2019 INDIVIDUAL CONNECTED CARE COMPREHENSIVE HEALTH INSURANCE POLICY

Version 2.0

MHC-5100

MONTANA HEALTH COOPERATIVE
P.O. BOX 5358
HELENA, MT 59604
855-447-2900

Individual Connected Care Comprehensive Health Insurance Policy

In this Policy, the Owner is referred to as "You" or "Your". The Montana Health Cooperative is referred to as "We", "Our", "Us", or "the Company.

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US. READ YOUR POLICY CAREFULLY.

We will pay the benefits set forth in this Policy. Benefit payment is governed by all the terms, conditions and limitations of this Policy. This Policy is effective on the Policy Effective Date shown in the Schedule of Benefits at 12:01 a.m. local time at Your place of residence. This Policy is issued in consideration of the application for this Policy and payment of the initial premium.

RIGHT TO EXAMINE THE POLICY: If, for any reason, You are not completely satisfied with this Policy, You may cancel this Policy by returning it to Us or to any agent appointed by Us within 10 days after You receive it. Returning this Policy to Us will void it from the Policy Effective Date of this Policy, and We will promptly refund Your entire premium payment.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

MEMBER RIGHTS: When requested by the insured or the insured's agent, Montana law requires Montana Health CO-OP to provide a summary of a Member's coverage for a specific health care service or course of treatment when an actual charge or estimate of charges by a health care provider, surgical center, clinic or Hospital exceeds $500.

GUARANTEED RENEWABLE: This Policy is Guaranteed Renewable. This means that We may not, on Our own, cancel or reduce coverage provided under this Policy. Subject to the Grace Period and Termination provisions in this Policy, this Policy will remain in force as long as the required premiums are paid when due. We may change Your premium but only if We change the premium on all similar policies in force in Your state.

Signed for Montana Health CO-OP

Chief Executive Officer	Secretary
	
Richard Miltenberger	Larry Turney

Individual Comprehensive Health Insurance
Non-Participating

IMPORTANT NOTICE

PLEASE READ THE COPY OF THE APPLICATION ATTACHED TO THIS POLICY. IF ANY INFORMATION ON THE APPLICATION IS NOT TRUE AND COMPLETE, WRITE TO US AT THE CUSTOMER SERVICE ADDRESS ON PAGE 4 WITHIN 10 DAYS. THE APPLICATION IS A PART OF THIS POLICY. THIS POLICY IS ISSUED ON THE BASIS THAT THE ANSWERS TO ALL QUESTIONS AND THE INFORMATION SHOWN ON THE APPLICATION ARE CORRECT AND COMPLETE.

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IMPORTANT INFORMATION

Montana Health CO-OP is pleased to provide You with this Group Policy for Covered Persons. This Policy provides a Provider Network through which Covered Persons may obtain medical care and services. The Provider Network is administered by University of Utah Health Plans. However, Covered Persons also may elect to receive services from an Out-of-Network Provider. When Covered Persons receive services from an In-Network Provider, generally benefits will be payable at a higher level. When services are provided by an Out-of-Network Provider, generally, benefits are payable at a lower level. You can obtain a list of In-Network Provider Directory on the Montana Health Cooperative Website at www.mhc.coop.

POLICY AND CUSTOMER SERVICES – UNIVERSITY OF UTAH HEALTH PLANS

- Our Third-Party Administrator, University of Utah Health Plans, (also referred to as "U of U Health Plans" in this Policy) administers the following services for this Policy.
  - Benefit Inquiries
  - Claims
  - Complaints, Grievances and Appeals
  - Preauthorization
  - Utilization Review Management Program
  - In-Network Providers
  - Prescription Drug Benefit Program

Contact University of Utah Health Plans Customer Service:

- Customer Service phone number: 844-262-1560
- Address: University of Utah Health Plans, PO Box 45180, Salt Lake City, UT 84145
- Address for Claim Submissions: University of Utah Health Plans, Attn: MHC, P.O. Box 45180, Salt Lake City, UT 84145
- Address for Complaints, Grievances and Appeals: University of Utah Health Plans Appeals Committee Chairperson, 6053 Fashion Square Dr., Suite 110, Murray, UT 84107. https://app.secure.uuhsc.utah.edu/uhealthplans/forms/appeal

- **U.S. Employee Benefits Security Administration:** 866-444-EBSA (3272)

VISION CUSTOMER SERVICES – VSP

- Our Third-Party Administrator, Vision Service Plan (VSP), administers the Pediatric Vision Care Benefit and Vision Network for this Policy.
  - Contact VSP for Customer Service: Telephone – (800) 877-7195 or (916) 851-5000
  - Address: VSP, 3333 Quality Drive, Rancho Cordova, CA 95670

CONTACT MONTANA HEALTH CO-OP

Please contact Montana Health CO-OP for billing and enrollment questions:

- Telephone Number: 855-447-2900
- Address: Montana Health Cooperative, P.O. Box 5358, Helena, MT 59604
- Website Address: www.mhc.coop

IMPORTANT NOTICE:
NOTICE OF WOMEN'S HEALTH CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

Coverage of mastectomies and breast reconstruction benefits are subject to applicable deductibles and copayment limitations consistent with those established for other benefits. All benefits are payable according to the Policy's Schedule of Benefits. Regular Preauthorization requirements apply.

If you would like more information on WHCRA benefits, call your plan administrator at 1-844-262-1560.

IMPORTANT NOTICE:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL OBLIGATIONS

Montana Health Cooperative (MHC) is required by law to maintain the privacy of all medical information within its organization; provide this notice of privacy practices to all Policyowners; inform Policyowners of our legal obligations; and advise Policyowners of additional rights concerning their medical information. MHC must follow the privacy practices contained in this notice from its **effective date of January 1, 2019** and continue to do so until this notice is changed or replaced.

MHC reserves the right to change its privacy practices and the terms of this notice at any time, provided applicable law permits the changes. Any changes made in these privacy practices will be effective for all medical information that is maintained including medical information created or received before the changes were made. All Policyowners will be notified of any changes by receiving a new Notice of Privacy Practices.

You may request a copy of this notice of privacy practices at any time by contacting Larry Turney, Chief Operating Officer, Montana Health Cooperative, P.O. Box 5358, Helena, MT 59604, (406)447-9510.

USES AND DISCLOSURES OF MEDICAL INFORMATION

As a condition of accepting coverage under this Policy, You agree that MHC may obtain your medical records for review. Your medical information may be used and disclosed for treatment, payment and/or health care operations. For example:

TREATMENT: Your medical information may be disclosed to a doctor or hospital that requests it to provide treatment to you or for disease and case management programs.

PAYMENT: Your medical information may be used or disclosed to pay claims for services which are covered under your health care coverage.

HEALTH CARE OPERATIONS: Your medical information may be used and disclosed to, conduct quality assessment and improvement activities, to engage in care coordination or case management, to pursue Right of Recovery and Reimbursement/ Subrogation, accreditation, conducting and arranging legal services, underwriting and rating, and for other administrative purposes.

AUTHORIZATIONS: You may provide written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke this authorization in writing at any time, but this revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

PERSONAL REPRESENTATIVE: Your medical information may be disclosed to you or to a family member, friend or other person to the extent necessary to assist with your health care or with payment for your health care but only if you agree we may do so or if they have the legal right to act for you, as described in the Individual Rights section of this notice.

RESEARCH: Your medical information may be used or disclosed for research purposes provided that certain established measures to protect your privacy are in place.

AS REQUIRED BY LAW: Your medical information may be used or disclosed as required by state or federal law. For example, we will use and disclose your Personal Health Information in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose your PHI when required by the Secretary of Health and Human Services and state regulatory authorities.

COURT OR ADMINISTRATIVE ORDER: Medical information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

MATTERS OF PUBLIC INTEREST: Medical information may be released to appropriate authorities under reasonable assumption that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. Medical information may be released to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others. Medical information may be disclosed when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody. Medical information may be disclosed for purposes of child abuse reporting.

MILITARY AUTHORITIES: Medical information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Medical information may be disclosed to federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

BUSINESS ASSOCIATES: From time to time we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your Personal Health Information. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

ACCESS: You have the right to receive or review copies of the Covered Person's medical information, with limited exceptions. You may at any time during the filing period, receive reasonable access to and copies of all documents, records, and other information upon request and free of charge. Documents may be viewed at the MHC office, 1005 Partridge Place Suite 6, Helena, MT 59602 between the hours of 8:00am and 5:00pm, Monday through Friday, excluding holidays. You may also request that MHC mail copies of all documentation including electronic delivery to an electronic mail address. Any request to obtain access to the Covered Person's medical information must be made in writing. You may obtain a form to request access by using the contact information above or you may send us a letter requesting access to the address located above. If the Covered Person's Personal Health Information is maintained in an electronic health record ("EHR"), you also have the right to request that an electronic copy be sent to you or to another individual or entity.

ACCOUNTING: You have the right to receive an accounting of the disclosures of your medical information made by our company or by a business associate of our company. This accounting will list each disclosure that was made of your medical information for any reason other than treatment, payment, health care operations and certain other activities since January 1, 2017; however, if disclosures for purposes of treatment, payment, or health care operations were made through an EHR, you have the right to request an accounting for such disclosures made during the previous three years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the medical information disclosed, the reason for the disclosure, and certain other information. If you request an accounting more than once in a 12-month period, there may be a reasonable cost- based charge for responding to these additional requests. For a more detailed explanation of the fee structure, please contact our office using the information at the end of this notice.

DESIGNATION OF PERSONAL REPRESENTATIVE: You have the right to designate a family member, friend or other person as your personal representative. Your medical information may be disclosed to your personal representative to the extent necessary to help with your health care or with payment for your health care. You may obtain a form to designate a personal representative by using the contact information at the end of this notice.

RESTRICTIONS ON DISCLOSURES: You have the right to request restrictions on our use or disclosure of your medical information. Generally, we are not required to agree to these additional requests. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. Any agreement to restrictions on the use and disclosure of your medical information must be in writing and signed by a person authorized to make such an agreement on behalf of the company; such restrictions shall not apply to disclosures made prior to granting the request for restrictions. The company will not be bound unless the agreement is so memorialized in writing.

CONFIDENTIAL COMMUNICATIONS: You have the right to request confidential communications about your medical information by alternative means or alternative locations. You must inform the company that confidential communication by alternative means or to an alternative location is required to avoid endangering you. You must make your request in writing and you must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location requested. The company must accommodate the request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premium and pay claims under your health plan.

AMENDMENT: You have the right to request that the company amend your medical information. Your request must be in writing and it must explain why the information should be amended. The company may deny your request if the medical information you seek to amend was not created by our company or for certain other reasons. If your request is denied, the company will provide a written explanation of the denial. You may respond with a statement of disagreement to be appended to the information you wanted amended. If the company accepts your request to amend the information, the company will make reasonable efforts to inform others, including the people you name, of the amendment and to include the changes in any future disclosures of that information.

BREACH NOTIFICATION: You have the right to receive notice of a breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Personal Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- A brief description of the breach, including the date of the breach and the date of its discovery, if known;
- A description of the type of Unsecured Personal Health Information involved in the breach;
- Steps you should take to protect yourself from potential harm resulting from the breach;
- A brief description of the actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- Contact information, including a toll-free telephone number, e-mail address, website, or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date, we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 individuals, we are required to immediately notify the Secretary of Health and Human Services. We also are required to submit an annual report to the Secretary of Health and Human Services of a breach that involves less than 500 individuals during the year, and we will maintain a written log of breaches involving less than 500 patients.

If you receive this notice on the MHC website or by any other electronic means, you may request a written copy of this notice by using the contact information at the end of this notice.

IMPORTANT INFORMATION
COMPLAINTS, QUESTIONS AND CONCERNS

If you want more information concerning our privacy practices, or you have questions or concerns, please contact our Privacy Office.

If you are concerned that: (1) the company has violated your privacy rights; (2) you disagree with a decision made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information; (3) to request that the company communicate with you by alternative means or at alternative locations, you may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. The address to file a complaint with the U.S. Department of Health and Human Services will be provided upon request.

The company supports your right to protect the privacy of your medical information. There will be no retaliation in any way if you choose to file a complaint with Montana Health Cooperative or with the U.S. Department of Health and Human Services.

The Privacy Office
Montana Health CO-OP
P.O. Box 5358, Helena, MT 59604
(406) 447-9510
E-mail:privacyoffice@mhc.coop

IMPORTANT NOTICE:
RIGHTS AND RESPONSIBILITIES STATEMENT

The organization's member rights and responsibilities statement specifies that members have:

1. Know the names and qualifications of health care professionals involved in your medical treatment.
2. Get up-to-date information about the services covered or not covered by your plan, and any limitations or exclusions.
3. Know how your plan decides what services are covered.
4. Get information about copayments and fees that you must pay.
5. Get up-to-date information about the health care professionals, hospitals and other providers that participate in the plan.
6. Be told how to file a complaint or appeal with the plan.
7. Know how the plan pays network health care professionals for providing services to you.
8. Receive information from health care professionals about your medications, including what the medications are, how to take them and possible side effects.
9. Receive from health care professionals as much information about any proposed treatment or procedure as you may need in order to consent to or refuse a course of treatment. Except in an emergency, this information should include a description of the proposed procedure or treatment, the potential risks and benefits involved, any alternate course of treatment (even if not covered) or non-treatment and the risks involved in each, and the name of the health care professional who will carry out the procedure or treatment.
10. Be informed by participating health care providers about continuing health care requirements after you are discharged from inpatient or outpatient facilities.
11. Be informed if a health care professional plans to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
12. Receive an explanation about non-covered services.
13. Receive a prompt reply when you ask the plan questions or request information.
14. Receive a copy of the plan's Member Rights and Responsibilities Statement.

IMPORTANT NOTICE:
SUBSCRIBER INFORMATION

In this Notice, the following terms have the meanings indicated:

"Subscriber" means the Policyowner of this Policy.

"Organization" means the Montana Health Cooperative.

The organization distributes the following written information to its subscribers upon enrollment and annually thereafter:

1. Benefits and services included in, and excluded from, coverage.
2. Pharmaceutical management procedures, if they exist.

3. Copayments and other charges for which members are responsible.
4. Benefit restrictions that apply to services obtained outside the organization's system or service area.
5. How to obtain language assistance.
6. How to submit a claim for covered services, if applicable.
7. How to obtain information about practitioners who participate in the organization.
8. How to obtain primary care services, including points of access.
9. How to obtain specialty care and behavioral healthcare services and hospital services.
10. How to obtain care after normal office hours.
11. How to obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services.
12. How to obtain care and coverage when subscribers are out of the organization's service area.
13. How to voice a complaint.
14. How to appeal a decision that adversely affects coverage, benefits or a member's relationship with the organization.
15. How the organization evaluates new technology for inclusion as a covered benefit.

SECTION 1—DEFINITIONS

The following are key words used in this Policy. When they are used, they are capitalized. Also, some terms are capitalized and described within the Schedule of Benefits or the provisions in which they appear in this Policy.

Accident means an unexpected traumatic incident or unusual strain which: (1) is identified by time and place or occurrence; (2) is identifiable by part of the body affected; (3) is caused by a specific event on a single day; (4) results in a bodily Injury; and (5) occurs while coverage under this Policy is in force for the Covered Person. Accident does not mean an unintentional accident caused by or during medical treatment or surgery for an Illness or Injury.

Advanced Practice Nurse means a registered professional nurse who has completed educational requirements related to the nurse's specific practice role, in addition to basic nursing education, as specified by the board pursuant to state law.

Affordable Care Act means the federal Patient Protection and Affordable Care Act (PPACA) that was signed into law on March 23, 2010.

Allowable Fee/Allowable Amount means the maximum amount that an In-Network Provider agrees contractually to accept as full payment for provided services for Covered Benefits under this Policy.

Ancillary Charge means a charge which the Covered Person is required to pay to a Preferred Pharmacy for a covered Brand-Name Prescription Drug Product for which a Generic substitute is available. The Ancillary Charge is determined by subtracting the contracted price of the Generic drug from the contracted price of the Brand-Name drug. Any Copayment amounts are in addition to the Ancillary Charge.

Annual Out-of-Pocket Maximum means the maximum amount that the Covered Person must pay every Calendar Year for Covered Medical Expenses incurred for Covered Benefits. The Annual Out-of-Pocket Maximum is shown in the Schedule of Benefits. It applies to all Covered Benefits except the *Preventive Health Care Services Benefit*.

The Annual Out-of-Pocket Maximum includes the following:

1. Calendar Year Deductible;
2. Copayments; and
3. Coinsurance.

When the Annual Out-of-Pocket Maximum is satisfied in the Calendar Year, We will then pay 100% of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Calendar Year. The Annual Out-of-Pocket Maximum must be satisfied each Calendar Year.

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference which does not apply to the deductible, coinsurance, or Out of Pocket Maximum. (This is called balance billing.)

Family Limit for the Annual Out-of-Pocket Maximum

The Family Annual Out-of-Pocket Maximum is an aggregate Out-of-Pocket Maximum and is shown in the Schedule of Benefits. The Family Annual Out-of-Pocket Maximum is the amount that must be satisfied during the Calendar Year. When one or more of Your Family members, who are insured under this Policy, have incurred and paid Covered Medical Expenses toward the Annual Out-of-Pocket Maximum that equal the Family Annual Out-of-Pocket Maximum for the Calendar Year, the Family Annual Out-of-Pocket Maximum will be met for that Calendar Year, and We then will pay 100% of Covered Medical Expenses incurred by all Family members for the remainder of the Calendar Year. The Family Annual Out-of-Pocket Maximum must be met each Calendar Year.

Coinsurance means a percentage amount a member is responsible to pay out-of-pocket for health care services after satisfaction of the applicable deductibles or copayments, or both. The Coinsurance is applied to the Allowable Fee for Covered Medical Expenses incurred for Covered Benefits. The Coinsurance amount is shown in the Schedule of Benefits, and applies to the Out-of-Pocket Maximum. No further co-insurance is assessed when the Out-of-Pocket Maximum is met.

Copay or Copayment means a fixed dollar amount the Covered Person is required to pay for specifically listed Covered Benefits as shown in the Schedule of Benefits. The required Copayment must be paid before benefits are payable under this Policy. Copayments are generally paid to the Provider at time of service. Copayments apply towards the satisfaction of the Out-of-Pocket Maximum.

Convalescent Home means an institution, or distinct part of such institution, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is: (1) a Skilled Nursing Facility; (b) an Extended Care Facility; (3) an Extended Care Unit; or (4) a Transitional Care Unit.

A Convalescent Home will primarily be engaged in providing:

1. Continuous nursing care services;
2. Health-related services; and
3. Social services.

Such Convalescent Home services must be provided by or under the direction and supervision of a licensed registered nurse, on a 24-hour basis, for Ill or Injured persons during the convalescent state of their Illness or Injuries. A Convalescent Home is not, other than incidentally: (1) a rest home; (2) a home for custodial care; or (3) a home for the aged. It does not include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and treatment of Mental Illness or Chemical Dependency.

Covered Benefits means all services covered under this Policy as provided under *Section 5, Covered Benefits*. Covered Benefits are payable as shown in the Schedule of Benefits.

Covered Dependent means Your spouse or domestic partner, and any of Your Dependent Children (as defined in this Policy) who are insured under this Policy. A Covered Dependent must be listed as Your Dependent in Your Application for this Policy and approved by Us. The required premium for the Covered Dependent's coverage under this Policy must be paid.

Covered Medical Expense means expenses incurred for Medically Necessary services, supplies, and medications that are based on the Allowable Fee and:

1. Covered under this Policy;
2. Provided to the Covered Person by and/or prescribed by a Covered Provider for the diagnosis or treatment of an active Illness or Injury or maternity care.

The Covered Person must be charged for such services, supplies and medications.

Covered Person means the Policyowner and/or the Policyowner's Covered Dependents.

Covered Provider means a licensed or certified health care practitioner or licensed facility that qualifies to treat the Covered Person for an Illness or Injury for the Covered Benefits provided under this Policy. The services rendered by a provider may, because of the limited scope of the Covered Provider's practice, be covered under this Policy only for certain services provided. To determine if a covered provider is covered under this Policy, We will: (1) review the nature of the services rendered; (2) the extent of licensure; and (3) Our recognition of the provider in connection with the benefits provided under this Policy.

Covered Providers are In-Network Providers and Out-of-Network Providers who have been recognized by Us as a provider of services for Covered Benefits provided under this Policy.

Covered Providers include the following professional providers:

1. A Physician;
2. A Physician Assistant;
3. A Dentist;
4. An Osteopath;
5. A Chiropractor;
6. An Optometrist;
7. A Podiatrist;
8. An Acupuncturist;
9. A Naturopathic Physician;
10. A Social Worker;
11. A Professional Counselor;
12. A Physical Therapist or Occupational Therapist;
13. An Advanced Practice Registered Nurse;
14. A Nurse Specialist; and
15. A Registered Nurse First Assistant who performs surgical first assistant services.
16. Addiction Counselors,
17. Speech Therapists,
18. Certified Registered Nurse Anesthetists;
19. Dieticians; and
20. Certified Nurse Midwives.

Services provided by the professional provider must be within the scope of the Covered Provider's license or certification and appropriate for the care and treatment of the Covered Person's Illness or Injury as provided by the Covered Benefits in this Policy. Services provided by a professional provider other than a Physician may require recommendation by a Physician. The professional

provider may not be a member of the Covered Person's Immediate Family.

Covered Providers include the following facility providers:

1. Hospitals;
2. Critical Access Hospitals;
3. Freestanding Surgical Facilities; and
4. Ancillary Care Facilities.

A facility that is a Covered Provider is also referred to as a "Covered Facility".

Critical Access Hospital means a facility that is located in a rural area, as defined in 42 U.S.C. 1395ww(d)(2)(D), and that has been designated by the Department of Public Health and Human Services as a critical access hospital pursuant to Montana law. Services will be provided in a Critical Access Hospital on the same basis as a "Hospital" as defined in this Policy.

Custodial Care means providing a sheltered, family-type setting for an aged person or disabled adult so as to provide for the person's basic needs of food and shelter and to ensure that a specific person is available to meet those basic needs.

Deductible means the fixed dollar amount of Covered Medical Expenses that the Covered Person must incur for certain Covered Benefits before We begin paying benefits for them. The Deductible must be satisfied each Calendar Year by each Covered Person, except as provided under "*Family Deductible Limit"* provision. The Deductible is shown in the Schedule of Benefits. Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. The following do not apply towards satisfaction of the Deductible: (1) services, treatments or supplies that are not covered under this Policy; (2) premium payments; and (3) amounts billed by Out-of-Network Providers, which include the Out-of-Network Provider Differential.

Family Deductible

The Family Deductible is an aggregate Deductible and is shown in the Schedule of Benefits. The Family Deductible is the amount that must be satisfied during the Calendar Year. When two or more family members, who are insured under this Policy, have paid an amount(s) toward the Deductible that equal the Family Deductible during the Calendar Year, the Family Deductible will be met for that Calendar Year. Once the Family Deductible is met for the Calendar Year, no further contributions toward the Family Deductible from Family members will be required for the remainder of that Calendar Year. The Family Deductible must be met each Calendar Year.

Dependent means Your:

1. Spouse or domestic partner; and
2. Dependent Child as defined in this Policy.

Dependent Child or Dependent Children means Your children who are:

1. Under age 26, regardless of their place of residence, marital status or student status; including: (a) newborn children; (b) stepchildren; (c) legally adopted children; (d) children placed for adoption with the Policyowner in accordance with applicable state

or federal law; (e) foster children; and (f) children for whom You are a legal guardian substantiated by a court or administrative order; and

2. Unmarried dependent Handicap Children age 26 and over. Refer to the definition of *Handicapped Child*.

A Dependent Child does not include a child who is enrolled for Medicare.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the fetus.

Emergency Care Services means healthcare items or services furnished or required to evaluate and treat an emergency medical condition.

Exchange means the Health Insurance Marketplace through which qualified consumers can compare and purchase insurance from insurance companies. The state may operate a State- based Exchange, a Federally-Facilitated Exchange, or an Exchange in partnership with the federal Department of Health and Human Services. Exchanges are required by the Affordable Care Act.

Health Insurance Marketplace means: (1) a State-based Exchange; (2) a Federally-Facilitated Exchange; or (3) an Exchange in partnership with the federal Department of Health and Human Services.

Holistic Medicine means a form of alternative and complementary medicine. Practitioners apparently receive some level of training at holistic schools or courses. Accredited and licensed Medical Doctors occasionally will practice "Holistic medicine". This approach to treatment uses a variety of herbal, spiritual, meditative, and other "natural" remedies and does not usually incorporate standard medical therapy in treatment of disease.

Home Health Agency means a public agency or private organization or subdivision of the agency or organization that is engaged in providing home health services to individuals in the places where they live.

Home Health Services means a professional nursing service provided to a homebound Covered Person that can only be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) provided such nurse does not ordinarily reside in the Covered Person's household or is not related to the Covered Person by blood or marriage.

Home Infusion Therapy Agency means a health care facility that provides home infusion therapy services.

Home Infusion Therapy Services means the preparation, administration, or furnishing of parenteral medications or parenteral or enteral nutritional services to an individual in that individual's residence. The services include an educational component for the patient, the patient's

caregiver, or the patient's family member.

Homeotherapy/Homeopathy means practice of prescribing very minute (very diluted) amounts of a substance, in order to effect a cure of an underlying illness. The prescribed and diluted substance is often toxic at regular concentrations, but in homeopathy is diluted to the point that very little if any of the active medication is actually present. Practitioners of Homeopathy are usually in the alternative and complimentary practitioner category, including Naturopaths.

Hospice means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

1. An Inpatient hospice facility, which is a facility managed directly by a Medicare-certified hospice that meets all Medicare certification regulations for freestanding inpatient hospice facilities; and

2. A residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

Hospital means a facility providing, by or under the supervision of licensed physicians, services for: (1) medical diagnosis; (2) treatment; (3) rehabilitation; and (4) care of injured, disabled, or sick individuals. Except as otherwise provided by law, services provided must include medical personnel available to provide emergency care on site 24 hours a day and may include any other service allowed by state licensing authority. A hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week, and provides 24-hour nursing care by licensed registered nurses. Hospital includes:

1. Hospitals specializing in providing health services for psychiatric, developmentally disabled, and tubercular patients; and

2. Specialty Hospitals.

This definition of "Hospital" does not include critical access hospitals. Refer to the definition for *Critical Access Hospital*.

The emergency care requirement for a hospital that specializes in providing health services for psychiatric, developmentally disabled, or tubercular patients is satisfied if the emergency care is provided within the scope of the specialized services provided by the hospital and by providing 24-hour nursing care by licensed registered nurses.

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

1. A nursing home;
2. A rest home;
3. A hospice facility;
4. A rehabilitation facility;
5. A skilled nursing facility;
6. A Convalescent Home;

7. A long-term, chronic care institution or facility providing the type of care listed above.

Illness means any sickness, infection, disease or any other abnormal physical condition which is not caused by an Injury. Illness includes pregnancy, childbirth and related medical conditions.

Indian has the same meaning as defined by Section 4 of the Indian Health Care Improvement Act.

Indian Services means services for Covered Benefits that are provided directly by:

1. An Indian Health Service;
2. An Indian Tribe;
3. A Tribal Organization;
4. An Urban Indian Organization; or
5. Services provided through referral under contract health services;

to Covered Persons who are Indians as defined in this Policy.

Indian Tribe means any Indian:

1. Tribe;
2. Band;
3. Nation; or
4. Other organized group or community, including:
    a. Any Alaska Native village; or
    b. Any regional or village corporation;

as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688; 43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Injury means physical damage to the Covered Person's body, caused directly and independently of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

In-Network Provider means a Covered Provider who has a participation contract in effect with the Montana Health CO-OP. PPO Network to provide services to Covered Persons under this Policy. The In-Network Provider's participation contract must be in effect with the Montana Health CO-OP PPO Network at the time services are provided for Covered Benefits in order for Covered Medical Expenses to be eligible for In-Network benefits.

Inpatient or Inpatient Care means care and treatment provided to a Covered Person who has been admitted to a facility as a registered bed and who is receiving services, supplies and medications under the direction of a Covered Provider with staff and privileges at the facility. Such facilities include:

1. Hospitals, including state designated Critical Access Hospitals;
2. Transitional care units;

3. Skilled nursing facilities;
4. Convalescent homes; or
5. Freestanding inpatient facilities.

Such facilities must be licensed or certified by the state in which it operates.

Investigational/Experimental Service/Technology means surgical procedures or medical procedures, supplies, devices, or drugs which at the time provided, or sought to be provided, are in Our judgment not recognized as conforming to accepted medical practice or the procedure, drug, or device:

1. Has not received the required final approval to market from appropriate government bodies;
2. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
3. Is not demonstrated to be as beneficial as established alternatives;
4. Has not been demonstrated to improve the net health outcomes; or
5. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Phases one, two and three clinical studies are considered investigational and are not covered.

Medically Necessary or **Medical Necessity** means treatment, services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of a Covered Person's Illness, Injury, or medical condition according to accepted standards of medical practice.

Medical Necessary or Medical Necessity does not include treatment, services, medicines, or supplies that are:

1. Considered experimental, investigatory, or primarily limited to research in its application to the Injury or Illness;
2. Primarily for scholastic, vocational or developmental training;
3. Primarily for educational training, except for educational training services provided for Preventive Health Care Services or medical conditions as provided under this Policy. Preauthorization is required for all educational services;
4. Primarily for the comfort, convenience or administrative ease of the Physician or other health care provider, or the Covered Person or the Covered Person's family or caretaker; and
5. Custodial Care.

We reserve the right to review medical care and/or treatment plans. We may rely on Our independent medical reviewer to determine if treatment is Medically Necessary. The fact that a Physician may order treatment does not, in itself, make it Medically Necessary, or make the expense a Covered Medical Expense.

Medical Policy means the utilization review program guidelines used for this Policy. The

guidelines are used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

Primary Care Physician means a provider who is:

1. Acting within the scope of the Covered Person's license; and
2. An In-Network Provider.

A Primary Care Physician includes the following providers: (1) Family Practice (FP); (2) Internal Medicine (IM); (3) Pediatrician (MD); (4) Obstetrics and Gynecology (OBGYN); (5) Gynecologist (GYN); (6) Geriatrician (MD); (7) Osteopath (DO); and (8) other providers performing services for Covered Persons in connection with the services provided by preceding specified providers, listed in (1) through (7), including: (a) Registered Nurse (RN); (b) Advanced Practical Registered Nurse (APRN); (c) Nurse Practitioner (NP); (d) Certified Nurse Midwife (CNM); and (e) Physician's Assistant (PA).

The following In-Network Providers who are qualified and willing to provide primary care services as the Covered Person's Primary Care Physician may be elected by the Covered Person to be the Covered Person's Primary Care Physician:

1. An Obstetrician;
2. A Gynecologist; or
3. A Pediatrician; and

Out-of-Network Provider means a Covered Provider who does not have a participation contract in effect with the Montana Health CO-OP In-Network Organization to provide services to Covered Persons under this Policy. When services are provided by an Out-of-Network Provider, the services provided are Out-of-Network.

Out-of-Network Provider Differential means the percentage by which the Allowable Fee is reduced to determine the amount this Policy will pay for Covered Benefits provided by Out-of- Network Providers. The Out-of-Network Provider Differential applies to:

1. Out-of-Network Professional Providers, including, but limited to: (a) Physicians; (b) Physician Assistants; and (c) Advance Nurse Practitioners;
2. Out-of-Network Facility Providers, including, but not limited to: (a) Hospitals; (b) Free-Standing Surgical Facilities; (c) Skilled Nursing Facilities; and (d) Convalescent Homes.

Policyholder means the person to whom this Policy is issued and is named as the Policyowner in the Schedule of Benefits. The Policyowner is the owner of this Policy, which means the Policyowner may exercise the rights set forth in this Policy. On the Policy Effective Date, the Policyowner is as designated in the application for this Policy. The Policyowner is also referred to as "You" or "Your".

Physician means a person licensed to practice medicine in the state where the service is provided. A Physician is also a Covered Provider.

Physician Specialist means a Physician who: (1) has obtained advanced training in various areas of a medical specialty; and (2) is board-certified in that specialty. Physician Specialist includes but is not limited to: (1) Anesthesiologists; (2) Dermatologists; (3) Ophthalmologists; (4) Orthopedic Surgeons; (5) Psychiatrists; (6) Radiation Oncologist; and (7) Surgeons. Physician Specialist does not include: (1) a Family Practice Physician; (2) an Internal Medicine Physician; or (3) an obstetrician; or (4) gynecologist.

Policy Effective Date means the date on which this Group Policy becomes effective. The Policy means the date on which this Policy becomes effective. The Policy Effective Date is shown in the Schedule of Benefits.

Professional Call means an interview between the Covered Person and the covered professional provider in attendance. The covered professional provider must examine the Covered Person and provide or prescribe medical treatment. "Professional Call" does not include telephone calls or any other communication where the Covered Person is not examined by the covered professional provider.

Outpatient means treatment or services that are provided when the Covered Person is not confined as a bed patient in a Covered Facility. This includes outpatient treatment at a Covered Facility as well as visits to a Physician or other Covered Providers.

Skilled Nursing Facility *(Refer to the definition of Convalescent Home).*

Surgery means manual procedures that: (a) involve cutting of body tissue; (b) debridement or permanent joining of body tissue for repair of wounds; (c) treatment of fractured bones or dislocated joints; (d) endoscopic procedures; and (e) other manual procedures when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Treatment means medical care, services or treatment or course of treatment which is ordered, prescribed and/or provided by a Physician to diagnose or treat an Injury or Illness, including:

1. Confinement, Inpatient or Outpatient services or procedures; and
2. Drugs, supplies, equipment, or devices.

The fact that a Treatment was ordered or provided by a Physician does not, of itself, mean that the Treatment will be determined to be Medically Necessary.

SECTION 2—WHEN COVERAGE TAKES EFFECT AND TERMINATES

If this Policy was purchased on the Exchange (Health Insurance Marketplace), the eligibility for coverage and termination provisions in this Section are subject to the Exchange rules governing eligibility, termination and any continued coverage provisions in this Policy.

ELIGIBILITY FOR COVERAGE

POLICYOWNER

This Policy is issued to You based on Your application for this insurance and payment of the initial premium. Your insurance coverage under this Policy is effective on the Policy Effective Date.

ELIGIBLE DEPENDENTS

Dependents who are eligible for insurance under this Policy are:

1. Your spouse or domestic partner; and
2. Your Dependent Children, which include:
    a. Your natural children;
    b. Your adopted children;
    c. Your foster children who have been placed in Your home provided You have assumed the legal obligation for total or partial support with the intent that the child resides with You on more than a temporary or short-term basis;
    d. Your step-children provided You are married to the parent of the child;
    e. A child for whom You are the legal guardian substantiated by a court order; and
    f. A child who is the subject of an administrative or court order and for whom You must provide coverage based on such administrative or court order.

Continued Coverage for Handicapped Children

A Covered Dependent Child, whose insurance under this Policy would otherwise terminate solely due to the attainment of age 26 (the limiting age), will continue to be a Covered Dependent Child while such Covered Dependent Child is and continues to be both:

1. Incapable of self-sustaining employment by reason of intellectual disability or physical disability; and
2. Chiefly dependent upon You for support and maintenance.

Proof of the intellectual disability or disability, and dependency must be furnished to Us by You within thirty-one (31) days of the Covered Dependent Child's attainment of the limiting age and subsequently as may be required by Us. However, We may not require such proof more frequently than annually after the two-year period following the Covered Dependent Child's attainment of the limiting age.

WHEN COVERAGE BECOMES EFFECTIVE FOR YOUR DEPENDENTS

You must enroll Your Dependents for insurance under this Policy. Eligible Dependents who are listed on Your application for this Policy, and approved by Us, will be insured under this Policy on the Policy Effective Date. Eligible Dependents who are acquired after the Policy Effective Date may be insured under this Policy as provided under the *New Eligible Dependents* provision.

NEW ELIGIBLE DEPENDENTS

If You acquire a new Eligible Dependent after the Policy Effective Date, You may enroll the new Dependent under this Policy by providing Us with the following:

1. Written notification of the new Eligible Dependent; and
2. Payment of any additional premium required for the new Eligible Dependent's coverage under this Policy.

Such written notification and premium payment must be given to Us within thirty-one (31) days of acquiring the new Eligible Dependent, unless otherwise specified in the *Enrollment Requirements for Newly Adopted and Newborn Children* provision in this Section. A special enrollment period is granted for marriage.

The effective date of coverage under this Policy for the new Eligible Dependent will be the first of the month following the date We receive notification and any due premium for the new Eligible Dependent's coverage, except as provided under the *Enrollment Requirements for Newly Adopted and Newborn Children* provision in this Section. Coverage will begin at 12:01 a.m. local time at Your place of residence. Montana Time, on the Eligible Dependent's effective date of coverage.

ENROLLMENT REQUIREMENTS FOR NEWLY ADOPTED AND NEWBORN CHILDREN

Adopted Child

Coverage under this Policy for Your newly adopted child will become effective from the date of Placement for the purpose of adoption and will continue unless:

1. Placement is disrupted prior to legal adoption; and
2. The child is removed from Placement.

"Placement" means the transfer of physical custody of a child who is legally free for adoption to a person who intends to adopt the child.

In order for the newly adopted child to be insured under this Policy, You must, within thirty-one (31) days of acquiring the newly adopted child, provide Us with the following:

1. Written notification of the Placement of the adopted child; and
2. Payment of any additional premium required for the adopted child's coverage under this Policy.

Newborn Child

Coverage under this Policy will be provided for each newborn child of a Covered Person from the moment of birth for thirty-one (31) days.

You must give Us:

1. Written notification of the birth of the child; and
2. Any additional premium due for the newborn child's coverage;

within sixty (60) days of the birth of the newborn child in order to have the newborn child's coverage extended beyond the thirty-one (31) day period. If notification and any required premium are not paid within the 60-day period, no further coverage will be provided for the newborn child after the 31-day period.

TERMINATION OF INSURANCE

POLICY TERMINATION BY THE COMPANY

This Policy will terminate at 12:01 a.m. local time at Your place of residence on the earliest of:

1. The end of the period for which no premium is paid, subject to the Grace Period; refer to Section 3;
2. The premium due date following the date We receive Your written request to terminate this Policy;
3. The date of Your death.

NONRENEWAL OR DISCONTINUANCE OF THIS POLICY BY THE COMPANY

This Policy will be renewed or continued at Your option. However, We may nonrenew or discontinue this Policy only if:

1. You fail to pay premiums in accordance with the terms of this Policy or if We do not receive timely premium payments;
2. You have : (a) performed an act or practice that constitutes fraud; or (b) made an intentional misrepresentation of a material fact under the terms of this Policy;
3. We cease to offer coverage in the individual market in accordance with applicable Montana State law; or

4. You no longer live, reside, or work in:
    a) The service area of the In-Network Organization used under this Policy; or
    b) An area for where We are authorized to do business;

    But only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

We will not discontinue offering a particular type of individual health insurance coverage We offer in the individual market unless We discontinue such coverage in accordance with applicable state law and unless:

1. We give notice to each covered individual provided coverage of this Policy type in the individual market of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage, subject to Health Insurance Marketplace guidelines;

2. We offer to each individual in the individual market provided coverage of this Policy type the option to purchase any other individual health coverage currently being offered by Us to individuals in the individual market; and

3. In exercising the option to discontinue coverage of this Policy type and in offering the option of coverage under subparagraph 2 above, We act uniformly, without regard to: (a) the claims experience of individuals; or (b) any health status-related factor of individuals who may become eligible for the coverage.

We will not discontinue offering all health insurance coverage in the individual market unless in accordance with applicable state law and unless:

1. We provide notice of discontinuation to the Commissioner of Insurance and each covered individual at least 180 days prior to the date of the discontinuation of coverage; and

2. All health insurance issued or delivered for issuance in Montana in the individual market is discontinued; and

3. Coverage under the health insurance coverage in the individual market is not renewed.

If We discontinue offering all health insurance coverage in the individual market as stated in the above paragraph, We will not provide for the issuance of any health insurance coverage in the individual market during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not renewed.

TERMINATION OF COVERED DEPENDENTS

A Covered Dependent's coverage will terminate at 12:01 a.m. at Your place of residence on the earliest of:

1. The end of the period for which premium is not paid, subject to the Grace Period;
2. The premium due date following the date a Covered Dependent Child ceases to be an Eligible Dependent as defined in this Policy;
3. The date Your coverage terminates, subject to Dependent Continuation provision in this section;
4. The premium due date following the date We receive Your written request to terminate Dependent coverage for Your spouse or domestic partner, and/or Dependent Children; or
5. The date of death of the Covered Dependent.

Also, refer to *Termination of Coverage for Handicapped Child* provision regarding additional termination provisions for handicapped children.

Termination of Coverage for Handicapped Child

In addition to the termination provisions indicated above, insurance coverage for a Covered Dependent Child who is a handicapped child age 27 and over will end on the earliest of:

1. The date the Dependent marries;
2. The date the Dependent obtains self-sustaining employment;
3. The date the Dependent ceases to be handicapped;
4. The date the Dependent ceases to be dependent upon You for support and maintenance;
5. Sixty (60) days after a written request for proof of handicap, if proof is not provided within such 60-day period;
6. The date You refuse to allow Us to examine the Dependent Child; or
7. The premium due date following the date We receive Your written request to terminate Dependent coverage under this Policy.

SUSPENSION OF COVERAGE DURING MILITARY SERVICE

If a Covered Person enters into active duty status for the military or naval service of the United States or any other country, coverage will be suspended as of the first date of active duty status, subject to any Health Insurance Marketplace guideline requirements. We request that You notify Us within thirty-one (31) days of the first date of active duty status; however, coverage will be suspended regardless of receipt of notification. When We receive notification of the active duty status, any required adjustment of premium will be made, including refund of premium if necessary.

Upon termination of active duty status, the Covered Person may request a resumption of coverage if the Covered Person:

1. Meets the eligibility requirements for this Policy as provided in the Eligible Dependents provision in this Section 2;
2. Makes the request for resumption of coverage in writing to Us within sixty (60) days of the Covered Person's termination of active duty status; and
3. Pays any required premium.

Coverage under this Policy will resume on the date immediately following Our receipt and verification of the above requirements.

CONTINUATION COVERAGE FOR DEPENDENTS

If coverage terminates under this Policy for a Covered Dependent due to:

1. Your death; or
2. Your divorce, or annulment or dissolution of marriage or domestic partnership, or legal separation from Your Covered Dependent spouse or domestic partner; or
3. A Covered Dependent Child attaining age 27, except as provided under the *"Termination of Coverage for Handicapped Child"* provision;

the Covered Dependent spouse or domestic partner, and Covered Dependent Child may elect to continue coverage under this Policy. The spouse or domestic partner may also elect to continue coverage for Covered Dependent children under age 27 for whom the spouse or domestic partner has the responsibility for care and support.

Notice of this election must be received by Us within 60 days of the event. No evidence of insurability will be required. Premium for the continued coverage must be paid within 31 days after the election is made. Premium will be based on Our rates in effect at the time of the continuation coverage.

SECTION 3—PREMIUMS

PAYMENT OF PREMIUM

All premium, any charges or fees for this Policy (hereinafter referred to as "premium") must be paid to Us. The premium for this Policy is shown in the Schedule of Benefits. If You do not pay premiums when due, this Policy will terminate subject to the *Grace Period*. The Premium Due Date is shown in the Schedule of Benefits.

UNPAID PREMIUM

On payment of a claim under this Policy, any premium then due and unpaid may be deducted from Your claim payment.

GRACE PERIOD – POLICY NOT PURCHASED ON THE EXCHANGE

THIS GRACE PERIOD PROVISION APPLIES IF THIS POLICY WAS NOT PURCHASED ON THE EXCHANGE.

After the first due premium payment, if a premium is not paid on or before the date it is due, it may be paid during the next thirty-one (31) days. These thirty-one (31) days are called the Grace Period. Coverage under this Policy will remain in force during the Grace Period. If any premium is unpaid at the end of the Grace Period, this Policy will automatically terminate at the end of the Grace Period. However, We will not terminate this Policy until We have mailed or delivered to You at Your last-known address shown in Our records a written notice, in addition to any billing statement, stating the date this Policy's termination will become effective, which will not be earlier than:

1. The beginning of the period for which premiums have not been paid in full if the notice of termination for nonpayment of premiums is mailed or delivered within fifteen (15) days after the due date of the missed premiums for that period; or
2. The date of mailing or delivery of notice of termination for nonpayment of premiums if the notice of termination for nonpayment of premiums is not mailed or delivered within fifteen (15) days after the premium due date for the applicable policy period.

We will give such termination notice to You at least thirty (30) days in advance of termination for nonpayment of premiums.

GRACE PERIOD—IF POLICY IS PURCHASED ON THE EXCHANGE AND POLICYOWNER IS RECEIVING ADVANCE PAYMENT OF PREMIUM TAX CREDIT

After the first due premium payment, if a premium is not paid on or before the date it is due, it may be paid during the next ninety (90) days. These ninety (90) days are called the Grace Period. Coverage under this Policy will remain in force during the Grace Period.

During the first month of the grace period, We will continue to pay claims incurred for Covered Medical Expenses. During the second and third months of the grace period, We will suspend payment of any claims until We receive the past due premiums. If payment is not received for all outstanding premium by the end of the grace period, this Policy will be terminated effective at 11:59 p.m. on the last day of the first month of the grace period. You will be responsible for the cost of any health care services You receive after the last day of the first month of the grace period.

PREMIUM RATE CHANGES

Subject to rate requirements applicable in the state of Montana, where this Policy is issued, We may change the rates for this Policy on any Policy Anniversary Date after this Policy has been in force for 12 months. However, the rates may be changed sooner than 12 months if a premium increase is necessitated by: (1) a state or federal law; (2) court decision; or (3) rule adopted by an agency of competent jurisdiction of the state or federal government. Any rate change will be made only when We change the rates for all policies in the same rate class on the same form as this Policy that are issued in the state of Montana.

We will give You at least 45 days prior written notice before the effective date of any rate change. The rates will never be changed due to a change in Your age or health. Such notice will be mailed to the Your last known address as shown in Our records. If We fail to provide the notice as stated in this provision, this Policy will remain in effect at the existing rate with the existing benefits until: (1) the full notice period has expired; or (2) the effective date of the replacement coverage is obtained by You, whichever occurs first.

PREMIUM REFUND

In the event of termination of this Policy or Your death, We will refund any portion of the advanced premium paid.

REINSTATEMENT

If any renewal dues payment is not paid within the time granted the Member for payment, a subsequent acceptance of dues by The Plan without requiring in connection therewith an application for reinstatement, shall reinstate the Contract; provided, however, that if The Plan requires an application for reinstatement and issues a conditional receipt for the dues tendered, the Contract will be reinstated upon approval of such application by Montana Health CO-OP or, lacking such approval, upon the 45th day following the date of such conditional receipt unless The Plan has previously notified the Member in writing of its disapproval of such application. The reinstated Contract shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as began more than ten days after such date. In all other respects, the Member and The Plan shall have the same rights thereunder as they had under the Contract immediately before the due date of the defaulted dues, subject to any provision endorsed hereon or attached hereto in connection with the reinstatement.

Third Party Payments for Premiums, Co-Payments, Coinsurance

Providers may not waive, rebate, give, pay or offer to waive, rebate, give or pay all of part of the Insured's deductible or other out of pocket costs including co-payments, coinsurance, or premiums. We will accept third party payments of premiums and cost sharing from:

- A Ryan White HIV/AIDS Program

- An Indian tribe or tribal organization
- Local, state or federal government programs, including grantees directed by a government program to make payments on its behalf

We will also accept third party payments from individuals such as family and friends, religious institutions and other not-for-profit organizations when all of the following criteria are met:

- The assistance is provided on the basis of the insured's financial need
- The institution/organization is not a healthcare provider
- The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

We do not count any financially interested third party cost-sharing payments toward deductibles or out of pocket maximums. If We discover financially interested third party payments of this type after the fact and these payments have already been counted toward the deductible or out of pocket maximum, We will exclude the financially interested third party from the accumulation toward the deductible or out of pocket maximum.

Should We reject a payment from a third party, we will inform you in writing of the reason for our rejection and your right to file a complaint with the Montana Commissioner's Office of Securities and Insurance.

SECTION 4—IN-NETWORK PROVIDER NETWORK OPTION

HOW TO SELECT A PRIMARY CARE PHYSICIAN – IN-NETWORK PROVIDER

At the time the Covered Person submits an application they can select a Primary Care Physician or when they receive their ID cards they can call the number specified on the back of the card to select an In-Network Primary Care Physician.

If the Covered Person chooses not to do either, a provider will be assigned to them through two methods. First, if the Covered Person sees an In-Network Primary Care Physician within the first three months and a claim is submitted, that Primary Care Physician will be assigned as the Covered Persons Primary Care Physician. Second, an In-Network Primary Care Physician will be selected by MHC and assigned to the Covered Person if the Covered Person has not completed one of the prior actions to select a Primary Care Physician. If MHC chooses a provider it will be after the first three (3) months of coverage and selected from the In-Network Primary Care Physicians closest to the Covered Person that provides outreach services.

The Covered Person may change their primary care provider at any time simply by calling the specified number on the back of their ID card and requesting a new In-Network Primary Care Physician.

WHY YOU MUST CHOOSE A PRIMARY CARE PHYSICIAN

An In-Network Primary Care Physician must be selected by the Covered Person or assigned by MHC. Note that once the In-Network Primary Care Physician is selected by the Covered Person or assigned by MHC the Covered Person has no further responsibility to the Primary Care Physician. The assignment of the In-Network Primary Care Physician allows MHC to better track the quality of care being provided and enables MHC and In-Network Physicians to provide educational and medical advice specifically tailored to the needs of that Covered Person.

The In-Network Primary Care Physician is an advisory service to the Covered Person and does not control the medical service a Covered Person may seek. Covered Benefits provided under this Policy are described in Section 5.

ARE OUT-OF-NETWORK SERVICES COVERED?

The Covered Person may choose to receive services from an Out-of-Network provider. Benefits may be payable at a lower level when an Out-of-Network Provider is utilized. The Covered Person should be aware that Out-of-Network providers and facilities may choose to balance bill the Covered Person for services rendered. Refer to the Schedule of Benefits. Out-of-Network Benefits provided under this Policy are described in Section 5.

WHAT ARE THE RESPONSIBILITIES OF THE COVERED PERSON WHEN USING IN-NETWORK PROVIDERS?

The Covered Person is responsible for ensuring that providers and facilities, at the time of service, are active In-Network Providers participating in the In-Network Organization. It is the responsibility of the Covered Person to utilize the providers and facilities that best meet their needs, keeping in mind the different benefits and payment levels. Covered Benefits provided under this Policy are described in Section 5.

IN-NETWORK ORGANIZATION

The In-Network Provider Organization used for this Policy is administered by University of Utah Health Plans, as shown on page 4, *Important Information*.

OUT-OF-NETWORK EMERGENCY SERVICES

If the Covered Person requires Emergency Services for an Emergency Medical Condition, while the Covered Person is traveling outside of the Service Area of the In-Network Organization or cannot reasonably reach an In-Network Provider, the benefits payable for Emergency Services received from an Out-of-Network Provider will be the same as would be payable for the services of an In-Network Provider. Refer to the Schedule of Benefits for Emergency Services.

OUT OF AREA SERVICES

Outside the Montana Health CO-OP service area and in areas where our members do not have reasonable access to a participating provider, the allowable fee, depending upon the services and supply, will be based on the participating provider reimbursement rate. For more detailed information, please contact Montana Health CO-OP customer service for assistance at 855-447-2900.

SECTION 5—COVERED BENEFITS

This Policy will pay Covered Medical Expenses for the following Covered Benefits when services are provided by a Covered Provider.

PAYMENT OF BENEFITS

Payment of Covered Medical Expenses will be:

1. Based on the Allowable Fee; and
2. Subject to the Deductible, Coinsurance, Copayments, and Annual Out-of-Pocket Maximum stated in the Schedule of Benefits, unless otherwise stated in the Schedule of Benefits or this Section for specified Covered Benefits.

EXCEPTIONS

When Services Are Provided By An Indian Service

If the Covered Person who is an Indian, as defined in this Policy, receives services for Covered Benefits directly by:

1. An Indian Health Service;
2. An Indian Tribe;
3. A Tribal Organization;
4. An Urban Indian Organization; or
5. through referral under contract health services;

this Policy will pay Covered Medical Expenses incurred for Covered Benefits on an In-Network basis without the application of: (1) the Deductible; (2) Coinsurance; (3) Annual Out-of-Pocket Maximum; and (4) any applicable Copayments.

However, if services for Covered Benefits shown in Section 5, Covered Benefits, are not rendered directly by an Indian Health Service, an Indian Tribe, a Tribal Organization, an Urban Indian Organization, or through referral under contract health services, this Policy will pay benefits on:

1. An In-Network basis if the Covered Person, who is an Indian as defined in this Policy, obtains services from an In-Network; or
2. An Out-of-Network basis if the Covered Person, who is an Indian as defined in this Policy, obtains services from a Non-In-Network; and

the Deductible, Coinsurance, Annual Out-of-Pocket Maximum, and any applicable Copayments will apply.

Benefits Paid Without Cost-Sharing Requirements for Certain Covered Persons Who Are Indians

The Deductible, Coinsurance, Annual Out-of-Pocket Maximum, and any applicable Copayments will not apply to a Covered Person who is an Indian, as defined in this Policy, and who:

1. Meets the specific federal government guidelines to exempt such Covered Person from the cost-sharing requirements of this Policy; and
2. Obtains services from either an In-Network Provider or Out-of-Network Provider.

BENEFITS ELIGIBLE FOR PAYMENT

Benefits will be eligible for payment if Covered Medical Expenses are:

1. Incurred for Covered Benefits while the Covered Person is insured under this Policy; and
2. The Treatment for which the Covered Medical Expenses are incurred is:
    a. The result of an Illness or Injury; and
    b. Medically Necessary, unless the Covered Benefit is for educational purposes only, as provided under this Policy; and
    c. Prescribed or treated by a Physician or other Covered Provider as provided under this Policy; and
    d. Meets Our Medical Policy.

Covered Benefits provided under this Policy are subject to the exclusions, limitations and all terms and conditions specified in this Policy.

ACCIDENT BENEFIT

Coverage will be provided for services rendered for bodily Injuries resulting from an Accident which occur after the Covered Person's Effective Date of Coverage.

AMBULANCE SERVICES

Coverage will be provided for transportation by a licensed ambulance service to the nearest Hospital with the appropriate staff and facilities to treat the Emergency Medical Condition of the Covered Person.

ANESTHESIA SERVICES

Anesthesia services provided by a Physician (other than the attending Physician) or nurse anesthetist. Services include: (1) the administration of spinal anesthesia; and (2) the injection or inhalation of a drug or other anesthetic agent. No benefits will be paid for:

1. Local anesthesia or intravenous (IV) sedation that is considered to be an inclusive service or procedure.
2. Hypnosis;
3. Anesthesia consultations before surgery that are considered to be inclusive services and procedures because the Allowable Fee for the anesthesia performed during the surgery includes the anesthesia consultation; or
4. Anesthesia for dental services or injection of health.

APPROVED CLINICAL TRIAL

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

1. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
2. Exempt from an investigational new drug application; or
3. Approved or funded by:
    a. The National Institute of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
    b. A cooperative group or center of the United States Department of Defense or the United States Department of Veteran Affairs;
    c. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes for Health for center support groups; or
    d. The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and provide unbiased scientific review by individuals who have no interest in the outcome of the review.

AUTISM SPECTRUM DISORDER COVERAGE

Coverage will be provided for the diagnosis and treatment of autism spectrum disorders for a Covered Dependent Child 18 years of age or younger. Coverage under this Benefit will be provided for such Covered Dependent Child who is diagnosed with one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic Disorder;
2. Asperger's Disorder; or
3. Pervasive Developmental Disorder not otherwise specified.

Coverage will include:

1. Habilitative or rehabilitative care that is prescribed, provided, or ordered by a Physician or a licensed psychologist, including but not limited to: (1) professional, counseling, and guidance services; and (2) Treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
2. Medications prescribed by a Physician;
3. Psychiatric or psychological care; and
4. Therapeutic care that is provided by: (1) a speech-language pathologist; (2) audiologist; (3) occupational therapist; or (4) physical therapist licensed in this state.

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including: (1) applied behavior analysis, which is also known as Lovaas therapy; (2) discrete trial training; (3) pivotal response training; (4) intensive intervention programs; and (5) early intensive behavioral intervention.

Applied behavior analysis covered under this provision must be provided by an individual who is: (a) licensed by the behavior analyst certification board; or (b) certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

When Continued Services Are Required

When treatment is expected to require continued services, We may request that the treating Physician provide a Treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The Treatment plan must be based on evidence- based screening criteria. We may ask that the Treatment plan be updated every 6 months.

As used in this provision, "Medically Necessary " means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician or psychologist licensed in this state and that will or is reasonably expected to:

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

For Covered Persons who are over the age of 18 and have autism, coverage is provided under the *Mental Illness* benefit in this Section 5.

BLOOD TRANSFUSIONS

Blood transfusions, including: (1) the cost of blood; (2) blood plasma; (3) blood plasma expanders; and (4) packed cells. Storage charges for blood are paid when the Covered Person has blood drawn and stored for the Covered Person's own use for a planned surgery.

CHEMICAL DEPENDENCY

Coverage for the diagnosis and Treatment of Chemical Dependency will be provided on the same basis as any other Illness. Treatment for Chemical Dependency will consist of both Inpatient and Outpatient Treatment. Preauthorization is required for Inpatient Residential Chemical Dependency Treatment; refer to *Section 6, Utilization Review Management Program.*

"Chemical Dependency" means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance and includes alcohol and substance abuse.

"Chemical Dependency Treatment Center" means a treatment facility that:

1. Provides a program for the treatment of alcoholism or drug addiction pursuant to a written treatment plan approved and monitored by a Physician or addiction counselor licensed by the state; and
2. Is licensed or approved as a treatment center by the Department of Public Health and Human Services or is licensed or approved by the state where the facility is located.

Inpatient Treatment Services

Benefits will be payable for the necessary Treatment of Chemical Dependency when provided in or by:

1. A Hospital;
2. A Physician; or
3. A Freestanding Inpatient Facility which is a part of a Chemical Dependency Treatment Center. Such facility must be approved by the Department of Public Health and Human Services.

Coverage will be provided under this Policy for:

1. Medically monitored and medically managed intensive Inpatient Care services; and
2. Clinically managed high-intensity residential services.

Inpatient Care Services are subject to Plan Notification and Preauthorization. Please refer to Section 6, Utilization Review Management Program.

Outpatient Treatment Services

Benefits will be payable for Outpatient Treatment of Chemical Dependency when such Treatment is provided in or by:

1. A Hospital;
2. A Chemical Dependency Treatment Center;
3. A Physician or prescribed by a Physician;
4. A licensed psychiatrist;
5. A psychologist;
6. A licensed social worker;
7. A licensed professional counselor; or
8. An addiction counselor licensed by the state.

Outpatient Treatment of Chemical Dependency is subject to the following conditions:

1. The Treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Chemical Dependency;
2. The Treatment must be provided to diagnose and treat recognized Chemical Dependency;
3. Chemical dependency services rendered via (a) marriage counseling; (b) hypnotherapy; or (c) services given by a staff member of a school or halfway house will not be covered.

CHIROPRACTIC SERVICES

Coverage will be provided for services provided by a licensed chiropractor within the scope of the Covered Person's license and practice. Benefits include chiropractic services provided in connection with the detection or correction of manual or mechanical means of:

1. Structural imbalance;
2. Distortion or subluxation in the human body for the purpose of removing nerve interference; and
3. The effects of such, where such interference is the result of or related to the distortion, misalignment, or subluxation in the vertebral column.

Benefits are subject to the Maximum Number of Visits per Calendar Year shown in the Schedule of Benefits.

CHRONIC DISEASE MANAGEMENT

Coverage will be provided for chronic disease management services for: (a) diabetes; (b) hypertension (high blood pressure); (c) high cholesterol; and (d) any other chronic disease required by the federal Affordable Care Act. The Covered Person must be diagnosed and receiving treatment for the chronic disease, and the Chronic Disease Management must be prescribed by a Physician.

CONVALESCENT HOME SERVICES

Coverage will be provided for services of a Convalescent Home as an alternative to Hospital Inpatient Care when:

1. Prescribed by a Physician; and
2. Preauthorization is obtained.

Coverage will be provided for Convalescent Home Physician visits.

No benefits will be payable for Convalescent Home Services if the Covered Person remains an Inpatient at the Convalescent Home when a skilled level of care is not Medically Necessary.

This Policy does not pay for custodial care services.

Benefits will be limited to the Maximum Number Days of Convalescent Home Services per Calendar Year as shown in the Schedule of Benefits.

DENTAL ACCIDENT SERVICES

Dental services provided by:

1. A Physician;
2. A Dentist;
3. An Oral surgeon; and/or
4. Any other Covered Provider;

will not be covered under this Policy except Medically Necessary services for the initial repair or replacement of sound natural teeth which are damaged as a result of an Accident will be covered under this Policy. The following will not be covered under this Policy, even if they are related to an Accident: (1) orthodontics; (2) dentofacial orthopedics; (3) Orthognathic surgery; or (4) related appliances.

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

DOWN SYNDROME

Coverage will be provided for medically necessary care, treatment, intervention, services, or items that are prescribed, provided, or ordered by a physician licensed in Montana and that will or is reasonably expected to reduce or improve the physical, mental, or developmental effects of Down syndrome; or assist in achieving maximum functional capacities that are appropriate for a child of the same age. "Medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician licensed in Montana and that will or is reasonably expected to reduce or improve the physical, mental, or developmental effects of Down syndrome; or assist in achieving maximum functional capacities that are appropriate for a child of the same age. Coverage includes habilitative or rehabilitative care, professional counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child. Therapeutic care that is provided as follows: up to 104 sessions per year with a speech-language pathologist, up to 52 sessions per year with a physical therapist, up to 52 sessions per year with an occupational therapist. Coverage is subject to deductible, copay and coinsurance.

When treatment is expected to require continued services, We may request that the treating physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is medically necessary. The treatment plan must be based on evidence-based screening criteria. We may ask that the treatment plan be updated every 6 months.

DURABLE MEDICAL EQUIPMENT

Coverage will be provided for the purchase or rental of Durable Medical Equipment. The equipment must be appropriate for therapeutic purposes where the Covered Person resides. Benefits will include repairs and necessary maintenance of purchased equipment, not otherwise provided under a manufacturer's warranty or purchase agreement.

"Durable Medical Equipment" means equipment or FDA approved medical devices that are Medically Necessary to aid in the Covered Person's recovery, mobility and/or support of life.

Durable Medical Equipment must be: (a) prescribed by a Physician; (b) be able to withstand repeated use (consumables are not covered); (c) primarily used to serve a medical purpose rather than for comfort or convenience; and (d) generally not useful to a person who is not ill or Injured.

If a type of equipment is specifically excluded under this Policy, it will not be covered under this Durable Medical Equipment benefit.

Durable Medical Equipment includes, but is not limited to: (a) canes; (b) crutches; (c) walkers; (d) standard manual or electric wheelchairs; and (e) standard hospital beds.

No benefits will be payable for the following: (1) exercise equipment; (2) car lifts or stair lifts; (3) biofeedback equipment; (4) self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition; (5) air conditioners and air purifiers; (6) whirlpool baths, hot tubs, or saunas; (7) waterbeds; (8) other equipment which is not always used for healing or curing; (9) computerized and "deluxe" equipment life motor-driven wheelchairs or beds when standard equipment is adequate. We will have the right to determine when standard equipment is adequate; (10) durable medical equipment required primarily for use in athletic activities; (11) replacement of lost or stolen durable medical equipment; (12) repair to rental equipment; and (13) duplicate equipment purchased primarily to the Covered Person's convenience when the need for duplicate equipment is not medical in nature.

Preauthorization is recommended for the original purchase or replacement of durable medical equipment over the amount indicated in the Schedule of Benefits. Please refer to *Section 6, Utilization Review Management Program.*

EDUCATION SERVICES

Coverage will be provided for education services other than diabetic education that are related to the Covered Person's medical condition.

EMERGENCY SERVICES

Coverage will be provided for emergency services provided in a Hospital's emergency room for an accidental Injury or an Emergency Medical Condition. Emergency Services include stabilization services. If services are received at an out-of-network facility and/or provider, charges will be applied to the out-of-network deductible and maximum out-of-pocket. No Preauthorization is required for Emergency Services; however, the Covered Person must notify Us within 48 hours of the Emergency Service as provided in *Section 6, Utilization Review Management Program.*

HABILITATIVE CARE AND REHABILITATIVE CARE

Coverage will be provided for habilitative care services when the Covered Person requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to: (1) physical and occupational therapy; (2) speech-language pathology; and (3) other services for people with disabilities. These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician.

Coverage will be provided for rehabilitative care services when the Covered Person needs help to keep, get back or improve skills and functioning for daily living that have been lost or impaired because a the Covered Person was sick, hurt or disabled. These services will include, but are not limited to: (1) physical and occupational therapy; (2) speech-language pathology; and (3) psychiatric rehabilitation.

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

Coverage for habilitative care and rehabilitative care are subject to the benefit requirements specified in the federal Affordable Care Act.

HOME HEALTH CARE SERVICES

Coverage will be provided for Home Health Care when prescribed by a Physician. Home Health Care services must be provided by a licensed home health agency to a Covered Person in the Covered Person's place of residence and is prescribed by the Covered Person's attending Physician as part of the Covered Person's treatment plan.

Services for home health care include: (1) nursing services; (2) home health aide services; (3) hospice services; (4) physical therapy; (5) occupational therapy; (6) speech therapy; (7) medical social worker; (8) medical supplies and equipment suitable for use in the home; and (9) Medically Necessary personal hygiene, grooming, and dietary assistance.

Benefits will be limited to the maximum number of home visits, per Calendar Year, shown in the Schedule of Benefits.

No benefits will be payable for:

1. Maintenance or custodial care visits;
2. Domestic or housekeeping services;
3. "Meals-on-Wheels" or similar food arrangements;
4. Visits, services, medical equipment, or supplies not approved or included as part the Covered Person's treatment plan for Home Health Care;
5. Services for mental or nervous conditions; or
6. Services provided in a nursing home or skilled nursing facility.

HOME INFUSION THERAPY SERVICES

The preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to the Covered Person by a Home Infusion Agency, includes:

1. Education for the Covered Person, the Covered Person's caregiver, or a Family Member;
2. Pharmacy;
3. Supplies;
4. Equipment; and
5. Skilled nursing when billed by the Home Infusion Therapy Agency.

Note: Skilled nursing services billed by a licensed Home Health Agency will be covered under the Home Health Care Benefit.

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

HOSPICE CARE SERVICES

Coverage will be provided for Hospice Care Services. Hospice Care Services is a coordinated program of home care and Inpatient Care that provides or coordinates palliative and supportive care to meet the needs of a terminally Ill Covered Person and the Covered Person's Immediate Family. Benefits include:

1. Inpatient and Outpatient care;
2. Home care;
3. Skilled and non-skilled nursing care;
4. Counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally-ill Covered Person; and
5. Instructions for care of the Covered Person, counseling and other support services for the Covered Person's Immediate Family.

HOSPITAL SERVICES – FACILITY AND PROFESSIONAL

INPATIENT CARE SERVICES BILLED BY A FACILITY PROVIDER

Coverage will be provided for Inpatient Care Services provided in a Hospital or a state designated Critical Access Hospital. Benefits include the following:

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

Inpatient Care is subject to Plan Notification and Preauthorization. Please refer to *Section 6, Utilization Review Management Program.*

Inpatient Care Services are subject to the following conditions:

1. Days of care:
    a. The number of days of Inpatient Care provided is 365 days.
    b. In computing the number of Inpatient Care days available, days will be counted according to the standard midnight census procedure used in most Hospitals. The day the Covered Person is admitted to a Hospital is counted, but the day the Covered Person is discharged is not. If a Covered Person is discharged on the day of admission, one day is counted.
    c. The day the Covered Person enters a Hospital is the day of admission. The day the Covered Person leaves a Hospital is the day of discharge.
2. The Covered Person will be responsible to the Hospital for payment of its charges if the Covered Person remains as an Inpatient when Inpatient Care is not Medically Necessary. No benefits will be provided for a bed reserved for the Covered Person. No benefits will be paid for Inpatient Care provided primarily for diagnostic or therapy services.

INPATIENT CARE MEDICAL SERVICES BILLED BY A PROFESSIONAL PROVIDER

NONSURGICAL SERVICES BY A COVERED PROVIDER, CONCURRENT CARE AND CONSULTATION SERVICES

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

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

OBSERVATION BEDS/ROOMS

Payment will be made for observation beds when Medically Necessary, and in accordance with Medical Policy guidelines.

OUTPATIENT HOSPITAL SERVICES

Coverage will be provided for ambulatory patient services rendered in the Hospital's outpatient facilities and equipment for: (1) surgery; (2) respiratory therapy; (3) chemotherapy; (4) radiation therapy; and (5) dialysis therapy. Outpatient Hospital facilities include a licensed Hospital's Ambulatory Care Facility or licensed Free-Standing Surgical Facility.

INFERTILITY TREATMENT – Diagnosis and Treatment

Coverage will be provided for the diagnosis and treatment of infertility, including:

- Medically Necessary evaluation to determine cause of infertility
- Artificial insemination (AI) or intrauterine insemination (IUI)
- Medically Necessary Reproductive procedures not related to in vitro fertilization.

The Plan will not pay for:

1. Prescription drugs used to treat infertility.
2. Services, supplies, drugs and devices related to invitro fertilization.

LABORATORY SERVICES

Coverage will be provided for:

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

Laboratory services include, but are not limited to, the following:

1. Laboratory X-ray Examinations;
2. Other Radiology Tests, including but not limited to: (a) computerized tomography scan (CT Scan); (b) MRIs; (c) nuclear medicine; and (d) Ultrasound;
3. Laboratory Tests, including but not limited to: (a) urinalysis; (b) blood tests; and (c) throat cultures;
4. Diagnostic Testing, including but not limited to: (a) Electroencephalograms (EEG); and (b) Electrocardiograms (EKG or ECG).

Such laboratory services must be:

1. Prescribed by a Covered Provider;
2. Medically Necessary

This benefit does not include diagnostic services, such as biopsies, which are services that are routinely covered under the *Surgical Services Benefit*.

MAMMOGRAM (PREVENTATIVE AND MEDICAL)

Coverage for Mammography examinations. The minimum mammography examination recommendations are:

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

MATERNITY AND NEWBORN CARE SERVICES

Coverage for maternity and newborn care services will be treated as any other illness. Coverage will be provided for maternity services, including: (1) prenatal care; (2) delivery of one or more newborn children; (3) postpartum care and benefits for childbirth; and (4) Hospital Inpatient Care for conditions related directly to pregnancy.

Coverage will include at least:

1. 48 hours of Inpatient Care following a vaginal delivery; and
2. 96 hours of Inpatient Care following delivery by cesarean section for the mother and newborn infant;

for the mother and newborn infant in a Hospital or other Covered Facility. A decision to shorten the length of Inpatient stay to less than that provided above must be made by the attending health care provider and the mother.

Preauthorization will be required if a decision is made to lengthen the time of Inpatient stay to more than the above required period.

Under Federal law, benefits may not be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than: (1) 48 hours following a vaginal delivery; or (2) 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Covered Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, under Federal law, Covered Providers may not be required to obtain Preauthorization from the Utilization Review Management Program for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Payment for any maternity services by the professional Covered Provider is limited to the Allowable Fee for total maternity care, which includes: (1) delivery; (2) prenatal care; and (3) postpartum care.

"Attending health care provider" means a Covered Provider licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.

NEWBORN INITIAL CARE

Coverage will be provided for the following:

1. The initial health care of a newborn child birth provided by a Physician;
2. Standby care provided by a pediatrician at cesarean section; and
3. Nursery Care – Hospital nursery care of newborn infants.

MEDICAL SUPPLIES

Coverage will be provided for the following supplies for use outside of a Hospital:

1. Supplies for insulin pumps, syringes and related supplies for conditions such as diabetes. It is recommended that the Covered Person purchase insulin pumps, syringes and related supplies under the Prescription Drug Benefit.
2. Injection aids, visual reading and urine test strips, glucagon emergency kits for

treatment of diabetes. One insulin pump for each warranty period is covered under the Durable Medical Equipment Benefit;

3. Sterile dressings for conditions such as cancer or burns;
4. Catheters;
5. Splints;
6. Colostomy bags and related supplies; and
7. Supplies for renal dialysis equipment or machines.

Medical supplies will be covered only when: (1) Medically Necessary to treat the Covered Person's condition for which benefits are payable under this Policy; and (2) prescribed by Physician.

MENTAL HEALTH

Coverage will be provided for the necessary care and treatment of Mental Illness that is no less favorable than the level of benefits provided for other physical Illnesses under this Group Policy. Benefits will include, but are not limited to:

1. Inpatient Care services, Outpatient services, Rehabilitation services, and medications for the treatment of Mental Illness.
2. Services provided by: (a) a licensed Physician; (b) a licensed Advanced Practice Registered Nurse with a specialty in mental health; (c) a licensed social worker; (d) a licensed psychologist; or (e) a licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed Physician; and
3. Services provided by a licensed Advanced Practice Registered Nurse with prescriptive authority and specializing in mental health.

"Mental Illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with: (1) present distress or a painful symptom; (2) a disability or impairment in one or more areas of functioning; or (3) a significantly increased risk of suffering: (a) death; (b) pain; (c) disability; or (d) an important loss of freedom.

Mental Illness must be considered as a manifestation of a behavior, psychological, or biological dysfunction in a person.

"Mental illness" includes but is not limited to the following disorders as defined by the American Psychiatric Association: (1) schizophrenia; (2) schizoaffective disorder; (3) bipolar disorder; (4) major depression; (5) panic disorder; (6) obsessive-compulsive disorder; and (7) autism.

"Mental Health Treatment Center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by an interdisciplinary team, including a licensed physician, psychiatric social worker, and psychologist, and a treatment facility that is: (1) licensed as a Mental Health Treatment Center by the state; (2) funded or eligible for funding under federal or state law; or (3) affiliated with a hospital under a contractual agreement with an established system for patient referral.

Coverage will be provided for Inpatient and Outpatient Treatment of Mental Illness. Benefits will be paid on the same basis as any other Illness.

INPATIENT CARE SERVICES

Coverage for Inpatient Care Services of Mental Illness, while the Covered Person is insured under this Policy, when such Inpatient Care Services are provided in: (1) a Hospital; (2) a Freestanding Inpatient Facility; or (3) a Physician. Inpatient Care Services must be Preauthorized; refer to Section 6, Utilization Review Management Program. Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity residential services are covered under this Policy. Medically monitored and medically managed intensive Inpatient Care Services and clinically managed high-intensity residential services provided at a Residential Treatment Center are covered under this benefit.

PARTIAL HOSPITALIZATION

Partial Hospitalization coverage will be provided for care and treatment of Mental Illness when Partial Hospitalization services are rendered by: (1) a Hospital; (2) a Freestanding Inpatient Facility; or (3) a Physician. Partial Hospitalization is considered to be Inpatient Care and must be Preauthorized; refer to Section 6, Utilization Review Management Program.

Benefits include Partial Hospitalization services for the Treatment of Mental Illness. Such services must be preauthorized; refer to Section 6, Utilization Review Management Program.

OUTPATIENT CARE SERVICES

Outpatient care and treatment of Mental Illness will be covered under this Policy if the Covered Person is not receiving Inpatient Mental Illness treatment and the Outpatient care and treatment is provided by: (1) a Hospital; (2) a Physician or prescribed by a Physician; (3) a Mental Health Treatment Center; (4) a Chemical Dependency Center; (5) a psychologist; (6) a licensed psychiatrist; (7) a licensed social worker; (8) a licensed professional counselor; or (9) a licensed addiction counselor.

Outpatient Mental Illness Treatment must be:

1. Provided to diagnose and treat recognized Mental Illness; and
2. Reasonably expected to improve or restore the level of functioning that has been affected by the Mental Illness.

No benefits will be payable for: (1) marriage counseling; (2) hypnotherapy; or (3) services given by a staff member of a school or halfway house.

ORTHOPEDIC DEVICES/ORTHOTIC DEVICES

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

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

PEDIATRIC SERVICES

Coverage will be provided for Pediatric preventive care services for Covered Dependent Children up to age eighteen (18). Benefits include but are not limited to: (1) appropriate immunizations as defined by Standards of Child Health Care issued by the American Academy of Pediatrics or other guidelines required by the state; (2) developmental assessments, which includes Physician visits for child health supervision services; (3) laboratory services; (4) topical fluoride varnish; and (5) any other care and services mandated by the federal Affordable Care Act.

PEDIATRIC VISION CARE PROGRAM

Coverage will be provided for vision care services for Covered Dependent Children under age 19. Vision Care services and the vision care In-Network used for this benefit are administered by VSP as shown on page 5, *Important Information*. A directory listing of the VSP In-Network Providers can be obtained from the VSP website, or You contact VSP by telephone or mail; the VSP contact information is shown on page 5.

Benefits will be provided for the covered services shown in the Schedule of Benefits for the stated frequency of services. The frequency of service for each covered service is once every 12 months, unless otherwise stated in the Schedule of Benefits.

The Covered Person may choose either eyeglasses or contact lenses during any Calendar Year; however, no benefits will be provided for both eyeglasses and contact lenses during the same Calendar Year period. Benefits payable under this Pediatric Vision Care Program benefit are subject to the terms, conditions, exclusions, limitations outlined in this Covered Benefit and this Policy.

EYE EXAMINATIONS

Benefits will be provided for one eye examination for each eligible Covered Dependent Child during the Calendar Year. The eye examination may be for one of the following: (1) eyeglasses; (2) contact lenses; or (3) for both eyeglasses and contact lenses during one examination. No benefits will be payable for another eye examination performed during the Calendar Year. No benefits will be payable for separate eye examinations for eyeglasses and contact lenses during the Calendar Year.

VISION CARE MATERIALS: EYEGLASS LENSES, COATINGS, AND FRAMES

Benefits will be provided for: (1) eyeglass lenses; (2) eyeglass coatings; and (3) eyeglass frames. The benefits payable are shown in the Schedule of Benefits.

The frame selection covered under this Vision Care benefit will be from a Pediatric Exchange Collection at the Physician's office.

CONTACT LENSES

In lieu of eyeglasses, the Covered Person may elect to receive Vision Care Materials for contact lenses as shown in the Schedule of Benefits. Either eyeglasses or contact lenses may be elected during the Calendar Year, but not both.

Benefits are payable for Necessary Contact Lenses for Covered Persons who have specific conditions for which contact lenses provide better visual correction. The Necessary Contact Lenses must be recommended and prescribed by the Vision Physician.

The following service limitations apply to In-Network benefits for Contact Lenses:

1. Standard (one pair of contact lenses per Calendar Year): Benefits are limited to one (1) contact lens per eye (total 2 lenses);
2. Monthly (six-month supply): Benefits are limited to six (6) lenses per eye (total 12 lenses);
3. Bi-weekly (3 month supply): Benefits are limited to six (6) lenses per eye (total 12 lenses); and
4. Dailies (one month supply): Benefits are limited to thirty (30) lenses per eye (total 60 lenses.

The following items are not covered under this contact lens benefit provision:

1. Other insurance policies or service agreements;
2. Artistically painted or non-prescription lenses;
3. Additional office visits for contact lens pathology;
4. Contact lens modification, polishing or cleaning; and
5. Orthoptics, vision training, supplemental testing.

PAYMENT OF BENEFITS

Benefits will be paid as shown in the Schedule of Benefits.

When services are received from an In-Network Provider, the benefits are fully covered at no cost to the Covered Person. Therefore, no claims have to be submitted to Us or VSP. The In- Network Provider will not require payment for the Vision Care services provided to the Covered Dependent Child.

When services are received from an Out-of-Network Provider, You will be responsible for paying the difference between the benefit payable under this Vision Care benefit and the amount billed by the Out-of-Network Provider. You will have to submit a claim to VSP to obtain reimbursement for any amount You pay that is covered under this Vision Care benefit.

CLAIMS AND APPEALS FOR DENIED CLAIMS

VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Denial of Preauthorization Requests. If VSP denies the Physician's request for Preauthorization, the Physician, You or Your authorized representative may request to appeal the denial. Please refer to the "Claim Appeals" provision below, for details on how to request an appeal. VSP will provide the requestor with a final review determination within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP will resolve any second level appeal within thirty (30) calendar days. You may designate any person, including the provider, as Your authorized representative.

Request for Appeals: If the Covered Dependent Child's claim for benefits is denied by VSP in whole or in part, VSP will notify You in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, You may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify You and the Covered Dependent Child for whom a claim for benefits was denied, including: (1) Your VSP Member Identification Number; (2) the Covered Dependent Child's name and date of birth; (3) the name of the provider of services; and (4) the claim number. You may state the reasons You believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give You the opportunity to: (1) review pertinent documents; (2) submit any statements, documents, or written arguments in support of the claim; and (3) appear personally to present materials or arguments. You or Your authorized representative should submit all requests for appeals to VSP.

VSP contact information for claims is shown on page 5, Important Information.

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply only to this Pediatric Vision Care benefit. No coverage will be provided under this Vision Care benefit for:

1. The purchase of two pairs of glasses instead of bifocals. Only one pair of glasses are payable under this Vision Care benefit per Calendar Year.
2. Replacement of lenses, frames or contacts.
3. Medical or surgical treatment.
4. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± .50 diopter power); or two pair of glasses in lieu of bifocals.
5. Replacement of lenses and frames furnished under This Plan which are lost or broken except at the normal intervals when services are otherwise available.
6. Medical or surgical treatment of the eyes.
7. Corrective vision treatment of an Experimental Nature.
8. Costs for services and/or materials above the benefits payable for the Covered Vision Care services.
9. Services or materials not indicated as Covered Vision Care benefit.

PHYSICIAN MEDICAL SERVICES

Coverage will be provided for services provided by a Physician (non-specialist or specialist) in the Physician's office during an office visit for medical services.

PRESCRIPTION DRUGS BENEFIT

Generic and Brand-Named Prescription Drugs are covered under this Policy, as provided in this Covered Benefit provision.

Covered Prescription Drugs are provided in the Prescription Drug Formulary for this Policy. The Prescription Drug Formulary will be provided to You with the issuance of this Policy. The formulary also may be obtained on Our website or by calling the Customer Service number appearing on page 4, *Important Information*.

Prescription drugs benefits described in the Summary of Benefits are arranged by Tiers to provide a structure for member cost-sharing in each category. Generally, the relationship is as follows: Tier 0 = Preventive; Tier 1 = Preferred Generic; Tier 2 = Preferred Brand; Tier 3 = Non-Preferred Brand and Non-Preferred Generic; Tier 4 = Preferred Specialty Drugs.

PRESCRIBING UNITS

A Prescribing Unit is the amount of the Prescription Drug or Specialty Drug that will be dispensed for a single Copayment or for which any minimum or maximum Coinsurance amount will be calculated. For any drug, if two (2) or more different strengths, methods of drug delivery, formulation or drug name are prescribed for use during the same time period, each will constitute a separate Prescribing Unit and Copayment/Coinsurance. We also reserve the right to cover the least number of tablets and/or capsules in order to obtain the daily dose needed as long as it is within the Plan's quantity limits and/or Plan's approved dose. Each strength will constitute a separate Prescribing Unit and Copayment/Coinsurance.

The Prescribing Unit of a Prescription Drug or Specialty Drug dispensed by a pharmacy pursuant to one (1) Prescription Order or Refill shall be limited to the lesser of:

- The quantity prescribed in the Prescription Order or Refill; or
- A 31-day supply
- The quantity limit for a specific drug; or

Any Covered Drug that has a duration of action extending beyond one (1) month shall require the number of Copayments per Prescribing Unit that is equal to the anticipated duration of the medication. For example, Depo-Provera is effective for three (3) months and would require three (3) Copayments.

DRUG FORMULARY, PREAUTHORIZATION, AND PRESCRIPTION DRUG SUPPLY LIMITS

The Prescription Drugs provided under this Policy are based on the Drug Formulary for this Policy. Therefore, only those prescription drugs listed in such Drug Formulary will be covered under this Policy.

Some Prescription Drugs may require preauthorization or have quantity limits. Others require step therapy or have special handling requirements. These measures are to promote safety and cost-effectiveness. The information related to these requirements is on the searchable Formulary on our Website, www.mhc.coop, under the Member dropdown. You can also get information by calling Customer Service (contact information as shown on page 5, Important Information), or by receiving a hard copy of the formulary on request.

The supply limits for Prescription Drugs are as follows:

1. Per prescription or refill at a retail Participating Provider Pharmacy or non-Preferred Provider Pharmacy is limited to a maximum of a 31-day supply;
2. Per prescription or refill received from the Participating Provider Mail Order Pharmacy or Non-Preferred Provider Mail Order Pharmacy is limited to a maximum of a 90-day supply based on the FDA-approved dosage regardless of the manufacturer packaging. However, Self-Administered Injectable Drugs are limited to a maximum of a 31-day supply per prescription or refill received from the Participating or Non-Participating Provider Mail Order Pharmacy.

Exclusions

No benefits will be payable for the following:

1. Non-legend drugs other than insulin.
2. Anabolic Steroids.
3. Fluoride supplements.
4. Over-the-counter drugs that do not require a prescription with the exception of those covered under the preventive benefit of the Affordable Care Act.
5. Any drug used for the purpose of weight loss.
6. Prescription Drugs for cosmetic purposes, including the Treatment of alopecia (hair loss), e.g., Minoxidil, Rogaine.
7. Prescription Drugs used for the treatment of erectile dysfunction.
8. Therapeutic devices (excluding insulin needles or syringes) or appliances, including:
    a. Needles;
    b. Syringes;
    c. Support garments; and
    d. Other nonmedicinal substances;

regardless of intended use, unless otherwise specified as a Covered Benefit under this provision.

9. Diabetic infusion sets, which include: (a) a cassette; (b) needle and tubing; and (3) one insulin-pump during the warranty period. Diabetic-infusion sets, pumps and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit.
10. Drugs or items labeled "Caution – limited by federal law to investigational use, or experimental drugs even though the Covered Person is charge for the item.
11. Off-label use of a medication;
12. Biological sera;
13. Blood or blood plasma.

14. Prescription Drugs which are to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is a patient in: (a) a Hospital; (b) rest home; (c) sanitarium; (d) extended care facility; (e) convalescent hospital; (f) nursing home; or (g) similar institution which operates or allows to be operated on its premises; or (h) a facility for dispensing pharmaceuticals; medications in these situations is part of the facility's charge.
15. Replacement prescription Drugs or Prescription Drugs due to loss, theft or spoilage.
16. Smoking deterrent drugs or aids.
17. Non-formulary and non-covered drugs.

PURCHASE AND PAYMENT OF PRESCRIPTION DRUGS

Prescription Drugs may be obtained using a Participating Provider Pharmacy or the In-Network Mail Order Pharmacy. Prescription drugs can also be obtained by using a Non-Participating Provider Pharmacy or Out-of-Network Mail Order Pharmacy at a higher cost to the member. The Prescription Drug Coinsurance and/or Copayment, if any, is shown in the Schedule of Benefits. The Prescription Drug Coinsurance and Copayments apply towards the satisfaction of the Annual Out-of-Pocket Maximum required under the Policy. If Prescription Drugs are purchased at a Non-Participating Provider Pharmacy, retail or mail order, the Covered Person must pay out-of-network coinsurance for the prescription at the time of purchase.

If Prescription Drugs are purchased at a retail Participating Provider Pharmacy, the Covered Person must present the Covered Person's Identification Card (ID) at the time of purchase and pay the required Prescription Drug Deductible, Coinsurance and/or Copayment as shown in the Schedule of Benefits.

If Prescription Drugs are purchased through the In-Network Mail Order Pharmacy, the Covered Person must provide the In-Network Mail Order Pharmacy with the completed order form, Deductible and/or Copayment amount, and the signed Physician prescription.

Third party service providers may not waive, rebate, give, pay or offer to waive, rebate, give or pay all of part of the Insured's deductible or other out of pocket costs for prescription drugs. We will accept third party payments of cost sharing from:

- A Ryan White HIV/AIDS Program
- An Indian tribe or tribal organization
- Local, state or federal government programs, including grantees directed by a government program to make payments on its behalf

We will also accept third party payments from individuals such as family and friends, religious institutions and other not-for-profit organizations when all of the following three criteria are met:

- The assistance is provided on the basis of the insured's financial need
- The institution/organization is not a healthcare provider
- The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

We do not count any financially interested third party cost-sharing payments toward deductibles or out of pocket maximums. If We discover financially interested third party payments of this type

after the fact and these payments have already been counted toward the deductible or out of pocket maximum, We will exclude the financially interested third party from the accumulation toward the deductible or out of pocket maximum.

Should We reject a payment from a third party, we will inform you in writing of the reason for our rejection and your right to file a complaint with the Commissioner's Office of Securities and Insurance.

Inborn Errors of Metabolism. Coverage will be provided for the treatment of inborn errors of metabolism: (a) that involve: (1) amino acid; (2) carbohydrate; and (3) fat metabolism; and (b) for which medically standard methods of: (1) diagnosis; (2) treatment; and (3) monitoring exist.

Coverage for inborn errors of metabolism will include expenses of: (a) diagnosing; (b) monitoring; and (c) controlling the disorders by nutritional and medical assessment, including but not limited to: (1) clinical services; (2) biochemical analysis; (3) medical supplies; (4) prescription drugs; (5) corrective lenses for conditions related to the inborn error of metabolism; (6) nutritional management; and (7) medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

"Medical foods" means nutritional substances in any form that are: (a) formulated to be consumed or administered enterally under supervision of a physician; (b) specifically processed or formulated to be distinct in one or more nutrients present in natural food; (c) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and (d) essential to optimize growth, health, and metabolic homeostasis.

"Treatment", as used in this benefit provision, means licensed professional medical services under the supervision of a physician.

POSTMASTECTOMY CARE AND RECONSTRUCTIVE BREAST SURGERY

POSTMASTECTOMY CARE

Coverage will be provided for Inpatient Hospital care for a period of time determined by the Attending Physician in consultation with the Covered Person, to be Medically Necessary following:

1. A mastectomy;
2. A lumpectomy; or
3. A lymph node dissection;

for the Treatment of breast cancer.

RECONSTRUCTIVE BREAST SURGERY

Coverage will be provided for all stages of Reconstructive Breast Surgery after a mastectomy including, but not limited to:

1. All stages of reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Prostheses and physical complications of all stages of mastectomy and breast reconstruction, including lymphedemas; and

4. Chemotherapy.

The above treatments must be provided in a manner determined in consultation with the Attending Physician and the Covered Person.

Coverage will be provided for breast prostheses as the result of a mastectomy.

For specific benefits related to postmastectomy care, please refer to that specific Covered Benefit, e.g., *Surgical Services, Hospital Services – Facility and Professional*.

"Mastectomy" means the surgical removal of all or part of a breast.

"Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes, but is not limited, to augmentation mammoplasty, reduction mammoplasty, and mastopexy.

We will provide written notice in compliance with the model language of the Women's Health and Cancer Rights Act of 1998 to a Covered Person of the availability of benefits with respect to the Women's Health and Cancer Rights Act of 1998 upon enrollment and subsequently on an annual basis.

PREVENTIVE HEALTH CARE SERVICES BENEFIT

Preventive Health Care Services for health care screenings or preventive purposes submitted with a preventive diagnosis will be covered at 100% of the Allowable Fee. This means that these Benefits are not subject to the Deductible, Coinsurance, Copayments, or Annual Out-of- Pocket Maximum when services are provided by an In-Network Provider. However, if Preventive Health Care Services are rendered or an established medical condition or by a Non-In-Network, the Preventive Health Care Services provided will be subject to the Deductible, Coinsurance, Copayments, and Annual Out-of-Pocket Maximum.

Preventive Health Care Services include, but are not limited to:

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

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

3. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;
   a) Lactation Services: Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. In addition, the plan will reimburse the Covered Person the actual cost for the purchase of a breast pump once per birth event. Hospital-grade pumps can be rented, per Medical Policy criteria.
   b) Contraceptives: Food and Drug Administration approved contraceptive methods, including certain contraceptive products, sterilization procedures for

women, and patient education and counseling for all women with reproductive capacity.

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

5. Any other Preventive Health Care Services required by the federal Affordable Care Act.

Educational training for Preventive Health Care Services that is necessary and prescribed by a Physician will be covered.

The following are some of the services provided under this Preventive Health Care Services Benefit. Coverage will be provided in accordance with the requirements of the federal Affordable Care Act:

1. **Blood Pressure Screening.**

2. **Cancer Screenings.** Coverage for cancer screenings includes, but is not limited to: (a) Breast Cancer Screenings (Mammograms); (b) Colorectal Cancer Screenings; (c) Prostate Cancer Screenings; and (d) any other cancer screenings required by the federal Affordable Care Act.

3. **Cholesterol Tests.**

4. **Counseling Services.** Coverage for counseling will be provided on such topics as: (a) quitting smoking; (b) losing weight; (c) eating healthfully; (d) treating depression; (e) reducing alcohol use; and (f) any other counseling services mandated by the federal Affordable Care Act.

5. **Diabetes Management and Supplies.** Coverage will be provided for Diabetes Self-Management, Equipment and Supplies. Benefits will be payable for outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a Covered Provider with expertise in diabetes.

   Benefits will be provided for diabetic equipment and supplies; however, such equipment and supplies are limited to the following: (1) insulin; (2) syringes; (3) injection aids; (4) devises for self-monitoring of glucose levels (including those for the visually impaired); (5) test strips; (6) visual reading and urine test strips; (7) one insulin pump for each warranty period; (8) accessories to insulin pumps; (9) one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States Food and Drug Administration; and (10) glucagon emergency kits. Diabetic equipment and supplies that are payable under the Prescription Drug Benefit will be paid under the Prescription Drug Benefit only.

6. **Flu and Pneumonia Shots.**

7. **Healthy Pregnancy Counseling.** Coverage will include, but not limited to, counseling, screening, and vaccines.

8. **Smoking/Tobacco Cessation.** Coverage will be provided for tobacco cessation interventions for Covered Persons who use tobacco products. Such interventions, which must be recommended by the U.S. Preventive Services Task Force (USPSTF), include:

   a. Counseling: The following counseling sessions, based on the "5-A" counseling format recommended by the USPSTF, include: (1) A brief one-time counseling

session of 10 minutes; or (2) when needed, longer counseling sessions over 10 minutes or multiple counseling sessions; and (3) augmented pregnancy tailored counseling for pregnant women;

b. Pharmacotherapy: FDA-approved pharmacotherapy, which is a combination therapy with counseling and medication, will be covered. FDA-approved pharmacotherapy includes: (1) nicotine replacement; and (2) therapy sustained-release bupropion and varenicline.

9. **Vaccinations.** Coverage will be provided for routine vaccinations against diseases such as measles, polio, or meningitis, or other diseases specified for vaccination in the federal Affordable Care Act.

10. **Well-Baby and Well-Child Care Visits.** Coverage will be provided for regular well- baby and well-child care visits, from birth to age 21, unless otherwise stipulated in the federal Affordable Care Act. Benefits will include, but not limited to, the following: (a) a history; (b) physical examination; (c) developmental assessment; (d) anticipatory guidance; (e) laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided in the Montana State Medicaid law; (f) routine immunizations according to the schedule for immunizations recommended by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services or as recommended by the American Committee on Immunization Practices.

    Services for Well-Baby and Well-Child Care:

    a. Must be provided by a Physician or other Covered Provider supervised by a Physician; and

    b. Will be limited to one visit payable to one provider for all of the services provided at each visit.

"Developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American Academy of Pediatrics.

For more detailed information on Preventive Health Care Services, contact Customer Service at the telephone number or website shown on page 4, *Important Information*.

PROSTHETIC DEVICES (NON-DENTAL)

Coverage will be provided for appropriate non-dental prosthetic devices used to replace a body part missing because of an Accident, Injury or Illness. Such non-dental prosthetic devices include: (1) artificial limbs; (2) eyes; or (3) other prosthetic appliances. Replacement of such devices will be covered only if: (1) functionally necessary; or (2) as required by a change in the Covered Person's physical structure.

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

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

No benefits will be paid for:

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

Preauthorization is recommended for the original purchase or replacement of prosthetics over $500. Please refer to Section 7, Utilization Review Management Program.

Note: The prosthesis will not be considered a replacement if the prosthesis no longer needs the medical needs of the Covered Person due to physical changes or a deteriorating medical condition.

RADIATION THERAPY SERVICES

Coverage will be provided for these services which include:

1. Chemotherapy. Coverage includes the use of drugs to approved for use in humans by the U.S. Food and Drug Administration (FDA);
2. X-rays;
3. Radium therapy; and
4. Radioactive isotope therapy;

for the treatment of benign or malignant disease conditions. All Radiation Therapy Services must be prescribed by the Attending Physician and performed by a Covered Provider for the treatment of disease.

REHABILITATION – FACILITY AND PROFESSIONAL SERVICES

Benefits will be payable for Rehabilitation Therapy and other covered services, as provided in this Covered Benefit, that are billed by a Rehabilitation Facility provider or a Professional Provider.

Coverage will be provided for services and devices required for rehabilitative care when prescribed by a Physician to improve, maintain or restore the Covered Person to the Covered Person's best possible physical functional level due to an Illness or Injury.

No benefits will be payable when the primary reason for Rehabilitation is any one of the following:

1. Custodial care;
2. Diagnostic admissions;
3. Maintenance, nonmedical self-help, or vocational educational therapy;
4. Social or cultural rehabilitation;
5. Learning and developmental disabilities; and
6. Visual, speech, or auditory disorders because of learning and developmental disabilities.

Benefits will not be provided under this Rehabilitation benefit for treatment of Chemical Dependency or Mental Illness as provided under the *Chemical Dependency* and *Mental Illness* benefits provided under this Policy.

Benefits will be provided for services, supplies and other items that are within the scope of this Rehabilitation benefit as described in this Rehabilitation benefit only as provided in and subject to the terms, conditions and limitations applicable to this Rehabilitation benefit and other

applicable terms, conditions and limitations of this Policy. Other Covered Benefit provisions of this Policy, such as but not limited to Hospital Services, do not include benefits for any services, supplies or items that are within the scope of this Rehabilitation benefit as provided in this Rehabilitation benefit.

REHABILITATION FACILITY INPATIENT CARE SERVICES BILLED BY A FACILITY PROVIDER

Benefits will be payable for the following services when the Covered Person receives Rehabilitation Inpatient Care and billed by the Rehabilitation Facility:

1. Room and Board Accommodations. Such room and board accommodations include, but are not limited to: (a) dietary and general; and (b) medical and rehabilitation nursing services.
2. Miscellaneous Rehabilitation Facility Services (whether or not such services are Rehabilitation Therapy or are general, medical or other services provided by the Rehabilitation Facility during the Covered Person's admission), including but not limited to:
    a. Rehabilitation Therapy services and supplies, including but not limited to: (1) Physical Therapy; (2) Occupational Therapy; and (3) Speech Therapy.
    b. Laboratory procedures;
    c. Diagnostic testing;
    d. Pulmonary services and supplies, including but not limited to: (1) oxygen; and (2) use of equipment for its administration;
    e. X-rays and other radiology;
    f. Intravenous injections and setups for intravenous solutions;
    g. Special diets when Medically Necessary;
    h. Operating room, recovery room;
    i. Anesthetic and surgical supplies;
    j. Drugs and medicines which:
        1) Are approved for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed;
        2) Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
        3) Require a Physician's written prescription.
3. Rehabilitation Facility Inpatient Care Services do not include services, supplies or other items for any period during which the Covered Person is absent from the Rehabilitation Facility for purposes not related to rehabilitation, including, but not limited to, intervening Inpatient admissions to an acute care Hospital. Preauthorization is recommended for Rehabilitation Facility Inpatient Care. Refer to Section 6, Utilization Review Management Program.

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

1. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
2. A freestanding facility or facility associated with or located within a Hospital or other facility;
3. A designated rehabilitation unit of a Hospital;
4. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Covered Person, regardless of the category of facility licensure.

"Rehabilitation Therapy" means a specialized, intense and comprehensive program of therapies and treatment services (including but not limited to Physical Therapy, Occupational Therapy, and Speech Therapy) provided by a Multidisciplinary Team for treatment of an Injury or physical deficit. A Rehabilitation Therapy program is:

1. Provided by a Rehabilitation Facility in an Inpatient Care or Outpatient setting;
2. Provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;
3. Designed to restore the patient's maximum function and independence; and
4. Medically Necessary to improve or restore bodily function and the Covered Person must continue to show measurable progress.

Rehabilitation Facility Inpatient Care is subject to the following conditions:

1. The Covered Person will be responsible to the Rehabilitation Facility for payment of the Facility's charges if the Covered Person remains as an Inpatient when Rehabilitation Facility Inpatient Care is not Medically Necessary. No benefits will be provided for a bed reserved for the Covered Person.
2. The term "Rehabilitation Facility" does not include:
    a. A Hospital when the Covered Person is admitted to a general medical, surgical or specialty floor or unit (other than a rehabilitation unit) for acute Hospital care, even though rehabilitation services are or may be provided as a part of acute care;
    b. A nursing home;
    c. A rest home;
    d. Hospice;
    e. A skilled nursing facility;
    f. A Convalescent Home;
    g. A place for care and treatment of Chemical Dependency;
    h. A place for treatment of Mental Illness;
    i. A long-term, chronic-care institution or facility providing the type of care listed above in this subparagraph.

REHABILITATION FACILITY INPATIENT CARE SERVICES BILLED BY A PROFESSIONAL PROVIDER

Coverage will be provided for all Professional services provided by a Covered Provider who is a physiatrist or other Physician directing the Covered Person's Rehabilitation Therapy. Such professional services include: (1) care planning and review; (2) patient visits and examinations; (3) consultation with other Physicians, nurses or staff; and (4) all other professional services provided with respect to the Covered Person. Professional services provided by other Covered Providers (i.e., who are not the Physician directing the Covered Person's Rehabilitation Therapy) are not included in this Rehabilitation benefit, but are included to the extent provided in and subject to the terms, conditions and limitations of other Covered Benefits under this Policy.

OUTPATIENT REHABILITATION SERVICES

Coverage will be provided for Rehabilitation Therapy provided on an outpatient basis by a Facility or Professional Provider.

RENAL DIALYSIS

Coverage will be provided for medically necessary care and treatment related to renal failure. Most patients with End State Renal Disease (ESRD) are eligible for Disability and Medicare. If you are enrolled in Medicare based on ESRD, it is illegal for Us to knowingly sell or issue an individual QHP with tax credits or individual policy to you. If you develop ESRD while a member, it may be to your advantage to seek coverage through the Medicare ESRD program. You can continue this coverage as well, but it will be subject to Coordination of Benefits.

SURGICAL SERVICES

Coverage will be provided for Medically Necessary surgical procedures performed by a Physician in a Hospital or a licensed surgical facility. Preauthorization is required for all surgeries.

SURGICAL SERVICES BILLED BY A PROFESSIONAL PROVIDER

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

SURGICAL SERVICES BILLED BY AN OUTPATIENT SURGICAL FACILITY OR FREESTANDING SURGERYCENTERS

Services of a surgical facility or freestanding (surgery centers) licensed, or certified for Medicare, by the state in which it is located and have an effective peer review program to assure quality and appropriate patient care. The surgical procedure performed in a surgical facility or freestanding

(surgery centers) is recognized as a procedure which can be safely and effectively performed in an Outpatient setting.

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

SURGICAL SERVICES BILLED BY A HOSPITAL (INPATIENT AND OUTPATIENT)

Coverage will be provided for services provided by a Hospital for surgical procedures and the care of fractures and dislocations performed in an Outpatient or Inpatient setting, including the usual care before and after surgery.

TELEMEDICINE

Coverage will be provided for the use of interactive audio, video, or other telecommunications technology that is used by a provider or facility to deliver health care services at a site other than where the patient is located and delivered over a secure HIPAA compliant connection. Health Care Services administered via telemedicine must be deemed medically necessary and administered by a licensed Health Care Provider. Telemedicine does not include the use of audio-only telephone, email, or fax transmissions.

THERAPEUTIC SERVICES – OUTPATIENT

Coverage will be provided for the following Outpatient therapeutic services: (1) Physical Therapy; (2) Speech Therapy; (3) Cardiac Therapy; (4) Occupational Therapy; and (5) Rehabilitation Therapy.

The therapist providing the services must be licensed or certified in the state in which services are provided. Preauthorization is recommended for Outpatient Therapeutic Services; refer to Section 6, *Utilization Review Management Program.*

TRANSPLANT BENEFITS

Coverage will be provided for Medically Necessary non-experimental transplants for the following: (a) kidney; (b) pancreas; (c) heart; (d) heart/lung; (e) single lung; (f) double lung; (g) liver; (h) cornea; (i) bone marrow/stem cell; (j) small bowel transplant; (k) simultaneous pancreas/kidney; and (l) renal transplant. Preauthorization is required for organ transplants; refer to *Section 6, Utilization Review Management Program*.

If We have contracts with any Centers of Excellence that provide Transplant services, We may recommend that the Centers of Excellence be used for certain Transplants because of the quality of the outcomes of these procedures.

Covered Benefits include the following when provided by the approved Institute of Excellence:

1. Organ procurement including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ and the transportation of the donor or donor organ to the location of the transplant operation.

2. Donor services, including the pre-operative services, transplant related diagnostic lab and x-ray services, and the transplant surgery hospitalization. Transplant related services are covered for up to six months after the transplant surgery.
3. Hospital Inpatient Care.
4. Surgical services.
5. Anesthesia.
6. Professional Covered Providers and diagnostic Outpatient services.
7. Licensed ambulance travel or commercial air travel for the Covered Person receiving the Transplant to the nearest Hospital with appropriate facilities.

Benefits will be payable subject to the following conditions:

1. When both the transplant recipient and donor are members, both will receive benefits.
2. When the transplant recipient is a Covered Person and the donor is not, both will receive benefits to the extent that benefits for the donor are not provided under other hospitalization coverage.
3. When the transplant recipient is not a Covered Person and the donor is a Covered Person, the donor will receive benefits to the extent that benefits are not provided to the donor by hospitalization coverage of the transplant recipient.

No benefits will be payable for:

1. Experimental or investigational procedures;
2. Transplants of a nonhuman organ or artificial organ transplant; and
3. Donor searches.

URGENT CARE

Care for an illness, injury or condition serious enough that a prudent layperson would seek care right away, but not so severe as to require Emergency Room Care.

If a condition requiring Urgent Care develops, You may go to the nearest Urgent Care Center, Physician's office, or any other Provider for treatment. This treatment may be subject to a Copayment and/or Coinsurance. Examples of Urgent Care conditions include fractures, lacerations, or severe abdominal pain.

WELL-CHILD CARE

Coverage will be provided for Well-Child Care for Covered Dependent Children under age eight (8) provided by a Physician or a health care professional supervised by a Physician. Coverage will include the following:

1. Histories;
2. Physical examinations;
3. Developmental assessments;
4. Anticipatory guidance;

5. Laboratory tests; and

6. Routine immunizations.

WELLNESS SERVICES

Coverage will be provided for Wellness Services. Benefits include, but are not limited to, the following: (a) Smoking Cessation; (b) Weight Management; (c) Stress Management; (d) Nutrition and Exercise; or (e) any other Wellness Service mandated by the federal Affordable Care Act.

SECTION 6—UTILIZATION REVIEW MANAGEMENT PROGRAM

Our Utilization Review Management Program is administered by University of Utah Health Plans Our Utilization Review Management Program provides for Prospective Utilization Review to assure that certain prescribed Treatments and elective procedures are Medically Necessary and appropriate.

Prospective Utilization Review requires the Covered Person to obtain Preauthorization for certain prescribed Treatments and elective procedures before the Treatments and procedures are rendered. The Covered Person must contact the Utilization Review Management Program representative to obtain the Preauthorization. The Utilization Review Management Program representative is shown on page 4, *Important Information*.

HOW TO USE THE UTILIZATION REVIEW PROGRAM

To use the Utilization Review Management Program, the Covered Person need only to call the Customer Service toll-free telephone number listed on page 4, Important Information. The Covered Person may have the Covered Person's representative place the call. A representative may be the Physician, the Covered Facility, or the Covered Person's authorized representative (e.g., family member). The Utilization Review Management Program representative will give the individual who calls a reference number to verify that the call has been received and a file started.

The individual who calls the Utilization Review Management Program will need to provide the following information:

1. The name and social security number of the Covered Person for whom Treatment has been prescribed and requires Preauthorization;
2. The Policyowner's name and this Policy's Policy Number which is shown in the Schedule of Benefits.
3. The name and telephone number of the attending Physician;
4. The name of the Covered Facility where the Covered Person will be admitted, if applicable;
5. The proposed date of admission, if applicable; and
6. The proposed Treatment.

PLEASE NOTE: Authorization by the Utilization Review Management Program representative does not verify a Covered Person's eligibility for coverage under this Policy, nor is it a guarantee that benefits will be paid for a proposed Treatment. Benefit payment will be made for a Covered Person only in accordance with all the terms and conditions of this Policy.

This Utilization Review Management Program does not include routine claim administration.

UTILIZATION REVIEW DEADLINES

- For prospective determinations (service not yet occurred): fifteen (15) days;
- For retrospective determinations (service has already occurred): thirty (30) days;
- For expedited determinations (urgent care): as soon as possible (72-hour maximum)

The insurer may seek a 15-day deadline extension for prospective and retrospective determinations.

PLAN NOTIFICATION

Plan Notification is recommended for any Inpatient admission, including admissions to a Hospital, Chemical Dependency Treatment Center, Mental Illness Treatment Center, Chemical Dependency or psychiatric residential treatment facility, intensive Outpatient programs, or other medical procedures or services, (or as may be noted for a Covered Benefit), as soon as the Covered Provider recommends or schedules to allow the Utilization Review Management Program to begin working with the Covered Person on the benefit management for the service. Plan Notification is requires contacting the Utilization Review Management Program in writing or by telephone.

MEDICAL TREATMENTS REQUIRING PREAUTHORIZATION

Preauthorization must be obtained for:

1. Benefits that specify that Preauthorization is required; and
2. Procedures listed in the Preauthorization Medical Treatments List.

Failure to obtain the required Preauthorization prior to receiving services will result in pended claims and a review for medical necessity.

PREAUTHORIZATION MEDICAL TREATMENT LIST

The following medical Treatments require Preauthorization:

- Ambulance for non-emergent services
  - Transportation by fixed-wing aircraft (plane)
  - Elective (non-emergency) transportation by ground, ambulance or medical van
- Autologous chondrocyte implantation
- BRCA testing (genetic testing for breast cancer risk)
- Cochlear device and/or implantation
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation
- Electric or motorized wheelchairs and scooters
- Gastrointestinal (GI) tract imaging through capsule endoscopy
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- pre-implantation genetic testing
- Injectables in excess of $1000 per dose
- Inpatient confinements (all)

    - Such as, surgical and nonsurgical confinements; confinements in a skilled nursing facility; mental health rehabilitation facility; substance abuse rehabilitation facility; and maternity and newborn confinements that exceed the standard length of stay (LOS)
- Gender Reassignment Surgery
- Lower limb prosthetics
- Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider
- Observation stays more than 24 hours
- Osseointegrated implant
- Osteochondral allograft/knee
- Proton beam radiotherapy
- Reconstructive or other procedures that may be considered cosmetic
    - Blepharoplasty/Canthoplasty
    - Breast reconstruction/breast enlargement
    - Breast reduction/mammoplasty
    - Cervicoplasty
    - Excision of excessive skin due to weight loss
    - Lipectomy or excess fat removal
    - Surgery for varicose veins, except stab phlebectomy
- Referral or use of nonparticipating physician or provider for non-emergent services, unless the member understands and consents to the use of a nonparticipating provider under their out-of-network benefits when available in their plan
- Spinal procedures
    - Artificial intervertebral disc surgery
    - Cervical, lumbar and thoracic laminectomy/laminotomy procedures
    - Spinal fusion surgery
- Transplants
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices for non-emergent services

UTILIZATION REVIEW PROCESS

When the Utilization Review Management Program representative conducts Utilization Reviews, the Utilization Review will include the following:

UTILIZATION REVIEW FOR MENTAL HEALTH TREATMENT

When Utilization Review is conducted for outpatient mental health Treatment, the Utilization Review Management Program representative will only request information that is relevant to the payment of the claim.

When a Utilization Review requires disclosure of personal information regarding the patient or client, including:

1. Personal and family history; or

2. Current and diagnosis of a mental disorder;

the identity of that individual will be concealed from anyone having access to that information in order that the patient or client may remain anonymous.

Request for Information

The Utilization Review Management Program representative may request only information that is relevant to the payment of a claim for Utilization Review of Outpatient mental health treatment.

DISCLSOURE OF PERSONAL INFORMATION

When a Utilization Review requires disclosure of personal information regarding the patient or client, including:

1. Personal and family history; or
2. Current and past diagnosis of a mental disorder;

the Utilization Review Management Program representative will conceal the identity of that individual from anyone having access to that information in order that the patient or client may remain anonymous.

DETERMINATIONS MADE ON APPEAL OR RECONSIDERATION

A Utilization Review determination that is:

1. Made on appeal or reconsideration; and
2. Adverse to a patient or to an affected health care provider;

may not be made on a question relating to the necessity or appropriateness of a health care Treatment without prior written findings, evaluation, and concurrence in the Adverse Determination by a health care professional trained in the relevant area of health care. Copies of the written findings, evaluation, and concurrence will be provided to the patient upon the Covered Person's written request to the Utilization Review Management Program within thirty (30) days of determination.

A determination made on appeal or reconsideration that health care Treatment rendered or to be rendered are medically inappropriate may not be made unless the health care professional performing the utilization review has made a reasonable attempt to consult with the patient's attending health care provider concerning the necessity or appropriateness of the health care Treatment.

Also, refer to the Complaints, Grievances and Appeals provision, in Section 10, regarding appeals for adverse determinations.

SECTION 7—COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when the Covered Person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1) "Plan" includes: group and nongroup health insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, if determined by the commissioner to be "excepted benefits" as defined in 33-22-140, MCA; school accident type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. "This Plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is Primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and In-Network arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

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

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

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

   b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

      ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (a) above shall determine the order of benefits;

      iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (a) above shall determine the order of benefits; or

      iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         - The **Plan** covering the **Custodial parent**;
         - The **Plan** covering the spouse of the **Custodial parent**;
         - The **Plan** covering the **non-custodial parent**; and then
         - The **Plan** covering the spouse of the **non-custodial parent**.

   c. For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary Plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary Plan**. The same would hold true if a person is a

dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary Plan** and the COBRA or state or other federal continuation coverage is the **Secondary Plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.(1) can determine the order of benefits.

5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary Plan** and the **Plan** that covered the person the shorter period of time is the **Secondary Plan**.

6) If the preceding rules do not determine the order of benefits, the **Allowable Expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This Plan** will not pay more than it would have paid had it been the **Primary Plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This Plan** and other **Plans**. Our Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This Plan** and other **Plans** covering the person claiming benefits. Our Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This Plan** must give Our Claims Administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This Plan**. If it does, Our Claims Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This Plan**. Our Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than We should have paid under this **COB** provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 8—EXCLUSIONS AND LIMITATIONS

All benefits provided under this Policy are subject to the exclusions and limitations in this Section and as stated under Section 5, Covered Benefits. No benefits will be paid under this Policy that are incurred by or results from any of the following.

1. Sanitarium care, custodial care, rest cures, custodial care or convalescent care to help the Covered Person with daily living tasks. Such tasks include, but limited to, the following: (a) walking; (b) getting in and out of bed; (c) bathing; (d) dressing; (e) feeding; (f) using the toilet; (g) preparing special diets; or (h) supervision of medication which is usually self-administered and does not require the continuous attention of medical personnel.

2. An Illness or Injury arising out of or in the course of doing any job or work for wage or profit, or Illness covered by any Workers' Compensation Law or Act, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This exclusion applies to all services and supplies provided to treat such Illness or Injury even though: (a) coverage under the government legislation provides benefits for only a portion of the services incurred; (b) the employer has failed to obtain such coverage required by law; (c) the Covered Person waives the Covered Person's rights to such coverage or benefits; (d) the Covered Person fails to file a claim within the filing period allowed by law for such benefits; (e) the Covered Person fails to comply with any other provision of the law to obtain coverage or benefits; and (f) the Covered Person was permitted to elect not to be covered by the Worker's Compensation Act but failed to properly make such election effective.

   This exclusion will not apply if the Covered Person is permitted by statute not be covered and the Covered Person elects not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws.

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

1. Services, supplies, drugs and devices which the Covered Person is entitled to receive or does receive TRICARE, the Veteran's Administration (VA), and Indian Health Services but not Medicaid. This exclusion is not intended to exclude Covered Medical Expenses from coverage if the Covered Person is a resident of a Montana State institution when benefits are provided.

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

2. War, or act of war, whether declared or not, rebellion, armed invasion, or insurrection;
3. Service in the Armed Forces or any auxiliary units of the Armed Forces;
4. Any loss for which a contributing cause was commission by the Covered Person of a felony, or attempt to commit a felony. This exclusion does not apply if the loss is related to being a victim of domestic violence.
5. Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline
6. Dental care and treatment except for such care or treatment due to accidental Injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;
7. Vision services, including, but not limited to, (a) eye examinations for the prescription or fitting of eyeglasses or contact lenses; (b) purchase of eyeglasses and contact lenses; (c) Lasik surgery; or (d) radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism). This exclusion does not apply to the Pediatric Vision Care benefit provided under this Policy;
8. Hearing aids and examinations for the prescription or fitting of hearing aids;
9. Cosmetic Surgery, unless (a) it is Medically Necessary; or (b) it is reconstructive surgery. Such reconstructive surgery must be: (a) incidental to or following surgery resulting from trauma, infection or other diseases of the involved part; and (b) because of congenital disease or anomaly of a covered Dependent Child which has resulted in a functional defect;
10. Foot care, including but limited to: (a) routine foot care; (b) treatment or removal of corns and callosities; (c) hypertrophy, hyperplasia of the skin or subcutaneous tissues; (d) cutting or trimming toenails; (e) any Treatment of congenital flat foot; (f) injections and nonsurgical Treatment of acquired flat foot, fallen arches, or chronic foot strain; (g) any Treatment of flat foot purely for the purpose of altering the foot's contour where no medicine or functional impairment exists; (h) orthotic appliances; (i) impression casting for orthotic appliances; (j) padding and strapping; or (k) fabrication;
11. Foot orthotic appliance provided for the treatment of any medical condition;
12. Continuous passive motion devices;
13. TENS units;
14. Treatment provided in a government hospital, except Montana residents who are confined in state medical institutions; benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers' compensation, employers' liability or occupational disease law;
15. Services rendered and separately billed by employees of hospitals, laboratories or other institutions;
16. Services performed by You or a member of Your Immediate Family;

17. Services for which there is no legal obligation for the Covered Person to pay or for which no charge would be made if insurance did not exist, unless such charge is regularly and customarily made in similar amount by the provider of such to other non-indigent patients, or unless, in either case, We are required by law to pay to the Government of the United States;

18. Nonsurgical Treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction, anterior or internal dislocation, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), or related appliances;

19. Unless otherwise included under this Policy as a Covered Benefit, dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;

20. Unless otherwise included under this Policy as a Covered Benefit, Vision care, except for medical treatment of the eyes by an ophthalmologist. Coverage is not provided for lenses, frames or contact lenses or any vision supplies;

21. Chiropractic maintenance therapy.

22. Private duty nursing;

23. Any expenses, procedures or services related to Surrogate pregnancy, delivery or donor eggs.

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

25. Reversal of an elective sterilization;

26. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition when the initial surgery was within the past 30 days.

27. Outpatient prescription drugs for which benefits are provided under the Prescription Drug Benefit in this Policy;

28. Abortion (*except when the life of the woman is endangered for reasons caused by or arising from the pregnancy or when the pregnancy is the result of an act of rape or incest*)

29. Transplants of a non-human organ or artificial organ transplant;

30. Any services, supplies, drugs and devices which are: (a) an investigational/Experimental Service; (b) not accepted medical practice; and (c) not a Covered Medical Expense. We may consult with Physicians or national medical specialty organizations for advice determining whether the service or supply is accepted-medical practices;

31. For travel by the Covered Person or a provider;

32. Orthodontics;

33. Services, supplies and devices relating to: (a) Holistic Medicine; (b) Holistic Healing; (c) Reiki; (d) Medical Herbalism; (e) Natural Healing; (f) acupuncture; (g) acupressure; (h) homeopathic treatments; (i) Rolfing; and other forms of Complementary and Alternative Medical treatments or therapy;

34. Services, supplies and devices relating to any of the following treatments or related procedures: (a) religious counseling; (b) self-help programs;

35. Vitamins. NOTE: Certain vitamins may be covered for specific conditions in accordance with published Medical Policy;

36. Food supplements and/or medical foods, except when used for Inborn Errors of Metabolism or Enteral Nutrition services as defined in the Medial Policy;

37. Services, supplies, drugs and devices for weight reduction or weight control, whether rendered for weight control or any other condition. This Exclusion does not include intensive behavioral dietary counseling for adult patients when services are provided by a Physician, Physician Assistant or Advanced Nurse Practitioner;

38. Education services, unless otherwise specified as a Covered Benefit, or tutoring services;

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

40. Computerized items including, but not limited to, the following: (a) durable medical equipment; (b) prosthetic limbs; and (c) communication devices. Payment for deluxe prosthetics and computerized limbs will be based on the Allowable Fee for a standard prosthesis;

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

42. Services, supplies, drugs and devices which are not listed as a Covered Benefit as provided in this Policy; or

43. All services, supplies, drugs and devices provided to treat any Illness or Injury arising out of employment as an athlete by or on a team.

44. For any of the following: (a) For appliances, splints, or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service in this Policy; (b) for orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw; (c) for implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies; (d) for alveolectomy or alveoloplasty when related to tooth extraction.

SECTION 9—CLAIM PROVISIONS

No claims have to be submitted when services are provided by an In-Network Provider. However, the Covered Person will need to submit a claim to Our Claims Administrator for reimbursement considerations when the Covered Person receives services from a Non-In-Network Provider/Facility.

HOW TO FILE A CLAIM

When a Covered Person receives services from of an In-Network, no claim form is required to be submitted to Us. However, if the Covered Person uses the services of a Non-In-Network, the Covered Person should file a claim with Us only if the Non-In-Network does not file one for the Covered Person.

Covered Providers participating in the In-Network Organization (PPO) Network shown on page 4, Important Information, will automatically file a claim directly to Us on behalf of the Covered Person for whom they provide services. Therefore, the Covered Person is not required to complete and submit a claim to Us.

If the Covered Person uses the services of a Non-In-Network, the Covered Person must submit to Us a completed claim form, unless the Non-In-Network completes and submits the claim to Us on behalf of the Covered Person.

NOTICE OF CLAIM

Written notice of claim must be given to Us within six (6) months after the occurrence or commencement of any loss covered by this Policy or as soon after that date as is reasonably possible. Notice given by or on behalf of the Covered Person or the beneficiary to Us at Our Claims Administration office address is shown on page 4, *Important Information*, or to any authorized insurance producer authorized by Us, with information sufficient to identify the Covered Person, will be considered notice to Us.

CLAIM FORMS

We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant will be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof of covering the occurrence, the character, and the extent of the loss for which claim is made.

PROOF OF LOSS

Written proof of loss must be furnished to Us at Our Claims Administrator's address is shown on page 4, *Important Information*, within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

TIME PAYMENT OF CLAIMS

Benefits payable under this Policy for any covered loss will be paid immediately upon receipt of due written proof of such loss.

Timely Settlement of Claims

We will pay or deny a claim within thirty (30) days after receipt of a proof of loss unless We make a reasonable request for additional information or documents in order to evaluate the claim. If We make a reasonable request for additional information or documents, We will pay or deny the claim within sixty (60) days of receiving the proof of loss unless We have notified You, Your assignee, or the claimant of the reasons for failure to pay the claim in full or unless We have a reasonable belief that insurance fraud has been committed and We have reported the possible insurance fraud to the Commissioner of Insurance. We will have the right to conduct a thorough investigation of all the facts necessary to determine payment of a claim.

If We fail to comply with the above provision and We are liable for payment of the claim, We will pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim payment was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after Our receipt of the proof of loss or 60 days after receipt of the proof of loss if We made a reasonable request for information or documents. Interest payments must be made to the person who receives the claim payment. Interest is payable under this provision only if the amount of interest due on a claim exceeds $5.

PAYMENT OF CLAIMS

Benefits payable under this Policy will be paid to Covered Person.

If any benefit payable under this Policy is payable to estate of the Covered Person or to a Covered Person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such benefits, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by Us to be equitably entitled to such benefit payment. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

PHYSICAL EXAMINATIONS AND AUTOPSY

We, at Our own expense, will have the right and opportunity to examine the person of the Covered Person when and as often as We may reasonably require during the pendency of a claim under this Policy and to make an autopsy in case of death where it is not forbidden by law.

RIGHT TO RECOVER

After We pay any claim under this Policy, We have the right to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim within six (6) months. The six-month period for Our review or audit will not begin until:

1. We have actual knowledge of:
    a. An invalid claim;
    b. Claim overpayment; or
    c. Other incorrect payment if We have paid a claim incorrectly because of an error, misstatement, misrepresentation, omission, or concealment, other than insurance fraud, by the health care provider or other person; and
2. The date that the Commissioner of Insurance determines that insufficient evidence of fraud exists if We pay a claim in which We:
    a. Suspect the health care provider or claimant of insurance fraud related to the claim; and
    b. Has reported evidence of fraud related to the claim to the Commissioner in accordance with Montana law.

However, We may perform a review or audit to reconsider the validity of a claim and may request reimbursement for an invalid or overpaid claim within 12 months from the date upon which We received notice of a determination, adjustment, or agreement regarding the amount payable with respect to a claim by:

1. Medicare;
2. A workers' compensation insurer;
3. Another health insurance issuer or group health plan;
4. A liable or potentially liable third party; or
5. A health insurance issuer that is domiciled in a state other than Montana under an agreement among plans operating in different states when the agreement provides for payment by the Montana health insurance issuer as host plan to Montana providers for services provided to an individual under a plan issued outside of the state of Montana.

PRESCRIPTION DRUG RECOVERY

Following cancellation of your policy, We may perform a pharmacy claim audit. If it is identified that pharmacy claims were paid proceeding the cancellation of the policy, We will initiate the recovery process with the formerly Covered Person up to and including collections.

SUBROGATION

We will be entitled to subrogate against a judgment or recovery received by the Covered Person from a third party found liable for a wrongful act or omission that caused the Injury necessitating benefit payment under this Policy. Such subrogation will be to the extent necessary for reimbursement of benefits paid under this Policy to or on behalf of the Covered Person.

The Covered Person will be required to furnish any necessary information and complete documents needed by Us in order to enforce the right to subrogation. Further, the Covered Person cannot take any action that would prevent Us from pursuing this right of subrogation

Third-Party Liability Provision

If You intend to institute an action for damages against a third party, You must give Us reasonable notice of Your intention to institute the action.

You may request that We pay a proportionate share of the reasonable costs of the third-party action, including attorney fees. However, We may elect not to participate in the cost of the action. If We make an election to participate, We will waive 50% of any subrogation rights granted to Us in accordance with Montana state law.

Our right of subrogation may not be enforced until the Injured Covered Person has been fully compensated for the Covered Person's injuries.

SECTION 10—COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS AND GRIEVANCES

We, the Montana Health Cooperative, have established a Complaint and Grievance process. We contract with University of Utah Health Plans, whose contact information appears on page 5, *Important Information*, to process claims, handle complaints, grievances and appeals on Our behalf through University of Utah Health Plans Customer Service and the University of Utah Health Plans Appeals and Grievances Department, respectively. A complaint involves a communication from the Covered Person expressing discontent or dissatisfaction with services. A grievance involves a complaint of unfair treatment or quality of care received from a provider's staff.

If the Covered Person has a complaint or grievance, the Covered Person may call University of Utah Health Plans Customer Service at the telephone number which appears on page 4, *Important Information*. The University of Utah Health Plans Customer Service representative will make every effort to resolve the issue within one (1) business day. If more time is needed, to resolve the matter, the University of Utah Health Plans Customer Service representative will notify the Covered Person of the extended time needed to respond.

The Covered Person may also file a written complaint. The mailing address of University of Utah Health Plans Customer Service appears on page 5, *Important Information*. Written complaints or grievances will be acknowledged within five (5) working days of receipt. The Covered Person will be notified of the response to or resolution of this matter within thirty (30) days of the Covered Person's written complaint or grievance.

CLAIMS PROCEDURES

A "Claim" is any request for a Policy benefit or benefits made for a Covered Person in accordance with this Policy's claims procedure. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a Claim under these procedures.

The initial benefit claim determination notice will be included in the Covered Person's explanation of benefits (EOB) or in a letter from Us. Written notification will be provided whether or not the decision is adverse.

The Covered Person becomes a "Claimant" when the Covered Person makes a request for a benefit or benefits in accordance with this Policy's claims procedures.

An Authorized Representative may act on behalf of a Claimant with respect to a benefit claim or appeal under these claims procedures. Claimants should complete and submit an Appointment of Authorized Representative form in order to appoint an authorized representative. For post-service claims, no person (including a treating health care professional) will be recognized as an authorized representative until We receive an Appointment of Authorized Representative form signed by the

Claimant. For other claims, We will recognize a health care professional with knowledge of the Claimant's medical condition as the Claimant's authorized representative unless the Claimant provides specific written direction otherwise.

An Appointment of Authorized Representative form may be obtained from, and completed forms must be submitted to the University of Utah Health Plans Customer Service Department at the address listed on page 4, *Important Information*. An assignment for purposes of payment does not constitute appointment of an authorized representative under these claims procedures. Once an Authorized Representative is appointed, the We will direct all information, notification, etc., regarding the claim to the authorized representative. The Claimant will be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise.

Any reference in these claims procedures to Claimant is intended to include the authorized representative of such Claimant appointed in compliance with the above procedures.

NOTIFICATION OF ADVERSE CLAIM DETERMINATION

1. Adverse benefit determination on a claim is "adverse" if it is: (a) a rescission or a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for a Policy benefit.

2. Notification of adverse benefit determination, in writing, will be provided to the Claimant of the adverse benefit determination on a claim and will include the following, in a manner calculated to be understood by the Claimant:

    a. A statement of the specific reason(s) for the decision. If the adverse benefit determination is a rescission, the notice, sent at least thirty (30) days in advance of implementing the rescission decision will include (a) clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact; (b) an explanation of why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact; (c) the date when the advance notice period ends and the date to which coverage is to be retroactively rescinded;

    b. Reference(s) to the specific Policy provision(s) on which the decision is based;

    c. If applicable, a description of any additional material or information necessary to perfect the claim and why such information is necessary;

    d. A description of this Policy's procedures and time limits for appeal of the decision, and the right to obtain information about those procedures, contact information for a consumer appeal assistance program, and if applicable, a statement of the right to sue in federal court;

    e. If applicable, a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);

    f. If the decision involves scientific or clinical judgment, either: (a) an explanation of the scientific or clinical judgment applying the terms of the Policy to the Claimant's medical circumstances; or (b) a statement that such explanation will be provided at no charge upon request;

g. In the case of an urgent care claim, an explanation of the expedited review methods available for such claims, and

h. A statement that reasonable access to and copies of all documents and records and other information relevant to the adverse benefit determination will be provided, upon request and free of charge.

Notification of the adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

YOUR RIGHT TO APPEAL

A Covered Person has a right to appeal an adverse benefit determination, including a rescission, under these claims procedures.

1. **How to File An Appeal.** If a Claimant disagrees with an adverse benefit determination, the Claimant (or authorized representative) may appeal the decision within 180 days from receipt of the adverse benefit determination. With the exception of urgent care claims, the appeal must be made in writing, should list the reasons why the Claimant does not agree with the adverse benefit determination, and must be sent to the address given for the University of Utah Health Plans Appeals and Grievances Department. If the Claimant (or authorized representative) is appealing an urgent care claim, the Claimant may appeal the claim verbally by calling the telephone number listed for urgent care appeals listed on the inside cover of this Policy.

   The Claimant may ask for Request for Review forms which may be obtained by contacting the University of Utah Health Plans, Appeals Committee Chairperson, 6053 Fashion Square Dr., Suite 110, Murray, UT 84107. A Request for Review form or a written appeal will be treated as received by the University of Utah Health Plans Appeals and Grievances Department (a) on the date it is hand-delivered to the above address and room; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark on any such envelope will be proof the date of mailing. Written appeals must be sent to the University of Utah Health Plans Appeals and Grievances Department following address shown on page 5. The Claimant has the right to contact the Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI), for assistance with an appeal. They can be reached at 840 Helena Ave, Helena, MT 59601, (406) 444-2040.

2. **Access to Documents.** The Claimant will, on request and free of charge, be given reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit determination, the names of each such expert will be provided on request by the Claimant, regardless of whether the advice was relied on by Us.

3. **Submission of Comments.** A Claimant has the right to submit documents, written comments, or other information in support of an appeal.

4. **Important Appeal Deadline.** The appeal of an adverse benefit determination must be filed within 180 days following the Claimant's receipt of the notification of adverse benefit determination, except that the appeal of a decision to reduce or terminate an

initially approved course of treatment (see the definition of concurrent care decision) must be filed within 180 days of the Claimant's receipt of the notification of the decision to reduce or terminate. Failure to comply with this important deadline may cause a Claimant to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

5. **Urgent Care Appeals.** In light of the expedited timeframes for decision of urgent care claims, an urgent care appeal may be submitted to the University of Utah Health Plans Appeals and Grievances Department by mail, telephone or electronically; refer to page 5, *Important Information*, for contact information. The claim should include at least the following information:

   a. The identity of the Claimant;

   b. A specific medical condition or symptom;

   c. A specific treatment, service, or product for which approval or payment is requested; and

   d. Any reasons why the appeal should be processed on a more expedited basis.

   e. If a physician with knowledge of the Claimant's medical condition determines the claim involves urgent care, We will treat the claim as an urgent care claim.

   f. If an urgent care claim is incomplete or was not properly submitted, We will notify the Claimant, or Claimant's authorized representative about the incomplete or improper submission no later than twenty-four (24) hours from Our receipt of the claim. Our notification will contain a reference to a specific Covered Person, a specific medical condition or symptom, and a specific health care service, treatment, or health care provider for which approval is being requested. The Claimant will have at least forty-eight (48) hours to provide the necessary information. We will notify the Claimant of the initial claim determination no later than twenty-four (24) hours after the earlier of the dates We receive the specific information requested or the due date for the requested information.

   g. Requests for an extension of a previously approved time period for treatments or number of treatments, and if the Claimant's claim involves urgent care, We will review the claim and notify the Claimant of Our determination no later than twenty-four (24) hours from the date We received the Claimant's claim, provided the Claimant's claim was filed at least twenty-four (24) hours prior to the end of the approved time period or number of treatments.

6. **Evidence Consideration.** The review of the claim on appeal will take into account all evidence, testimony, new and additional records, documents or other information the Claimant submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial adverse benefit determination.

   If the University of Utah Health Plans Grievances and Appeals Department considers, relies on or generates new or additional evidence in connection with its review of the claim, it will provide the Claimant with the new or additional evidence free of charge as soon as possible and with sufficient time to respond before a final determination is required to be provided by the University of Utah Health Plans Grievances and Appeals

Department. If the University of Utah Health Plans Grievances and Appeals Department relies on new or additional reasons in denying the Claimant's claim on review, the University of Utah Health Plans Appeals and Grievances Department will provide the Claimant with the new or additional reasons as soon as possible and with sufficient time to respond before a final determination is required to be provided by the University of Utah Health Plans Appeals and Grievances Department.

7. **Scope of Review.** The independent and impartial person who reviews and decides the Claimant's appeal will be a different individual than the person who decided the initial adverse benefit
determination and will not be a subordinate of the person who made the initial adverse benefit determination. The review on appeal will not give deference to the initial adverse benefit determination and will be made anew. The University of Utah Health Plans Appeals and Grievances Department will not make any decision regarding hiring, compensation, termination, promotion or other similar matters with respect to the individual selected to conduct the review on appeal based upon how the individual will decide the appeal.

8. **Medical Professionals.** In the event that a claim is denied on the grounds of medical judgment, the University of Utah Health Plans Appeals and Grievances Department will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same person who was consulted, if any, regarding the initial benefit determination or a subordinate of that person.

TIME PERIOD FOR NOTIFICATION OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATIONS

1. **Urgent Care Claims.** Urgent Care Claims Appeals will be completed as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt by the University of Utah Health Plans Appeals and Grievances Department of the written appeal or completed Request for Review form. The University of Utah Health Plans Appeals and Grievances Department will notify the Claimant and/or the Covered Person's Authorized Representative verbally and provide a follow-up written notice no later than seventy-two (72) hours after receipt of the appeal request.

   "Urgent Care Claim" is a claim for medical care to which applying the time periods for making pre-service claims decisions could seriously jeopardize the claimant's life, health or ability to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the care that is the subject of the claim. If the treating Physician determines the claim is "urgent," the Plan must treat the claim as urgent.

2. **Pre – and Post-Service Claims.** The appeal of a pre-service claim shall be decided within a reasonable time appropriate to the medical circumstances no later than thirty (30) days after receipt by the University of Utah Health Plans Appeals and Grievances Department of the written appeal or completed Request for Review form. The appeal of a post-service claim will be decided within a reasonable period but no later than sixty (60) days after receipt by the University of Utah Health Plans Appeals and Grievance Department of the

written appeal or completed Request for Review form.

"Pre-Service Claim" is a request for approval of a benefit in which the terms of the Plan condition the receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Examples of a Pre-Service Claim include but are not limited to a Pre-Certification of general items or health services or a request for Pre- Determination to determine coverage for a specific procedure.

"Post-Service Claim" is a claim that under this Plan is not a Pre-Service Claim (i.e., a claim that involves consideration of payment or reimbursement of costs for medical care that has already been provided).

3. **Concurrent Care Claims.** The appeal of a decision to reduce or terminate an initially approved course of treatment will be decided before the proposed reduction or termination takes place. The University of Utah Health Plans Appeals and Grievances Department will decide the appeal of a denied request to extend any concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

   "Concurrent Care" is when the Claimant has more than one medical condition existing and more than one Physician actively treats the condition related to their expertise, each physician can demonstrate medical necessity, and the treatments are provided on the same date(s). For example, an orthopedic surgeon cares for the patient's fracture while the hospitalist oversees diabetes and hypertension management.

4. **Rescission Claims.** The appeal of a decision to rescind coverage due to a fraud or intentional misrepresentation of a material fact will be decided no later than sixty (60) days from the date the University of Utah Health Plans Appeals and Grievances Department received the Claimant's appeal.

NOTIFICATION OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

1. If the decision on appeal upholds, in whole or in part, the initial adverse benefit determination, the final internal adverse benefit determination notice will be provided, in writing, to the Claimant and will include the following, written in a manner calculated to be understood by the Claimant:

   a. The specific reason(s) for the final internal adverse benefit determination, including a discussion of the decision. If the final internal adverse benefit determination upholds a rescission, the notice will include: (1) the basis for the fraud; or (2) intentional misrepresentation of a material fact;

   b. A reference to the specific Policy provision(s) on which the decision is based, including identification of any standard relied upon in this Policy to deny the claim (such as a medical necessity standard), on which the final internal adverse benefit determination is based;

   c. A description of the internal appeal and external review procedures (and for urgent care claims only, a description of the expedited review process applicable to such claims);

d. If applicable, a statement describing the Claimant's right to request an external review and the time limits for requesting an external review;

e. If applicable, a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the final internal adverse benefit determination (or a statement that such information will be provided free of charge upon request);

f. If applicable, an explanation of the scientific or clinical judgment for any final internal adverse benefit determination that is based on a medical necessity or an experimental treatment or similar exclusion or limitation as applied to the claimant's medical circumstances; or a statement that such explanation will be provided at no charge on request;

g. Contact information for a consumer appeal assistance program and, if applicable, a statement of the claimant's right to file a civil action under Section 502(a) of ERISA; and

h. A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination.

2. Notification of an adverse decision on appeal of an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

EXTERNAL REVIEW PROCEDURES

1. In most cases, and except as provided in this section, the Claimant must follow and exhaust the internal appeals process outlined above before the Claimant may submit a request for external review. In addition, external review is limited to only those adverse benefit determinations that involve:

   a. Rescissions of coverage; and

   b. Medical judgment, including those adverse benefit determinations that are based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or adverse benefit determinations that certain treatments are experimental or investigational.

STANDARD EXTERNAL REVIEW

1. A Claimant (or someone acting on the Claimant's behalf) may request external review of an adverse benefit determination within 120 days after the date of receipt of a notice of an adverse benefit determination or a final internal adverse benefit determination. The request for external review must be made in writing or orally to the University of Utah Health Plans Appeals and Grievances Department at the address indicated on page 5 of this Policy or by

calling (844) 262-1560. Within five (5) business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether:

a. The Claimant is (or was) covered under this Policy at the time the health care item or service was requested or, in the case of retrospective review, the Claimant was covered under this Policy at the time the health care item or service was provided;

b. The adverse benefit determination or final internal adverse benefit determination is not based on the fact that the Claimant was not eligible for coverage under this Policy;

c. The Claimant has exhausted this Policy's internal appeal process (unless exhaustion is not otherwise required); and

d. The Claimant has provided all the information and forms required to process an external review.

2. The Claimant will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc., needed to complete the request, and set forth the time limit for the Claimant to provide the additional information needed: (a) the longer of the initial four month period within which to request an external review; or (2) if later, forty-eight (48) hours (or such longer period specifically identified in the notice) after the receipt of the notice.

3. If the request is not eligible for external review, the University of Utah Health Plans Appeals and Grievances Department will: (a) outline the reasons for ineligibility in the notice; and (b) provide the Claimant with contact information for the U.S. Employee Benefits Security Administration (toll free number is shown on page 5, *Important Information.*).

4. If the request is eligible for external review, the University of Utah Health Plans Appeals and Grievances Department will assign the request to an Independent Review Organization (IRO) to conduct the external review.

5. To ensure independence of the external review and to minimize potential bias, the University of Utah Health Plans Appeals and Grievances Department will contract with at least three IROs who are accredited by URAC or a similar nationally recognized accrediting organization and will rotate assignments among the three IROs (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO shall not be eligible for any financial incentives based upon the likelihood that the IRO will support the denial of claims.

EXTERNAL REVIEW PROCESS

1. **Eligibility.** The IRO will provide the Claimant with written notice of the request's eligibility and acceptance for external review. The Claimant may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the request for external review.

2. **Submission of Documents.** Within 5 business days after the date the IRO is assigned, the University of Utah Health Plans Appeals and Grievances Department must submit the documents and any information considered in making the benefits denial to the IRO. Failure to timely provide such documents and information will not constitute cause for delaying the external review. Failure to timely provide the documents and information will allow the IRO to terminate the external review and reverse the adverse benefit determination or final internal adverse benefit determination. If the IRO does so, it must notify the Claimant and the University of Utah Health Plans Appeals and Grievances Department within one (1) business day of making the decision.

3. **Reconsideration.** On receiving any information submitted by the Claimant, the IRO must forward the information to the University of Utah Health Plans Appeals and Grievances Department within one (1) business day. The University of Utah Health Plans Appeals and Grievances Department may then reconsider its adverse benefit determination or final internal adverse benefit determination. If the University of Utah Health Plans Appeals and Grievances Department decides to reverse its adverse benefit determination or final internal adverse benefit determination, it must provide written notice to the Claimant and the IRO within one (1) business day after making the decision. On receiving this notice, the IRO will end its external review.

4. **Standard of Review.** The IRO will review all the information and documents timely received. The IRO will review the claim de novo and is not bound by any decisions or conclusions reached under Our internal claims and appeals process. In addition to the documents and information timely received, and to the extent the information or documents are available, the IRO will consider the following in reaching a decision:

   a. The Claimant's medical records;

   b. The Claimant's treating provider's or providers' recommendations;

   c. Reports from appropriate health care professionals and other documents, opinions, and recommendations submitted by Us, University of Utah Health Plans Appeals and Grievances Department, and the Claimant;

   d. The terms and conditions of this Policy, including specific coverage provisions, to ensure that the IRO's decision is not contrary to the terms and conditions of this Policy, unless the terms and conditions do not comply with applicable law;

   e. Appropriate practice guidelines, which must include applicable evidence-based standards;

   f. Any applicable clinical review criteria developed and used by Us unless the criteria: (1) are inconsistent with the terms and conditions of this Policy; and (2) do not comply with applicable law;

   g. The applicable medical policies of this Policy;

   h. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider them appropriate.

5. **Notice of Decision.** The IRO will send written notice of its decision to the Claimant and the

University of Utah Health Plans Appeals and Grievances Department within 45 days after the IRO receives the request for external review. The notice will include:

a. A general description of the reason for the external review request, including: (1) information sufficient to identify the claim; and (2) the reason for the prior denial;

b. The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

c. References to the evidence or documentation considered in reaching the decision, including: (1) specific coverage provisions; and (2) evidence-based standards;

d. A discussion of the principal reason(s) for the IRO's decision, including: (1) the rationale for its decision; and (2) any evidence-based standards relied on in making the decision;

e. A statement that the IRO's determination is binding, unless other remedies are available to the Plan or the claimant under state or federal law;

f. A statement that judicial review may be available to the claimant and this Policy; and

g. Contact information for Montana's Consumer Assistance Program.

6. **Compliance with IRO Decision:** If the IRO reverses the University of Utah Health Plans Appeals and Grievances Department's adverse benefit determination or final internal adverse benefit determination, We will immediately provide coverage or issue payment according to the written terms and benefits of this Policy.

EXPEDITED EXTERNAL REVIEW

1. Expedited External Review may be requested when:

   a. An adverse benefit determination involves: (1) a medical condition with regard to which the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health, or ability to regain maximum function; and (2) a request for an expedited internal appeal has been filed; or

   b. A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Claimant's treating health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, and a request for an expedited internal appeal has been filed.

   c. A final internal adverse benefit determination involves:

      1) A medical condition where the timeframe for completing a standard external review under the interim final regulations would seriously jeopardize the

Claimant's: (a) life; or (b) ability to regain maximum function; or

2) An admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility; or

3) A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Claimant's treating health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

2. The request for an expedited external review must be made in writing to the University of Utah Health Plans Appeals and Grievances Department at the address indicated on page 5, *Important Information*. Immediately upon receipt of the request for an expedited external review, a determination will be made as to whether the request meets the requirements earlier set forth above in Standard External Review. The Claimant will be notified of the determination, and an IRO will be assigned as described above in Standard External Review.

3. The Standard of Review, Notice of Decision and Compliance with IRO Decision will apply as set forth above in those sections applicable to Standard External Review, except that the IRO will provide written notice of the final external review decision to the Claimant as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours (7 days for experimental/investigational review) after the IRO receives the request for an expedited external review. If the IRO's decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours after the date it verbally conveyed the decision.

SECTION 11—GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Policy, including the application, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this Policy or to waive any of its provisions.

MISSTATEMENT OF AGE

If the age of the Covered Person has been misstated, all amounts payable under this Policy will be such as the premium paid would have purchased at the correct age.

REPRESENTATIONS

In the absence of fraud, any statement made by You will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed application.

COORDINATION WITH MEDICARE

In the event you have Medicare coverage and to the extent Medicare pays for benefits, any benefits paid under Medicare will be determined **before** benefits are paid under this contract or Policy. Therefore, the benefits under this contract or Policy are **Secondary** to Medicare. In the event Medicare does not pay benefits, then this contract or Policy will pay benefits as **primary**. Please note that the combined payments made by Medicare and this plan will not exceed the maximum allowance of the primary payer for the covered services provided to the member.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability (as defined in this Policy) commencing after the expiration of such two-year period.

No claim for loss incurred or disability (as defined in this policy) commencing after two (2) years from the date of issue of this Policy will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

CHANGE OF BENEFICIARY

Unless the Covered Person makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the Covered Person. The consent of the beneficiary or beneficiaries will not be requisite to surrender or assignment of this Policy, or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

ASSIGNMENT

You can assign any rights You have under this Policy. However, no assignment is binding on Us until We receive a copy of it. Each assignment will be subject to any payments made or action taken by Us before We received such assignment. We are not responsible for the validity of any assignment.

LEGAL ACTIONS

No action of law or equity will be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of 3 years after the written proof of loss is required to be furnished.

NONPARTICIPATING

This Policy does not share in any distribution of surplus. No dividends are payable.

CONFORMITY WITH MONTANA STATUTES

The provisions of this Policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the You reside on or after the effective date of this Policy.

INDIVIDUAL CONNECTED CARE COMPREHENSIVE HEALTH INSURANCE POLICY

INDIVIDUAL COMPREHENSIVE HEALTH POLICY
NON-PARTICIPATING
GUARANTEED RENEWABLE