DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Healthy Montana Kids

Evidence of Coverage

Effective October 1, 2025

Revised October 1, 2025

Contents

The HMK Coverage Group agrees to make payment for the medical, Behavioral Health, surgical, Hospital, and Pharmacy services named in this Evidence of Coverage (EOC) subject to the following conditions:

1. All statements made in the HMK Program Application for eligibility must be true and correct.

2. Payments by the HMK Coverage Group will be subject to the terms, conditions, and limitations of this EOC.

3. Payment will only be made for services that are provided to the Members after the Effective Date of this EOC and before the date on which this EOC terminates.

ARTICLE ONE – DEFINITIONS

This article defines certain words used throughout this EOC. These words will be capitalized whenever they are used as defined.

ACCIDENT

An unexpected traumatic incident or unusual strain which is:

- Identified by time and place of occurrence; and
- Identifiable by Member or part of the body affected; and
- Caused by a specific event on a single day.

Some examples are:

- Fracture or dislocation;
- Sprain or strain;
- Abrasion, laceration;
- Contusion;
- Embedded foreign body;
- Burns; and
- Concussion.

ADMISSION CERTIFICATION

Prior to a scheduled Inpatient admission, the facility, Provider, Member or a Family Member must notify the Claim Administrator of the proposed admission. The Claim Administrator's professional staff certifies that the admission is Medically Necessary, that the setting is the most appropriate for the Member's condition, and that Benefits are available for the proposed Inpatient stay.

ADMISSION CERTIFICATION for emergency care and maternity care

Notification to the Claim Administrator by the Member, Family Member, or Hospital of an emergency Inpatient admission or an Inpatient admission related to pregnancy, including pre-term labor, complications of pregnancy, or delivery.

ALLOWABLE FEE

The Provider's actual charge or any amount determined by the Claim Administrator to be an appropriate fee for a specific service, whichever is less.

ADVANCE MEMBER NOTIFICATION (AMN)

Refers to the process in which a Provider informs the Member that a service is not Medically Necessary in accordance with the Claim Administrator Medical Policy prior to having the service performed, and requests the Member sign an AMN to accept responsibility for payment if the Member wishes to proceed with the service.

AMBULANCE
A privately or publicly owned motor vehicle or aircraft that is maintained and used for the emergency transport of patients that is licensed and further defined in 50-6-302, MCA.

BEHAVIORAL HEALTH
The blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services.

BENEFITS OR COVERED BENEFITS
The payment to the Participating Provider for services covered under this EOC which are provided to Members.

BENEFIT MANAGMENT
A program designed to involve Members, Members' healthcare Providers, and the Claim Administrators' (Blue Cross and Blue Shield of Montana and Conduent) professional staff manage healthcare Benefits while maintaining the quality of care.

BENEFIT PERIOD
MEDICAL AND BEHAVIORAL HEALTH BENEFIT
The Benefit Period is October 1 through September 30. If a Member's Effective Date is after October 1, the Member's Benefit Period begins with the Effective Date and ends September 30.

DENTAL BENEFIT
The Benefit Period for Dental is July 1 through June 30. If a Member's Effective Date is after July 1, the Member's Benefit Period begins with the Effective Date and ends June 30.

BLUE CROSS AND BLUE SHIELD OF MONTANA (BCBSMT)
BCBSMT, a Division of Health Care Services Corporation, a mutual legal reserve company, is a Claim Administrator for the Department.

CARDIAC REHABILITATION THERAPY
Medically supervised program that helps improve the health and well-being of people who have heart problems.

CARE MANAGEMENT
A process that assesses and evaluates options and services required to meet the Member's healthcare needs. Care Management may involve a team of healthcare professionals, including covered Providers, BCBSMT, and other resources to work with Members to promote quality, cost-effective care.

CHEMICAL DEPENDENCY
Addiction to drugs or alcohol. Refer to Substance Use Disorder.

CHEMICAL DEPENDENCY OR SUBSTANCE USE DISORDER TREATMENT CENTER
A facility that provides treatment for Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Physician or a licensed addiction counselor. The facility must be approved as a Substance Use Disorder Treatment Center by the Department or an equivalent facility licensed by the state where the facility is located.

CHILD/CHILDREN
For purposes of coverage under the HMK Program the term "child" means an individual 18 years old or younger.

CLAIM ADMINISTRATORS
Claim Administrator means a Department contractor that provides consulting services to the Department and other administrative functions, including the processing and payment of claims. The Claim Administrators perform administrative functions only.

COMPLAINT
A verbal or written communication by a Member or his or her authorized representative that identifies an adverse action by the Department.

COMMUNITY BASED PSYCHIATRIC REHABILITATION AND SUPPORT (CBPRS)
Rehabilitation services provided in home, school, and community settings for youth with serious emotional disturbance (SED) and/or substance use disorder (SUD) who are at risk of out of home or residential placement, or risk removal from current setting for youth under six years of age.

CONDUENT
The fiscal agent/Claim Administrator for the Montana Department of Public Health and Human Services, who processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

CONTINUED STAY REVIEW
The BCBSMT's review of an Inpatient stay beyond what was initially certified to assure that the setting and the level of care continues to be the most appropriate for the Member's condition.

COPAYMENT
The percentage or specific dollar amount of Covered Medical Expenses and Allowable Fees for services payable by the Member.

COVERED MEDICAL EXPENSE
Expenses incurred for Medically Necessary medical and Dental services and supplies that are:
- Covered under this EOC; and
- In accordance with the Medical Policy; and
- Provided to Members by and/or ordered by a Participating Provider for the diagnosis or treatment of active Illness or injury or in providing maternity care.

DENTAL
Covered Dental services delivered by Dental Providers in the Montana Healthcare Program Dental Network.

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

DISENROLLMENT
The process of ending the Member's membership in the HMK Coverage Group by a determination of ineligibility made by the Department or by voluntary withdrawal by the Member.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND MEDICAL SUPPLIES (DMEPOS)
DMEPOS is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of an illness or injury and is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be DMEPOS. DMEPOS are items that are reasonable and necessary in amount, duration, and scope to achieve their purpose. DMEPOS must be medically necessary, prescribed, delivered in the most appropriate and cost effective manner, and may not be excluded by state or federal rules or regulations.

EFFECTIVE DATE

The Effective Date of a Member's coverage means the date the Member is determined eligible for Benefits by the Department.

EMERGENCY CARE

Healthcare items and services furnished or required to evaluate and treat an Emergency Medical Condition.

EMERGENCY MEDICAL CONDITION

An Emergency Medical Condition is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably expected to result in any of the following:

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

EVIDENCE OF COVERAGE (EOC)

This document that explains covered services, service limits, defines the plan's obligations, and explains the rights and responsibilities of the Member.

EXCLUSION

Services not paid for with state and federal funds by the HMK Coverage Group.

EXTENDED BEHAVIORAL HEALTH BENEFITS

Benefits provided to an HMK Member who is determined to have a Serious Emotional Disturbance (SED).

FAMILY

Means one or more Children residing in the same household with a parent, adoptive parent, guardian, or caretaker relative. A Family may also be an emancipated Child or a Child living independently. The Department may determine if a household is a "Family" for purposes of HMK eligibility.

FERTILITY PRESERVATION

Means procedures consistent with established medical practices and professional guidelines published by a national association for practitioners of reproductive medicine or clinical oncology.

HABILITATIVE CARE

Coverage is provided for habilitative care services when the individual requires help to maintain, learn, or improve skills and functioning for daily living or to prevent deterioration. These services include: (1) physical therapy; (2) occupational therapy; (3) speech-language pathology; and (4) Behavioral Health professional treatment. Habilitative services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. Services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician or mid-level practitioner.

HEALTHY MONTANA KIDS (HMK) COVERAGE GROUP

The HMK Coverage Group is a benefit program for eligible Montana children administered by the Department through the HMK Plan. Administrative Rule of Montana 37.79.101 provides HMK Coverage Group information.

HEALTHY MONTANA KIDS (HMK) NETWORK

A Provider or group of Providers who have contracted with BCBSMT to provide medical and Behavioral Health services to Members covered under the HMK Coverage Group.

HOSPITAL

A short-term, acute-care, general Hospital licensed by the state where it is located and which:

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

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

- A nursing home;
- A rest home;
- Hospice;
- A rehabilitation facility;
- A skilled nursing facility;
- A convalescent home;
- A place for care and treatment of Substance Use Disorder;
- A place for treatment of mental illness; or
- A long-term, chronic-care institution or facility providing the type of care listed above.

IDENTIFICATION (ID) CARD

A document issued to each HMK Member that identifies that Member is eligible for the HMK Coverage Group.

ILLNESS

An alteration in the body or any of its organs or parts, which interrupts or disturbs the performance of vital functions, thereby causing or threatening pain or weakness; a sickness or disease.

INSTITUTE FOR MENTAL DISEASE (IMD)

An institution for the treatment and care of persons suffering from mental diseases under Medicaid regulations (42 CFR § 440.160).

INCLUSIVE SERVICES/PROCEDURES

- A portion of a service or procedure which is Medically Necessary for completion of the service or procedure; or
- A service or procedure which is already described or considered to be part of another service or procedure.

INPATIENT OR HOSPITAL INPATIENT

Services or supplies provided to a Member who has been admitted to a Hospital as a registered bed patient and who is receiving services under the direction of a Participating Provider with staff privileges at that Hospital.

INPATIENT BENEFITS (for Substance Use Disorder or Mental Illness)

The payment to a Provider for services for Medically Necessary care and treatment of Substance Use Disorder or Mental Illness which are provided in a setting that is medically appropriate. Such services must be provided:

- By a Hospital, freestanding Inpatient facility, or Physician; and
- While Members are in a Hospital as an Inpatient; or
- While Members are confined as an Inpatient in a Freestanding Inpatient Facility.

INTERPRETER SERVICES

HMK will pay for Interpreter Services provided to eligible HMK Members if:

- The service is a Medically Necessary service;

- The service is a HMK covered service;
- Reimbursement is to the Provider of the service (the Interpreter), not a third party;
- Another payer is not responsible for payment;
- Services were performed in a prompt, efficient fashion; and
- A complete request for payment is received within 365 days of the service provided. This means that the request for payment will include all information necessary to successfully pay the claim.

INVESTIGATIONAL/EXPERIMENTAL/UNPROVEN SERVICE OR CLINICAL TRIAL

Surgical procedures or medical procedures, supplies, devices, or drugs which at the time provided, or sought to be provided, are in the judgment of the Department not recognized as conforming to accepted medical practice, or:

The procedure, drug, or device:

- Has not received required final approval to market from appropriate government bodies; or
- Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes as described by BCBSMT Medical Policy; or
- Is not demonstrated to be as beneficial as established alternatives; or
- Has not been demonstrated to improve the net health outcomes; or
- Is one in which the improvement claimed is not demonstrated to be obtainable outside the Investigational or Experimental setting.

MAXIMUM FAMILY LIABILITY

When the Copayments for services incurred during the Benefit Period for one or more Members in a Family total more than $215, Members will not be required to pay any additional Copayments for Covered Medical Expenses for the remainder of the current Benefit Period.

MEDICAL POLICY

The policy of the Claim Administrator which is used to determine if healthcare services including medical procedures, medication, medical equipment, processes and technology meet nationally accepted criteria, such as:

- Services must have final approval from the appropriate governmental regulatory agencies;
- Scientific studies have conclusive evidence of improved net health outcome; and
- Services must be in accordance with any established standards of good medical practice.

MEDICALLY NECESSARY

Services or items reimbursable under the HMK Coverage Group, and that are:

1. Reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a Member, which:
   - Endanger life;
   - Cause suffering or pain;
   - Result in illness or infirmity;
   - Threaten to cause or aggravate a handicap; or
   - Cause physical deformity or malfunction.

2. A service or item is not Medically Necessary if there is another service or item for the Member that is equally safe and effective and substantially less costly including, when appropriate, no treatment at all.

3. Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not Medically Necessary for purposes of the HMK Plan. Experimental services are procedures and items, including prescribed drugs, considered experimental or investigational by the U.S. Department of Health and Human Services, including the Medicare program, or DPHHS' designated review organization or procedures and

items approved by the U.S. Department of Health and Human Services for use only in controlled studies to determine the safety and effectiveness of such services.

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

MEMBER OR ENROLLED CHILD OR HEALTHY MONTANA KIDS (HMK) MEMBER

A Child who has been certified and notified by the Department as eligible for the HMK Coverage Group. For purposes of this document the term "Member" includes a parent, guardian, or caretaker who is responsible for decisions and notification for the Child enrolled in the HMK Coverage Group.

MENTAL HEALTH TREATMENT CENTER

A facility which provides treatment for Mental Illness through multiple modalities or techniques following a written treatment plan approved and monitored by an interdisciplinary team, including a licensed Physician, psychiatric social worker, and psychologist. The facility must also be:

- Licensed as a Mental Health Treatment Center by the state;
- Funded or eligible for funding under federal or state law; or
- Affiliated with a Hospital with an established system for patient referral.

MENTAL ILLNESS

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

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

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

The following conditions are paid as any other medical condition.

- Developmental disorders;
- Speech disorders;
- Psychoactive Substance Use Disorders;
- Eating disorders;
- Impulse control disorders (except for intermittent explosive disorder and trichotillomania); and
- Severe Mental Illness.

MOBILE CRISIS RESPONSE

Mobile Crisis Response Services provide integrated, short-term crisis response, stabilization, and intervention for members experiencing a mental health or substance use crisis in the community. Mobile Crisis Response Services will provide a service that is a mobile, on-site therapeutic response to a member experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the member or others.

Mobile Crisis Response Services are a tiered model that includes the following:
(1) The American Rescue Plan Act (ARPA) Mobile Crisis Response Model;
(2) Mobile Crisis Team Services; and
(3) Mobile Crisis Services.

MONTH

For the purposes of this EOC, a Month is the actual calendar Month.

MULTIDISCIPLINARY TEAM

When used in the Rehabilitation Therapy portion of the EOC, Multidisciplinary Team is a group of health service Providers who must be either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided.

NON-COVERED OR NON-PARTICIPATING PROVIDER

Any Provider who is not under contract with the Claim Administrator to provide HMK Coverage Group Benefits. Non-Participating Providers are not included in the HMK Network. Services received from a Non-Participating Provider:

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

PHARMACY (NON-COVERED OR NON-PARTICIPATING)

Any Provider who is not enrolled as a Montana Healthcare Programs Provider. In addition, any Provider that is under any sanctions, suspensions, Exclusions or civil monetary penalties imposed by the Medicare program is a Non-Covered Provider. Services received from a Non-Participating or Non-Covered Provider will not be covered.

OBSERVATION BEDS/ROOM

Outpatient beds which are used to:

- Provide active short-term medical/surgical nursing services; or
- Monitor the stabilization of the patient’s condition.

OCCUPATIONAL THERAPY

Therapy involving the treatment of neuromusculoskeletal and psychological dysfunction through the use of specific tasks or goal-oriented activities; designed to address the functional performance of an individual. These services emphasize useful and purposeful activities related to neuromusculoskeletal functions and to provide training in activities of daily living (ADL). (See Habilitative Care and Rehabilitative Care.)

OUTPATIENT

Services or supplies provided to Members by Participating Providers while Members are not Inpatient.

OUTPATIENT BENEFITS FOR SUBSTANCE USE DISORDER OR MENTAL ILLNESS

The payment for services Medically Necessary for care and treatment of Substance Use Disorder or Mental Illness provided by:

- A Hospital, if Members are not confined as a Hospital Inpatient;
- A Physician, if Members are not confined as a Hospital Inpatient;
- A Mental Health Treatment Center;
- A Substance Use Disorder Treatment Center if Members are not confined as an Inpatient;
- A licensed psychologist;
- A licensed social worker;
- A licensed professional counselor; or
- A licensed addiction counselor.

Outpatient Benefits are subject to the following additional conditions:

- The services must be given to diagnose and treat recognized Substance Use Disorder or recognized Mental Illness;
- The treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Substance Use Disorder or Mental Illness;
- No Benefits will be provided for marriage counseling, hypnotherapy, or for services given by a staff member of a school or halfway house.

PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS

An ambulatory (Outpatient) program offers active treatment which is therapeutically intensive, encompassing structured clinical services within a stable, therapeutic program. The program can involve day, evening, and weekend treatment. The underlying aim of this treatment is stabilization of clinical instability resulting from severe impairment and/or dysfunction in major life areas.

A Partial Hospitalization program offers four to eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PHARMACY

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

PHYSICAL THERAPY

Treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living, and pain relief. Treatment may include active and passive modalities using a variety of means and techniques based upon biomechanical and neurophysiological principles. (See Habilitative Care and Rehabilitative Care.)

PHYSICIAN

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

PLAN ADMINISTRATOR

Montana Department of Public Health and Human Services.

PRIOR AUTHORIZATION

Approval in advance to obtain services. Some services are covered only if Members' doctors or other Participating Providers get "Prior Authorization". This process is used to inform HMK Members whether or not a proposed service, medication, supply, or ongoing treatment is Medically Necessary, based on the Medical Policy, and is a covered Benefit under this EOC. This also includes the Retrospective Review and Admission Certification process.

PROVIDER (PARTICIPATING PROVIDER)

Medical and Behavioral Health

A Provider in the HMK network who will provide medical and Behavioral Health services covered in the EOC.

Pharmacy, Dental, DMEPOS, Eyeglasses, Ambulance

A Provider who is enrolled as a Montana Healthcare Programs Provider and who will provide services covered under this EOC.

PSYCHIATRIC RESIDENTIAL TREATMENT CENTER (PRTF)

Inpatient psychiatric Hospital services for individuals under 21 years of age.

RECOVERY CARE BED

A bed occupied in an Outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATIVE CARE

Coverage is provided for rehabilitative care services when the individual needs help to keep, get back or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt or disabled. Rehabilitative services include but are not limited to: (1) physical therapy; (2) occupational therapy; (3) speech-language pathology; and (4) Behavioral Health professional treatment. Rehabilitative services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. These services may be provided in a variety of Inpatient and/or Outpatient settings as prescribed by a Physician or mid-level practitioner.

REHABILITATION UNIT

- Inpatient licensed general Hospital which provides services by a Multidisciplinary Team under the direction of a qualified Physician; or
- Physician's office.

RETROSPECTIVE REVIEW

The Claim Administrator's review of services, supplies, or treatment after they have been provided, and the claim has been submitted, to determine whether or not the services, supplies, or treatment were Medically Necessary.

SERIOUS EMOTIONAL DISTURBANCE (SED)

A behavioral health condition that meets the SED requirements found in the Children's Mental Health (mt.gov).

SEVERE MENTAL ILLNESS

The following disorders as defined by the American Psychiatric Association:

- Schizophrenia;
- Schizoaffective disorder;
- Bipolar disorder;
- Major depression;
- Panic disorder;
- Obsessive-compulsive disorder; and
- Autism

SCHEDULE OF BENEFITS

Included with this EOC, the Schedule of Benefits lists coverage Benefit Periods, co-payments payable for services, and maximum liability for coverage periods for services provided under this EOC.

SPEECH THERAPY

Treatment of communication impairment and swallowing disorders. (See Habilitative Care and Rehabilitative Care.)

SUBSTANCE USE DISORDER

Alcoholism, drug addiction, or substance abuse. Inpatient and Outpatient services are available for treatment of Substance Use Disorder.

TELEHEALTH

The use of a secure interactive audio and video, or other telecommunications technology by a healthcare Provider to deliver healthcare services at a site other than the site where the patient is located. Does not include audio only (phone call), e-mail, and/or facsimile transmission.

TREATMENT FACILITY

1. For treatment of Substance Use Disorder, it means a facility which provides treatment for Substance Use Disorders in a community-based residential setting for persons requiring 24-hour supervision and which is a Substance Use Disorder Treatment Center that is approved by the Montana Department of Public Health and Human Services.

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

2. For treatment of Mental Illness, it means a facility licensed by the state specializing in the treatment of Mental Illness for persons requiring 24-hour supervision which is:
   a. A psychiatric residential Treatment Facility (PRTF); or
   b. A Therapeutic Group Home.

URGENT CARE

Medically Necessary care for a condition that is not life threatening but that requires treatment that cannot wait for a regularly scheduled clinical appointment because of the potential of the condition worsening without timely medical intervention.

ARTICLE TWO – PARTICIPATING PROVIDER

This EOC allows benefits for Covered Medical Expenses which are provided by a Participating Provider. A Participating Provider is a Provider which has satisfied the necessary qualifications to practice medical care within the state of Montana or another state and which has been recognized by BCBSMT as a HMK Provider for medical or Behavioral Health services or is enrolled as a Montana Healthcare Programs Provider for Pharmacy, Dental, eyeglasses, DMEPOS, applied behavior analysis (ABA) services for benefits described in this EOC. Some Providers may be "participating" only for certain specific services because of a limited scope of practice. To determine if a Provider is "participating," the HMK Coverage Group looks to the nature of the services rendered, the extent of licensure, and the HMK Coverage Group's recognition of the Provider.

HMK Members may obtain a list of Providers for medical and Behavioral Health services from BCBSMT upon request or download it from the BCBSMT website. Contact BCBSMT at 1-855-258-3489 to request a list of HMK Participating Providers.

HMK Members may obtain a list of enrolled Montana Healthcare Providers for Pharmacy, Dental, eyeglasses, DMEPOS and supplies, applied behavior analysis (ABA) services, Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHCs) through a search on the Montana Healthcare Provider website.

HMK Members may obtain a list of HMK dental and eyeglass Providers through a search on the HMK website or by calling 1-800-362-8312.

ARTICLE THREE – HEALTHY MONTANA KIDS (HMK) NETWORK

HMK Members are encouraged to choose a primary care Provider from the list of HMK Providers. A primary care Provider will be better able to know Members and their medical history, determine Members' healthcare needs, and help Members use the Medically Necessary Benefits available under the HMK Coverage Group.

Section I: Use of the Healthy Montana Kids (HMK) Network

HMK Members are encouraged to have their care directed by the primary care Providers they select. Members are responsible for making appointments with their HMK Providers. Members' primary care Providers will provide healthcare, or if Members' primary care Providers determine it is Medically Necessary to do so, may refer Members to another Provider or recommend a specialist in the HMK Network. They will also help Members arrange or coordinate Medically Necessary hospitalization.

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

If HMK Members have not chosen a primary care Provider, they still need to use the HMK Network to obtain Benefits.

Covered medical and Behavioral Health Benefits are only available if Members use the HMK Network, except:

1. If the Medically Necessary services are not available in the HMK Network; **AND**
2. Prior Authorization has been approved by BCBSMT on behalf of HMK for services to be paid outside of the HMK Network.

Covered Pharmacy services must be obtained through an enrolled Montana Healthcare Programs Provider. Certain drugs will need a prior authorization. Please refer to Article Four, Section III: Prior Authorization for more information regarding obtaining a Prior Authorization for Pharmacy services.

Prior Authorization is required for some medical and behavioral health services. Members' healthcare Providers must obtain Prior Authorization from the applicable Claim Administrator. For a comprehensive list of services that require a Prior Authorization, please refer to the HMK Member Guide posted at https://dphhs.mt.gov/HMK.

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

The Claim Administrator will review claims to determine if the services were Medically Necessary. The HMK Coverage Group does not pay for services that are determined to not be Medically Necessary, non-covered, Investigational, Experimental, Unproven, require Prior Authorization and are not preauthorized, or not performed in an appropriate setting. When a service is denied as not Medically Necessary, Participating Providers may not balance bill the Member for the services, unless the Member or the Member's authorized representative has signed an AMN.

The AMN process does not apply to services that are not covered by the HMK Coverage Group, even if medically necessary, and Members may be billed for these services.

Section III: Emergency Care and Urgent Care

Emergency Care
If Members need Emergency Care, go to the nearest doctor or Hospital. Members may need Emergency Care if their condition is severe, if they have severe pain, or if they need immediate medical attention to prevent any of the following:

- Serious jeopardy of the Member's health;
- Serious impairment to the Member's bodily functions; or
- Serious damage to a bodily organ or part.

Members are responsible for notifying their primary care Provider as soon as possible that they have received Emergency Care and plan to receive follow-up care from their primary care Provider.

Urgent Care
Some situations require prompt medical attention although they are not emergencies. In these situations, HMK Members are responsible for notifying their primary care Provider as soon as possible and describe the situation. The primary care Provider will then direct Members' care.

Unless Members have approval from the Claim Administrator, they must receive Urgent Care from a HMK Provider. If Members receive services from a Provider who is not an HMK Provider, they may have to pay for these services.

Section IV: Out-of-State Services

Except for two circumstances listed below, the HMK Coverage Group will not pay for routine, non-emergency, and non-urgent care received outside of the state of Montana. The member is responsible for obtaining prior authorization from the HMK Coverage Group for routine, non-emergency, and non-urgent care received out of state. Providers and Members can call BCBSMT at 1-855-258-3489 for more information. Children who spend time away from Montana with a parent or relative must receive approval from HMK Coverage Group for each instance of such treatment, otherwise claims will not be paid and the member will be responsible for payment.

Exceptions:
1) Medically Necessary Services for a Child receiving care from a HMK Provider outside of Montana, but in a county bordering Montana, are covered.

2) Out-of-state Pharmacy benefits are covered if the Provider is enrolled as a Montana Healthcare Programs Provider.

Section V: Prohibition on Payment Outside of the United States

The HMK Coverage Group will not pay for items or services of medical assistance to any Provider located outside of the United States.

ARTICLE FOUR – BENEFIT MANAGEMENT

Benefit Management involves Members, Participating Providers, and BCBSMT/Conduent Claims Administrator staff managing healthcare benefits while maintaining quality of care.

The advantages of Benefit Management are to:

- Assure Members of coverage before they receive treatment, services, or supplies;
- Provide information regarding proposed procedures or alternate treatment plans;
- Direct Members to the Provider networks, including participating out-of-state networks; and

Assist Members in determining out-of-pocket expenses and identifying possible ways to reduce them.

Section I: Healthy Montana Kids (HMK) Claim Administrators

The HMK Coverage Group provides Covered Benefits through the following Claim Administrators:

- Conduent
  The following Covered Benefit claims are processed by Conduent:
  1. Pharmacy;
  2. Dental;
  3. Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS);
  4. Hearing Aids;
  5. Home Infusion Therapy;
  6. Applied Behavioral Analysis (ABA);
  7. Eyeglasses;
  8. Outpatient benefits provided by FQHCs and RHCs; and
  9. Ambulance.

  Participating Providers may contact Conduent at 1-800-362-8312.

- BCBSMT
  All other Covered Benefit claims not listed under Covered Benefit claims processed by Conduent are administered by BCBSMT.

  Participating Providers may contact BCBSMT at 1-855-313-8914.

Section II: Inpatient Admissions

This section applies to facilities that provide licensed Inpatient care including Hospitals and Free-Standing Inpatient Facilities.

Inpatient admissions are reviewed through the Admission Certification process, the Continued Stay Review process, or through Retrospective Review upon receipt of the claims for the Inpatient stay. Use the BCBSMT Benefit Management program for Member Inpatient admissions to avoid unexpected out-of-pocket expenses, benefit reductions, or claim denials.

1. Admission Certification or Prior Authorization

   When Members have scheduled Inpatient admissions, the Hospital or Provider must contact the Claim Administrator, BCBSMT at 1-855-313-8914. BCBSMT will review the Inpatient admission to certify:
   a. The service is Medically Necessary;
   b. The length of stay and level of care are appropriate; and
   c. The service setting is appropriate (Inpatient vs. Outpatient).

   NOTE: Inpatient admissions for diagnostic tests prior to surgery will be approved only if services cannot be provided on an Outpatient basis.

   The Claim Administrator will certify the admission for the appropriate length of stay and level of care based on the information provided by the Provider and Hospital. Members and Providers will receive, in writing, an approval for the appropriate length of stay or a denial of the admission. Members will be covered for days and services that have been certified under the HMK Coverage Group. If the admission is determined by the Claim Administrator to not be appropriate, the Member will be notified by mail.

2. Admission Certification for Emergency Care Unscheduled Inpatient Admission

   In the event of an unscheduled Inpatient admission, the Claim Administrator, BCBSMT requires Admission Certification within 24 hours of admission, or the next working day, after

the admission. Unscheduled admissions are emergency admissions or pregnancy-related admissions for pre-term labor, complications of pregnancy or delivery. Admission Certification will alert the Claim Administrator's professional staff of opportunities to work with Members and their healthcare Providers to avoid additional unexpected out-of-pocket expenses while continuing to maintain the quality of care.

3. Continued Stay Review

   If an Inpatient admission extends beyond the approved length of stay that was certified, the Claim Administrator, BCBSMT, in consultation with Members' healthcare Providers, will review the stay to ensure that the length of stay and level of care are Medically Necessary. Additional Medically Necessary Inpatient days may be certified following the Continued Stay Review. If additional days are not certified, the Claim Administrator will send letters to Members and Providers once the decision to disallow additional days has been made. The Claim Administrator will make a phone call to the facility where the additional days are denied.

Section III: Prior Authorization

Members' healthcare Providers are responsible for obtaining Prior Authorization for out-of-state services, and Covered Benefits that require Prior Authorization listed in Article Five – Covered Benefits.

The Prior Authorization process may require additional documentation from Members' healthcare Providers for some services. In these cases, a written request must be submitted to the Claim Administrator by Members' healthcare Providers and should include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, photographs, x-rays, etc.

For Prior Authorization on medical health services, Member's healthcare Providers should contact BCBSMT at 1-855-313-8914 or at the number on the back of Members' ID cards.

For Prior Authorization on Behavioral Health services, except Applied Behavioral Analysis (ABA), Member's healthcare Providers should contact BCBSMT at 1-855-699-9907 or on the number on the back of Members' ID cards.

For Prior Authorization on Pharmacy and Home Infusion Therapy claims, Members' prescribers or dispensing Pharmacy should call the Drug Prior Authorization Unit, Mountain-Pacific Quality Health, at 1-800-395-7961.

For Prior Authorization on DMEPOS, Hearing Aid, , Applied Behavioral Analysis (ABA), and Ambulance claims (emergency and non-emergency), Member's healthcare Providers should call Mountain-Pacific Quality Health at 1-800-219-7035 .

If Prior Authorization is not obtained, a Retrospective Review of medical and Behavioral Health claims will be performed by the applicable Claim Administrator after the claims have been submitted to determine whether or not the services, supplies, or treatment were Medically Necessary. If a service, supply, or treatment is deemed Medically Necessary, HMK Coverage Group will pay the claim. If not, HMK Coverage Group will not pay the claim.

Section IV: Unplanned Inpatient Stays

1. Inpatient Care:

   For a planned Inpatient stay, Members' Providers will need to obtain approval for Admission Certification prior to the Inpatient stay. For unplanned, non-emergency Inpatient stays, Members' Providers must submit requests for approval for Admission Certification within 48 hours after the admission. The Claim Administrator will review the admission to verify that:

   a. The service is Medically Necessary.
   b. The length of stay and the setting are appropriate.
   c. The level of care is appropriate.

2. If Admission Certification is not obtained prior to an Inpatient stay, a Retrospective Review may be completed to determine whether or not the services, supplies, or treatment were Medically Necessary. If a service, supply, or treatment is deemed Medically Necessary, HMK Coverage Group will pay the claim. If not, HMK Coverage Group will not pay the claim.

Section V: Care Management

The goal of Care Management is to help the Member receive the most appropriate care that is also cost effective. If the Member has an ongoing medical condition or a severe, prolonged illness, the Member should contact BCBSMT to discuss Care Management. If appropriate, a care manager will be assigned to work with the Member and the Member's Providers to facilitate a treatment plan. Care Management includes Member Education, referral coordination, utilization review and individual care planning.

A care manager may identify a problem or need and work with the Provider to develop and recommend viable alternatives to assist, maintain or enhance the quality of treatment, which provide cost controls through implementation of the agreed upon treatment plan.

A written treatment plan may be developed by the care manager in conjunction with Members, the attending physician, and BCBSMT. The treatment plan includes:

1. Treatment plan objectives;
2. Courses of treatment identified to accomplish care objectives, including identifying any non-covered services needed for care management of the Member's ongoing medical condition or severe, prolonged illness;
3. Assignment of responsibility for obtaining objectives;
4. Signatures of each party (care manager, attending physician, and the Member or parent or guardian); and
5. Estimated costs and savings.

This treatment plan may include both covered services and non-covered services. The HMK Coverage Group must approve any treatment plan which includes non-covered services. Once the treatment plan is agreed upon by all parties, Benefits for non-covered services or supplies shall be paid on the same basis as if they were Covered Services under the terms and provisions of this EOC. HMK Coverage Group will not pay for non-covered services that are not specifically identified in the signed treatment plan.

Section VI: Copayments

GENERAL

Dental Services Benefit Period……..…… July 1 through June 30
HMK Services Benefit Period..... October 1 through September 30

The Benefits of this Schedule are subject to this Benefit Period unless otherwise specified.

Copayment ..... Varies by Covered Services

There are no Copayments for covered services for families with at least one enrollee who is a Native American or Native Alaskan. This determination will be made by the Montana Department of Public Health and Human Services at the time of enrollment.

Maximum Family Copayment liability ..... $215 per Benefit Year

PRIOR AUTHORIZATION

Certain services require Prior Authorization. See Article Four of this EOC entitled "Benefit Management" and Article Five entitled "Covered Benefits" for details.

COPAYMENTS

P**ROFESSIONAL PROVIDER BENEFITS**

Outpatient Visit (including Office and Home Visits) ..... $3 Copayment Per Visit
Surgical Services ..... No Copayment
Diagnostic X-ray and Laboratory Services ..... No Copayment
Well-baby/Well-child Visit ..... No Copayment
Home Health Services…… ..... $3 Copayment Per Visit
Chiropractic Services…….. ..... $3 Copayment Per Visit

OUTPATIENT THERAPY

Professional and Facility-Based Services – Outpatient ..... $5 Copayment Per Visit

HOSPITAL AND OTHER SERVICES

Inpatient

Semi Private Room and Board Charges, per admission ..... $25 Copayment

All Inpatient admissions require Admission Certification for full benefits to be paid. See Article Four of this EOC entitled "Benefit Management" for details.

Outpatient Hospital and Facility Benefits

Nonemergency Care

Covered Facility Services and Supplies ..... $5 Copayment Per Visit
Visit for Diagnostic X-ray and Laboratory Services Only ..... No Copayment

Urgent and Emergency Services

Urgent Care Office Visit ..... $3 Copayment Per Visit
Outpatient Emergency Room ..... $5 Copayment Per Visit
Ambulance ..... No Copayment

Inpatient Hospital Copayment applies if the Emergency Room visit results in an Inpatient stay. If Members are admitted for an Inpatient stay, the Emergency Room Copayment will be waived.

SUBSTANCE USE DISORDER AND MENTAL ILLNESS

All Inpatient admissions require Admission Certification in order for full Benefits to be paid.

Substance Use Disorder

Outpatient and Inpatient (professional Provider and facility)

Outpatient ..... $3 Copayment
Inpatient ..... $25 Copayment

Mental Illness

Outpatient
Mental Health Counseling (professional Provider office visit).....$3 Copayment
Mental Health Professional Visit at a Facility.....$5 Copayment
Inpatient .....$25 Copayment
Extended Behavioral Health .....No Copayment

PHARMACY BENEFIT
Generic .....No Copayment
Brand-Name.....No Copayment

OTHER
Laboratory (in the Doctor's Office) ..... No Copayment
Visits at FQHC or RHC .....No Copayment
Well Child .....No Copayment
Well Baby .....No Copayment
Immunizations .....No Copayment
Dental Services…….....No Copayment

ARTICLE FIVE – COVERED BENEFITS

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

The HMK Coverage Group will make payment for certain professional Provider and Hospital services based on the Allowable Fee for Covered Medical Expenses provided by Participating Providers during the Benefit Period and while this EOC is in force. (See Article Two entitled "Participating Provider.") Payment by the HMK Coverage Group will be subject to the Copayments shown in the Schedule of Benefits.

Section I: Inpatient Hospital Services

BCBSMT administers claims for Inpatient Hospital Services and Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-313-8914.

1. The number of allowable Inpatient days of care shall be determined by BCBSMT in accordance with the Milliman Care Guidelines, HCSC Medical Policies Criteria, and Medical Director Directive.

    a. Days of care guidelines:

        1. The day a Member enters a Hospital is the day of admission.
        2. The day a Member leaves a Hospital is the day of discharge.
        3. The number of Inpatient care days available under the HMK Coverage Group will be computed as follows:
            - Days will be counted according to the standard midnight census procedure used in most Hospitals.
            - The day a Member is admitted to a Hospital is counted.
            - The day of discharge is not counted.
            - If a Member is discharged on the day of admission, one day will be counted.

2. Room and Board Accommodations include:

    a. Bed and board, which includes special diets and nursing services.
    b. Intensive care and cardiac care units only when such services are Medically Necessary. Intensive care and cardiac care units include:
        1. Special equipment; and
        2. Concentrated nursing services provided by nurses who are Hospital employees.

NOTE: Members will be responsible to Hospitals for payment of charges if Members remain as Inpatient when Inpatient care is not Medically Necessary and if Members' representatives signed a private pay agreement/Advance Member Notification specific to a service and date. No Benefits will be paid for Inpatient care provided primarily for diagnostic or therapy services.

3. Miscellaneous Inpatient Hospital Benefits include:

    a. Laboratory procedures;
    b. Operating room, delivery room, recovery room;
    c. Anesthetic supplies;
    d. Surgical supplies;
    e. Oxygen and use of equipment for its administration;
    f. X-ray;
    g. Intravenous injections and setups for intravenous solutions;
    h. Respiratory therapy, chemotherapy, radiation therapy, dialysis therapy;
    i. Physical Therapy, Speech Therapy, and Occupational Therapy; and
    j. Drugs and medicines which:
        1) Are approved for use in humans by the U.S. Food and Drug Administration;
        2) Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
        3) Require a Physician's written order.

4. Transplant Benefits include:

    a. Heart, heart/lung, single lung, double lung, liver, pancreas, kidney, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplants.
    b. For organ and tissue transplants involving a living donor, transplant organ/tissue procurement and transplant-related medical care for the living donor are covered.
    c. Transplants of a nonhuman organ or artificial organ implant are not covered.
    d. Donor searches are not covered.

5. Nursery Care Benefits include:

    a. Hospital nursery care of a newborn infant of an HMK Member is a covered service during the infant's eligibility period.
    b. Nursery care for newborns born into an HMK Family may be covered if the Department is notified in the Month of the birth or within ten (10) days following the birth if the baby is born at the end of the Month. (See Article Five, Section XIV: Newborn Care – Care of newborn of non-covered Family member for important notification requirements.)

Section II: Observation and Recovery Beds/Rooms

BCBSMT administers claims for Observation/Recovery Beds/Rooms.

Payment will be made for Observation Beds/Rooms and Recovery Care Beds/Rooms when Medically Necessary, and in accordance with BCBSMT Medical Policy guidelines. Observation and Recovery Beds/Rooms services are subject to the following limitations:

1. The HMK Coverage Group will pay Observation Beds/Room and Recovery Care Bed Benefits when provided for less than 24 hours.

2. Benefits for Observation Beds/Rooms and Recovery Care Beds/Rooms will not exceed the semiprivate room rate that would be billed for an Inpatient stay.

Section III: Outpatient Hospital Services

BCBSMT administers claims for Outpatient Hospital Services. Participating Providers may contact BCBSMT at 1-855-313-8914.

1. Emergency room care for accidental injury.

2. Emergency room care for an Emergency Medical Condition.

3. Use of the Hospital's facilities and equipment for surgery.

4. Use of the Hospital's facilities and equipment for respiratory therapy, chemotherapy, radiation therapy, and dialysis therapy.

Section IV: Outpatient Therapies – See Section XI: Rehabilitation/Habilitation Therapy Benefits

Section V: Outpatient Diagnostic Services

1. Outpatient Diagnostic Services provided by FQHCs and RHC claims are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312. Applicable guidance for claims submission for services provided by these types of Providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/

2. Outpatient Diagnostic Service claims from all other types of Participating Providers are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-313-8914.

The following Outpatient Diagnostic Services are provided:

1. Diagnostic x-ray examinations;

2. Laboratory and tissue diagnostic examinations; and

3. Medical diagnostic procedures.

Section VI: Freestanding Surgical Facilities (Surgicenters)

Freestanding Surgical Facility claims are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-313-8914. Prior Authorization is required.

Surgicenter services are available if:

1. The center is licensed by the state in which it is located or certified for Medicare;

2. The center has an effective peer review program to assure quality and appropriate patient care; and

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

Section VII: Mammograms

Claims for mammograms are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-313-8914.

The Department will pay the HMK Coverage Group allowable charge for routine mammograms.

Section VIII: Post-mastectomy Care

Post-mastectomy Care claims are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-313-8914.

Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer. Covered services include, but are not limited to:

1. Inpatient care for the period of time as determined by the attending Physician, in consultation with the Member, to be necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer. Prior Authorization is required for Inpatient Hospital services.

2. All stages of reconstructive breast surgery after a mastectomy are covered.

3. The cost of the breast prosthesis as the result of the mastectomy is covered.

4. All stages of one reconstructive breast surgery on the non-diseased breast to establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed.

5. Chemotherapy.

6. Prosthesis and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Section IX: Surgical Services

BCBSMT administers Covered Benefits for surgical services and Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-313-8914.

Surgical services include cutting procedures and care of fractures and dislocations. Such services include usual care before and after surgery. Payment for these services is subject to the following conditions:

1. If more than one surgical procedure is performed during one operating session, The HMK Coverage Group will pay only the Allowable Fee for one procedure plus one-half of the Allowable Fee for any other procedures. When two surgeons of different specialties perform distinctly different procedures in one session, all claims will be reviewed before any determination on payment is made. No additional payment will be made for incidental surgery. “Incidental surgery” is a procedure which is an integral part of, or incidental to, the primary surgical service and performed during the same operative session. Surgery is not incidental if:

    a. It involves a major body system different from the primary surgical services.
    b. It adds significant time or complexity to the operating sessions and patient care.

2. If an operation or procedure is performed in two or more steps, total payment will be limited to the Allowable Fee for the initial procedure.

3. If two or more surgeons acting as co-surgeons perform the same operations or procedures other than as an assistant at surgery, the Allowable Fee will be divided among them. If a surgeon is acting as an assistant at surgery, payment for the services will be subject to the limitations listed below.

4. An assistant at surgery is a Physician or non-physician assistant who actively assists the operating Physician in the performance of covered surgery. The services of an assistant at surgery shall be considered for payment under the following conditions:

    a. Benefit payments are not available when the assistant at surgery is present only because the facility Provider requires such services.
    b. Benefit payments for the assistant at surgery will be paid only if such services are determined to be Medically Necessary.
    c. If the assistant at surgery is a Physician, payment will be made at 20 percent (20%) of the Allowable Fee for the surgical procedure or the assistant's charge, whichever is less.
    d. If the assistant at surgery is a non-physician assistant or surgical technician, payment will be 10 percent (10%) of the Allowable Fee for the surgical procedure or the assistant's charge, whichever is less.
    e. If two surgeons are paid as primary surgeons or co-surgeons for their multiple surgeries, no allowance as an assistant at surgery will be made to either of the surgeons. Any charges for an additional assistant at surgery will be subject to review.

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

Section X: Anesthesia Services

BCBSMT administers anesthesia services and Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-313-8914.

Anesthesia services provided by a Physician (other than the attending Physician or assistant), or nurse anesthetist are generally Covered Benefits if the services are determined to be Medically Necessary to provide care for a condition covered by this EOC.

Anesthesia services include:

1. Administration of spinal anesthesia;
2. The injection or inhalation of a drug or other anesthetic agent used to cause muscles to relax, or a loss of sensation or consciousness; and
3. Supervision of the individual administering anesthesia.

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

Exclusions to Anesthesia Benefit coverage under the HMK Coverage Group are:

1. Hypnosis;
2. Local anesthesia that is considered to be an Inclusive Service/Procedure; and
3. Anesthesia consultations before surgery that are considered to be Inclusive Services/Procedures.

Section XI: Rehabilitation/Habilitation Therapy Benefits

Outpatient Rehabilitation/Habilitation Therapy Covered Benefit claims from FQHCs and RHCs are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312. Applicable guidance for claims submission for services provided by these types of Providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

All other Outpatient Rehabilitation/Habilitation Therapy Covered Benefit claims are administered by BCBSMT and Prior Authorization is not required. Participating Providers may contact BCBSMT at 1-855-313-8914.

Payment by the HMK Coverage Group for Rehabilitation/Habilitation Therapy is based on the Allowable Fee and is subject to the Copayments identified in the Schedule of Benefits. These services must be Medically Necessary and provided by Participating Providers. (Please read Article Two entitled "Participating Providers.")

Outpatient Rehabilitation/Habilitation Therapy Benefits

1. Therapy service provided to Members by a Multidisciplinary Team under the direction of a qualified Physician.

2. Members of the Multidisciplinary Team may include but are not limited to a licensed psychologist, licensed Speech Therapist, licensed Physical Therapist, or licensed Occupational Therapist.

3. Services must be Medically Necessary to maintain, improve or restore bodily function and the Member must continue to show measurable progress.

4. Outpatient Rehabilitation/Habilitation therapy do not require Prior Authorization.

Inpatient Rehabilitation/Habilitation Therapy Benefits

1. Therapy service provided to Members by a Multidisciplinary Team under the direction of a qualified Physician.

2. Members of the Multidisciplinary Team may include but are not limited to a licensed psychologist, licensed Speech Therapist, licensed Physical Therapist, or licensed Occupational Therapist.

3. Services must be Medically Necessary to maintain, improve or restore bodily function and the Member must continue to show reasonable progress.

Rehabilitation/Habilitation Therapy Benefit Exclusions:

1. Rehabilitation/Habilitation Therapy is not covered when the primary reason for the therapy is one of the following:
   a. Custodial care;
   b. Diagnostic admissions;
   c. Nonmedical self-help or vocational educational therapy;
   d. Learning disabilities; and
   e. Social or cultural rehabilitation.

Section XII: Medical Services (Non-Surgical)

Medical services are those non-surgical covered services provided by Participating Providers during office, home, or Hospital visits which do not include surgical or maternity services.

Outpatient medical service claims from FQHCs and RHCs are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312. Applicable guidance for claims submission for services provided by these types of Providers is explained in the Montana Medicaid Provider Manuals. Outpatient medical service claims from all other types of Providers are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-313-8914.

BCBSMT administers claims for all Inpatient medical services. BCBSMT administers claims for Outpatient medical services provided by all other types of Participating Providers. Participating Providers may contact BCBSMT at 1-855-313-8914.

Outpatient medical services (non-surgical) include the following:

1. Outpatient medical services include physical examinations and immunizations provided for home, office, and Outpatient Hospital visits.
2. Services provided via telehealth are allowed.

Inpatient claims for services provided by FQHCs and all other Inpatient claims are processed through BCBSMT. Prior Authorization may be required for certain non-surgical medical services administered by BCBSMT. It is recommended Participating Providers contact BCBSMT at 1-855-313-8914 if they are uncertain whether a Covered Benefit needs Prior Authorization.

Inpatient Medical services (non-surgical) include the following:

1. Inpatient medical services are covered for eligible Hospital admissions.
2. Medical care visits, limited to one visit per day per Participating Provider.
3. Intensive medical care rendered to Members whose condition requires a Physician's constant attendance and treatment for a prolonged period of time.
4. Concurrent Care services.

   Concurrent Care is:
   a. Medical care rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or
   b. Medical care by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Member's condition requires the skills of separate Physicians.

5. Consultation Services are services of a consulting Physician requested by the attending Physician. These services include:
   a. Evaluation and management services provided at the request of another Participating Provider;
   b. The consultant's opinion and any services ordered or performed must be documented in the Member's medical record and communicated by written report to the requesting Participating Provider; and
   c. Evaluation and management consultation services requested by a Participating Provider from a non-Participating Provider and subsequent referrals or treatment services must be Prior Authorized by BCBSMT.

   Benefit coverage will not be provided under the HMK Coverage Group for:
   a. Staff consultations required by Hospital rules, and
   b. Family consultations.

Section XIII: Maternity Services

BCBSMT administers claims for maternity services and Admission Certification is required for Hospital admissions. For Admission Certification contact BCBSMT at 1-855-313-8914.

Payment for any maternity services is limited to the Allowable Fee for total maternity care which includes:

1. Prenatal and postpartum care delivery of one or more newborns.
2. In Hospital medical services for conditions related directly to pregnancy.
3. Prenatal vitamins.

Inpatient Hospital care following delivery will be covered for the length of time determined to be Medically Necessary. At a minimum, Inpatient care coverage will be at least 48 hours following a vaginal delivery and at least 96 hours following a delivery by cesarean section. The decision to shorten the length of Inpatient stay to less than that stated above must be made by the attending Participating healthcare provider and the mother.

Section XIV: Newborn Care

Newborn care claims from FQHCs and RHCs are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312. Applicable guidance for claims submission for services provided by these types of Providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

BCBSMT administers newborn care claims for all other types of Providers. Participating Providers may contact BCBSMT at 1-855-313-8914.

Newborn of **Covered Member**:

Benefits are provided for the newborn baby of eligible Members. Covered Benefits must be provided by Participating Providers and can include:

1. The initial care of a newborn at birth provided by Participating Providers,
2. Standby care provided by a pediatrician during a Cesarean section, and
3. Covered Benefits for 31 days following the birth.
    a. The newborn services will be provided under the eligible Member's coverage.
    b. Coverage for the newborn will terminate at the end of the 31-day period.
    c. In order to avoid interruption in coverage for the newborn, an HMK application for eligibility for the newborn must be received prior to the end of the 31-day period.

Continued HMK coverage after birth for the newborn is subject to meeting eligibility requirements as determined by the Department.

Section XV: Well-Baby/Well-Child Care

Well-Baby/Well-Child care claims from FQHCs and RHCs are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312. Applicable guidance for claims submission for services provided by these types of Providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

BCBSMT administers well-baby/well-child care claims for all other types of Providers. Participating Providers may contact BCBSMT at 1-855-313-8914.

Covered Benefits include:

1. A well-baby/well-child examination by a Participating Provider following the recommended guidelines of the American Academy of Pediatrics (AAP), which shall include a medical history,

physical examination, developmental assessment, and anticipatory guidance. Full guidelines can be found at https://brightfutures.aap.org.

2. Laboratory tests according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in MCA § 53-6-101.

3. Routine immunizations according to the schedule of immunizations which is recommended by the Immunization Practices Advisory Committee of the United States Department of Health and Human Services Centers for Disease Control and Prevention.

4. Sport and employment physicals.

Payment will be made based on the Allowable Fee. No payment will be made for duplicate services with respect to any scheduled visit.

Section XVI: Vision Benefits and Medical Eye Care

Vision claims from FQHCs and RHCs are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312. Applicable guidance for claims submission for services provided by these types of Providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/

BCBSMT administers vision claims for all other types of Providers. Participating Providers may contact BCBSMT at 1-855-313-8914.

Vision Benefits include:

1. Services for the medical treatment of diseases or injury to the eye by a licensed Physician or optometrist working within the scope of his/her license.

2. Vision exams.

3. Eyeglasses are covered by the Department and claims are administered by Conduent.

    a. HMK will pay for one pair of glasses within a 365-day period.
    b. Contact lenses are not covered.
    c. For more information about eyeglasses, call 1-800-362-8312.

Section XVII: Dental Services

Dental claims from Dentists, FQHCs and RHCs are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312.

Dental services include:

1. A Child may receive up to $1,900 in covered Dental services per Benefit Year (July 1 through June 30).
2. Dentists may charge families for services over $1,900 per Member per Benefit Year. Families can make payment arrangements with dentists.
3. Dental implants are a covered benefit.
    a. Implant services covered as a dental benefit have a lifetime limit of $1,500 per person.
    b. Dental implants to replace congenitally missing teeth are covered as a medical benefit and the $1,500 limit does not apply.

4. For more information about HMK Dental services, call 1-800-362-8312.

Services and supplies provided by a Hospital, surgicenter, or by a mobile anesthesia Provider in conjunction with Dental treatment will be covered only when a non-dental physical Illness or injury exists which makes the care Medically Necessary to safeguard the Member's health. Complexity of Dental treatment and length of anesthesia are not considered non-dental physical Illness or injury.

Coverage is available for Dental anesthesia in the Hospital, surgicenter, or by a mobile anesthesia Provider.

Other conditions are subject to medical review.

The HMK Coverage Group may pay for Medically Necessary services provided by Dentists and oral surgeons for the initial repair or replacement of sound natural teeth damaged as a result of an Accident. Dental accidents should be reported immediately to BCBSMT at 1-855-313-8914.

Exclusions to Outpatient and Inpatient Dental Services include:

a. orthodontics,
b. dentofacial orthopedics, or
c. related appliances.

Section XVIII: Dental Fluoride

Claims for Dental fluoride provided by a Dentist are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312.

BCBSMT administers claims for Dental fluoride provided by all other types of Participating Providers. Participating Providers may contact BCBSMT at 1-855-313-8914.

Dental varnish fluoride applications are covered when provided by a Physician or other Participating Provider who is not a Dentist. Prescribed oral fluoride preparations are a covered Pharmacy benefit.

Section XIX: Audiological Benefits

BCBSMT administers audiological claims for Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

Audiological Benefits include:

1. Hearing exams, including newborn hearing screens in a Hospital or Outpatient setting, are covered. Coverage includes assessment and diagnosis.

2. Hearing aids, hearing aid supplies, including batteries, and hearing aid repairs are covered by the Department and administered by Conduent. Hearing aids require Prior Authorization.
   a. Hearing aids may be covered under the Montana Healthcare Program if all the following conditions are satisfied:
      1) the member's physician or mid-level practitioner has referred the member to an audiologist for an audiological evaluation.
      2) The licensed audiologist has determined a prescription hearing aid would be effective in improving the members' hearing.
      3) The licensed audiologist's evaluation has concluded that the member requires a prescription hearing aid or aids.
      4) Prior authorization for the prescription hearing aid has been granted by the department or its designated review organization. The prescription hearing aid is provided by a licensed hearing aid dispenser or an audiologist.
   b. The HMK Coverage Group will pay for a single or one set of hearing aids within a 5-year period.
   c. c. To request prior authorization for hearing aids:

1) Submit prior authorization requests to Mountain Pacific Quality Health (MPQH), the DPHHS utilization review contractor, through the Qualitrac Portal.
2) Include appropriate supporting documentation with the request.
3) Upon completion of the review, the member and requesting provider are notified. The provider receives an authorization number that must be included on the claim. If the requesting provider does not receive the authorization number within 10 business days of being notified of the review approval, the requesting provider may call MPQH at (800) 219-7035.

d. HMK Members must be enrolled on the date of the Prior Authorization request and on the date of service, including the date hearing aids are provided to HMK Members

3. Cochlear implants and associated components are Covered Benefits and are administered by BCBSMT. Cochlear replacement parts may be covered benefits under DMEPOS and are administered by Conduent.
   a. Prior Authorization is required for cochlear implants and associated components. Participating Providers may contact BCBSMT at 1-855-313-8914.
   b. HMK Members must be enrolled on the date of the Prior Authorization request and on the date of service.

Section XX: Radiation Therapy Service

BCBSMT administers claims for radiation therapy Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

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

Section XXI: Chemotherapy

The use of drugs approved for use in humans by the U.S. Food and Drug Administration ordered by the attending Physician for the treatment of disease is covered.

Section XXII: Diabetic Education

BCBSMT administers diabetic education claims for Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

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

See Section XXXIII: Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS) for important information regarding diabetic equipment and supplies covered by the HMK Coverage Group.

Section XXIII: Diagnostic Services – See Section V: Outpatient Diagnostic Services

Section XXIV: Behavioral Health Inpatient Benefits

BCBSMT administers Inpatient Behavioral Health claims for Covered Benefits. Prior Authorization is required. Participating Providers may contact BCBSMT at 1-855-699-9907.

1. The HMK Coverage Group will pay for Inpatient Behavioral Health services that are Covered Benefits if provided by a Participating Provider. Covered Benefits must be provided by one of the following types of Providers:

a. Hospital;
b. Psychiatric Residential Treatment Facility; or a
c. Therapeutic Group Home.

2. Therapeutic Group Home Leave refers to temporary residence at another location, and such leave is allowed, but limited to 14 paid days per benefit year, effective July 1, 2015.

3. Inpatient admission to a 24-hour therapeutically structured service location must receive Prior Authorization.

Section XXV: Behavioral Health Outpatient Benefits

Behavioral Health Outpatient claims from FQHCs and RHCs are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312. Applicable guidance for claims submission for services provided by these types of Providers is explained in the Montana Medicaid Provider Manuals found at the following website: http://medicaidprovider.mt.gov/.

BCBSMT administers Behavioral Health Outpatient benefit claims for all other types of Participating Providers. Participating Providers may contact BCBSMT at 1-855-313-8909.

1. The HMK Coverage Group will pay for Outpatient Behavioral Health services that are Covered Benefits if provided by a Participating Provider. Outpatient Behavioral Health services may be furnished in a variety of settings:
   a. community based settings; or in a
   b. mental health Hospital.

2. Behavioral Health Outpatient Benefits include individual, Family and/or group psychotherapy office visits.

3. Services provided via telehealth are allowed.

Section XXVI: Extended Behavioral Health Benefits

1. The HMK Coverage Group will provide Covered Benefits which include community based mental health services available for Children who have been diagnosed as having a Serious Emotional Disturbance (SED). Claims for extended behavioral health benefits are administered by BCBSMT. Participating Providers may contact BCBSMT at 1-855-699-9907.

2. Extended Behavioral Health Benefits are in addition to the Behavioral Health Outpatient Benefits and must be provided by a Covered Behavioral Health Provider.

3. Extended Behavioral Health services are available for Children who are determined to have an SED. Extended Mental Health Benefits include the following community-based services:
   a. Therapeutic Family Care/Home Supports (moderate level);
   b. Day Treatment;
   c. Respite Care; and
   d. Community Based Psychiatric Rehabilitation and Support (CBPRS).

Section XXVII: Applied Behavior Analysis (ABA)

Applied Behavioral Analysis (ABA) is covered and administered by Conduent. ABA services require Prior Authorization. Participating Providers may contact Conduent at 1-800-362-8312.

a. ABA services must be provided by Montana Healthcare Program Participating Providers.
b. HMK Members must be enrolled on the date of the Prior Authorization request and on the date(s) of service.

Section XXVIII: Substance Use Disorder

Payment by the Department for Substance Use Disorder services of Participating Providers will be based on the Allowable Fee and is subject to the copayments identified in the Schedule of Benefits. These services must be Medically Necessary and provided by a Participating Provider. (See Article Three entitled "Participating Providers.")

BCBSMT administers Substance Use Disorder Inpatient and Outpatient claims for Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914. Prior Authorization is required for Inpatient Benefits.

Inpatient Benefits:

1. Inpatient treatment for alcoholism and drug addiction services are Covered Benefits. Inpatient Services are provided as medical benefits.

Outpatient Benefits:

1. Outpatient treatments for alcoholism and drug addiction services are Covered Benefits.

2. BCBSMT administers claims for Outpatient Substance Use Disorder services.

3. These services must be Medically Necessary and provided by a Participating Provider.

Section XXIX: Ambulance Services

Ambulance services must be approved by the Montana Healthcare Programs Transportation Center. Providers may contact the Montana Healthcare Programs Transportation Center at 1-877-362-5861.

Ambulance claims are administered by Conduent. Participating Providers may contact Conduent at 1-800-362-8312.

Licensed ground and air Ambulance services are covered to the nearest Hospital equipped to provide the necessary treatment when the service is for a life-endangering medical condition or injury. Ambulance transport must be Medically Necessary meaning other forms of transportation would endanger the health of the Member. HMK only pays for loaded miles when the patient is on-board the Ambulance.

Additional information can be found on the DPHHS website at http://medicaidprovider.mt.gov/.

Section XXX: Transportation and Per Diem

BCBSMT administers claims for transportation and per diem Covered Benefits. Members or Family Members may contact BCBSMT at 1-855-258-3489.

The HMK Coverage Group will provide financial assistance towards expenses for HMK Members' transport, meals and lodging while enroute to Medically Necessary medical care. It is important to have Members' Participating Providers submit requests for Prior Authorization to the Claim Administrator and receive approval for Medically Necessary medical care before Member or Family Members submit request for travel and per diem.

1. Prior Authorization is required for all transportation and per diem reimbursement. Members' Participating Providers must sign and submit Prior Authorization forms to the Claim Administrator before Members travel to receive medical care.

2. Members must schedule an appointment and attend the appointment prior to receiving transportation and per diem reimbursement.

3. Coverage of per diem and transportation is available for an adult companion to accompany a minor who must travel to receive care.

4. HMK will only pay per diem and transportation to the nearest Provider that can provide the needed services, regardless of where the Member chooses to receive care.

Section XXXI: Chiropractic Services

BCBSMT administers claims for chiropractic Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

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

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

Section XXXII: Prescription Drugs

DPHHS administers claims for prescription drugs. Providers may contact DPHHS Provider Relations at 1-800-624-3958.

Drug coverage is limited to those products where the pharmaceutical manufacturer has signed a rebate agreement with the Federal government. Federal regulations further allow states to impose restrictions on payment of prescription drugs through Preauthorization and Preferred Drug Lists.

Prescription drugs purchased at a nonparticipating Pharmacy are not a benefit of this EOC and will not be paid by the HMK Coverage Group. Members will be responsible for payment of drugs purchased at a non-participating Pharmacy.

The prescription drug benefit administered by DPHHS is set forth in ARM Title 37, chapter 86, part 11.

Additional information can be found on the DPHHS website at: http://medicaidprovider.mt.gov.

Section XXXIII: Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)

DMEPOS Covered Benefits are administered by Conduent and prior authorizations obtained through Mountain Pacific Quality Health (MPQH). Participating Providers may contact Conduent at 1-800-362-8312. Prior Authorization is required for DMEPOS and medical supplies that cost more than $1,000. Participating Providers may contact MPQH at 1-800-219-7035.

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

1. DMEPOS does not include equipment or supplies that are useful or convenient but are not Medically Necessary. DMEPOS includes things like oxygen equipment, wheelchairs, prosthetic limbs, and orthotics.

2. Diabetic equipment and supplies include: insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for the warranty period, and accessories to insulin pumps. (See Section XXII regarding Diabetic Education and Section XXXVI: Nutrition Services.)

Section XXXIV: Home Health Services

BCBSMT administers home health service claims for Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914. The ordering Provider must submit Prior Authorization to BCBSMT prior to providing services.

The HMK Coverage Group will pay for home health services provided by a licensed home health agency to Members considered homebound in Members' place of residence for the purposes of postponing or preventing institutionalization.

1. Home health services include:
   a. Skilled nursing services;
   b. Home health aide services;
   c. Physical Therapy services;
   d. Occupational Therapy services;
   e. Speech Therapy services; and
   f. Medical supplies and equipment suitable for use in the home.

2. Home health services not covered:
   a. Respite care;
   b. Participating home health agencies will be required to use a participating home infusion therapy Provider who will bill the Claim Administrator directly;
   c. Compensation for daily prescriptions and oral medications will not be allowed through the home health agency; and
   d. Compensation for ~~A~~ambulance services will not be allowed through the home health agency.

Section XXXV: Hospice Services

BCBSMT administers claims for hospice services. Participating Providers may contact BCBSMT at 1-855-313-8914.

The HMK Coverage Group will cover Medically Necessary hospice services from licensed Providers.

1. A plan of care must be submitted to the Claim Administrator prior to providing services.

2. Hospice services must be Prior Authorized before services are provided.

3. Volunteer services are not a Covered Benefit.

Section XXXVI: Nutrition Services

BCBSMT administers claims for nutrition services that are Covered Benefits. Participating Providers may contact BCBSMT at 1-855-313-8914.

The HMK Coverage Group will cover nutrition counseling directly with Members or with Members' parents or guardians for treatment of diabetes and obesity.

Nutritional supplements for treatment of metabolic disorders are covered under the HMK DMEPOS benefit (See Section XXXIII).

Section XXXVII: Mobile Crisis

Conduent administers claims for Mobile Crisis Response services that are Covered Benefits. Participating Providers may contact Conduent at 1-800-362-8312. Prior Authorization is not required.

The medical necessity criteria for Mobile Crisis services is as follows:

1. The member must be experiencing a behavioral health crisis that is unable to be resolved by phone triage or phone triage was not available.
2. Rapid intervention is needed to attempt to stabilize the member's condition safely.
3. The member requires the following to diffuse the crisis:
    a. psychotherapy;
    b. mobilization of resources to defuse the crisis and restore safety; or
    c. provision of psychotherapeutic intervention to minimize emotional trauma.

To find out more regarding provider and services requirements for the tiered model, please refer to the Behavioral Health and Developmental Disabilities Division Policy for Mobile Crisis Response Services at BHDD Manuals Page (mt.gov).

Section XXXVIII: Fertility Preservation Services

BCBSMT administers claims for fertility preservation services. Fertility preservation services are available to HMK eligible individuals who are:

1. Diagnosed by a physician as having an active cancer diagnosis requiring treatment that may cause a substantial risk of sterility or infertility; and
2. between the ages of 12 and 19.

HMK members will be eligible to receive services involving collection of eggs and sperm consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine or the American Society of Clinical Oncology. Fertility preservation services do not cover storage of eggs and sperm.

Section XXXIX: Other Services

BCBSMT is the Claims Administrator for Covered Benefits listed below. Participating Providers may contact BCBSMT at 1-855-313-8914.

1. Blood transfusions, including cost of blood, blood plasma, blood plasma expanders, and packed cells. Storage charges for blood are covered when Members have blood drawn and stored for their own use for a planned surgery.

2. Medically Necessary nutrition formula for Medically Necessary treatment of conditions in addition to inborn errors of metabolism.

3. Licensed professional medical services provided under the supervision of a Physician for inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage includes the diagnosis, monitoring, and control of the disorder by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

4. Supplies used outside of a Hospital are covered ONLY if the supplies are prescribed by a Participating Provider and Medically Necessary to treat a condition that is covered by the HMK Coverage Group.

ARTICLE SIX– GENERAL EXCLUSIONS AND LIMITATIONS

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

1. Any services, supplies, drugs, and devices, which are:

a. Not Medically Necessary to treat active Illness or injury;
b. Not an accepted medical practice. (The HMK Coverage Group may consult with the Physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice);
c. Not a covered service;
d. An Investigational/Experimental/Unproven Service or Clinical Trial; and/or
e. Not provided in the appropriate setting.

2. Worker's Compensation: All services and supplies which would be provided to treat Illness or injury arising out of employment when Members' employers are required by law to obtain coverage or have elected to be covered under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This Exclusion applies to all services and supplies provided to treat such Illness or injury even though:

   a. Coverage under the employment related government legislation provides Benefits for only a portion of the services incurred.
   b. Members' employers have failed to obtain such coverage as required by law.
   c. Members have waived their rights to such coverage or Benefits.
   d. Members fail to file claims within the filing period allowed by law for such Benefits.
   e. Members fail to comply with any other provision of the law to obtain such coverage or Benefits.
   f. Members have elected to not be covered by the Workers' Compensation Act but failed to properly make such election effective.

   This Exclusion will not apply if Members are permitted by statute to not be covered and they effectively elect not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws (example: Independent Contractor holding a valid Independent Contractor Exemption Certificate).

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

3. Other government services and supplies: Services and supplies that are paid for by the United States or any city, county, or state. This Exclusion applies to any programs of any agency or department of any government.

   Note: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to Members from the HMK Coverage Group. An example of this would be vaccines administered to HMK Members by a county health Provider. When such a circumstance occurs, Members will receive an Explanation of Benefits.

4. Comprehensive school and community treatment (CSCT) services.

5. Third Party Automobile Liability. Services, supplies, and medications provided to treat any injury to the extent the Member receives, or would be entitled to receive, Benefits under an automobile insurance policy. **Note:** Any services, supplies and medications provided by the HMK Coverage Group to treat the Members for Accident related injuries which may be covered by third party liability are subject to the lien and subrogation rights of the State of Montana.

6. Third-Party Premises Liability: Services, supplies, and medications provided to treat any injury to the extent Members receive, or would be entitled to receive Benefits from a premises liability policy. Examples of such policies are a homeowners or business liability policy. **Note:** Any services, supplies and medications provided by the HMK Coverage Group to treat Members for Accident

related injuries which may be covered by third party liability are subject to the lien and subrogation rights of the State of Montana.

7. Injury or Illness resulting from war, declared or undeclared, insurrection, rebellion, or armed invasion.

8. Benefits for Members incarcerated in a criminal justice institution except for those receiving pre-release screening, diagnostic and case management services. Members are excluded from coverage only if they meet the definition of an inmate of a public institution as defined at 42 CFR 435.1009.

9. Any loss for which a contributing cause was commission by Members of criminal acts, or attempts by Members to commit felonies, or engaging in an illegal occupation.

10. Treatment for Temporomandibular Joint Dysfunction (TMJ).

11. Services and supplies related to ridge augmentation or vestibuloplasty.

12. Dental Services except as specifically included in this EOC.

13. Visual augmentation services including:
    a. Contact lenses; or
    b. Radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism).

    See Article Five, Section XVI: Vision Benefits and Medical Eye Care for important information on vision Benefits, including eyeglasses, provided by the HMK Coverage Group.

14. Service animals, including purchase, training, and maintenance costs.

15. Services or supplies related to cosmetic surgery, except as specifically included in this EOC.

16. Any drugs or supplies used for cosmetic purposes or cosmetic treatment.

17. Any additional charge for any service or procedure which is determined by the Claim Administrator to be an Inclusive Service/Procedure.

18. Private duty nursing.

19. Services for which Members are not legally required to pay or charges that are made only because Benefits are available under this EOC.

20. Any services or supplies related to in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, and fertility enhancing treatment – except for services provided under fertility preservation in the covered benefits section.

21. Sterilization or the reversal of an elective sterilization.

22. Abortion (except an abortion which is Medically Necessary to save the life of the mother or to terminate a pregnancy which is the result of rape or incest).

23. Foot care including but not limited to:
    a. Routine foot care;
    b. Treatment or removal of corns or callosities;
    c. Hypertrophy, hyperplasia of the skin or subcutaneous tissues; and/or
    d. Cutting or trimming of nails.

24. Services provided for Members before their Effective Date of coverage or after Members' coverage terminates.

25. Services or supplies relating to any of the following treatments or related procedures:

    a. Acupuncture;
    b. Acupressure;
    c. Biofeedback and Neurofeedback;
    d. Naturopathy and naturopathic physician services;
    e. Homeopathy;
    f. Hypnosis;
    g. Hypnotherapy;
    h. Rolfing;
    i. Holistic medicine;
    j. Marriage counseling;
    k. Religious counseling;
    l. Self-help programs; and
    m. Stress management;

26. Any services or supplies not furnished in treatment of an actual Illness or injury such as, but not limited to, insurance physicals and premarital physicals. Note: Well-child checkups, immunizations, and sport or employment physicals are covered.

27. Sanitarium care, custodial care, rest cures, or convalescent care to help Members with daily living tasks. Examples of such care would include, but are not limited to:

    a. Walking;
    b. Getting in and out of bed;
    c. Bathing;
    d. Dressing;
    e. Feeding;
    f. Using the toilet;
    g. Preparing special diets; and
    h. Supervision of medication which:
        1. Is usually self-administered; and
        2. Does not require the continuous attention of medical personnel.

    No payment will be made for admissions or parts of admissions to a Hospital, skilled nursing facility, rest home, nursing home, rehabilitation facility, convalescent home or extended care facility for the types of care outlined in this Exclusion.

28. Supplements.

29. Food supplements (except for those for inborn errors of metabolism and medical conditions where such supplements are Medically Necessary).

30. All invasive medical procedures undertaken for the purpose of weight reduction such as gastric bypass, gastric banding or bariatric surgery (including all revisions).

31. Charges associated with health or weight loss clubs, or clinics.

32. Benefits shall not be paid for services or items provided by an entity, institute, or Provider located outside of the United States.

33. Education or tutoring services, except as specifically included as a Benefit of this EOC.

34. Any services or supplies not provided by a Participating Provider or that were provided by a Non-Participating Provider following referral from a Participating Provider, but for which Prior Authorization was not obtained before the services were received.

35. Services and supplies primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature.

36. Any services and supplies which are not listed as a Benefit of this EOC.

ARTICLE SEVEN – CLAIMS FOR BENEFITS

Section I: Claims Processing

MEDICAL AND BEHAVIORAL HEALTH
In order to have Member Benefit claims processed through the HMK Coverage Group, Members' Participating Providers must submit all claims for services no later than 12 months after the date on which Members received the services. All claims must give enough information about the services for the Claim Administrator to determine whether they are covered under the EOC. The HMK Provider must submit all non-Pharmacy claims to the address listed on the back of Members' ID cards. Claims for ABA, ambulance, dental, DMEPOS, eyeglasses, FQHCs, pharmacies, RHCs, must be submitted to Conduent, PO Box 8000, Helena, MT 59604.

Section II: Prior Authorization

MEDICAL AND BEHAVIORAL HEALTH CLAIMS
Prior Authorization is required in order to receive some Benefits provided under this EOC. Listed Covered Benefits in this EOC that require Prior Authorization are noted under each Covered Benefit. The appropriate Claim Administrator is identified for claim processing purposes under each Covered Benefit. A request for Prior Authorization must be submitted for consideration to the Claim Administrator in the following manner:

1. A written request for Prior Authorization must be submitted to the applicable Claim Administrator in writing by the Participating Provider.

2. The written request should explain the proposed services being sought, the functional aspects of the service and why it is being done.

3. Any additional documentation such as study molds, x-rays, or photographs necessary for a determination should be mailed to the attention of the applicable Claim Administrator at the address listed on the back cover of this document. HMK Member's names, addresses, and Member numbers must be included.

The applicable Claim Administrator will review the request and all necessary supporting documentation to determine if the services are Medically Necessary. The decision will be made in accordance with the terms of this EOC. In no event shall a coverage determination be made more than 14 days following receipt of all documents.

A request for Prior Authorization does not guarantee that Benefits are payable.

Section III: Payment for Professional and Hospital Services

1. Payment for services Members receive from Participating Providers will be made by the Claim Administrator directly to the Provider.

2. No payment can be made by the Claim Administrator to the following:

a. Members, even if the payment is requested for reimbursement for services Members paid directly to a Provider or Hospital. Reimbursement may be made to Members for transportation services according to the provision of this EOC.
b. Members and Providers jointly.
c. Any person, firm, or corporation who paid for the services on Members' behalf.

3. Non-Participating Providers may refuse payment for a covered service under the HMK Coverage Group. In the event a Non-Participating Provider does refuse to accept payment for a covered service under the HMK Coverage Group, the expenses will be the responsibility of Members.

4. Benefits payable under this EOC are not assignable by Members to any third party.

ARTICLE EIGHT – COMPLAINTS, APPEALS AND CONFIDENTIAL INFORMATION

Section I: Complaints

HMK Members and Participating Providers may report verbal or written Complaints to the applicable Claim Administrator and/or Department about any aspect of service delivery provided or paid for by the HMK Coverage Group Call BCBSMT at 1-855-258-3489. Call Conduent at 1-800-624-3958. Call DPHHS at 1-406-444-4455

Section II: Appeals

MEDICAL AND BEHAVIORAL HEALTH

1. First Level Appeal:
If Members or Participating Providers do not agree with a denial or partial denial of a claim, Members or Participating Providers have 180 days from receipt of the denial to appeal the decision on the claim. Members or Participating Providers must write to BCBSMT and ask for a review of the claim denial. BCBSMT will acknowledge Members' or Participating Providers' requests for appeals within 10 days of receipt of requests. To file a written appeal, Members or Participating Providers must state their issue and ask for a review of the denied claim and send it to:

HMK Customer Service Department
Blue Cross and Blue Shield of Montana
P.O. Box 660255
Dallas, TX 75266-0255

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

2. Second Level Appeal:
If Members or Participating Providers do not agree with the First Level determination, Members or Participating Providers may fax their Second Level appeal request to 1-406-444-6565 within 90 days of receiving the First Level determination or mail it to the address below:

Office of Administrative Hearings
Montana Department of Public Health and Human Services
P.O. Box 202922
Helena, MT 59620-2953

The Office of Administrative Hearings will contact Members or Participating Providers to conduct an impartial administrative hearing. The Hearing Officer will research statutes, rules, regulations,

policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, they issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district court.

ABA, AMBULANCE, PHARMACY, DENTAL, DMEPOS, EYEGLASSES, HEARING AIDS, FQHC, RHC

1. First Level Appeal:
   If Members or Participating Providers do not agree with a denial or partial denial of a claim, Members must appeal within 90 days, and Participating Providers must appeal within 30 days, from receipt of the denial. To request an Administrative Review, the request must be in writing, must state in detail all objections, and must include any substantiating documents and information which Members or Participating Providers wish the Department to consider in the Administrative Review. The request must be mailed or delivered to:

   Montana DPHHS
   111 N. Sanders
   PO Box 4210
   Helena, MT 59620-4210

   Once the Administrative Review has been completed Members or Participating Providers will receive a letter outlining the Department's decision. Members or Participating Providers may choose to make a Second Level Appeal with the Department of Public Health and Human Services Office of Administrative Hearings.

2. Second Level Appeal:
   If Members or Participating Providers do not agree with the First Level determination, Members may fax their Second Level appeal requests to 1-406-444-6565 within 60 days of receiving the First Level determination, and Participating Providers within 30 days of receiving the First Level determination, or mail it to the address below:

   Office of Administrative Hearings
   Montana Department of Public Health and Human Services
   P.O. Box 202922
   Helena, MT 59620-2922

,

   The Office of Administrative Hearings will contact Members or Participating Providers to conduct an impartial hearing. The Hearing Officer will research statutes, rules, regulations, policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, they issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district court.

Section III: Confidential Information and Records

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

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

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

2. Release of medically related information -- Members accept this EOC under the following conditions:

    a. Members authorize all Providers of healthcare services or supplies, including medical, Hospital, Dental, and vision, to furnish to the HMK Coverage Group any medically related information pertaining to any Illness, injury, service, or supply for which Benefits are claimed under this EOC for the purposes of Benefit determination.

    b. Members waive all provisions of law which otherwise restrict or prohibit Providers of healthcare services or supplies, including medical, Hospital, Dental, and/or vision, from disclosing or testifying such information.

ARTICLE NINE – BLUECARD® PROGRAM

Section I: Out-of-Area Services

BCBSMT has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Member obtains healthcare services outside of the BCBSMT service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

Typically, when accessing care outside the BCBSMT service area, the Member will obtain care from healthcare Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, the Member may obtain care from non-participating healthcare Providers. BCBSMT payment practices in both instances are described below.

Section II: BlueCard® Program

Under the BlueCard® Program, when a Member incurs Covered Medical Expenses within the geographic area served by a Host Blue, BCBSMT will remain responsible for fulfilling BCBSMT's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever the Member incurs Covered Medical Expenses outside the BCBSMT service area and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Medical Expenses is calculated based on the lower of:

- The billed covered charges for the Member's covered services; or
- The negotiated price that the Host Blue makes available to BCBSMT.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSMT uses for the Member's claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the Member's calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSMT would then calculate the Member's liability for any Covered Medical Expenses according to applicable law.

Non-Participating Healthcare Providers Outside of the BCBSMT Service Area

Member Liability Calculation

When the Member incurs Covered Medical Expenses outside of the BCBSMT service area for services provided by non-participating healthcare Providers, the amount the Member pays for such services will generally be based on either the Host Blue's non-participating healthcare Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the non-participating healthcare Provider bills and the payment BCBSMT will make for the covered services as set forth in this paragraph.

Exceptions

In certain situations, BCBSMT may use other payment bases, such as billed covered charges, the payment BCBSMT would make if the healthcare services had been obtained within the BCBSMT service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount BCBSMT will pay for services rendered by non-participating healthcare Providers. In these situations, the Member may be liable for the difference between the amount that the non-participating healthcare Provider bills and the payment BCBSMT will make for the covered services as set forth in this paragraph.

ARTICLE TEN – EVIDENCE OF COVERAGE (EOC) – GENERAL PROVISIONS

Section I: Department Powers and Duties

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

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

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

Section II: Entire Evidence of Coverage (EOC); Changes

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

Section III: Modification of Evidence of Coverage (EOC)

The Department may modify this EOC through the administrative rulemaking process and amendment of ARM 37.79.304, the administrative rule that incorporates this document by reference.

Section IV: Clerical Errors

No clerical error on the part of the Claim Administrator shall operate to defeat any of the rights, privileges, or Benefits of any Member covered under this EOC. Upon discovery of errors or delays, an equitable adjustment of charges and Benefits may be made. Clerical errors shall not prevent administration of this EOC in strict accordance with its terms.

Section V: Notices Under Evidence of Coverage (EOC)

Any notice required by this EOC shall be in writing and may be given by United States mail, postage paid. Notice to the Member will be mailed to the address appearing on the records of the Claim Administrator. Notice to the medical and Behavioral Health Claim Administrator should be sent to BCBSMT at the address listed on the back cover of this document. Notices to the Pharmacy, Dental, DMEPOS, Vision, FQHC, and RHC Claim Administrator should be sent to Conduent at PO Box 8000, Helena MT 59604. Notices are effective on the date mailed.

Section VI: Benefits Not Transferable

No person, other than Members, are entitled to the Benefits identified under this EOC. This means that Members are not allowed to transfer or assign their coverage under the HMK Coverage Group to another person.

Section VII: Validity of Evidence of Coverage (EOC)

If any part, term, or provision of this EOC is held by the courts to be illegal or in conflict with any law, the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the EOC did not contain the particular part, term, or provision held to be invalid.

Section VIII: Execution of Papers

Members agree to execute and deliver any documents requested by the Department which are Necessary to administer the terms of this EOC.

Section IX: Members' Rights

Members have no rights or privileges except as specifically provided in the EOC.

Section X: Alternate Care

The HMK Coverage Group may, at its sole discretion, make payment for medical, vision or Dental services which are not listed as a Benefit of this EOC. Such payments may be made only when it is determined by the Department that it is in the best interest of the HMK Coverage Group and/or Members to make payment for alternate care.

Section XI: Civil Rights Protection for Children

Children enrolled in the HMK Coverage Group have a right to:

1. Equal Access to Services without regard to race, color, national origin, disability, age, or sexual orientation;
2. A bilingual interpreter, where necessary for effective communication;
3. Auxiliary aids to accommodate a disability; and
4. File a Complaint if the Member believes they were treated in a discriminatory fashion.

If Members need additional information regarding these protections, please contact:

Office of Civil Rights
Departments of Health & Human Services
Federal Office Building, Room 1426
1961 Stout Street
Denver, CO 80294
Telephone: (303) 844-2024
FAX: (303) 844-2025
TDD: (303) 844-3439

Section XII: Statement of Representations

Any HMK Member who, with intent to defraud or knowing that he or she is facilitating a fraud against the Department, submits an application or files a claim containing a false, incomplete, or misleading statement is guilty of fraud. Any HMK Member who submits bad faith claims, or facilitates bad faith claims to be submitted, misrepresents facts or attempts to perpetrate a fraud upon the Department may be subject to criminal charge or a civil action brought by the Department or the HMK Coverage Group as permitted under State or Federal laws. The Department reserves the right to take appropriate action in any instance where fraud is at issue.

Section XIII: Recovery, Reimbursement, and Subrogation

By enrollment in the HMK Coverage Group, Members agree to the provisions of this section as a condition precedent to receiving Benefits under the HMK Coverage Group.

1. Right to Recover Benefits Paid in Error. If a payment in excess of the HMK Coverage Group Benefits is made in error on behalf of Members to which Members are not entitled, or if a claim for a non-covered service is paid, the Claim Administrator has the right to recover the payment from any one or more of the following:

   a. any person such payments were made to, for, or on behalf of Members;
   b. any insurance company; and
   c. any other individuals or entities that received payment on behalf of Members.

   By receipt of Benefits by Members under the HMK Coverage Group, Members authorize the recovery of amounts paid in error.

   The amount of Benefits paid in error may be recovered by any method that the Claim Administrator, in its sole discretion, will determine is appropriate.

2. Reimbursement. The HMK Coverage Group's right to reimbursement is separate from and in addition to the HMK Coverage Group's right of subrogation. Reimbursement means to repay a party who has paid something on another's behalf, generally under Third Party Liability. If the HMK Coverage Group pays Benefits for medical expenses on Members' behalf, and another party was actually responsible or liable to pay those medical expenses, the HMK Coverage Group has the right to be reimbursed.

   Accordingly, if Members settle, are reimbursed, or recover money by or on behalf of Members, from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage,

underinsured coverage, or other insurance policies or funds for any Accident, injury, condition, or Illness for which Benefits were provided by the HMK Coverage Group, Members agree to reimburse the HMK Coverage Group for the Benefits paid on behalf of Members. The HMK Coverage Group shall be reimbursed, in first priority, from any money recovered from a liable third party, as a result of said Accident, injury, condition, or Illness. Reimbursement to the HMK Coverage Group will be paid first, even if Members are not paid for all damage claims and regardless of whether the settlement, judgment or payment received is for or specifically designates the recovery, or a portion thereof, as including healthcare, medical, disability, or other expenses or damages.

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

   Members agree to subrogate to the HMK Coverage Group any and all claims, causes of action, or rights that Members have or that may arise against any entity who has or may have caused, contributed to, or aggravated the Accident, injury, condition, or Illness for which the HMK Coverage Group has paid Benefits, and to subrogate any claims, causes of action, or rights Members may have against any other coverage, including but not limited to liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

   In the event Members decide not to pursue a claim against any third party or insurer, by or on behalf of Members, Members will notify the HMK Coverage Group, and specifically authorize the HMK Coverage Group in its sole discretion, to sue for, compromise, or settle any such claims in Members' names, to cooperate fully with the HMK Coverage Group in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

4. The Following Paragraphs Apply to Both Reimbursement and Subrogation

   a. Under the terms of the HMK Coverage Group, the Department **is not** required to pay any claims where there is evidence of liability of a third party. However, the HMK Coverage Group, in its discretion, may instruct the Claim Administrator to pay Benefits while the liability of a party other than the Member is being legally determined.

   b. If the HMK Coverage Group makes payments which Members, or any other party on Members' behalf, is or may be entitled to recover against any third party responsible for an Accident, injury, condition or Illness, the HMK Coverage Group has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment. Members or someone acting on behalf of Members will execute and deliver instruments and papers and do whatever else is necessary to secure and preserve the HMK Coverage Group's right of recovery.

   c. Members will cooperate fully with the Department, its agents, attorneys, and assigns, regarding the recovery of any monies paid by the HMK Coverage Group from any party other than Members who are liable. This cooperation includes, but is not limited to, providing full and complete disclosure and information to the Department, upon request and in a timely manner, of all material facts regarding the Accident, injury, condition, or Illness; all efforts by any person to recover any such monies; provide the Department with any and all documents, papers, reports, and the like regarding demands, litigation or settlements involving recovery of monies paid by the

HMK Coverage Group; and notifying the Department of the amount and source of any monies received from third parties as compensation or damages for any event from which the HMK Coverage Group may have a reimbursement or subrogation claim.

d. Members will respond within ten (10) days to all inquiries of the Department regarding the status of any claim Members may have against any third parties or insurers, including but not limited to, liability, no-fault, uninsured and underinsured insurance coverage.

e. Members will notify the Department of the name and address of any attorney engaged to pursue any personal injury claim on behalf of Members.

f. Members will not act, fail to act, or engage in any conduct directly, indirectly, personally, or through third parties, either before or after payment by the HMK Coverage Group, the result of which may prejudice or interfere with the HMK Coverage Group's rights to recovery hereunder. Members will not conceal or attempt to conceal the fact that recovery occurred or will occur.

g. The HMK Coverage Group will not pay or be responsible, without its written consent, for any fees or costs associated with Members pursuing claims against any third party or coverage, including, but not limited to, attorney fees or costs of litigation.

h. Monies paid by the HMK Coverage Group will be repaid in first priority, notwithstanding any anti-subrogation, "made whole," "common fund," or similar statute, regulation, prior court decision, or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

Section XIV Relationship Between HMK Coverage Group and Professional Providers

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

Under the laws of Montana, the Claim Administrator cannot be licensed to practice medicine or surgery, and the Claim Administrator does not assume to do so.

Neither the Department nor the Claim Administrator are responsible or liable for the negligence, wrongful acts, or omissions of any Participating Provider, employee, or Member providing or receiving services. Neither the HMK Coverage Group nor the Claim Administrator is liable for services or facilities which are not available to Members for any reason.

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

Section XV: When Members Move Out of State

If Members move from Montana, they will no longer be eligible for coverage under the HMK Coverage Group. Members will be responsible for any services received from out-of-state medical Providers. Returned mail with out-of-state forwarding addresses shall be considered conclusive evidence that Members have moved out of state and Members will be disenrolled from the HMK Coverage Group.

Section XVI: Authority of the Department

The Department has the authority to interpret uncertain terms and to determine all questions arising in the administration, interpretation, and application of the HMK Coverage Group, giving full consideration to all

evidence reasonably available to it. All such determinations are final, conclusive, and binding except to the extent they are appealed under the claims procedure.

Section XVII: BCBSMT is an Independent Corporation

BCBSMT is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting BCBSMT to use the Blue Cross and Blue Shield Service Mark in the state of Montana, and that BCBSMT is not contracting as the agent of the Association.

The Member further acknowledges and agrees that the Member has not entered into this EOC based upon representations by any person other than BCBSMT and that no person, entity, or organization other than BCBSMT shall be held accountable or liable to the Member for any of BCBSMT's obligations to the Member created under this EOC. This paragraph shall not create any additional obligations whatsoever on the part of BCBSMT other than those obligations created under other provisions of this EOC**.**

Section XVIII: Conduent is the Fiscal Agent for the Department

Conduent is the Fiscal Agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.