclusion applies to all services and supplies provided to treat such illness or injury even though one or more of the following apply:

- 1) Coverage under the government legislation provided benefits for only a portion of the services incurred.
- 2) Your employer failed to obtain such coverage as required by law: This exclusion does not apply if your employer was not required and did not elect to be covered under any workers' compensation law; occupational disease law; or employer's liability act of any state, country, or the United States.
- 3) The Member waived his or her rights to such coverage or benefits.
- 4) The Member failed to file a claim within the filing period allowed by law for such benefits.
- 5) The Member fails to comply with any other provision of the law to obtain such coverage or benefits.
- 6) The Member was permitted to elect not to be covered by the workers' compensation law; but failed to properly make such election effective. This exclusion does not apply if you are permitted by statute not to be covered and you elect not to be covered by a workers' compensation law; occupational disease law; or liability law.

If the Member enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, the BCBSMT Managed Care Plan will not cover past or future medical services that are the subject of (or related to) that settlement. In

addition, if the Member is covered by a workers' compensation program that limits benefits if providers other than those specified are used, and the Member receives care or services from a provider not specified by the program, the BCBSMT Managed Care Plan will not cover the balance of any costs remaining after the program has paid.

## c. Expenses Covered by Other Insurance Policies

Exclusions include expenses that a Member is entitled to have covered (or that are paid) under an automobile insurance policy, a premise liability policy, or other liability insurance policy (such as a home owners or business liability policy). Exclusions also include expenses the Member would be entitled to have covered under such policies if not covered by the BCBSMT Managed Care Plan, unless applicable law requires the BCBSMT Managed Care Plan to provide primary coverage.

## 21. CHARGES MEMBERS ARE NOT OBLIGATED TO PAY

Exclusions include services and supplies for which a Member is not legally, or as a customary practice, required to pay in the absence of insurance or a Hospital medical payment plan.

## 22. THIRD PARTY LIABILITY

Exclusions include services and supplies when another person or entity is legally responsible for causing or contributing to the condition which is being treated, and is therefore liable at law for the cost of treatment, except as provided in the subrogation provisions of your Employer's Plan Document/Summary Plan Description

## 23. UNUSUAL CIRCUMSTANCES

Neither the Health Plan nor any Network or Participating Providers shall have any liability or obligation because of a delay or failure to provide Covered Medical Services or benefits under the following circumstances:

- a. complete or partial destruction of facilities;
- b. war;
- c. riot;

- d. civil insurrection;
- e. major disaster;
- f. disability of a significant part of the participating Hospital and/or provider Network;
- g. epidemic; or
- h. labor dispute not involving the Health Plan, participating Hospitals, and/or other Participating Providers.

Network Providers will make their best efforts to provide services and benefits within the limitations of available facilities and personnel. If the rendering of Covered Medical Services or benefits is delayed due to a labor dispute involving the Health Plan or Network Providers, non-emergency care may be deferred until after the resolution of the labor dispute.

**24. VOCATIONAL REHABILITATION**

**25. DENTAL COVERAGE**

Exclusions include dental coverage (see B.28, provision 2, for limited coverage due to accidental injury).

**26. VISION SERVICES AND APPLIANCES**

Exclusions include vision services and appliances including eye exams, glasses, contact lenses, radial keratotomy or other surgery to correct vision, and orthoptic or vision training (These may be covered by a separate Employer vision plan).

**27. TREATMENT FOR MALOCCLUSION OF THE JAW**

Exclusions include services for temporomandibular joint dysfunction (TMJ), anterior or internal dislocations, derangements, myofascial pain syndrome, and orthodontics (dentofacial orthopedics) or related appliances. Surgical treatment for these conditions will be allowed only if prior authorized by the Health Plan.

**28 ORGAN OR TISSUE TRANSPLANTS**

Organ and tissue transplants are excluded, except as provided in B.28, provision 13.

**29 SPEECH THERAPY**

Developmental Speech Therapy is excluded from

coverage.

**30. ANY ADDITIONAL CHARGES FOR INCLUSIVE PROCEDURES OR SERVICES**

Exclusions include additional charges for Inclusive Procedures or services (as defined in Section C Definitions of this Amendment).

**31. SERVICES OR SUPPLIES NOT PROVIDED BY A COVERED PROVIDER OR WHICH ARE NOT LISTED AS A BENEFIT IN THIS AMENDMENT.**

## **Section C**

# **DEFINITIONS**

### **ALLOWABLE FEE**

The allowance for each procedure or service set by the Health Plan based on:

1. any applicable contractual fee agreement between the Health Plan and the provider; and/or
2. the Health Plan's selected methodology for assigning allowances to procedure/service codes.

### **BENEFIT YEAR**

The period defined as a Benefit Year in your Employer's Plan Document/ Summary Plan Description.

### **CASE AND DISEASE MANAGEMENT**

Case management services to Members identified as having significant medical risks, chronic health care needs, or a catastrophic accident or illness which can benefit from focused services of a case management nurse. This nurse works with the Member, attending Physician, and family to identify and arrange the most appropriate, effective, and cost-efficient treatment or Disease Management program possible and make the best use of available insurance benefits.

### **CERTIFICATION (OF MEDICAL NECESSITY) AND PRE-CERTIFICATION**

Certification is a determination by the Health Plan that a Hospital inpatient stay meets Medical Necessity criteria for inpatient benefits. Additionally, a determination that the inpatient Hospital stay also meets (or fails to meet) the criteria for the In-Network Level of Benefits. Pre-Certification is Certification in advance of a non-emergency admission.

### **CHEMICAL DEPENDENCY**

Substance abuse and addiction, including alcoholism and drug addiction, involving such substances as ethyl alcohol, tranquilizers,

narcotics, narcotic synthetics, sedatives/ hypnotics, amphetamines, cocaine, hallucinogens, products containing tetra-hydro-cannabinol, and volatile inhalants.

### **CHEMICAL DEPENDENCY TREATMENT FACILITY**

A facility that provides a program for the treatment of Chemical Dependency in accordance with a written treatment plan approved and monitored by a Physician or addiction counselor certified by the state. The facility must also be approved as a Chemical Dependency Treatment Facility by the Montana Department of Public Health and Human Services.

### **COINSURANCE(COINSURANCE MAXIMUM)**

Coinsurance is a means of cost sharing. The Health Plan pays a percentage of allowed charges (after any applicable Deductible has been met) and the Member pays a percentage -- the Coinsurance. Coinsurance Maximum is the same as the Out-of-Pocket Maximum defined in this section. See the current Schedule of Benefits for your current Coinsurance for various services.

### **COPAYMENT**

Copayment like Coinsurance is also a means of cost sharing. You pay a fixed dollar amount, the Copayment for a Covered Medical Service and the Health Plan pays remaining Allowable Fees. See the current Schedule of Benefits for any current Copayment obligations. Copayment is the cost sharing method typically used for a Managed Care Benefit Plan.

### **COVERED MEDICAL EXPENSE**

An expense within Allowable Fees and any specified benefit limitations for a Covered Medical Service.

### **COVERED MEDICAL SERVICE**

A service, procedure, or supply that meets the following criteria:

- 1 Listed as a benefit in Section B 1-28 and not excluded in Section B 29 of this Amendment.

2. Determined to be Medically Necessary for the diagnosis or treatment of injury, illness, or maternity care (unless a preventive benefit clearly listed in this Amendment).
3. Provided to a Member by a Covered Provider.
4. Provided and coded in accordance with applicable medical policy.

### **COVERED PROVIDER**

A provider of medical services (individual or facility), who/which has both:

1. satisfied the necessary requirements to practice or provide medical services within the State of Montana or in another state or country where services are received; and
2. been recognized by the Health Plan as a provider of the kind of services received, based on the nature of the services and extent of the providers licensure.

A provider may, because of the limited scope of practice, be a Covered Provider only for certain services.

### **CREDITABLE COVERAGE**

Previous comprehensive medical coverage of a new Enrollee under any of the following plans and programs, provided there is no 63-day or greater lapse in coverage:

- Group health plan.
- Individual health plan.
- Medicare.
- Medicaid.
- Indian Health Services coverage.
- State health risk pool.
- Public health plan.
- Other coverage as specified by the Health Reform Act of 1996.

There must not be a lapse of 63 days or more between the previous coverage and Enrollment in your Employer's Employee benefit program. If there was an earlier 63-day or greater lapse in the prior coverage, only prior coverage since the

lapse is Creditable Coverage.

### **CUSTODIAL CARE**

The provision of room and board, with or without routine nursing care, training, personal hygiene, and other forms of self care or supervisory care for a person who is mentally or physically disabled as a result of retarded development or body infirmity, and who is not under special medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable such person to live outside an institution. Custodial Care includes services or treatment that could be rendered safely by a person without medical skills and is mainly to help the patient with daily living activities.

### **DEDUCTIBLE**

Allowable Fees a Member and family must pay before a Health Plan makes payment.

### **DENTAL PLAN**

A plan of dental benefits that is separate from this BCBSMT Managed Care Plan.

### **DEPENDENT (OR ELIGIBLE DEPENDENT)**

An individual who has a relationship to a Member which makes the individual eligible to be Enrolled in this BCBSMT Managed Care Plan under your Employer's Plan Document/Summary Plan Description.

### **DURABLE MEDICAL EQUIPMENT**

The most cost effective, appropriate equipment for Medically Necessary therapy of a medical condition in your home. Covered Durable Medical Equipment must meet the following criteria:

1. Able to withstand repeated use — consumable goods are not covered.
2. Generally not useful to a person who is not ill or injured.
3. Primarily used to serve a medical purpose rather than comfort and convenience.
4. Prescribed by a Physician.

The following are examples of items that are not covered as Durable Medical Equipment:

1. Exercise equipment.

2. Car lifts or stair lifts.
3. Biofeedback equipment.
4. Self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition.
5. Air conditioners and purifiers.
6. Whirlpool baths, hot tubs, or saunas.
7. Water beds.
8. Computerized and deluxe equipment like motor-driven wheelchairs or beds when standard equipment is adequate.
9. Other equipment which is not always used for healing or curing.

**EFFECTIVE DATE**

The date on which a new Enrollee’s coverage begins.

**EMERGENCY MEDICAL CONDITION**

A condition manifesting itself with symptoms of sufficient severity, including severe pain, and which the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. The Member’s health would be in serious jeopardy.
2. The Member’s bodily functions would be seriously impaired.
3. A bodily organ or part would be seriously damaged.

**EMPLOYEE OR ELIGIBLE EMPLOYEE**

An individual who is employed by the Employer designated on the Cover Page and who is eligible to be Enrolled in this BCBSMT Managed Care Plan under the Employer’s Plan Document/ Summary Plan Description.

**EMPLOYEE ASSISTANCE PROGRAM (EAP) AND EMPLOYEE ASSISTANCE PROGRAM ADMINISTRATOR**

A program providing confidential, short-term counseling services to subscribers and family members, and administered by an Employee Assistance Program administrator on contract

with the Employer.

**ENROLL, ENROLLED**

An eligible individual’s act of completing necessary requirements and procedures to obtain coverage or membership; a plan’s or program’s act of extending coverage or membership; and the past extension of coverage or membership which is still in effect in any plan or program to which the term is applied.

**EXPERIMENTAL PROCEDURES OR SERVICES**

Treatment, which is considered Experimental because it meets one of the following criteria:

1. Prescription drugs not approved by the FDA to be lawfully marketed for the proposed use, and it is not identified in the American Hospital Formulary Service, the AMA Drug Evaluation, or the Pharmacopoeia as an appropriate use.
2. It is subject to review or approval by an institutional review board (meaning that a Hospital considered it Experimental and put it under review to meet federal regulations, or review is required and defined by federal regulations, particularly those of the FDA or Department of Health and Human Services).
3. It is the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in FDA regulations, regardless of whether it’s an FDA trial.
4. It has not been demonstrated through prevailing, peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
5. The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, and effectiveness (or effectiveness compared with conventional alternatives), and/or that usage should be substantially confined to research settings.
6. It is not a covered benefit under Medicare as determined by the Centers for Medicare and Medicaid Services (CMMS, formerly HCFA) because it is considered experimental, investigational, or unproven.
7. It is experimental, investigational, unproven, or not a generally acceptable medical practice in

the predominate opinion of independent experts utilized by the administrator of each plan.

8. It is not Experimental or investigational in itself pursuant to the above and would not be Medically Necessary, but it is being provided in conjunction with the provision of a treatment, procedure, device, or drug which is experimental, investigational, or unproven.

### **HOME HEALTH AGENCY**

An agency licensed by the state which provides part-time skilled nursing services and other covered therapeutic services including Physical, Speech, and Occupational Therapy, medical social services, and home health aide services.

### **HOME INFUSION THERAPY**

The preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Member by a Home Infusion Therapy Agency. Services include education for the Member, the Member's care giver, or a family member.

### **HOME INFUSION THERAPY AGENCY**

A health care organization or agency that provides Home Infusion Therapy services. A licensed Hospital that provides Home Infusion Therapy services must have a Home Infusion Therapy agency license or endorsement.

### **HOME HEALTH CARE PLAN**

A written treatment plan established by a Physician who certifies that the Home Health Care Plan is Medically Necessary.

### **HOSPICE**

A facility, agency, or service that meets the following criteria:

1. Arranges, coordinates, and/or provides care for the terminally ill patient.
2. Is licensed, accredited, or approved by the state to establish and manage Hospice care programs.
3. Maintains records of Hospice care services

provided and bills for such services.

4. Is a Home Health Agency, which provides Hospice care.

### **HOSPITAL**

An acute-care facility licensed by the state where it is located and which meets the following criteria:

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

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

- a. a nursing or convalescent home.
- b. a rest home.
- c. Hospice.
- d. a rehabilitation facility.
- e. a skilled nursing facility.
- f. a place for care and treatment of Chemical Dependency.
- g. a place for the treatment of Mental Illness.
- h. a long-term chronic-care institution or facility providing the type of care listed above.

The term Hospital for purposes of Certification includes any facility that provides inpatient medical, psychiatric, or Chemical Dependency services, not just facilities that meet the above definition.

### **IDENTIFICATION CARD (IDENTIFICATION NUMBER)**

A Health Plan Identification Card, which provides information such as a unique subscriber Identification Number, a group Identification Number, and other information required for claims administration by the Health Plan. It may also include information on Dependent coverage, plan requirements, and customer service. It may also include information on other insurance coverage offered by your Employer such as dental, vision or pharmacy coverage.

### **INCLUSIVE SERVICES/PROCEDURES**

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

## **IN-NETWORK (NETWORK)**

The group of In-Network Providers defined below.

### **IN-NETWORK LEVEL OF BENEFITS**

The highest level of benefits provided by the BCBSMT Managed Care Plan, as defined in the current Schedule of Benefits. The requirements for this Level of Benefits are specified in this Amendment.

### **IN-NETWORK (NETWORK) PROVIDER**

A Covered Provider who has contractually agreed to provide medical services to members of a Managed Care Plan according to the fees and other terms of a Managed Care Plan contract. Benefits for services provided In-Network (by an In-Network Provider) are typically higher level benefits (the In-Network Level of Benefits) than benefits for services Out-of-Network (by another provider) — unless there is a required referral or Health Plan approval. For referral/Health Plan approval requirements see Section A of this Amendment. See [www.bluecrossmontana.com](http://www.bluecrossmontana.com) and specify the “NorthWestern Energy Managed Care” or Blue-Choice” plans for a listing of BCBSMT Managed Care Plan In-Network Providers. Please note that “Participating Providers” defined below are not In-Network Providers.

### **MANAGED CARE BENEFIT PLAN**

A plan of managed medical benefits and the requirements, arrangements, and conditions for receipt of benefits. The Managed Care Benefit Plan described in this Amendment is the BCBSMT Managed Care Plan. A Managed Care Benefit Plan is administered by a Managed Care Plan (defined below) and includes both higher level benefits (the In-Network Level of Benefits) when medical services are received In-Network or with required referral/Health Plan approval, and lower level (Out-of-Network Benefits) for most other Covered Medical Services.

### **MANAGED CARE PLAN**

A Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), or other organization, which is licensed in the State of Montana to provide managed health care

benefits primarily through its In-Network Providers. Blue Cross and Blue Shield of Montana, termed “Health Plan” in this Amendment has a contract with your Employer to provide or administer a Managed Care Benefit Plan (termed “BCBSMT Managed Care Plan” in this Amendment) for Eligible Employees (and their Dependents) who select it.

### **MAXIMUM LIFETIME BENEFIT**

The maximum benefit a medical plan pays to any one member per lifetime. See the current Schedule of Benefits for the Maximum Lifetime Benefit in effect.

### **MEDICAL NECESSITY (MEDICALLY NECESSARY)**

A service or supply provided by a Covered Provider of this BCBSMT Managed Care Plan and determined by the Health Plan to meet the following criteria:

1. Appropriate for the symptoms and diagnosis of the Member’s condition, illness, or injury.
2. Provided for the diagnosis, or the direct care and treatment of the Member’s condition, illness, or injury.
3. In accordance with standards of accepted medical practice.
4. Not primarily for the convenience of the Member or the provider.
5. The most appropriate supply or level of service that can safely be provided to the Member. When applied to inpatient care, this further means that the Member requires acute care as a bed patient due to the nature of the services rendered or the Member’s condition, and the Member cannot receive safe or adequate care on an outpatient basis.

The fact that services were recommended or performed by a Covered Provider does not automatically make the services Medically Necessary and a service may meet Medical Necessity criteria but not be a covered benefit of this BCBSMT Managed Care Plan. To determine if a planned procedure or service meets Medical Necessity criteria and is a covered benefit of this

BCBSMT Managed Care Plan you may obtain a Prior Authorization by calling the Health Plan.

### **MEMBER**

An Enrolled Employee or former Employee who has continued coverage under the Employer's Employee Benefit Plan, or an Enrolled Dependent who remains eligible and covered by the Employer's Employee Benefit Plan and any insurance plan or program offered by the Employer to which the term Member is applied.

### **MENTAL ILLNESS**

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

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

Mental Illness does not include:

1. Developmental disorders.
2. Speech disorders.
3. Psychoactive substance abuse disorders.
4. Eating disorders (except bulimia and anorexia nervosa).
5. Impulse control disorders (except for intermittent explosive disorder and trichotilomania).
6. Severe Mental Illness (defined below).

### **MID-LEVEL PRACTITIONER**

A licensed APRN (Nurse Practitioner), PA (Physician Assistant), or CNMW (Certified Nurse Midwife) who practices in conjunction with a licensed MD or OD. This practice must include 24-hour coverage for emergency admissions and health care.

### **MORBID OBESITY**

A condition of persistent and uncontrollable weight gain that is potentially life threatening and is defined as a body mass index (BMI) greater than 40. BMI is calculated as weight (kilograms)/height (meters) squared.

### **OBSERVATION BEDS/ROOMS**

Outpatient beds that are used to either:

1. provide active short-term medical/surgical nursing services, or
2. monitor the stabilization of the patient's condition.

### **OCCUPATIONAL THERAPY**

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

### **OUT-OF-NETWORK**

Outside the Network (the group of In-Network Providers) defined above.

### **OUT-OF-NETWORK LEVEL OF BENEFITS**

The lower level of benefits provided by this BCBSMT Managed Care Plan (as defined in the current Schedule of Benefits) for Covered Medical Services received from a Covered Provider outside the Network without required referral or Health Plan approval. (Required referral/Health Plan approval is specified in Section A of this Amendment.). A few Covered Medical Services have no Out-of-Network benefits -- See A.1, provision 4 for a listing of these medical services.

### **OUT-OF-NETWORK PROVIDER**

Any Covered Provider who is not an In-Network Provider of the BCBSMT Managed Care Plan, as defined above. Out-of-Network Providers include Participating Providers who are participating only to the extent that they accept this Health Plan's Allowable Fees, but who have not agreed to other terms of a Managed Care Plan Network contract.

### **OUT-OF-POCKET MAXIMUM**

The maximum amount of any Coinsurance which are credited toward an insurance plan's Out-of-Pocket Maximum, that you must pay in a Benefit Year for:

1. an individual Member (the individual Out-of-Pocket Maximum), or

2. Enrolled family Members (the family Out-of-Pocket Maximum).

Once a Member meets the BCBSMT Managed Care Plan's individual Out-of-Pocket Maximum, no more Coinsurance must be made for that Member for the remainder of the Benefit Year. Once an Enrolled family has met the BCBSMT Managed Care Plan's family Out-of-Pocket Maximum, no more Coinsurance must be made for any Enrolled family Member for the remainder of the Benefit Year. See the Schedule of Benefits for the current Benefit Year for information on the individual and family Out-of-Pocket Maximums and the Coinsurance that is credited to the Out-of-Pocket Maximum for this BCBSMT Managed Care Plan.

**PARTIAL HOSPITALIZATION  
(FOR MENTAL ILLNESS  
ONLY)**

A time-limited ambulatory (outpatient) program offering active, therapeutically intensive treatment, which involves structured clinical services within a stable, therapeutic program. The program can involve day, evening, and weekend treatment. The underlying aim of this treatment is clinical stabilization required due to severe impairment and/or dysfunction in major life areas. A Partial Hospitalization program should offer four – eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

**PARTICIPATING PROVIDER**

A Covered Provider who has agreed to accept Allowable Fees as payment in full and not bill the Health Plan's Members extra amounts. A List of the Health Plan's Participating (or member) Providers, is available at the web site: [www.bluecrossmontana.com](http://www.bluecrossmontana.com). These are Covered Providers on the "All Plans" list but not on the "NothWestern Energy Managed Care" or "Blue Choice" list of Network Providers. You may also call the customer service number on the Identification Card for this BCBSMT Managed Care Plan.

**PERSONAL CARE PHYSICIAN (PCP)**

A physician or Mid-Level Practitioner, who specializes in family practice, internal medicine, general practice, or pediatrics, and who is selected by a Member to manage their continuum of care and coordination of Covered Medical Services. Alternatively, a Member may select an In-Network OB/GYN as the PCP if that physician has agreed to be a Personal Care Provider.

**PHYSICAL THERAPY**

Treatment of disease or injury by physical means such as hydrotherapy; heat or similar modalities; physical agents; bio-mechanical and neuro-physiological principles; and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a body part.

**PHYSICIAN**

An individual who has satisfied the necessary qualifications to practice as an MD (Doctor of Medicine) or OD (Doctor of Osteopathy).

**PLAN DOCUMENT/SUMMARY PLAN  
DESCRIPTION**

The Employer's Description of its Employee insurance benefit program including any amendment there to.

**POINT-OF-SERVICE PLAN**

A Point-of-Service Plan is a medical plan in which the level of benefits you receive for a medical service is determined by the Covered Provider you use for the service. If you use an In-Network Provider, you receive higher level (In-Network) Benefits. If you use a Covered Provider outside the Health Plan's Network without required referral/Health Plan approval, you receive lower level (Out-of-Network) benefits with a separate Deductible and Out-of-Pocket Maximum. The BCBSMT Managed Care Plan is a Point-of-Service Plan.

**PRESCRIPTION DRUG PLAN**

The plan of prescription drug benefits administered by a Prescription Benefit Management vendor under a separate agreement with your Employer.

**PRE-EXISTING CONDITION**

A condition for which medical advice, diagnosis, care, or treatment (including prescription drugs) was recommended or received by a Member within the six-month period ending on the Member's Enrollment date. Pregnancy and any conditions of an Eligible Dependent newborn or an adopted Eligible Dependent child are not Pre-Existing Conditions.

### **PRIOR AUTHORIZATION**

A process to inform you whether a proposed service, medication, supply, or ongoing treatment meets the following criteria for coverage by this BCBSMT Managed Care Plan:

1. Is Medically Necessary.
2. Complies with applicable medical policy.
3. Is a benefit of the BCBSMT Managed Care Plan.

A Prior Authorization will also let you know if the service, supply, etc. meets criteria for the In-Network Level of Benefits.

See Section A.1 for more information on obtaining a Prior Authorization.

### **PROFESSIONAL PROVIDER**

An individual who has satisfied the necessary qualifications to practice medicine within the State of Montana or another state or country. Professional Providers may include, but are not limited to, Physicians; Mid-Level Practitioners; podiatrists; or physical, occupational, or speech therapists.

### **REHABILITATION SERVICES**

Specialized treatment, for an injury or physical deficit, which meets the following criteria:

1. Provided in an inpatient or outpatient setting.
2. An intense, comprehensive program of therapies and services provided by a multi-disciplinarian team of health service Covered Providers who are licensed, certified, or otherwise approved to practice

their respective professions in the state where the services are provided. This also includes associated general and medical services incidental to rehabilitation care.

3. Designed to restore the patient's maximum function and independence.
4. Under the direction of a qualified Physician and includes a formal written treatment plan with specific goals.
5. The patient must be making continued progress towards the stated goals on the plan of care to continue with the services.

Rehabilitation Services includes respiratory, pulmonary, cardiac, Physical Therapy, Occupational Therapy, and Speech Therapy.

### **SCHEDULE OF BENEFITS**

A Benefit-Year description of Deductibles, Coinsurance, Coinsurance Maximums, Copayment, Out-of-Pocket Maximums, Maximum Lifetime Benefits and other benefit-specific limitations and conditions that apply to benefits received under this BCBSMT Managed Care Plan during the Benefit Year. The current Schedule of Benefits must be read in conjunction with this Amendment for a complete description of current benefits.

### **SEVERE MENTAL ILLNESS**

Severe Mental Illness shall mean conditions defined as severe under 33-22-706 MCA:

1. Schizophrenia.
2. Schizo-affective disorder.
3. Bipolar disorder.
4. Major depression.
5. Panic disorder.
6. Obsessive-compulsive disorder.
7. Autism.

### **SKILLED NURSING FACILITY CARE**

Medically Necessary inpatient skilled nursing services provided by an institution, or distinct part thereof, which is licensed pursuant to state or local law to provide skilled nursing services only. A skilled nursing facility is primarily engaged in providing continuous nursing care by, or under the direction and supervision

of, a registered nurse for sick or injured persons during the convalescent stage of their illness or injuries. Skilled Nursing Facility Care is not, other than incidentally, a rest home or home for Custodial Care or for the aged. In no event does this term include care by an institution or any part of an institution, which is primarily engaged in the care and treatment of Mental Illness or Chemical Dependency.

### **SPEECH THERAPY**

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

### **TRANSPLANT NETWORK**

A Network of transplant centers designated by the Health Plan to provide transplant services according to the terms of this BCBSMT Managed Care Plan Amendment. Institutions that participate in a Transplant Network must meet established criteria for quality and agree to a negotiated, all-inclusive rate for a package of transplant services that includes professional, facility and ancillary services, and/or a pre-determined length of time.