

**MONTANA UNIVERSITY SYSTEM**

choices

# Summary Plan Description

*Managed Care Plan Supplement*

**Effective July 1, 2013**



**MANAGED CARE OPTION SUMMARY PLAN DESCRIPTION**  
**A SUPPLEMENT**  
**TO THE MONTANA UNIVERSITY SYSTEM**  
**EMPLOYEE GROUP BENEFITS SUMMARY PLAN DESCRIPTION**

This Supplement replaces corresponding medical benefit sections of the Montana University System Employee Group Benefits Summary Plan Description for Plan Participants enrolled in the Managed Care Option (MCO) Plan.

For purposes of this Supplement:

“Employer” means Montana University System (MUS)

“Health Plan” means Blue Cross Blue Shield of Montana (BCBSMT), PacificSource Health Plan (PacSource), or Allegiance Benefit Plan Management, Inc. (Allegiance) Managed Care Plans

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## HOW TO OBTAIN BENEFITS

Medical benefits under the MCO Plan are payable as set forth in Section 2, Medical Benefits, and are subject to all terms and conditions of this Plan. You, as a Plan Participant, must also be eligible for benefits as described in the MUS Traditional Summary Plan Description.

### SECTION 1: OBTAINING BENEFITS

#### 1.1 STEPS TO TAKE IN ADVANCE OF RECEIVING SERVICES

1. Make sure you have a current Identification Card that contains the correct Identification Number, Plan Participant name, Dependent Coverage information and Effective Date of Coverage. Plan Participants on the MCO Plan will receive a medical Identification Card from the Health Plan and a separate dental Identification Card from Delta Dental. If you need services before you receive your card or have lost it, ask your Health Care Provider to call the Health Plan or the campus Human Resources/Benefits Office to verify Coverage. Replacement cards may be ordered by calling the Health Plan.
2. Providers who are Participating Providers with the Health Plan will accept the Allowable Fee and not balance bill Plan Participants for charges in excess of the Allowable Fee. Make sure there is an available Health Plan Network (In-Network or Participating) Provider or Preferred Facility in your area that you and any enrolled dependents feel comfortable using for your health care needs. You may also want to determine if there are specialists in the Health Plan Network that will provide specialty service medical needs.

For a full list of In-Network Providers and updates list, see the Health Plan website. The Health Plan website allows you to search for In-Network Providers statewide or in your area.

3. In advance of receiving services, know and optimize your benefits:
  - a. Obtain Pre-certification for inpatient Hospital stays. All non-Emergency inpatient Hospital admissions should be Pre-certified (prior to admission) by calling the Health Plan to make sure the stay meets Medical Necessity requirements for inpatient benefits. All Emergency admissions should be certified within twenty-four (24) hours after admission to make sure any continued stay meets Medical Necessity criteria for inpatient benefits. The Hospital may make this call to assure payment, but since you are responsible for all charges that are not covered benefits of the Health Plan, you should call as well prior to incurring the charges. You should also call to confirm that the Hospital is an In-Network facility if you are unsure. Precertification is especially critical for any inpatient facility admissions or stays for transplants, treatment of Severe Mental Illness, and Rehabilitation Services or recovery, as stated for these services in Section 2.

- b. Determine if you need Prior Authorization by the Health Plan for specific proposed medical procedures, equipment, or supplies. You must call the Health Plan and obtain Prior Authorization to receive benefits for:
  - 1. Durable Medical Equipment that costs more than \$2,500.
  - 2. Infertility treatment.
  - 3. Obesity management.
  - 4. Travel.
  
- c. Identify services for which Prior Authorization is recommended. These include, but are not limited to the following (retrospective review will be done if Prior Authorization for these services is not obtained):
  - 1. Cardiac and/or pulmonary rehabilitation.
  - 2. Chronic pain programs.
  - 3. Home Health Care services.
  - 4. Hospice.
  - 5. Magnetic Resonance Imaging (MRI), Computer Axis Tomography (CAT scan, CT scan), or Positron Emission Tomography (PET Scans).
  - 6. Reconstructive surgery.
  - 7. Surgical treatment of TMJ.
  - 8. Organ or Tissue transplant.
  - 9. Non-emergency surgery.
  - 10. Genetic testing, with the exception of genetic counseling for routine Breast Cancer Susceptibility gene (BRCA) testing and evaluation.
  - 11. Growth hormone therapy.
  - 12. Dialysis.
  - 13. Home Infusion services.
  - 14. Neuropsychiatric testing.
  - 15. Outpatient infusion services, rendered at home or in any infusion center (not in Provider's office or Hospital).
  - 16. Speech Therapy.
  - 17. Any of the following surgeries: pacemaker insertion; reconstructive surgery; reduction mammoplasty (breast reduction surgery); varicose vein ligation and stripping or laser ablation; blepharoplasty/eyelid surgery; palatopharyngoplasty (repair of cleft palate); rhinoplasty, septoplasty, uvulopalato-pharyngoplasty (UPPP) or other surgeries that could be considered cosmetic under some circumstances.
  - 18. Rehabilitative, extended or skilled nursing health care services provided in an inpatient facility other than a Hospital including, but not limited to, a Skilled Nursing Facility.
  - 19. Out-of-Network/out-of-state services for which the In-Network Level of Benefits is in place.

Call the Health Plan to obtain Prior Authorization for any services or procedures that are new or outside standard medical practice (and which may be excluded if considered to be experimental or investigational), or that are only Covered under some circumstances (as described in Section 2) in order to assure Coverage.

- d. Obtain the In-Network Level of Benefits (the highest level of benefits described in the current Schedule of Benefits) by:
  1. obtaining Covered Medical Services from a Health Plan Network Provider listed on the Health Plan website for the MCO Plan (contact the Health Plan concerning Network exceptions); or
  2. obtaining Covered Medical Services for an Emergency Medical Condition or obtaining Covered facility/Professional Services for Urgent Care (care for an Urgent Medical Condition) from any licensed Provider. In the case of a medical Emergency, Plan Participants are encouraged to obtain services from the closest in proximity appropriate Provider. You will receive the In-Network Level of Benefits for immediate treatment of an Emergency Medical Condition by any licensed Provider including an Out-of-Network Provider. However, you will only receive the In-Network Level of Benefits for any Out-of-Network follow up care (after the medical Emergency has ended) if the above Precertification requirements set forth in Section 2, 3 (a) are met.

Non-Emergency care received from a licensed Provider who is not a Health Plan Network Provider will be Covered at the Out-of- Network Level of Benefits (described in the current Schedule of Benefits). However, note that the medical services identified in Section 2, 2.1.3 (a., b., and c.) are not available as an Out-of-Network benefit.

- e. Determine if there are frequency, duration, or dollar limits on services you plan to receive so you can consider alternatives, if needed (see Section 2, the current “*Choices Take 2*” Enrollment Workbook Schedule of Benefits).
- f. If you obtain non-Emergency services out of state or use an Out-of-Network Provider in Montana, try to use a Health Plan Participating Provider. Health Plan Participating Providers have agreed to accept Allowable Fees. This will protect you against charges in excess of the Health Plan’s Allowable Fees.

## **1.2 STEPS TO TAKE TO RECEIVE BENEFITS AND PAYMENT**

1. Present your Identification Card to the Physician, Hospital, Facility or other health care Provider when you or any covered dependents receive services or treatments, and pay any required co- payments.
2. Make sure the Provider has your current Identification Number and address. If you change your address, notify your campus Human Resources/Benefits Office.
3. Most Providers will file a claim for you. However, you are responsible for making sure a claim has been filed. A CLAIM MUST BE SUBMITTED TO THE HEALTH PLAN WITHIN TWELVE (12) MONTHS AFTER THE DATE SERVICES OR TREATMENT ARE RECEIVED OR COMPLETED. You may need to complete a standard claim form (which should be available from the Provider) if you use a Provider who is out-of-network. See

Section 6 “How to Obtain Benefits” in the MUS Traditional Summary Plan Description, provision B., “Filing A Claim”. Note that a Plan Participant or Subscriber becomes a claimant when he or she makes a request for a Plan benefit or benefits in accordance with the Plan’s claims procedures.

4. Payment will automatically be sent directly to Network Providers or Providers who have agreed to accept Allowable Fees, as well as to other Providers whose bills include an assignment of benefits from you. You will receive payment directly for services from other Providers for which no assignment of benefits has been made. For both In-Network and Providers who have agreed to accept Allowable Fees, you will not be responsible for paying charges for Covered Medical Services above Allowable Fees.
5. Respond to requests for information about accidents, Pre-Existing Conditions, other insurance coverage, additional information for Prior Authorization or Precertification or any other requests for information from the Health Plan. Your claim will not be adjudicated until and unless the required information is received within the time frame required by the Health Plan.
6. Monitor invoices from the Provider and Explanation of Benefits (EOBs) from the Health Plan to make sure the Health Plan received and adjudicated a claim for services and that the Provider received any payment due.

### **1.3 EXPLANATION OF BENEFITS (EOBs) & NOTIFICATION OF CLAIM APPEAL RIGHTS**

If a claim is denied in whole or in part, the claimant will receive written notice of the adverse benefit determination. A claim Explanation of Benefits (EOB) will be provided by the Health Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific MCO Plan provision(s) or rule(s) upon which the claims decision was based which resulted in the denial or partial denial;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the claimant’s right to appeal the adverse benefit determination for a full and fair review.

If a claimant does not understand the reason for any adverse benefit determination, he or she should contact the Health Plan at the address or telephone number shown on the EOB form. See the MUS Traditional Summary Plan Description for appeals procedures for further information.

## **1.4 SELF-AUDIT AWARD PROGRAM**

To receive a self-audit reward of up to \$1,000, check bills from your medical Providers to make sure you have not been double billed for services or billed for services you haven't received. You can receive an award of 50% of identified over- charges up to \$1,000 as follows:

- a. The over-charges may not have already been detected by the Health Plan or reported by the Provider,
- b. The over-charges must be \$50 or more, and
- c. The over-charges must be within Allowable Fees for Covered Medical Expenses.

To receive a self-audit award, take the following steps:

- a. Notify the Health Plan of the error before it is detected by the Plan or Provider.
- b. Contact the Provider to verify the error and determine or work out a correct billing.
- c. Have copies of the corrected billing sent to the Health Plan for verification, claims adjustment and calculation of the self-audit award.



# **MEDICAL BENEFITS**

## **SECTION 2: PLAN BENEFITS**

### **2.1 COVERED EXPENSES & SERVICES, GENERALLY**

#### **2.1.0 COVERED MEDICAL EXPENSES**

Covered Medical Expenses of the MCO Plan are:

- a. expenses within Allowable Fees (you are responsible for amounts over Allowable Fees if you use a Provider other than In-Network or Providers who have agreed to accept Allowable Fees);
- b. expenses within the specified benefit limitations contained in this Supplement and the current Schedule of Benefits, and which meet other requirements of the MUS Traditional Summary Plan Description (such as applicable waiting periods); and
- c. expenses for Covered Medical Services, defined below.

#### **2.1.1 COVERED MEDICAL SERVICES**

Covered Medical Services are services, procedures, treatments and supplies:

- a. Listed in this Supplement as Covered Medical Services, and not specified as exclusions in this Supplement or in the current Schedule of Benefits;
- b. Determined by the Health Plan to be Medically Necessary for the diagnosis or treatment of:
  1. Injury;
  2. Illness;
  3. Pregnancy; or
  4. Are preventive services specified in this section.
- c. Are provided in accordance with the terms of this MCO Plan including any Prior Authorization requirements and incurred within any time or service limits;
- d. Provided to a Plan Participant by a licensed Provider; and
- e. Provided and coded in accordance with applicable Medical Policy.

Covered Medical Expenses are paid or credited to the Plan Participant's Deductible, Copayment and Coinsurance obligations for the applicable level of benefits as described below.

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

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

- a. Services provided by an In-Network Provider (in certain instances In-Network benefits may be available for services provided by an Out-of- Network Provider when an In-Network Provider is not available. Contact the Health Plan concerning Network exceptions).
- b. Treatment of an Emergency Medical Condition or Facility/Professional Services for Urgent Care an urgent medical condition by any Provider.

You will be responsible for any Deductible, Copayment and Coinsurance amounts, described in the current Enrollment Workbook Schedule of Benefits for the In-Network Level of Benefits. See Sections 2.2 through 2.12 for any special requirements for receiving the In-Network Level of Benefits for particular Covered Medical Services or services with limited Coverage.

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

You will receive the reduced Out-of-Network Level of Benefits (described in the current Enrollment Workbook Schedule of Benefits) for all other Covered Medical Services obtained Out- of-Network, with some exceptions. There are no Out-of-Network benefits for the following services:

- a. organ or tissue transplant services.
- b. infertility treatment.
- c. obesity management.

(Note that b. & c. require Prior Authorization for any benefits.)

For Covered Medical Services eligible for the Out-of-Network Level of Benefits, you will be responsible for any applicable Copayment, Deductible, and Coinsurance amounts described in the current “*Choices Take 2*” Enrollment Workbook Schedule of Benefits. You will also be responsible for any charges in excess of the Health Plan’s Allowable Fee by Non-Participating Providers who do not accept the Health Plan’s Allowable Fees as full compensation as well as any applicable Out-of-Network differential.

## **2.2 DIAGNOSTIC/LAB**

### **2.2.0 DIAGNOSTIC / LABORATORY SERVICES**

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

Coverage includes radiology, laboratory and tissue diagnostic examinations, and diagnostic machine tests (such as EKGs) made for the purpose of diagnosing Injury or Illness when Hospital confinement is not required and benefits are not provided elsewhere in this Supplement.

Radiology and laboratory benefits shall not be provided for the following:

- a. Dental examinations or treatments, except for dental x-rays resulting from Injuries sustained in an accident (covered under Section 2.12. 3).
- b. Visual examinations.
- c. Premarital examinations and routine physical checkups, including examinations made as a requirement of employment or governmental authority, except as provided in Section 2.8.0.

## **2.3 EMERGENCY**

### **2.3.0 AMBULANCE**

Coverage only includes emergency ground or air transportation to the nearest Hospital or medical facility that is equipped to furnish the services, unless otherwise approved by the Health Plan. The emergency transportation must be Medically Necessary. Medical Necessity is established when the patient's condition is such that other means of transportation would endanger the health of the Plan Participant. Transportation is not covered if not Medically Necessary. Please see the current "Choices Take 2" Enrollment Workbook Schedule of Benefits for the ambulance transportation Copayment.

### **2.3.1 EMERGENCY CARE**

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

The Emergency room Copayment (as identified in the current "Choices Take 2" Enrollment Workbook Schedule of Benefits) only includes the facility charge for the room. Any lab fees, diagnostic fees, or Professional Service charges are subject to Deductible and Coinsurance.

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

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

If an Emergency Medical Condition is determined to exist which requires Hospital admission or any follow-up services, you must notify the Health Plan within twenty-four (24) hours of (or the next working day after) the initial Emergency care so the Health Plan can coordinate the subsequent follow-up care and assure continued In-Network Benefits. If you are incapable of calling or having a representative call the Health Plan within twenty-four (24) hours (or on the

next working day), you should contact the Health Plan as soon as medically possible. Once medical stabilization is achieved, the Health Plan may require transfer to a Network Hospital for the In-Network Level of Benefits to continue.

## **2.4 HOSPITAL**

### **2.4.0 INPATIENT HOSPITAL CARE**

*Pre-certification of all non-Emergency Hospital admissions is strongly recommended. See Section 2.3.1 for Emergency admissions.*

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

### **2.4.1 OUTPATIENT HOSPITAL SERVICES**

Hospital services and supplies described in Section 2.4.0 are covered if a Plan Participant is treated at a licensed Hospital, but not admitted for bed patient care. Charges for observation beds/rooms are Covered when Medically Necessary and in accordance with Medical Policy for services of less than twenty-four (24) hours and for charges not exceeding the room rate that would be charged for an inpatient stay of one day. See Section 2.10.0 for information on outpatient surgical services.

## **2.5 MATERNITY, GYNECOLOGY AND NEWBORN CARE**

### **2.5.0 OBSTETRICS AND GYNECOLOGY/GYN**

Coverage includes Medically Necessary obstetrical and gynecological services.

If you enroll in the MUS prenatal wellness program within the first trimester of pregnancy the following will be waived:

1. Copayments for the in-network prenatal and post-natal office visits.
2. Deductible and coinsurance on in-network professional service charges for the delivery.

See the MUS Traditional Summary Plan Description for information on the MUS prenatal wellness program and how to enroll. Without timely enrollment in the prenatal wellness program, charges are subject to deductible and coinsurance as described in the current “*Choices Take 2*” Enrollment Workbook Schedule of Benefits.

Ultrasounds will be subject to standard Deductible and Coinsurance with the first two exempted if the Plan Participant enrolls in the MUS prenatal wellness program as described above.

## **2.5.1 FACILITY OBSTETRICAL DELIVERY CARE AND SERVICES**

Precertification of all non-Emergency Hospital admissions is strongly recommended. See Section 2.3.1 for Emergency admissions.

Coverage includes facility obstetrical delivery care and services for covered female members including services of a licensed birthing center. A minimum 48-hour inpatient facility stay is allowed for a normal delivery, and a minimum 96-hour inpatient facility stay is allowed for a cesarean section delivery, unless otherwise agreed and deemed appropriate by the Plan Participant and attending Provider.

## **2.5.2 ROUTINE NEWBORN CARE**

Coverage includes the initial routine care of a newborn at birth provided by a Physician, standby care provided by a pediatrician at cesarean section, and facility nursery care of newborn infants.

## **2.6 MISCELLANEOUS**

### **2.6.0 CONGENITAL ANOMALY**

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

### **2.6.1 DIALYSIS**

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

### **2.6.2 HOME INFUSION THERAPY**

Coverage includes, but is not limited to antibiotic therapy, enteral nutrition, total parenteral nutrition, pain management, and specialized disease state therapy.

### **2.6.3 INBORN ERRORS OF METABOLISM (including PKU)**

Coverage includes the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist. Treatment includes diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment including, but not limited to: clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status. Supplies, including medical foods, are exempt from Deductible.

### **2.6.4 INJECTIBLE BENEFIT**

Coverage includes injectible medications administered at the Provider's office or facility, when not able to be self injected including, but not limited to contraception, pain control, and administration of antibiotics. Injectibles billed without an office visit are exempt from Deductible and only subject to Coinsurance.

## **2.7 PHYSICIAN**

### **2.7.0 INPATIENT PROVIDER CARE**

*Precertification of all non-Emergency Hospital admissions is strongly recommended. See Section 2.3.1 for Emergency admissions.*

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

### **2.7.1 OUTPATIENT OFFICE VISIT SERVICES**

Coverage includes health care services provided by a Physician or Mid-Level Practitioner working in a Physician's office or clinic, or by other office/clinic staff members under Physician direction. This includes, but is not limited to diagnostic, treatment, laboratory, x-ray, radiation and referral services.

The In-Network office visit Copayment only covers the office visit Allowable Fee. Any laboratory, x-ray, radiation, tests, or ancillary procedures are subject to Deductible and Coinsurance unless Covered under preventive benefits described in Sections 2.8.0 and 2.8.1 below.

## **2.8 PREVENTIVE**

### **2.8.0 ADULT PREVENTIVE SERVICES**

Coverage includes the following age and sex appropriate periodic tests and services:

1. Nineteen (19) years and older :
  - a. One physical exam every year, including history, screening for high-risk behavior, urinalysis, Hemoglobin or Hematocrit, basic metabolic panel and cholesterol and lipid screening.
  - b. For female Plan Participants, the physical exam also includes a gynecological exam and pap test.
  - c. Routine breast cancer susceptibility gene (BRCA) testing, including counseling and evaluation for the routine BRCA test itself, if appropriate, for a woman as determined by her Licensed Health Care Provider or Physician.
  - d. For male Plan Participants, the physical exam also includes PSA screening (included in office visit Copayment).
  - e. One ECG/EKG baseline (subject to Coinsurance & Deductible).
  - f. For female Plan Participants, one mammogram every year (paid at 100% In-Network; see current Enrollment Workbook Schedule of Benefits for Out-of-Network benefit).
  - g. Routine colonoscopy, proctoscopy, sigmoidoscopy or fecal occult blood screen.

- h. Bone density scan every five (5) years (subject to Coinsurance & Deductible) for female Plan Participants age sixty (60) and over and for male Plan Participants age seventy (70) and over.
2. Preventive immunizations and allergy shots: Allergy shots and preventive immunizations recommended by the Centers for Disease Control Immunization Guidelines are Covered excluding immunizations recommended because of increased risk due to type of employment or travel, including, but not limited to, malaria, yellow fever, hepatitis B, and tuberculosis. Preventive immunizations include (but are not limited to) diphtheria, chicken pox, tetanus, hepatitis B, pertussis, oral polio vaccine, measles, mumps, rubella, HPV, shingles, pneumonia, flu, and tests for tuberculosis.

Note: These immunizations are available through public health clinics at a lower cost.

### **2.8.1 WELL CHILD BENEFITS**

Well-Child Care Benefits include:

1. Routine Outpatient Well-Child Care for Dependent children for a medical history, physical examination, developmental assessment, and anticipatory guidance by a Physician; laboratory tests according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in Montana law and routine immunizations according to the schedule recommended by the U.S. Department of Health and Human Services. Visits are covered at the following approximate ages:
  - A visit for any newborn who did not receive a newborn exam in a Hospital or birthing facility or who was discharged from a Hospital in less than thirty-six (36) hours;
  - 1 month;
  - 2 months;
  - 4 months;
  - 6 months;
  - 9 months;
  - 12 months;
  - 15 months;
  - 18 months;
  - 24 months; and
  - one per year thereafter.
2. An age and gender appropriate physical examination every two (2) years from age eight (8) through age eighteen (18) including a gynecological examination and pap test for pubescent girls at the discretion of the Physician and any associated routine testing provided or ordered at the time of a physical examination.

3. Immunizations according to the schedule recommended by the U.S. Department of Health and Human Services and allergy shots.
4. Recommended preventive services as set forth in the recommendations of the U.S. Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at [www.HealthCare.gov/center/regulations/prevention.html](http://www.HealthCare.gov/center/regulations/prevention.html).

## **2.9 SEVERE MENTAL ILLNESS CARE**

### **2.9.0 SEVERE MENTAL ILLNESS CARE**

*Precertification of all non-emergency Hospital admissions is strongly recommended. See Section 2.3.1 for Emergency admissions.*

Coverage includes Medically Necessary care and treatment provided by a Hospital, Psychiatric Hospital, Mental Health Treatment Center, or Free Standing Inpatient Facility for the treatment of Severe Mental Illness. Outpatient services for the treatment of Severe Mental Illness are also covered by the Plan. Residential Care or treatment is not a Covered Service. Benefits for Severe Mental Illness will be paid the same as any other Illness.

The following disorders are defined by the American Psychiatric Association as Severe Mental Illness:

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

## **2.10 SURGERY**

### **2.10.0 SURGICAL CENTER & OUTPATIENT HOSPITAL SURGERY SERVICES**

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

Coverage includes Surgical Center or Outpatient Hospital services and supplies and Professional services furnished in connection with a Covered surgical procedure performed in the Center, provided the Center is licensed or certified for Medicare by the state in which it is located. See Sections 2.4.0 and 2.7.0 for Coverage of Inpatient surgery, and see information on specific surgeries below.



**2.10.1 MASTECTOMY**

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

**2.10.2 RECONSTRUCTIVE BREAST SURGERY**

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

Reconstructive breast surgery after a mastectomy is covered.

Coverage is provided for:

- a. Reconstruction of the breast on which the mastectomy was performed.
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- c. Prostheses and treatment of physical complications at all stages of a mastectomy and breast reconstruction, including lymphedemas.

**2.10.3 ORAL SURGERY**

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

Coverage includes non-cosmetic surgical treatment for the excision of lesions of the oral cavity, tongue, cheek, and maxillary/mandibular fracture, or for the treatment of degenerative joint disease that is associated with rheumatoid arthritis or osteoarthritis of the TMJ. Surgical treatment of TMJ pain, dysfunction, or disease is Covered when Medically Necessary. Non-surgical treatment is not covered.

**ORTHOGNATHIC SURGERY (RECONSTRUCTIVE JAW SURGERY)** *Prior Authorization is strongly recommended.*

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

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

**2.10.4 RECONSTRUCTIVE SURGERY**

*Prior Authorization is strongly recommended.*

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

## **2.11 URGENT CARE**

### **2.11.0 URGENT CARE**

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

The Copayment (identified in the current Enrollment Workbook Schedule of Benefits) applies to Allowable Facility and Professional Fees for Urgent Care from any licensed Provider. Any lab and/or diagnostic fees are subject to Deductible and Coinsurance.

## **2.12 SERVICES WITH LIMITED COVERAGE**

The following are health care services and supplies that are covered as described below with special limitations. Some of these services have no Out-of-Network Level of Benefits, as specified next (and as listed in Section 2.1. 3). They are only covered when provided by a Network Provider. Some services require Prior Authorization by the Health Plan (in advance of the service) for any benefits (either In-Network or Out-of-Network). Some have dollar or service limits, or require a Physician's order.

### **2.12.1 CHEMICAL DEPENDENCY TREATMENT**

*Precertification of non-Emergency Hospital admissions is strongly recommended. See Section 2.3.1 for Emergency admissions.*

Coverage is provided for inpatient and outpatient treatment for alcoholism and chemical dependency (excluding costs for medical detoxification, which is covered under Section 2.4.0). Coverage is set forth in the current Enrollment Workbook Schedule of Benefits.

### **2.12.2 CHIROPRACTIC SERVICES**

Please refer to the current Schedule of Benefits for visit limitations. The In-Network office visit Copayment covers Allowable Professional fees. Deductible and Coinsurance apply to x-rays, ultrasounds, and other ancillary procedures.

### **2.12.3 DENTAL SERVICES FOR ACCIDENTAL INJURY**

Coverage is provided for the treatment of accidental dental Injury only. It is limited to the restorative services and supplies necessary for the treatment of a fractured jaw or other accidental Injury to sound natural teeth completed within twelve (12) months after the date of the accidental Injury. Services for the treatment of accidental Injury to teeth caused by biting or chewing are excluded from coverage under this provision but may be covered by an MUS Dental Plan.

### **2.12.4 DURABLE MEDICAL EQUIPMENT (DME), PROSTHETICS, OXYGEN SUPPLIES, AND FOOT ORTHOTICS**

*Prior Authorization is required for DME expenses in excess of \$2,500. Coinsurance for DME does not count toward the individual or family annual Out-of- Pocket Maximum (Coinsurance Maximum).*

Coverage is provided for the following services and supplies requiring a Physician's written prescription:

- a. Rental (up to purchase price) of a Hospital-type bed, wheelchair, walker or other durable therapeutic equipment and repair of purchased equipment (provided the equipment is designed for prolonged use, serves a specific therapeutic purpose in the treatment of an Illness or Injury, is primarily and customarily used for a medical purpose, is appropriate for use in the home, and is not generally useful to a person in the absence of Illness or Injury) or the purchase of this equipment if economically justified, whichever is less. For DME for which purchase is not feasible, reasonable rental charges will be paid. The Health Plan may determine reasonable rate.

*Requests for computerized and "deluxe" equipment, like motor-driven wheelchairs, are reviewed on an individual basis. The Health Plan will have the right to decide when standard equipment is adequate. Coverage does not include maintenance, replacement due to loss, or duplication. Replacement can occur when equipment or prosthetics are no longer repairable or when DME has been outgrown.*

- b. Foot orthotics (limited to a dollar amount per year specified in the current Schedule of Benefits excludes Coverage of orthotics for the sole purpose of treating sports-related activities).
- c. Oxygen services and supplies.
- d. Prosthetic appliances including the purchase and fitting of breast prostheses and the purchase and fitting of artificial limbs, larynx, eyes, other prosthetic appliances or permanent internally implanted devices that are not experimental. Repair, maintenance, replacement due to loss, and duplication are not Covered. Replacement can occur when the item is no longer repairable.

#### **2.12.5 DISEASE PROCESS EDUCATION & DIETARY NUTRITIONAL COUNSELING**

*See the current "Choices Take 2" Enrollment Workbook Schedule of Benefits for benefit maximum.*

Coverage consists of Disease Management educational programs including Medically Necessary dietary or nutritional counseling. The program must be a certified educational program administered by an In-Network facility or In-Network Providers. Covered programs or clinics include, but are not limited to diabetes, multiple sclerosis, respiratory, polio, and cardiac clinics. Educational services are otherwise excluded.

#### **2.12.6 HOME HEALTH SERVICES**

*Prior Authorization is strongly recommended.*

Coverage includes the following services and supplies furnished by a licensed Home Health Agency for the care of a Plan Participant in accordance with a Home Health Care Plan as prescribed by a Physician:

- a. Part time or intermittent skilled nursing care provided by a registered nurse or licensed practical/vocational nurse;
- b. Physical, Speech, Occupational, Respiratory, and Home Infusion therapies (up to the Home Health visit maximum);
- c. Medical supplies, prescribed medications, equipment and lab services provided at home; or
- d. Part time or intermittent home health aid services required to allow the Plan Participant to be treated at home.

Home health services are limited as specified in the current Schedule of Benefits.

The following services, treatments, or supplies are not covered:

- a. Services and supplies not part of the Home Health Care Plan;
- b. Domestic or housekeeping services;
- c. Services for mental or nervous conditions;
- d. Transportation; or
- e. Disposable supplies self-administered in the home (gauze, bandages, etc.) and DME and prostheses, which are Covered elsewhere.

#### **2.12.7 HOSPICE SERVICES**

*Prior Authorization is strongly recommended.*

Hospice care is Covered for a Plan Participant who is diagnosed with a terminal illness and is expected to live no more than six (6) months. The services must be Medically Necessary and must be ordered by a Physician. The following Hospice services are Covered:

- a. Facility expenses of a Hospice facility, Hospital, or Skilled Nursing Facility for board, room, and other services and supplies furnished to a person while inpatient for pain control and other acute and chronic symptom management. Expenses for a private room are Covered only up to the regular daily expense for a semi-private room unless a private room is Medically Necessary or a semi-private room is unavailable.

- b. Hospice expenses for:
  - 1. Nursing care provided by a registered nurse or licensed practical nurse, and services of a home health aide.
  - 2. Medical social services provided under the direction of a Physician.
  - 3. Psychological or dietary counseling.
  - 4. Consultation or Disease and Case Management services.
  - 5. Medically Necessary Physical and Occupational Therapy.
  - 6. Medical supplies, drugs, and medicines prescribed by a Physician.
  - 7. Expenses for consultant or Case and Disease Management services, or Physical or Occupational Therapy by health care Providers who are not employees of the Hospice - but only when the Hospice retains responsibility for the care.

#### **2.12.8 INFERTILITY TREATMENT**

*Prior Authorization is required. No Out-of-Network benefits are available.*

Benefits include diagnostic and evaluation services to determine if treatment for infertility is necessary. Follow-up treatment is limited to Plan Participants who have been diagnosed as biologically infertile in accordance with accepted medical practice. Artificial insemination attempts per Plan Participant are limited to the number specified in the current Enrollment Workbook Schedule of Benefits. Medically indicated fertility drugs that are authorized must be obtained through the MUS Prescription Drug Plan under the terms of that Plan. Infertility benefits do not include in-vitro fertilization, and are not provided to Plan Participants who have undergone a voluntary sterilization procedure.

#### **2.12.9 MENTAL ILLNESS SERVICES**

*Precertification of non-Emergency Hospital admissions is strongly recommended. See Section 2.3.1 for Emergency admissions.*

Coverage is provided for Medically Necessary inpatient and outpatient treatment of Mental Illness. Inpatient services are Covered as specified in the current “Choices Take 2” Enrollment Workbook Schedule of Benefits. Two (2) partial hospitalization days can be received in lieu of one inpatient day. Outpatient benefits are covered as specified in the current “Choices Take 2” Enrollment Workbook Schedule of Benefits.

Covered Medical Services do not include treatment of the following conditions:

- a. developmental and learning disorders;
- b. speech disorders;
- c. psychoactive substance abuse disorders;
- d. eating disorders (except bulimia and anorexia nervosa);
- e. impulse control conduct disorders (except intermittent explosive disorder and trichotillomania);
- f. mental retardation; or
- g. inpatient confinement for environmental change.

### **2.12.10 OBESITY MANAGEMENT**

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

Coverage includes non-surgical treatment for reducing or controlling weight under an authorized treatment plan with enrollment in Take Control. Medically indicated drugs that are authorized must be obtained through the MUS Prescription Drug Plan under the terms of that Plan. Bariatric surgery is covered. See the MUS Traditional Summary Plan Description, Section 7, provision F., no. 39 Bariatric Surgery” for more information.

### **2.12.11 REHABILITATIVE SERVICES**

*Prior Authorization is strongly recommended.* Please refer to the current “*Choices Take 2*” Enrollment Workbook Schedule of Benefits for inpatient and outpatient maximums.

Coverage includes respiratory, pulmonary, cardiac, physical or occupational therapy that is ordered by a Physician and determined to show proven gain in function. For services to be eligible for coverage, the Plan Participant must meet one or more of the following criteria:

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

Coverage is provided for services of a licensed speech therapist for speech therapy, also known as speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders when all of the following criteria are met:

- a. There is a documented condition that can be expected to improve with therapy within a reasonable time.
- b. Improvement would not normally be expected to occur without intervention.
- c. Treatment is rendered for a condition that is the direct result of a diagnosed neurological muscular or structural abnormality affecting the organs of speech.
- d. Therapy has been prescribed by the speech language pathologist or Physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all conditions are met.

Speech Therapy is not covered if:

- a. Treatment is for stuttering.
- b. Treatment is for behavioral or learning disorders.

### **2.12.12 SKILLED NURSING FACILITY CARE**

Please refer to the current “*Choices Take 2*” Enrollment Workbook Schedule of Benefits for maximum days covered.

Coverage is provided for Medically Necessary care where a Plan Participant requires confinement in a licensed skilled nursing facility, or within part of an institution that offers skilled nursing facility care.

### **2.12.13 TRANSPLANTS**

Benefits are only available through the designated Transplant Network. No Out-of-Network Benefits are available. *Prior Authorization or Precertification is strongly recommended.*

The Health Plan has designated certain hospitals where benefits are available for organ or tissue transplants and transplant services. These Hospitals have been selected based on experience in serving as transplant medical facilities. No benefits are available from other, non-designated Hospitals (except under circumstances approved in advance by the Health Plan). In some instances, the designated hospital may not be located in the Health Plan's service area, therefore requiring travel. Contact the Health Plan for a list of designated organ or tissue transplant facilities. Covered organ or tissue transplant services and supplies (defined next) for all covered organ or tissue transplant procedures have limits. Please refer to the current "Choices Take 2" Enrollment Workbook Schedule of Benefits for limits.

#### **a. Covered Organ or Tissue Transplant Services**

Coverage includes the following:

1. Evaluation.
2. Pre-transplant care.
3. Transplant and certain specific donor-related services.
4. Follow-up treatment.
5. Travel reimbursement benefit up to the maximum specified in the current "Choices Take 2" Enrollment Workbook Schedule of Benefits during the date(s) for which a transplant contract is in effect, or up to one (1) year after the date of the transplant, whichever is longer.

#### **b. Covered Transplants**

The following human organ/ tissue transplants are covered:

1. Corneal.
2. Heart.
3. Kidney.
4. Liver.
5. Lung.
6. Pancreas.

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

1. Allogenic and syngeneic bone marrow transplants (requires HLA typing match on at least five (5) out of six (6) loci) for:
  - a. Acute lymphocytic leukemia and non-acute lymphocytic leukemia.
  - b. Chronic myelogenous leukemia.
  - c. Aplastic anemia.
  - d. Fanconi's anemia.
  - e. Infantile malignant osteopetrosis.
  - f. Large-cell lymphoma.
  - g. Lymphoma.
  - h. Severe Combined Immunodeficiency Disease (SCIDS).
  - i. Wiscott Aldrich Syndrome.
  
2. Autologous bone marrow transplants
  - a. Acute lymphocytic leukemia and non-acute lymphocytic.
  - b. Leukemia.
  - c. Burkitts lymphoma.
  - d. Large-cell lymphoma.
  - e. Non-Hodgkin's lymphoma.
  - f. Hodgkin's disease.
  - g. Neuroblastoma.
  
3. Stem cell transplants in conjunction with high-dose chemotherapy are covered, when Medically Necessary. Prior Authorization is recommended (a retrospective review will be performed if services are not Prior Authorized). High-dose chemotherapy with either allogenic or autologous stem-cell transplant will be considered on an individual case basis.
  
- c. Donor Benefits

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

- d. No Coverage for the following:
  1. Services or expenses related to the transplantation of animal or artificial organs.
  2. Transplants that are not currently approved under Medicare transplant guidelines.
  3. Charges that are not routinely made to all patients receiving similar human organ or tissue transplants.
  4. Benefits for a human organ or tissue transplant donor who has coverage for services related to the organ/tissue donation elsewhere. If the donor does not have coverage elsewhere, and the recipient is a Plan Participant, then the donor will be covered under this Health Plan, but only for health services related to the organ/tissue donation.
  5. Experimental or Investigational Procedures.



## **2.13 PLAN EXCLUSIONS**

The following medical services and supplies are exclusions of this MCO Plan:

### **2.13.1 NON-COVERED SERVICES**

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

### **2.13.2 SERVICES WHICH ARE NOT MEDICALLY NECESSARY**

### **2.13.3 NON-AUTHORIZED SERVICES**

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

### **2.13.4 PRESCRIPTION DRUGS**

Exclusions include outpatient prescription drugs, which are covered by a separate Prescription Drug Plan.

### **2.13.5 PRE-EXISTING CONDITIONS**

Pre-existing medical conditions are excluded for up to one year from a Plan Participant's coverage effective date. However, the period of exclusion may be reduced by creditable coverage as described in the MUS Traditional Summary Plan Description.

### **2.13.6 HEARING AID SERVICES**

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

### **2.13.7 COMPLICATIONS FROM INELIGIBLE PROCEDURES**

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

### **2.13.8 ELECTIVE, COSMETIC, AND VOLUNTARY HEALTH SERVICES**

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

- a. Surgery and any related services for the sole intent to improve appearance.
- b. Services and supplies for cosmetic purpose, including the restoration of hair, appearance of skin, and/or body shape.
- c. Personal hygiene and convenience items including, but not limited to air conditioners, humidifiers, or physical fitness equipment.
- d. Lifestyle improvements, such as physical fitness programs.
- e. Services and/or memberships provided through facilities including, but not limited to health clubs, fitness centers, or spas.

- f. Dietary regimen supplements and/or exercise programs for the controlling or reduction of weight, except the limited obesity treatment benefit (described in Section 2.12. 10).
- g. Dietary supplements, except medical foods required for the treatment of inborn errors of metabolism (described in Section 2.6.3).
- h. Treatment leading to (or in connection with) sexual reassignment including, but not limited to surgery and mental health counseling.
- i. Services and supplies for (or related to) conception by artificial means, except as provided in Section 2.12. 8.
- j. Services and supplies needed to reverse a sterilization procedure, including tubal ligations and vasectomies.
- k. Treatment of sexual dysfunction.
- l. Pastoral, financial, or legal counseling.
- m. Charges for family counseling without the patient present, recreational counseling or milieu therapy.
- n. All services related to routine, non-medically necessary foot care including, but not limited to the treatment or removal of corns, calluses, or nails; hypertrophy; hyperplasia of skin or subcutaneous tissues; cutting or trimming of nails; treatment of weak, strained, or flat feet; fallen arches; orthotic appliances, lifts, and orthopedic shoes (except the foot orthotic benefit set forth in Section 2.12. 4); padding and strapping; and fabrication.
- o. Physical examinations and other services required for obtaining or maintaining employment, insurance, or government licensing, unless they are a portion of an annual physical assessment covered as an adult preventive service (as defined in Section 2.8.0).
- p. School, sports, and camp physicals, unless they are part of an annual physical assessment covered as a preventive service (as defined in Section 2.8.0 or 2.8.1).
- q. Over-the-counter supplies including, but not limited to bandages, splints, and medications, with the exception of foods for inborn errors of metabolism.
- r. Any device for the sole purpose of enhancing sports-related activities.
- s. Immunizations for foreign travel.
- t. Education or tutoring services, except as provided in Section 2.12. 5.
- u. Hair transplant procedures, wigs and artificial hairpieces. This exclusion will not apply to the purchase of one wig or artificial hairpiece within three (3) months of cancer treatment.

**2.13.9 NURSING HOME AND RELATED CONVALESCENT CARE**

Except as specifically provided in this Supplement, exclusions are:

- a. Confinement in a skilled nursing facility, convalescent Hospital, or other facility, or that part of such facility used for:
  - 1. convalescent, custodial, or rest care;
  - 2. mental illness or chemical dependency care; or
  - 3. training or schooling.
- b. Services or articles for custodial, convalescent, or maintenance care; domiciliary care; rest care; or care designed primarily to assist in the activities of daily living.

c. Long-term care services.

**2.13.10 EXPERIMENTAL PROCEDURES**

Exclusions include experimental procedures (and/or medical treatments, procedures, drugs, devices, or biologics that are Experimental, Investigational, or used for research.

**2.13.11 NON-STANDARD, OR SELF PRESCRIBED SERVICES AND SUPPLIES**

Except as specifically provided in this Supplement, Plan exclusions include all services for non-standard or self-prescribed therapies. Exclusions include, but are not limited to:

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

**2.13.12 INJURY OR SICKNESS RELATED TO ILLEGAL ACTIVITIES**

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

**2.13.13 INJURY OR SICKNESS RELATED TO A RIOT**

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

**2.13.14 LEGALLY-ORDERED SERVICES**

Exclusions include services which are required by a court order, or as a condition of parole or probation.

**2.13.15 ADMINISTRATIVE CHARGES**

Exclusions include charges for missed appointments or other administrative sanctions.

**2.13.16 INJURIES OR SICKNESS RELATED TO MILITARY SERVICE**

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

**2.13.17 SERVICES INCURRED OUTSIDE THE COVERAGE PERIOD**

Exclusions include services incurred outside the coverage period including:

- a. while the Plan Participant is not covered;
- b. prior to the effective date of coverage for a Plan Participant; and
- c. after a Plan Participant's termination of coverage and after any extension of benefits or continuation of coverage as specified in the MUS Traditional Summary Plan Description.

**2.13.18 TRAVEL/LIMITATIONS**

Commercial and personal automobile transportation benefits are limited up to a maximum of \$1,500 in any one Benefit Year and are for the patient only. Transportation of the patient in an emergency to the nearest facility qualified to treat the Injury or disease, or as otherwise provided in the ambulance benefit (Section 2.3.0) or organ transplant benefit (Section 2.12.13), and approved by the Health Plan are subject to limitations in those sections and the MUS Traditional Summary Plan Description, Section 7, provision F., no. 13.

**2.13.19 CERTAIN PRIVATE ROOM CHARGES**

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

**2.13.20 DUPLICATE SERVICES OR SERVICES COVERED UNDER ANOTHER BENEFIT PLAN**

Except as specifically provided in this Supplement, and subject to the Coordination of Benefits Section of the MUS Traditional Summary Plan Description, all services covered by another benefit plan are excluded including, but not limited to:

a. Government-Covered Services and Supplies

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

Under certain circumstances, the law allows certain governmental agencies to recover expenses for services rendered to the Plan Participant from the Health Plan. When such a circumstance occurs, the Plan Participant will receive an EOB.

b. Workers' Compensation Covered Services

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

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

1. Coverage under the government legislation provided benefits for only a portion of the services incurred.

2. The Plan Participant's employer failed to obtain such coverage as required by law. This exclusion does not apply if the Plan Participant's employer was not required and did not elect to be covered under any workers' compensation law; occupational disease law; or employer's liability act of any state, country, or the United States.
3. The Plan Participant waived his or her rights to such coverage or benefits.
4. The Plan Participant failed to file a claim within the filing period allowed by law for such benefits.
5. The Plan Participant failed to comply with any other provision of the law to obtain such coverage or benefits.
6. The Plan Participant was permitted to elect not to be covered by the workers' compensation law but failed to properly make such election effective. This exclusion does not apply if the Plan Participant is permitted by statute not to be covered and elects not to be covered by a workers' compensation law; occupational disease law; or liability law.

If the Plan Participant enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, the Health Plan will not cover past or future medical services that are the subject of (or related to) that settlement. In addition, if the Plan Participant is covered by a workers' compensation program that limits benefits if Providers other than those specified are used, and the Plan Participant receives care or services from a Provider not specified by the program, the Health Plan will not cover the balance of any costs remaining after the program has paid.

c. **Expenses Covered by Other Insurance Policies**

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

**2.13.21 CHARGES PLAN PARTICIPANTS ARE NOT OBLIGATED TO PAY**

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

**2.13.22 THIRD PARTY LIABILITY**

Exclusions include services and supplies when another person or entity is legally responsible for causing or contributing to the condition which is being treated, and is therefore liable at law for the cost of treatment, unless the Plan Participant complies with subrogation provisions of the

MUS Traditional Summary Plan Description.

**2.13.23 UNUSUAL CIRCUMSTANCES**

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

- a. complete or partial destruction of facilities;
- b. war;
- c. riot;
- d. civil insurrection;
- e. major disaster;
- f. disability of a significant part of the participating Hospital and/or Provider Network;
- g. epidemic; or
- h. labor dispute not involving the Health Plan, participating Hospitals, and/or other Participating Providers.

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

**2.13.24 VOCATIONAL REHABILITATION**

**2.13.25 DENTAL COVERAGE/LIMITATIONS**

Exclusions include dental Coverage (see Section 2.12, provision 3). Limited Coverage is provided for treatment required because of accidental Injury to sound natural teeth. Services must be completed within twelve (12) months after the date of the accidental injury.

**2.13.26 VISION SERVICES AND APPLIANCES**

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

**2.13.27 SERVICES OR TREATMENT FOR MALOCCLUSION OF THE JAW**

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

**2.13.28 ORGAN OR TISSUE TRANSPLANTS**

Organ or tissue transplants are excluded, except as provided in Section 2.12.13.

**2.13.29 SPEECH THERAPY**

Speech Therapy is excluded from Coverage for developmental delays, behavioral or learning disorders, or stuttering.

**2.13.30 RESIDENTIAL CARE PROGRAMS**

**2.13.31 ANY ADDITIONAL CHARGES FOR INCLUSIVE PROCEDURES OR SERVICES**

Exclusions include additional charges for inclusive procedures or services.

**2.13.32 SERVICES OR SUPPLIES NOT PROVIDED BY A LICENSED PROVIDER OR WHICH ARE NOT LISTED AS A BENEFIT IN THIS SUPPLEMENT**

**2.13.33 CHARGES RESULTING FROM LEAVING A HOSPITAL OR FACILITY CONTRARY TO MEDICAL ADVICE**

**2.13.34 DIRECT-ENTRY MIDWIFE**

Charges for services of a direct-entry midwife or lay midwife or for the practice of direct-entry midwife. A direct-entry midwife is one practicing midwifery and licensed pursuant to Montana Code Annotated 37-27-101 et seq. "Direct-entry midwife" means a person who advises, attends, or assists a woman during pregnancy, labor natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.