

Montana University System's Flexible Benefits Program

2006 – 2007

CHO

Managed Care Plan Amendment

ALLEGIANCE ADMINISTERED MANAGED CARE PLAN DESCRIPTION

AN AMENDMENT TO MONTANA UNIVERSITY SYSTEM PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

This Amendment replaces corresponding medical benefit sections of the Montana University System Plan Document/ Summary Plan Description for Members Enrolled in the Allegiance Administered Managed Care Plan (AAMCP).

For purposes of this Amendment:

“Employer” means Montana University System

“TPA” means Allegiance Administered Managed Care Plan

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

Other capitalized terms are defined in Section C, Definitions.

Employer Contact:

Your campus Human Resource Office

TPA Contact:

Allegiance Customer Services at 1-877-778-8600 or visit their web site at

www.abpmtpa.com/mus

Utilization Management Company:

StarPoint at 1-800-342-6510

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HOW TO OBTAIN BENEFITS

Payment of benefits by the Allegiance Administered Managed Care Plan will be made on the basis of your submission of required information to the TPA.

SECTION A. OBTAINING MANAGED CARE PLAN BENEFITS

A.1 AVAILABILITY OF THE ALLEGIENCE ADMINISTERED MANAGED CARE PLAN

Allegiance Administered Managed Care Plan is available to the following eligible Members:

1. Any Member whose primary residence is within the state of Montana and is also within the Service Area* of this Plan. **Please note that even if primary residence is within the state of Montana, in order to receive the In-Network level of benefit, use of an In-Network provider (including hospitals and ambulatory surgical centers) is required, except for emergency services;** and
2. Members who temporarily reside outside of the state of Montana, but whose primary residence is within the state of Montana and is also within the Service Area* of this Plan. **Please note that even though you temporarily reside outside the state of Montana, in order to receive the In-network level of benefit, use of an In-Network provider (including hospitals and ambulatory surgical centers) is required, except for emergency services.**

The Allegiance Administered Managed Care Plan is not available to the following eligible Members:

1. Any Member whose primary residence is not within the state of Montana; and
2. Any Member whose primary residence is within the state of Montana, but not within this Plan’s Service Area*.

“Service Area” for the Allegiance Administered Managed Care Plan is defined by zip code and by city for hospitals as listed in the Choices Enrollment Workbook.

A.2 STEPS TO TAKE IN ADVANCE OF RECEIVING SERVICES

1. Make sure you have a current Identification Card from the TPA. Make sure it contains the correct Identification Number, name(s), Dependent coverage information, and date(s) of birth. If you need services before you receive your card or have lost it, ask your provider to verify your coverage by calling the TPA or your Employer at the numbers or location on the Cover Page. Replacement cards can also be ordered by calling the TPA.
2. The Allegiance Administered Managed Care Plan (AAMCP), encourages you to seek an In-Network physician to coordinate all your health care services, but you are permitted to self-refer to any Allegiance In-Network provider. In order to receive the highest level (the In-Network Level) of benefits, services must be provided by an Allegiance provider.

You may search for Network Providers statewide or in your area by using the Allegiance’s website at www.abpmtpa.com/mus. If you need care not available in the in-state Allegiance Network, you may also search this website for National Access Network Providers, whose Covered Services will qualify for the In-Network Level of Benefits. Note: **If an In-Network provider refers you to another provider (another physician, a specialist, a facility, a lab, a therapist, etc) it is your responsibility to ensure that this provider is an In-Network provider in order to receive benefits at the In-Network level. If you receive services from an out-of-network provider regardless of whether it is referred by an In-Network provider, benefits will only be paid at the Out-of-Network level.** For all referrals it is the responsibility of the member to check Allegiance’s website at www.abpmtpa.com/mus to see if the provider is either in-state under the Multi-Provider search or, if residence is out-of-

state, search under the National Access Network.

3. In advance of receiving any non-emergency services, know and optimize your benefits:

a. Obtain Pre-Certification for in-patient Hospital stays. All non-emergency inpatient Hospital stays should be Pre-Certified (prior to admission) by calling the utilization management company to make sure the stay meets Medical Necessity requirements for inpatient benefits. All emergency admissions should be Certified within 72 hours after admission, or at the first opportunity, to make sure any continued stay meets Medical Necessity criteria for inpatient benefits. The Hospital will typically make this call to assure payment, but since you are responsible for any charges that are not benefits of the Managed Care Plan, you should call for your own protection. *Pre-Certification is especially critical for any inpatient facility admissions/stays for: organ transplants, treatment of Mental Illness or Chemical Dependency, and Rehabilitation Services or recovery, as stated in Section B.*

b. Determine if you need Prior Authorization for specific proposed medical procedures, equipment, or supplies. You must call the TPA prior to beginning any treatment and obtain Prior Authorization to receive benefits for:

- 1) infertility treatments;
- 2) obesity management (nonsurgical).
- 3) organ transplant.

c. Identify services for which Medical Necessity may be in doubt. Any and all such services are subject to medical review and adjudication of claims can only be completed after services have been rendered and submitted to the TPA. However, you may call Allegiance's customer service to obtain a pre-determination of benefits for services that are new or outside standard medical practice (and which may be excluded as

experimental), or that are only covered under some circumstances (as described in Section B).

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

1) obtaining Covered Medical Services from an Allegiance In-Network Provider listed on the Allegiance search directory at the Allegiance web site (see Cover Page); or

2) obtaining Covered Medical Services from an Out-of-Network Provider for treatment of an Emergency Medical Condition. In the case of a medical emergency you are encouraged to obtain services from the closest appropriate provider. You will receive the In-Network Level of Benefits for immediate treatment of an Emergency Medical Condition by any Covered Provider, including an Out-of-Network Provider. However, you will only receive the In-Network Level of Benefits for any Out-of-Network follow up care (after the medical emergency has ended) if the above Prior Authorization requirements are met.

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

A.3 STEPS TO TAKE TO RECEIVE BENEFITS AND

PAYMENT

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- 1. Present your Identification Card to the Physician, Hospital, or other health care provider when you or any covered Dependents receive services, and pay any required Co-payments.
- 2. Make sure the provider has your current Identification Number and address. If you change your address, notify the TPA and your Employer at the numbers or location on the Cover Page.
- 3. Payment will automatically be sent directly to Providers whose bills include an assignment of benefits from you. You will receive payment directly for services for which no assignment of benefits has been made. For In-Network Providers, you will not be responsible for paying charges for Covered Medical Services above Allowable Fees.
- 5. Respond to requests for information about accidents, other insurance coverage, or any other information requests from the TPA. Your claim will not be paid until the required information is received.

explanation of a denial or partial denial of benefits, you may file an appeal as described in your Employer’s Plan Document/ Summary Plan Description.

CLAIMS FILING DEADLINE

Claims must be filed within one year from the date the expenses were first incurred to receive benefits.

EXPLANATION OF BENEFITS (EOB)

Check EOBs to determine if you have received the benefits described in this Managed Care Plan Amendment, and to determine what fees you owe the provider. This includes any Deductible, Copayments not paid at the time of service, Coinsurance, charges for un-Covered Medical Services, and charges in excess of Allowable Fees.

A.4 CLAIMS ASSISTANCE

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If you need assistance with a claim or an explanation of how a claim was paid, call customer service number on your Identification Card. If you are not satisfied with the

MEDICAL BENEFITS

SECTION B.

MANAGED CARE PLAN BENEFITS

B.1 COVERED MEDICAL EXPENSES AND SERVICES

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1. COVERED MEDICAL EXPENSES

Covered Medical Expenses of the Allegiance Administered Managed Care Plan are:

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

2. COVERED MEDICAL SERVICES

Covered Medical Services are services, procedures, and supplies:

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

Covered Medical Expenses are paid or credited to the Member’s Deductible, Copayment and Coinsurance obligations for the applicable level of

benefits as described below.

3. IN-NETWORK LEVEL OF BENEFITS

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

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

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

4. OUT-OF-NETWORK LEVEL OF BENEFITS

You will receive the reduced Out-of-Network Level of Benefits (described in the Schedule of Benefits) for all other Covered Medical Services with some exceptions. There are no Out-of-Network benefits for the following services unless Prior Authorized by Allegiance:

- a. Infertility treatment; and
- b. Obesity management (non-surgical).

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

B.2 (Provision Reserved.)

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B.3 INPATIENT HOSPITAL CARE

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Pre-Certification of all Hospital admissions is

strongly recommended.

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

B.4 INPATIENT PROVIDER CARE
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Pre-Certification of all Hospital admissions is strongly recommended.

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

B.5 OUTPATIENT HOSPITAL SERVICES
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Hospital services and supplies described in B.3 are covered if a Member is treated at a licensed Hospital, but not admitted for bed patient care. Charges for Observation Beds/Rooms are covered when Medically Necessary for services of less than 24 hours and for charges not exceeding the room rate that would be charged for an inpatient stay of one day.

B.6 OUTPATIENT OFFICE VISIT SERVICES
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Coverage includes health care services provided by a Physician or Mid-Level Practitioner working in a Physician’s office or clinic, or by other office/clinic staff members under Physician direction.

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

B.7 AMBULANCE TRANSPORTATION
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Coverage only includes emergency ground or emergency air transportation to the nearest Hospital or medical facility that is equipped to furnish the services, unless transportation to another facility is Medically Necessary. The emergency transportation must be Medically Necessary. The Medical Necessity is established when the patient’s condition is such that other means of transportation would endanger the health of the Member. Transportation is not covered if not Medically Necessary. Please see the current Schedule of Benefits for ambulance transportation Copayments

B.8 AMBULATORY SURGICAL CENTER SERVICES AND SUPPLIES
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Coverage includes ambulatory surgical center or outpatient Hospital services and supplies furnished in connection with a covered surgical procedure performed in the center, provided the center is licensed or certified for Medicare by the state in which it is located.

B.9 CONGENITAL ANOMALY
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Coverage includes the treatment only of medically diagnosed congenital defects and birth abnormalities.

B.10 EMERGENCY CARE
.....

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

The emergency room Copayment (as identified in the Schedule of Benefits) only includes the facility charges. Any professional charges and/or any lab

or diagnostic fees are subject to Deductible and Coinsurance.

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

The In-Network Level of Benefits is provided for Out-of-Network emergency services immediately required to diagnose and treat an Emergency Medical Condition at the nearest appropriate medical facility without prior referral by an In-Network Physician or Mid-Level Practitioner.

If an Emergency Medical Condition is determined to exist that requires Hospital admission or any follow-up services, you must notify the utilization management company within 24 hours of (or the next working day after) the initial emergency care so the utilization management company 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 utilization management company within 72 hours, you should contact the utilization management company as soon as medically possible. Once medical stabilization is achieved, the utilization management company may recommend transfer to an In-Network Hospital for the In-Network Level of Benefits to continue.

B.11 DIALYSIS

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

B.12 HOME INFUSION THERAPY

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

B.13 INJECTIBLE BENEFIT

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

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

B.14 MASTECTOMY

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

B.15 RECONSTRUCTIVE BREAST SURGERY

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

Coverage is provided for:

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

B.16 OBSTETRICS AND GYNECOLOGY/GYN

Coverage includes Medically Necessary obstetrical and gynecological services.

The Copayment, as identified in the Schedule of Benefits, applies to professional services for:

- a. all charges billed as a global fee associated with maternity care, including prenatal care, delivery and postnatal care; and
- b. Additional charges billed by the Physician for any lab or x-ray charges associated with the maternity care.

One global Copayment is applied per pregnancy regardless of Benefit Year.

B.17 OBSTETRICAL DELIVERY CARE AND SERVICES

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

B.18 ROUTINE NEWBORN CARE

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

B.19 INBORN ERRORS OF METABOLISM (INCLUDING PKU)

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

B.20 ORAL SURGERY

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

ORTHOGNATHIC SURGERY (RECONSTRUCTIVE JAW SURGERY)

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

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

B.21 ADULT PREVENTIVE SERVICES

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

a. routine gynecological exams, Pap tests, and related lab charges;

b. colonoscopies, proctoscopies, sigmoidoscopies, or hemocults;

c. Immunoassays for tumor antigen or prostate specific antigen (PSA); and

d. routine diagnostic x-rays and laboratory services including chemistry screens, bone density scans, cholesterol and other blood fats tests, and T4 thyroid tests.

2. Adult immunizations recommended by the Centers for Disease Control Immunization Guidelines, excluding immunizations recommended because of increased risk due to type of employment or travel, such as, but not limited to: malaria, yellow fever, hepatitis B, and tuberculosis.

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

Routine mammograms, limited to one per Benefit year.

B.22 RECONSTRUCTIVE SURGERY

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Coverage is provided in order to restore bodily function or correct deformity resulting from a disease, trauma, or congenital or developmental

abnormality. Coverage includes any consequences or complications that may arise from a covered surgery or related service.

B.23 PROVISION RESERVED

B.24 SEVERE MENTAL ILLNESS

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Pre-Certification of all Hospital admissions is strongly recommended.

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

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

B.25 URGENT CARE

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

The urgent care Copayment (as identified in the Schedule of Benefits) only covers the office visit Allowable Fees. Any laboratory, x-ray, radiation or other test or procedures are subject to the Deductible and Coinsurance.

B.26 WELL CHILD BENEFITS

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- 1. Coverage includes well-child examinations by Physician from birth through age eighteen. Such exams shall include a medical history, routine physical examination, and routine development assessment, limited to 10 visits through the age of 24 months.
 - 2. Laboratory tests are covered according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in MCA 53-6-

101.

- 3. Routine immunizations are covered according to the schedule of immunizations recommended by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services.

B.27 DIAGNOSTIC / LABORATORY SERVICES

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- 1. Coverage includes x-ray, 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 Amendment.
 - 2. X-ray and laboratory benefits shall not be provided for the following:
 - a. dental examinations or treatments, except for dental x-rays resulting from injuries sustained in an accident (covered under B.28, provision 2);
 - b. visual examinations; and
 - c. premarital examinations and routine physical checkups, including examinations made as a requirement of employment or governmental authority, except as provided in B.21.

B.28 SERVICES WITH LIMITED COVERAGE

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

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

1. CHEMICAL DEPENDENCY TREATMENT

Pre-Certification of all Hospital admissions is strongly recommended.

Coverage is provided for inpatient and outpatient treatment for alcoholism and drug addiction (excluding costs for medical detoxification, which is covered under B.3). Coverage is limited as described in the current Schedule of Benefits.

2. DENTAL SERVICES FOR ACCIDENTAL INJURY

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

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

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

3. DIETARY AND NUTRITIONAL COUNSELING

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

4. EDUCATION PROGRAMS

See the current Schedule of Benefits for maximum limits.

Coverage is provided when services are provided only by an In-Network Physician or Mid-Level Practitioner. The program must be a certified educational program administered by an In-Network facility or Professional Provider. Covered

programs/clinics include, but are not limited to: diabetes, multiple sclerosis, respiratory, polio, and cardiac clinics. Educational services are otherwise excluded.

5. DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS

Prior Authorization is strongly recommended for DME expenses in excess of \$500. Coinsurance does not apply to annual Coinsurance Maximum.

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

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

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

6. HOME HEALTH SERVICES

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

- a. part time or intermittent skilled care provided by a registered nurse or licensed practical/vocational nurse;
- b. Physical, Occupational, respiratory, and Home Infusion therapies (up to the maximum benefit) for the therapies as described in other provisions of this Amendment and the current Schedule of Benefits;
- c. medical supplies, prescribed medications, and lab services provided at home; and
- d. part time or intermittent home health aid services required to allow the Member to be treated at home.

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

The following services are non-covered home health services:

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

7. HOSPICE SERVICES

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

- a. facility expenses of a Hospice facility, Hospital or Skilled Nursing Facility for board, room, and other services and

supplies furnished to a person while inpatient for pain control and other acute and chronic symptom management (*Expenses for a private room are covered only up to the regular daily expense for a semi-private room, unless Medically Necessary*); and

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

8. INFERTILITY TREATMENT

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

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

9. MENTAL ILLNESS

Prior Authorization of all Hospital admissions is strongly recommended.

Coverage is provided for Medically Necessary inpatient and outpatient treatment of Mental Illness. Inpatient services are limited to a maximum of 21 days; no maximum for Severe Mental Illness defined in 33-22-706, MCA. See Section C Definitions. Please also refer to the

Schedule of Benefits, for visit limits; no maximum for Severe Mental Illness as defined in 33-22-706, MCA. Covered Medical Services do not include treatment of the following conditions:

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

10. CHIROPRACTIC SERVICES

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

11. OBESITY MANAGEMENT

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

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

- a. Initial evaluation and history;
- b. Follow-up monthly visits;
- c. X-ray and laboratory tests;
- d. Other miscellaneous tests such as ECG, stress test, tread mill;
- e. Continued care based upon medical necessity and independent medical review.

12. REHABILITATIVE SERVICES

Please refer to your Schedule of Benefits for inpatient and outpatient maximums.

Coverage includes pulmonary, cardiac, respiratory, Physical, Occupational, and Speech

Therapy that is ordered by a covered Physician and determined to show proven gain in function. For therapies to be eligible for coverage, the Member must meet one or more of the following criteria:

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

13. ORGAN TRANSPLANTS

No Out-of-Network Level of Benefits is available. Benefits (the In-Network Level) are only available through the designated Transplant Network or when an Allegiance In-Network Provider is authorized due to unavailability of a designated Transplant Network provider. Prior Authorization of outpatient services and Pre-Certification of the Hospital stay is strongly recommended.

The TPA has designated certain Hospitals to perform covered transplants. These Hospitals have been selected for their experience in performing transplants and no benefits are available from other Hospitals (except under rare circumstances approved in advance by the Plan Administrator). In some instances, the designated Hospital may not be located in the service area, therefore requiring travel. Contact the TPA for a list of designated organ transplant facilities. Please refer to the Schedule of Benefits for maximum amounts of coverage.

a. Covered Transplant Services

Coverage includes the following services for covered transplants:

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

b. Covered Transplants

The following human organ/ tissue transplants are covered:

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

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

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

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

2). Autologous Bone Marrow Transplants

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

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

c. Donor Benefits

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

d. No Coverage for the Following:

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

14. SKILLED NURSING FACILITY CARE

Please refer to Schedule of Benefits for maximums.

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

B.29 PLAN EXCLUSIONS

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

1. NON-COVERED SERVICES

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

2. SERVICES WHICH ARE NOT MEDICALLY NECESSARY

3. NON-AUTHORIZED SERVICES

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

4. PRESCRIPTION DRUGS

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

5. PRE-EXISTING CONDITIONS

Pre-Existing Conditions are excluded for up to one year from a Member's coverage Effective Date. However, the period of exclusion may be reduced by Creditable Coverage as described in Section C Definitions of this Amendment. Contact the TPA at the number indicated on the Cover Page for assistance in determining if you are entitled to any reduction in the Pre-Existing Condition exclusion period.

6. HEARING AID SERVICES

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

7. COMPLICATIONS FROM INELIGIBLE PROCEDURE

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

8. ELECTIVE, COSMETIC, AND VOLUNTARY HEALTH SERVICES

Except as specifically provided in this Amendment, exclusions include all services related to voluntary personal health improvement, cosmetic, or other

elective health care including, but not limited to:

- a. Surgery and any related services for the sole intent to improve appearance.
- b. Services and supplies for cosmetic purposes, including the restoration of hair, appearance of skin, and/or body shape.
- c. Personal hygiene and convenience items including, but not limited to: air conditioners, humidifiers, or physical fitness equipment.
- d. Lifestyle improvements, such as physical fitness programs.
- e. Services and/or memberships provided through facilities including, but not limited to: health clubs, fitness centers, or spas.
- f. Dietary regimen supplements and/or exercise programs for the controlling or reduction of weight, except the limited obesity treatment benefit (described in B.28, provision 11).
- g. Dietary supplements, except medical foods required for the treatment of inborn errors of metabolism (described in B.19).
- h. Procedures, services, drugs, and supplies related to elective abortions, except when the pregnancy is the result of an act of rape or incest.
- i. Treatment leading to (or in connection with) sexual reassignment including, but not limited to: surgery and mental health counseling.
- j. Services and supplies for (or related to) conception by artificial means, except as provided in B.28, provision 8.
- k. Services and supplies needed to reverse a sterilization procedure, including tubal ligations and vasectomies.
 1. Treatment of non-organic sexual dysfunction.
- m. Pastoral, financial, or legal counseling.

- n. Counseling services for adolescent behavior problems, learning delays, self discovery and improvement, and family and marital problems, except as provided by the Employee Assistance Program.
- o. All services related to routine, non-Medically Necessary foot care including, but not limited to: the treatment or removal of corns, calluses, or nails; hypertrophy; hyperplasia of skin or subcutaneous tissues; cutting or trimming of nails; treatment of weak, strained, or flat feet; fallen arches; orthotic appliances, lifts, and orthopedic shoes (except the foot orthotic benefit provided in B.28, provision 5); padding and strapping; and fabrication.
- p. Physical examinations and other services required for obtaining or maintaining employment, insurance, or government licensing, unless they are a portion of an annual physical assessment covered as an adult preventive service (as defined in B.21 or B.26).
- q. School, sports, and camp physicals, unless they are part of an annual physical assessment covered as a preventive services (as defined in B.21 or B.26).
- r. Over-the-counter supplies including, but not limited to: bandages, splints, and medications.
- s. Any device for the sole purpose of enhancing sports-related activities.
- t. Immunizations for foreign travel.
- u. Education or tutoring services, except as provided in B.28, provision 4.

9. NURSING HOME AND RELATED CONVALESCENT CARE

Except as specifically provided in this Amendment, exclusions include:

- a. Confinement in a skilled nursing facility or convalescent Hospital, or that part of such facility used for:

- 1) convalescent, custodial, or rest care;
- 2) Mental Illness or Chemical Dependency care; or
- 3) training or schooling.

- b. Services or articles for custodial, convalescent, or maintenance care; domiciliary care; rest care; or care designed primarily to assist in the activities of daily living.
- c. Long-term care services.

10. EXPERIMENTAL PROCEDURES

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

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

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

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

12. INJURY OR SICKNESS RELATED TO A RIOT

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

13. LEGALLY-ORDERED SERVICES

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

14. ADMINISTRATIVE CHARGES

Exclusions include charges for missed appointments or other administrative sanctions.

15. 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.

16. SERVICES INCURRED OUTSIDE THE COVERAGE PERIOD

Exclusions include services incurred outside the coverage period including:

- a. while the Member is not covered;
- b. prior to the Effective Date of coverage for a Member; and
- c. after a Member's termination of coverage and after any extension of benefits or continuation of coverage as specified in your Employer's Plan Document/Summary Plan Description.

17. TRAVEL

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

18. 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.

19. DUPLICATE SERVICES OR SERVICES COVERED UNDER ANOTHER BENEFIT

PLAN

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

a. Government-Covered Services and Supplies

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

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

b. Workers' Compensation-Covered Services

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

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

- 1) Coverage under the government legislation provided benefits for only a portion of the services incurred.
- 2) Your employer failed to obtain such coverage as required by law: This exclusion does not apply if your employer was not required and did not elect to be covered under any workers' compensation law; occupational disease law; or employer's liability act of any state, country, or the United States.
- 3) The Member waived his or her rights to such coverage or benefits.
- 4) The Member failed to file a claim

within the filing period allowed by law for such benefits.

- 5) The Member fails to comply with any other provision of the law to obtain such coverage or benefits.
- 6) The Member was permitted to elect not to be covered by the workers' compensation law; but failed to properly make such election effective. This exclusion does not apply if you are permitted by statute not to be covered and you elect not to be covered by a workers' compensation law; occupational disease law; or liability law.

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

c. Expenses Covered by Other Insurance Policies

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

20. CHARGES MEMBERS ARE NOT OBLIGATED TO PAY

Exclusions include services and supplies for which

a Member is not legally, or as a customary practice, required to pay in the absence of insurance or a Hospital medical payment plan.

21. THIRD PARTY LIABILITY

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

22. UNUSUAL CIRCUMSTANCES

Neither the TPA 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 TPA, MUS, 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 TPA or Network Providers, non-emergency care may be deferred until after the resolution of the labor dispute.

23. VOCATIONAL REHABILITATION

24. DENTAL COVERAGE

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

25. VISION SERVICES AND APPLIANCES

Exclusions include vision services and appliances including eye exams, glasses, contact lenses, radial

keratotomy or other surgery to correct vision, and orthoptic or vision training (These may be covered by a separate Employer vision plan).

26. TREATMENT FOR MALOCCLUSION OF THE JAW

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

27. ORGAN OR TISSUE TRANSPLANTS

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

28. SPEECH THERAPY

Developmental Speech Therapy is excluded from coverage

29. ANY ADDITIONAL CHARGES FOR INCLUSIVE PROCEDURES OR SERVICES

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

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

Section C

DEFINITIONS

ALLOWABLE FEE

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

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

BENEFIT YEAR

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

CASE AND DISEASE MANAGEMENT

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

CERTIFICATION (OF MEDICAL NECESSITY) AND PRE-CERTIFICATION

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

CHEMICAL DEPENDENCY

Substance abuse and addiction, including alcoholism and drug addiction, involving such substances as ethyl alcohol, tranquilizers, narcotics, narcotic synthetics, sedatives/

hypnotics, amphetamines, cocaine, hallucinogens, products containing tetra-hydro-cannabinol, and volatile inhalants.

CHEMICAL DEPENDENCY TREATMENT FACILITY

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

COINSURANCE

Coinsurance is a means of cost sharing. The Plan pays a percentage of allowed charges (after any applicable Deductible has been met) and the Member pays a percentage -- the Coinsurance. See the current Schedule of Benefits for your current Coinsurance for various services.

COINSURANCE MAXIMUM

The maximum amount of any Coinsurance, which is Coinsurance credited toward the Coinsurance Maximum that you must pay in a Benefit Year for:

1. an individual Member (the individual Coinsurance Maximum), or
2. Enrolled family Members (the family Coinsurance Maximum).

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

the Coinsurance and Copayments that are credited to the Coinsurance for this Managed Care Plan.

Coinsurance Maximum excludes any Copayments or Deductibles.

COPAYMENT

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

COVERED MEDICAL EXPENSE

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

COVERED MEDICAL SERVICE

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

1. Listed as a benefit in Section B 1-28 and not excluded in Section B 29 of this Amendment.
2. Determined to be Medically Necessary for the diagnosis or treatment of injury, illness, or maternity care (unless a preventive benefit clearly listed in this Amendment).
3. Provided to a Member by a Covered Provider.
4. Provided and coded accordingly.

COVERED PROVIDER

A provider of medical services (individual or facility), who/which has satisfied the necessary requirements to practice or provide medical services within the State of Montana or in another state or country where services are received.

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

CREDITABLE COVERAGE

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

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

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

CUSTODIAL CARE

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

DEDUCTIBLE

Allowable Fees a Member and family must pay before the Allegiance Administered Managed Care Plan makes payment.

DENTAL PLAN

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

DEPENDENT OR ELIGIBLE DEPENDENT

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

DURABLE MEDICAL EQUIPMENT

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

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

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

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

EFFECTIVE DATE

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

EMERGENCY MEDICAL CONDITION

A condition manifesting itself with symptoms of

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

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

EMPLOYEE OR ELIGIBLE EMPLOYEE

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

EMPLOYEE ASSISTANCE PROGRAM (EAP) AND EMPLOYEE ASSISTANCE PROGRAM ADMINISTRATOR

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

ENROLL, ENROLLED

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

EXPERIMENTAL PROCEDURES OR SERVICES

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

1. Prescription drugs not approved by the FDA to be lawfully marketed for the proposed use, and it is not identified in the American Hospital Formulary Service, the AMA Drug Evaluation, or the Pharmacopoeia as an appropriate use.
2. It is subject to review or approval by an institutional review board (meaning that a Hospital considered it Experimental and put it under review to meet federal regulations, or

review is required and defined by federal regulations, particularly those of the FDA or Department of Health and Human Services).

3. It is the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in FDA regulations, regardless of whether it's an FDA trial.
4. It has not been demonstrated through prevailing, peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
5. The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, and effectiveness (or effectiveness compared with conventional alternatives), and/or that usage should be substantially confined to research settings.
6. It is not a covered benefit under Medicare as determined by the Centers for Medicare and Medicaid Services (CMMS, formerly HCFA) because it is considered experimental, investigational, or unproven.
7. It is experimental, investigational, unproven, or not a generally acceptable medical practice in the predominate opinion of independent experts utilized by the administrator of each plan.
8. It is not Experimental or investigational in itself pursuant to the above and would not be Medically Necessary, but it is being provided in conjunction with the provision of a treatment, procedure, device, or drug which is experimental, investigational, or unproven.

HOME HEALTH AGENCY

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

HOME HEALTH CARE PLAN

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

HOME INFUSION THERAPY

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

HOME INFUSION THERAPY AGENCY

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

HOSPICE

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

1. Arranges, coordinates, and/or provides care for the terminally ill patient.
2. Is licensed, accredited, or approved by the state to establish and manage Hospice care programs.
3. Maintains records of Hospice care services provided and bills for such services.
4. Is a Home Health Agency, which provides Hospice care.

HOSPITAL

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

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

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

- a. a nursing or convalescent home.
- b. a rest home.
- c. Hospice.
- d. a rehabilitation facility.
- e. a skilled nursing facility.
- f. a place for care and treatment of Chemical

- Dependency.
- g. a place for the treatment of Mental Illness.
- h. a long-term chronic-care institution or facility providing the type of care listed above.

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

**IDENTIFICATION CARD
(IDENTIFICATION NUMBER)**

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

INCLUSIVE SERVICES/PROCEDURES

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

IN-NETWORK (NETWORK)

The group of In-Network Providers defined below.

IN-NETWORK LEVEL OF BENEFITS

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

IN-NETWORK (NETWORK) PROVIDER

A Covered Provider who has contractually agreed to provide medical services to members of the Allegiance Administered Managed Care Plan according to the fees and other terms of a provider contract. Benefits for services provided In-Network (by an In-Network Provider) are typically

higher level benefits (the In-Network Level of Benefits) than benefits for services Out-of-Network (by another provider) — unless there is a required approval. For approval requirements see Section A of this Amendment. The Allegiance directory at: www.abpmtpa.com/mus allows you to search for In-Network Providers.

MANAGED CARE BENEFIT PLAN

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

MAXIMUM LIFETIME BENEFIT

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

MEDICAL NECESSITY (MEDICALLY NECESSARY)

A service or supply provided by a Covered Provider of this Managed Care Plan and de-termined to meet the following criteria:

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

Member cannot receive safe or adequate care on an outpatient basis.

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

MEMBER

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

MENTAL ILLNESS

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

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

Mental Illness does not include:

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

MID-LEVEL PRACTITIONER

A licensed APRN (Nurse Practitioner), PA (Physician Assistant), or CNMW (Certified Nurse Midwife) who practices in conjunction

with a licensed MD or OD This practice must include 24-hour coverage for emergency admissions and health care.

MORBID OBESITY

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

OBSERVATION BEDS/ROOMS

Outpatient beds that are used to either:

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

OCCUPATIONAL THERAPY

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

OUT-OF-NETWORK

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

OUT-OF-NETWORK LEVEL OF BENEFITS

The lower level of benefits provided by this Managed Care Plan (as defined in the current Schedule of Benefits) for Covered Medical Services received from a Covered Provider outside the Network. A few Covered Medical Services have no Out-of-Network benefits -- See A.1, provision 4 for a listing of these medical services.

OUT-OF-NETWORK PROVIDER

Any Covered Provider who is not an In-Network Provider of the Allegiance Administered Managed Care Plan, as defined above.

PARTIAL HOSPITALIZATION (FOR MENTAL ILLNESS ONLY)

A time-limited ambulatory (outpatient) program offering active, therapeutically intensive treatment, which involves structured clinical services within a stable, therapeutic program. The program can

involve day, evening, and weekend treatment. The underlying aim of this treatment is clinical stabilization required due to severe impairment and/or dysfunction in major life areas. A Partial Hospitalization program should offer four – eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PHYSICAL THERAPY

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

PHYSICIAN

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

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

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

POINT-OF-SERVICE PLAN

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

PRESCRIPTION DRUG PLAN

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

PRE-EXISTING CONDITION

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

PRIOR AUTHORIZATION

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

1. Is Medically Necessary.
2. Complies with coverage criteria..
3. Is a benefit of the Allegiance administered Managed Care Plan.

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

NOTE: PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT OF THE CLAIM(S). ELIGIBILITY FOR CLAIM PAYMENTS IS DETERMINED AT THE TIME CLAIMS ARE ADJUDICATED SINCE THE LEVEL OF BENEFIT, IF ANY IS SUBJECT TO ALL PLAN PROVISIONS INCLUDING, BUT NOT LIMITED TO, MEDICAL NECESSITY, PATIENT ELIGIBILITY, DEDUCTIBLES, CO-PAYMENTS AND ANY PLAN LIMITATIONS OR MAXIMUMS IN EFFECT WHEN THE SERVICES ARE PROVIDED. PROVIDERS AND COVERED PERSONS ARE INFORMED AT THE TIME CLAIMS ARE AUTHORIZED THAT AUTHORIZATION OF A COURSE OF TREATMENT BY THE PLAN DOES NOT GUARANTEE PAYMENT OF CLAIMS FOR THE SAME. IN THE EVENT OF A CONFLICT BETWEEN THE TERMS OF THIS AMENDMENT AND ANY STATEMENT MADE FOR PURPOSES OF PRIOR AUTHORIZATION, THE TERMS OF THIS AMENDMENT WILL PREVAIL.

PROFESSIONAL PROVIDER

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

REHABILITATION SERVICES

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

1. Provided in an inpatient or outpatient setting.
2. An intense, comprehensive program of therapies and services provided by a multi-disciplinarian team of health service Covered Providers who are licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. This also includes associated general and medical services incidental to rehabilitation care.
3. Designed to restore the patient's maximum function and independence.
4. Under the direction of a qualified Physician and includes a formal written treatment plan with specific goals.
5. The patient must be making continued progress towards the stated goals on the plan of care to continue with the services.

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

SCHEDULE OF BENEFITS

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

SERVICE AREA

Service Area for the Allegiance Administered Managed Care Plan is defined by zip code and by city for hospitals as listed in the Choices Enrollment Workbook.

SEVERE MENTAL ILLNESS

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

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

SKILLED NURSING FACILITY CARE

Medically Necessary inpatient skilled nursing services provided by an institution, or distinct part thereof, which is licensed pursuant to state or local law to provide skilled nursing services only. A skilled nursing facility is primarily engaged in providing continuous nursing care by, or under the direction and supervision of, a registered nurse for sick or injured persons during the convalescent stage of their illness or injuries. Skilled Nursing Facility Care is not, other than incidentally, a rest home or home for Custodial Care or for the aged. In no event does this term include care by an institution or any part of an institution, which is primarily engaged in the care and treatment of Mental Illness or Chemical Dependency.

SPEECH THERAPY

Treatment for the correction of speech impairment resulting from disease or trauma. Developmental Speech Therapy is not covered.

TRANSPLANT NETWORK

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