2025 INDIVIDUAL HEALTH INSURANCE POLICY

THIS POLICY IS NOT A MEDICARE POLICY: If you are eligible for Medicare, contact our office directly or review plans on our website: https://mountainhealth.coop/med-supp/

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INDIVIDUAL HEALTH INSURANCE POLICY

In this Policy, the Policyholder is referred to as "You" or "Your". The Montana Health Cooperative, doing business as Mountain Health Cooperative is referred to as "We", "Us", "Our", "the Company", "the Plan", "Mountain Health Co-op", "MHC", or "the Co-Op".

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

We will pay the covered Medical Expenses for Covered Benefits as set forth in this Policy after the Effective Date of this Policy and before the Policy terminated conditioned upon the following: (1) All statements made in the application or statement of health are true and accurate; (2) We receive timely premium payments. Payment of premiums is a condition precedent to coverage in accordance with the Termination of Insurance and Grace Period under this Policy.

Benefit payment is governed by all the terms, conditions, and limitations of this Policy. This Policy is effective on the Policy Effective Date shown in the Summary of Benefits and Coverage (SBC) at 11:59:59 pm local time at Your plan of residence. This Policy is issued in consideration of the application for this Policy and payment of initial premium.

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

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

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

Signed for Mountain Health Co-op

Blair Fjeseth, Chief Executive Officer

IMPORTANT NOTICE

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

IMPORTANT INFORMATION

Mountain Health Co-op is pleased to provide you with this Policy for a Members. This policy provides a Provider Network through which Members may obtain medical care and services while maximizing your Covered Benefit. However, a Member also may elect to receive services from an Out-of-Network Provider. When a Member receives services from an In-Network Provider, generally benefits will be payable at a higher level. When services are provided by an Out-of-Network Provider, generally, benefits are payable at a lower level. You can obtain a list of the In-Network provider directory on the Mountain Health Co-op website at https://mountainhealth.coop/.

IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS INSURANCE DUPLICATED SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

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

This insurance duplicates Medicare benefits when the benefits stated in the Policy and coverage for the same event is provided by Medicare.

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

Hospitalization
Physician services
Outpatient prescription drugs if you are enrollment in Medicare Part D
Other approved items and services

POLICY AND CUSTOMER SERVICES

Mountain Health Co-op and our approved delegates administer the following services for this policy. Contact Customer Service regarding these services:

- Benefit Inquiries
- Claims and Customer Service
- Complaints, Grievances, and Appeals
- Preauthorization
- Utilization Review Management Program
- Complex Care Management
- Population Health Management
- Prescription Drug Benefit Program

CONTACT CUSTOMER SERVICE:

- Customer Service Phone Number: (800) 299-6080
- Address: Mountain Health Co-op
- PO Box 30311
- Salt Lake City, UT 84130

Claims Submission: Mountain Health Co-op

- PO Box 30311
- Salt Lake City, UT 84130

Complaints, Grievances and Appeals: Mountain Health Co-op

- PO Box 30311
- Salt Lake City, UT 84130

OTHER IMPORTANT CONTACT INFORMATION

- Montana Commissioner of Securities and Insurance
- 840 Helena Ave, Helena, MT 59601 | 800-332-6148 | 406-444-2040

CONTACT MOUNTAIN HEALTH CO-OP

- Phone Number: 800-299-6080
- Address: Mountain Health Co-op

  PO Box 5338, Helena MT 59604

  or

  810 Hileah Street Helena, MT 59601

IMPORTANT NOTICES

MEMBERS RIGHTS AND RESPONSIBILITIES STATEMENT

A Member has the right to:

I. Members have the right to receive information about their health plan, its practitioners and providers, and members' rights and responsibilities.
II. Members have the right to courteous treatment. We respect your right to:

    I. Be treated with respect and recognition of your dignity. We will not discriminate in the care offered to you based on race, religion, national origin, sex, age, sexual preference, type of illness, or financial status.
    II. Be addressed in a manner that is comfortable to you.
    III. Know your health care providers. You have the right to ask all personnel involved in your care to introduce themselves, state their position, and explain what they are going to do for you.
III. Members have the right to available and accessible services, including emergency services. Responsibility for payment for such services will be determined by Your coverage.
IV. Members have the right to privacy.
V. Members have the right to a candid discussion of appropriate or medically-necessary treatment options for their conditions, regardless of cost or benefit coverage.
VI. Members have the right to be informed about their health care and to receive information about proposed treatments and alternatives. Members have the right to an explanation from health care providers of:
    I. Diagnosis
    II. Recommended treatment and alternatives to treatment
    III. Potential outcomes and/or prognosis
    IV. Significant benefits and risks of each alternative
VII. Members have the right to participate with providers in making decisions about their care. These rights generally include:
    I. Giving informed consent. i.e. agreeing to treatment based on a full explanation of your disease and the risks and benefits or proposed treatment, as well as alternative treatments.
    II. Refusing diagnostic procedures or treatment. It is your right to decide whether you wish to be treated, and if so, by which method of treatment.
VIII. Members have the right to appropriate confidentiality of all medical and financial records in accordance with state and federal law. Generally, your medical records will not be released to persons outside your health plan unless you grant permission in writing, or we are required or permitted, under applicable law, to use or release this information. Certain examples of permitted releases of information are:
    I. If required by a court order
    II. To medical personnel in a medical emergency
    III. As necessary to facilitate complaint Investigations or inspections by federal or state entities
    IV. To qualified personnel for research, audit or program evaluation, as long as individuals cannot be identified
IX. Members have a right to voice complaints or appeals about their health plan or the care provided.
X. Members have the right to make recommendations regarding the plan's member rights and responsibilities.

A Member has the responsibility to:

I. Members have the responsibility to understand their health problems and to participate in developing mutually agreed upon treatment goals to the greatest degree possible. Once members and their health care provider(s) have agreed upon a treatment plan, it is the member's

responsibility to follow the prescribed plan and instructions for care. Advise the health care provider treating you if you are unable to follow a treatment plan.

II. Members have the responsibility to make informed decisions. Because you are responsible for the decisions you make about your care, we encourage you to gather as much information as you need to make your decisions.

III. Members have the responsibility to be honest and to provide, to the extent possible, information that the health plan needs to administer plan benefits and its providers need to provide care. Provide an accurate and complete medical history.

IV. Members have the responsibility to report changes in their health. Tell your doctor about any changes in your health.

V. Members have the responsibility to know their providers. Try to know the names and the positions of everyone who cares for you (doctors, dentists, nurses, etc.).

MEMBER INFORMATION

In this Policy the following terms have the meanings indicated: "Member" means the Policyowner of this Policy. "Organization" means the CO-OP.

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

I. Benefits and services included in, and excluded from, coverage.

II. Pharmaceutical management procedures if they exist.

III. Copayments and other charges for which Members are responsible.

IV. Benefit restrictions that apply to services obtained outside the organization's system or service area.

V. How to obtain language assistance.

VI. How to submit a claim for covered services, if applicable.

VII. How to obtain information about practitioners who participate in the organization.

VIII. How to obtain primary care services, including points of access.

IX. How to obtain specialty care and behavioral healthcare services and hospital services.

X. How to obtain care after normal office hours.

XI. How to obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services.

XII. How to obtain care and coverage when subscribers are out of the organization's service area.

XIII. How to voice a complaint.

XIV. How to appeal a decision that adversely affects coverage, benefits or a Member's relationship with the organization.

XV. How the organization evaluates new technology for inclusion as a covered benefit.

SECTION 1 – DEFINITIONS

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

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

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

Affordable Care Act means the federal Patient Protection and Affordable Care Act (PPACA) that was signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act that was signed into law on March 30, 2010.

Allowable Fee/Allowable Amount means the maximum amount on which payment is based for covered health services for both In-Network and Out-of-Network Providers. The allowable fee will be based on but not limited to one or more of the following:

I. Medicare Resource-Based Relative Value Scale (RBRVS) is a system established by Medicare to pay physicians for a "work unit." The RBRVS value is determined by multiplying a "relative value" of the service by a "converter" to determine the value for a certain procedure.
II. Diagnosis-related group (DRG) methodology is a system used to classify hospital cases into groups that are expected to have similar hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range.
III. Provider's billed charge or a discount from the Provider's billed charge.
IV. Case rate methodology which provides an all-inclusive rate for an episode of care.
V. Per diem methodology which provides an all-inclusive daily rate paid to a facility.
VI. Flat fee or a flat rate.
VII. Percentage of base Medicare reimbursement. The amount negotiated with the pharmacy benefit manager or manufacturer or the actual price for prescription or drugs.
VIII. The allowable fee may be adjusted based on value and quality performance innovation incentive settlement amounts
IX. For Out-of-Network providers the allowable fee is reduced by the Out-of-Network Provider Differential.
X. The Allowable Fee/Allowable Amount policy can be found at htpps://www.mountainhealth.coop

Annual Out-of-Pocket Maximum The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of Covered Benefits. The Annual Out-of-Pocket limit doesn't include your monthly premiums.

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

I. Calendar Year Deductible
II. Copayments; and
III. Coinsurance

Family Limit for the Annual Out-of-Pocket Maximum

The Family Annual Out-of-Pocket Maximum is reached when two or more family members, who are insured under this Policy, have incurred and paid deductibles, copays, and coinsurance equal to the amount listed in the Summary of Benefits and Coverage (SBC) for that specific plan. When the total out-of-pocket expense is reached within the Calendar Year of the effective policy, We then will pay 100% of Covered Medical Expenses incurred by all Family members for the remainder of the Calendar Year. The total of out-of-pocket medical expenses returns to zero at the end of the Calendar Year, and the accumulation would begin again for the new Calendar Year.

Calendar Year means the twelve (12) month period January 1 to December 31.

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

Copay or Copayment means a fixed dollar amount the Member is required to pay for specifically listed Covered Benefits as shown in the SBC. Copayments are generally paid to the Provider at time of service. Copayments apply towards the satisfaction of the Annual Out-of-Pocket Maximum.

Convalescent Home means an institution, or distinct part of such institution, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is:

I. Skilled Nursing Facility;
II. Extended Care Facility;
III. Extended Care Unit; or
IV. Transitional Care Unit.

A Convalescent Home will primarily be engaged in providing:

I. Continuous nursing care services;
II. Health-related services; and
III. Social services.

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

Covered Benefits/Covered Services means all Medically Necessary services, supplies, medications and devices covered under this Policy as provided under Section 5, Covered Benefits. Covered Benefits are payable as shown in the SBC.

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

Covered Medical Expense means expenses incurred for Medically Necessary Covered Benefits that are based on the Allowable Fee and:

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

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

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

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

Covered Providers include the following professional providers:

I. A Physician;
II. A Physician Assistant;
III. A Dentist;
IV. An Osteopath;
V. A Chiropractor;
VI. An Optometrist;
VII. A Podiatrist;
VIII. An Acupuncturist;
IX. A Naturopathic Physician;
X. A Licensed Social Worker;
XI. A Licensed Professional Counselor;
XII. A Physical Therapist or Occupational Therapist;
XIII. An Advanced Practice Registered Nurse;
XIV. A Nurse Specialist;
XV. A Registered Nurse First Assistant who performs surgical first assistant services;
XVI. Licensed Addiction Counselors,
XVII. Speech Therapists,
XVIII. Certified Registered Nurse Anesthetists;

XIX. Dieticians;
XX. Certified Nurse Midwives;
XXI. A Psychologist;
XXII. Audiologist;
XXIII. Licensed marriage and family therapist

Services provided by the professional provider must be within the scope of the Covered Provider's license or certification and appropriate for the care and treatment of the Member's Illness or Injury as provided by the Covered Benefits in this Policy. Members may choose any willing provider operating within the scope of their license. Services provided by a professional provider other than a Physician may require recommendation by a Physician. The professional provider may not be a member of the Member's Immediate Family.

Covered Providers include the following facility providers:

I. Hospitals;
II. Critical Access Hospitals;
III. Freestanding Surgical Facilities;
IV. Ancillary Care Facilities.

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

Critical Access Hospital means a facility that is located in a rural area, as defined in 42 U.S.C. 1395 ww(d)(2)(D), and that has been designated by the Department of Public Health and Human Services (HHS) or the Centers for Medicare and Medicaid Services (CMS) as a Critical Access Hospital pursuant to State and Federal law. Services will be provided in a Critical Access Hospital on the same basis as a "Hospital" as defined in this Policy.

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

Deductible means the amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services.

The Deductible is shown in the SBC. The following do not apply towards satisfaction of the Deductible:

I. Services, treatments or supplies that are not covered under this Policy;
II. Copay amounts paid by the Member;
III. The premium payments paid by the Member; and
IV. Amounts billed by Out-of-Network provider above the Allowable Fee.

Family Deductible

The Family Deductible is an aggregate Deductible as is shown in the SBC. The Family Deductible must be satisfied by two of more family members, who are insured under this Policy, during the calendar year the policy is in force. Once the Family deductible is met for the Calendar Year, no further payments toward the Family Deductible from Family members will be required for the remainder of that Calendar Year.

Dependent means Your:

I. Spouse or domestic partner; and
II. Dependent Child as defined in this Policy.

Dependent Child or Dependent Children means Your children who are:

I. Under age 26, regardless of their place of residence, marital status or student status; including: (a) newborn children; (b) stepchildren; (c) legally adopted children; (d) children placed for adoption with the Policyowner in accordance with applicable state or federal law; (e) foster children; and (f) children for whom You are a legal guardian substantiated by a court or administrative order; and
II. Unmarried dependent Handicapped Children age 26 and over. Refer to the definition of Handicapped Child.

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

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in Emergency Medical Treatment and Labor Act (EMTALA), including:

I. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
II. serious impairment to bodily functions, or
III. serious dysfunction of any bodily organ or part

This definition includes mental health conditions and substance use disorders.

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

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

Health Insurance Marketplace means:

I. a State-based Exchange;
II. a Federally Facilitated Exchange; or
III. an Exchange in partnership with the federal Department of Health and Human Services.

Holistic Medicine means a form of alternative and complementary medicine. Practitioners receive some level of training at holistic schools or courses. Accredited and licensed Medical Doctors occasionally will practice "Holistic

medicine". This approach to treatment uses a variety of herbal, spiritual, meditative, and other "natural" remedies and does not usually incorporate standard medical therapy in treatment of disease.

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

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

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

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

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

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

I. An Inpatient hospice facility, which is a facility managed directly by a Medicare certified hospice that meets all Medicare certification regulations for freestanding inpatient hospice facilities; and
II. A residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

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

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

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

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

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

I. A nursing home;
II. A rest home;
III. A hospice facility;
IV. A rehabilitation facility;
V. A skilled nursing facility;
VI. A Convalescent Home;
VII. A long-term, chronic care institution or facility providing the type of care listed above.

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

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

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

I. An Indian Health Service;
II. An Indian Tribe;
III. A Tribal Organization;
IV. An Urban Indian Organization; or
V. Services provided through referral under contract health services to Members who are Indians as defined in this Policy.

Indian Tribe means any Indian:

I. Tribe;
II. Band;
III. Nation; or
IV. Other organized group or community, including:
    I. Any Alaska Native village; or
    II. Any regional or village corporation;
    as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688; 43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

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

In-Network Provider means a Covered Provider who has a participation contract in effect with MHC's Network to provide services to Members under this Policy. The In-Network Provider's participation contract must be in effect

at the time services are provided for Covered Benefits in order for Covered Medical Expenses to be eligible for In-Network benefits.

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

I. Hospitals, including state designated Critical Access Hospitals;
II. Transitional care units;
III. Skilled nursing facilities;
IV. Convalescent homes; or
V. Freestanding inpatient facilities.

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

Investigational/Experimental Service/Technology means any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by Us, it fails to meet any one of the following criteria:

I. The service/technology has final approval from the appropriate government regulatory bodies;
II. Medical or scientific evidence regarding the service/technology is sufficiently comprehensive to permit well substantiated conclusions concerning the safety and effectiveness of the service/technology;
III. The service/technology's overall beneficial effects on health outweigh the overall harmful effects on health;

The service/technology is as beneficial as any established alternative; and
The service/technology must show improvement that is attainable outside the investigational setting improvements must be demonstrated when used under the usual conditions of medical practice.

When used under the usual conditions of medical practice, the service/technology should be reasonably expected to satisfy the criteria of Medical Necessity. For Members enrolled in approved clinical trials, preventative medical costs are covered under the plan. Approved clinical trials are phase I, phase II, phase III or phase IV clinical trials conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition and is one of the following:

I. A federally funded or approved trial;
II. A clinical trial conducted under an FDA investigational new drug application; and
III. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Medically Necessary or Medical Necessity means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, in a manner that is:

I. in accordance with generally accepted standards of medical practice in the United States;

II. clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury or disease;
III. not primarily for the convenience of the patient, physician, or other health care provider;
IV. not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results to the diagnosis, injury, disease, or symptoms; and

When a medical question-of-fact exists, medical necessity shall include the most appropriate available supply or level-of-service for the individual in question, considering potential benefits and harms to the individual, and known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence. For established interventions, the effectiveness shall be based on:

I. scientific evidence;
II. professional standards; and
III. expert opinion.

Medically Necessary for autism spectrum disorders is defined in the Autism Spectrum Benefit below or means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician or psychologist licensed in this state and that will or is reasonably expected to: (a) prevent the onset of an illness, condition, injury, or disability; (b) reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (c) assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

Medically Necessary for down syndrome is defined in the Down Syndrome Benefit below or means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician licensed in this state and that will or is reasonably expected to: (a) reduce or improve the physical, mental, or developmental effects of Down syndrome; or (b) assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of Physicians practicing in relevant clinical areas and any other relevant factors. We reserve the right to review medical care and/or treatment plans and may consult with Physicians or national medical specialty organizations for advice in determining whether services were Medically Necessary. The fact that services were recommended or performed by a Covered Provider does not make the services Medically Necessary or a Covered Expense.

Medical Policy means the policy and utilization review program guidelines used for this Policy. The policy and guidelines are used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

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

Out-of-Network Provider means a Covered Provider who does not have a participation contract in effect with the CO-OP In-Network Organization to provide services to Members under this Policy. When services are provided by an Out-of-Network Provider, the services provided are Out-of-Network and an Out-of-Network Provider Differential will be applied. Member will be subject to reduced benefits under the plan and will be subject to Balance Billing by the Out-of-Network Provider. In compliance with the federal No Suprises Act, when You receive Emergency Care Services or when You get treated by an Out-Of-Network Provider at an In-Network hospital, hospital outpatient department, Critical Access Hospital, or ambulatory surgical center, You are protected from surprise/balance billing. See "Surprise Billing" in this Policy for additional information.

To maximize your plan's benefits, always make sure your healthcare provider is an MHC In-Network Provider.

Out-of-Network Provider Differential means the percentage by which the Allowable Fee is reduced to determine the amount this Policy will pay for Covered Benefits provided by Out-of- Network Providers. @ In compliance with the federal No Suprises Act, when You receive Emergency Care Services or when You get treated by an Out-Of-Network Provider at an In-Network hospital, hospital outpatient department, Critical Access Hospital, or ambulatory surgical center, You are protected from surprise/balance billing. See "Surprise Billing" in this Policy for additional information and htpps://www.mountianhealth.coop

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

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

Physician Specialist means a Physician who:

I. has obtained advanced training in various areas of a medical specialty; and
II. is board-certified in that specialty. Physician Specialist includes but is not limited to:
    I. Anesthesiologists;
    II. Dermatologists;
    III. Ophthalmologists;
    IV. Orthopedic Surgeons;
    V. Psychiatrists;
    VI. Radiation Oncologist;
    VII. Surgeons.

Physician Specialist does not include:

I. Family Practice Physician;
II. Internal Medicine Physician;
III. Obstetrician; or
IV. Gynecologist.

Policy Effective Date or Effective Date means the date on which this Policy becomes effective. The Policy Effective Date is shown in the SBC.

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

Preauthorization/Prior Approval means a decision by Us that a service, treatment plan, prescription drug, or durable medical equipment is Medically Necessary. See Section 6 for more information.

QHDHP means a health savings account-Qualified High Deductible Health Plan as provided under section 223 of the federal Internal Revenue Code.

Qualified Payment Amount means the median of contracted rates for a specific service in the same geographic region within the same insurance market.

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

Summary of Benefits and Coverage (SBC) is a snapshot of Our Policy costs, benefits, covered health care services, and other features that are important to You. SBCs also explain Our Policy's unique features like cost sharing rules and include significant limits and exceptions to coverage.

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

Telehealth means the use of audio, video, or other telecommunications technology or media, including audio-only communication, that is: (A) used by a health care provider or health care facility to deliver health care services; and (B) delivered over a secure connection that complies with state and federal privacy laws. Telehealth does not include delivery of health care services by means of facsimile machines or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

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

I. Confinement, Inpatient or Outpatient services or procedures; and
II. Drugs, supplies, equipment, or devices.

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

SECTION 2—WHEN COVERAGE TAKES EFFECT AND TERMINATES

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

In general, an applicant may apply for or change coverage in a Policy during an annual open enrollment period or as a result of a special enrollment period. Special enrollment rights include but may not be limited to birth, adoption, marriage, divorce, legal separation, loss of minimum essential coverage, loss of coverage due to moving outside the service area, and any other event set out by applicable law. If coverage is allowed as a result of a special enrollment right, application must be made for coverage within sixty (60) days from the date of the special enrollment event. Coverage is contingent upon timely application and payment of the appropriate premium as establish by the Exchange and Us.

ELIGIBILITY FOR COVERAGE

POLICYOWNER

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

ELIGIBLE DEPENDENTS

Dependents who are eligible for insurance under this Policy are:

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

Continued Coverage for Handicapped Children

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

I. Incapable of self-sustaining employment by reason of intellectual disability or physical disability; and

II. Chiefly dependent upon You for support and maintenance.

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

WHEN COVERAGE BECOMES EFFECTIVE FOR YOUR DEPENDENTS

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

NEW ELIGIBLE DEPENDENTS

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

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

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

The effective date of coverage under this Policy for the new Eligible Dependent will be the first of the month following the date We receive notification and any due premium for the new Eligible Dependent's coverage, except as provided under the Enrollment Requirements for Newly Adopted and Newborn Children provision in this Section. Coverage will begin at 12:00 a.m. local time at Your place of residence. Montana Time, on the Eligible Dependent's effective date of coverage.

ENROLLMENT REQUIREMENTS FOR NEWLY ADOPTED AND NEWBORN CHILDREN

Adopted Child

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

I. Placement is disrupted prior to legal adoption; and
II. The child is removed from Placement.

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

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

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

Newborn Child

Coverage under this Policy will be provided for each newborn child of a Member from the moment of birth for thirty-one (31) days. You must give Us:

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

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

TERMINATION OF INSURANCE

POLICY TERMINATION BY THE COMPANY

This Policy will terminate at 11:59 p.m. local time at Your place of residence on the earliest of:

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

NONRENEWAL OR DISCONTINUANCE OF THIS POLICY BY THE COMPANY

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

I. You fail to pay premiums in accordance with the terms of this Policy or if We do not receive timely premium payments;
II. You have: (a) performed an act or practice that constitutes fraud; or (b) made an intentional misrepresentation of a material fact under the terms of this Policy;
III. We cease to offer coverage in the individual market in accordance with applicable Montana State law;
IV. You no longer live, reside, or work in:
    I. The service area of the In-Network Organization used under this Policy; or
    II. An area for where We are authorized to do business;

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

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

I. We give notice to each covered individual provided coverage of this Policy type in the individual market of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage, subject to Health Insurance Marketplace guidelines;
II. We offer to each individual in the individual market provided coverage of this Policy type the option to purchase any other individual health coverage currently being offered by Us to individuals in the individual market; and
III. In exercising the option to discontinue coverage of this Policy type and in offering the option of coverage under subparagraph 2 above, We act uniformly, without regard to:
IV. the claims experience of individuals; or
V. any health status-related factor of individuals who may become eligible for the coverage.

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

I. We provide notice of discontinuation to the Commissioner of Insurance and each covered individual at least 180 days prior to the date of the discontinuation of coverage; and
II. All health insurance issued or delivered for issuance in Montana in the individual market is discontinued; and
III. Coverage under the health insurance coverage in the individual market is not renewed. If We discontinue offering all health insurance coverage in the individual market as stated in the above paragraph, We will not provide for the issuance of any health insurance coverage in the individual market during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not renewed.

TERMINATION OF COVERED DEPENDENTS

A Covered Dependent's coverage will terminate at 11:59:59 p.m. at Your place of residence on the earliest of:

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

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

Termination of Coverage for Handicapped Child

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

I. The date the Dependent marries;
II. The date the Dependent obtains self-sustaining employment;
III. The date the Dependent ceases to be handicapped;

IV. The date the Dependent ceases to be dependent upon You for support and maintenance;
V. Sixty (60) days after a written request for proof of handicap, if proof is not provided within such 60-day period;
VI. The date You refuse to allow Us to examine the Dependent Child; or
VII. The premium due date following the date We receive Your written request to terminate Dependent coverage under this Policy.

SUSPENSION OF COVERAGE DURING MILITARY SERVICE

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

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

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

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

CONTINUATION COVERAGE FOR DEPENDENTS

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

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

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

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

SECTION 3—PREMIUMS

PAYMENT OF PREMIUM

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

GRACE PERIOD –

THIS GRACE PERIOD PROVISION APPLIES IF THIS POLICY WAS NOT PURCHASED ON THE EXCHANGE OR IF THE ON EXCHANGE POLICY DID NOT QUALITY FOR ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT (APTC).

After the first due premium payment is received by Us in full, if a premium is not paid on or before the date it is due, it may be paid during the next thirty (30) days. These thirty (30) days are called the Grace Period. If a payment for Covered Services or Covered Benefits is paid by Us during the Grace Period and You do not pay Your premiums in full by the Grace Period end date, You will be responsible for refunding Us for any payments made by Us during the Grace Period term. If any premium is unpaid at the end of the Grace Period, this Policy will automatically terminate effective as of the last paid through date. We must provide Member with not less than thirty (30) days written notice of the due date of the premium. However, We will not terminate this Policy until We have mailed or delivered to You at Your last-known address shown in Our records a written notice, in addition to any billing statement, stating the date this Policy's termination will become effective

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

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

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

PREMIUM RATE CHANGES

Subject to rate requirements applicable in the state of Montana, where this Policy is issued, We may change the rates for this Policy on any Policy Anniversary Date after this Policy has been in force for 12 months. However, the rates may be changed sooner than 12 months if a premium increase is necessitated by:

I. a state or federal law;
II. court decision; or
III. rule adopted by an agency of competent jurisdiction of the state or federal government.

Any rate change will be made only when We change the rates for all policies in the same rate class on the same form as this Policy that are issued in the state of Montana.

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

PREMIUM REFUND

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

REINSTATEMENT

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

THIRD PARTY PAYMENTS FOR PREMIUMS, COPAYMENTS, COINSURANCE

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

I. A Ryan White HIV/AIDS Program
II. An Indian tribe or tribal organization
III. Local, state or federal government programs, including grantees directed by a government program to make payments on its behalf
IV. A private not-for-profit organization when all of the following criteria are met:
    I. the assistance is provided on the basis of the Member's financial need
    II. The assistance is provided regardless of your health status
    III. The institution/organization is not a healthcare provider
    IV. The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

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

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

A violation of this provision will result in the premium and cost sharing payments not being accepted which may result in the retroactive termination or cancellation of coverage. Should We reject a payment from a third party, we will inform you in writing of the reason for our rejection and your right to file a complaint with the Montana Commissioner's Office of Securities and Insurance.

SECTION 4—IN-NETWORK PROVIDER NETWORK OPTION

The participation status of a provider in the network will impact the amount that We pay for Covered Medical Expenses. Providers that have signed an agreement to participate in our network are considered In-Network Providers. Providers that have not signed an agreement with Us to participate in our network are considered Out-of-Network Providers. You are responsible for determining whether a provider is an In-Network Provider or an Out-of-Network Provider.

It is not safe to assume that when you are treated at an In-Network Facility, all services are performed by In-Network Providers. Whenever possible, you should arrange for professional services, such as surgery and anesthesiology, to be provided by an In-Network provider. Doing so will help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements By agreement, an In-Network provider may not bill a Member for any amount in excess of the contracted Allowable Fee. However, the agreement does not prohibit the provider from collecting copayments, deductibles, coinsurance, and amounts for non-covered services from the Member. And, if the CO-OP was to become insolvent, an In-Network provider agrees to continue to provide Covered Services to a Member for the duration of the period for which premium was paid to the CO-OP on behalf of the Member. Again, the In-Network provider may only collect applicable copayments, deductibles, coinsurance, and amounts for non-covered services from the Member.

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

At the time the Member submits an application they can select a Primary Care Physician or when they receive their ID cards they can call the number specified on the back of the card to select an In-Network Primary Care Physician. A Pediatrician, Obstetrician, or Gynecologist may be chosen as a Primary Care Physician.

If the Member chooses not to do either, a provider will be assigned to them through two methods. First, if the Member sees an In-Network Primary Care Physician within the first three months and a claim is submitted, that Primary Care Physician will be assigned as the Members Primary Care Physician. Second, an In-Network Primary Care Physician will be selected by the CO-OP and assigned to the Member if the

Member has not completed one of the prior actions to select a Primary Care Physician. If the CO-OP chooses a provider it will be after the first three (3) months of coverage and selected from the In-Network Primary Care Physicians closest to the Member that provides outreach services.

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

If the Member's In-Network provider stops participating then the Member may request continued treatment from that provider for a period of time after the provider stops participating for a period of 90 days or until the next policy renewal date, whichever is longer. For pregnancy, the continuity of care period is through the postpartum period.

However, to qualify for continuity of care, the provider must: (1) agree that the Member is in an active course of treatment, which means a condition which a provider reasonably believes could cause harm to an Member if care by the treating provider is suddenly discontinued, such as pregnancy or an ongoing course of treatment for an episode of cancer or other condition for which discontinuing care by the current treating physician may worsen the condition and interfere with anticipated outcomes; (2) agree to accept the same allowed amount as the provider would have accepted if the provider had remained a In-Network Provider; and (3) agree not to seek payment from the Member of any amount for which the Member would not have been responsible if the provider had remained an in-network provider. Continuity of care protections are only for an active course of treatment and are not required for routine primary and preventive care.

WHY YOU MAY CHOOSE A PRIMARY CARE PHYSICIAN

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

The In-Network Primary Care Physician is an advisory service to the Member and does not control the medical service a Member may seek. Covered Benefits provided under this Policy are described in Section 5. However, by seeing your Primary Care Physician on a regular basis and calling him or her first when You have an urgent concern, You will stay healthier and experience fewer medical and emergency room (ER) visits, which means lower Out-of-Pockets costs for You. Your Primary Care Physician can help You manage any chronic conditions You may have and make personalized recommendations to improve your health.

ARE OUT-OF-NETWORK SERVICES COVERED?

Member may choose to receive services from an Out-of-Network provider. Benefits will be payable at a lower level when an Out-of-Network Provider is voluntarily used. An Out-of-Network Provider Differential will be applied. Member should be aware that Out-of-Network providers and facilities may choose to bill Member the difference between Our Allowable Fee and their billed charge, which is a practice known as balance billing. Member will be responsible for the balance billed amount and that balance billed amount could be very large. Member should avoid using Out-of-Network Providers. Refer to the SBC for specific benefit information under the Out-of-Network column. Out-of-Network Benefits provided under this Policy are described in Section 5. In certain circumstances, we may directly reimburse Member for services/supplies obtained from Out-of-Network providers. In compliance with the federal No Suprises Act, when You receive Emergency Care Services or get treated by an Out-Of-Network Provider at an In-Network hospital or ambulatory surgical center, You are protected from surprise/balance billing. See “Surprise Billing” in this Policy for additional information.

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

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

IN-NETWORK ORGANIZATION

The In-Network Provider Organization used for this Policy is administered by our Third-Party Administrator, as shown under Important Information in this Policy.

OUT-OF-NETWORK EMERGENCY CARE SERVICES

If the Member requires Emergency Care Services for an Emergency Medical Condition, while the Member is traveling outside of the Service Area of the In-Network Organization, or cannot reasonably reach an In-Network Provider, the benefits payable for Emergency Care Services received from an Out-of-Network Provider will be the greater of the payment to an In-Network Provider, the amount We use to determine payments for out-of-network providers but using in-network cost sharing provisions, or the amount that would be paid under Medicare for Emergency Care Services. Your covered expenses are based on Our Qualified Payment Amount (QPA) and You are not subject to Balance Billing by the Out-of-Network Provider. In compliance with the federal No Suprises Act, when You receive Emergency Care Services or get treated by an Out-Of-Network Provider at an In-Network hospital or ambulatory surgical center, You are protected from surprise/balance billing. See “Surprise Billing” in this Policy for additional information. Ground ambulance transportation services and bills are excluded from the above paragraph and are not subject to the No Suprises Act but are subject to the In-Network Provider and Out-of-Network Provider provisions of this Policy.

If you are admitted to a hospital as an inpatient following the stabilization of your emergency condition, your physician or hospital should contact our Medical Management team at (800) 299-6080 as soon as possible to make a benefit determination on your admission. If you are admitted to an Out-of-Network hospital, the CO-OP may require you to transfer to an In-Network facility once your condition is stabilized in order to continue receiving benefits at the In-Network provider level. Refer to the SBC for Emergency Care Services benefit detail found under the emergency room care benefit.

SECTION 5—COVERED BENEFITS

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

PAYMENT OF BENEFITS

Payment to providers is based on the Allowable Fee. In-Network Providers agree to accept payment of the Allowable Fee for Covered Medical Expenses as full payment. We generally pay In-Network Providers directly.

Out-of-Network Providers have not agreed to accept the Allowable Fee as full payment for Covered Medical Expenses. Out-of-Network Providers can bill the difference between the amount that We pay, if any, and the amount of their billed charge (the balance billed amount). Member will be responsible for the balance billed amount. We may pay you directly for services provided by an Out-Network Providers. In compliance with the federal No Suprises Act, when You receive Emergency Care Services or get treated by an Out-Of-Network Provider at an In-Network hospital or ambulatory surgical center, You are protected from surprise/balance billing. See "Surprise Billing" in this Policy for additional information.

Member will be responsible for all copayments, coinsurance and deductibles. Member may be fully responsible for any medical expenses that are not Covered Medical Expenses/Covered Benefits, are not Medically Necessary, are Investigational, and/or for medical expenses for which a benefit maximum has been reached, regardless of whether the provider is an In-Network Provider or an Out-of-Network provider.

Payment of Covered Medical Expenses will be:

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

EXCEPTIONS

When Services Are Provided By An Indian Service

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

I. An Indian Health Service;
II. An Indian Tribe;
III. A Tribal Organization;
IV. An Urban Indian Organization; or
V. through referral under contract health services;

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

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

I. An In-Network basis if the Member, who is an Indian as defined in this Policy, obtains services from an In-Network; or
II. An Out-of-Network basis if the Member, who is an Indian as defined in this Policy, obtains services from a Non-In-Network; and
III. the Deductible, Coinsurance, Annual Out-of-Pocket Maximum, and any applicable Copayments will apply. Refer to the SBC for cost-sharing by type of service.

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

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

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

BENEFITS ELIGIBLE FOR PAYMENT

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

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

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

ACCIDENT BENEFIT

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

ACUPUNCTURE

Coverage will be provided for acupuncture up to the maximum per Calendar Year shown in the SBC.

ALLERGY TESTING

Coverage will be provided for allergy testing ordered by a physician or other qualified provider who is treating the Member.

AMBULANCE SERVICES

Coverage will be provided for transportation by a licensed ground or air ambulance service to the nearest site with the appropriate staff and facilities to treat the Member illness or injury or Emergency Medical Condition of the Member. Emergency air ambulance transport services from the site of accident, injury or illness may be considered medically necessary when the criteria for Member Illness or injury or Emergency Medical Condition are met and the Member is in a critical condition and/or has unstable vital signs, respiratory, cardiac status, a life threating condition or the point of pick up is inaccessible by ground ambulance or ground ambulance poses a threat to the Members survival.

ANESTHESIA SERVICES

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

I. Local anesthesia or intravenous (IV) sedation that is considered to be an inclusive service or procedure;
II. Hypnosis;
III. Anesthesia consultations before surgery that are considered to be inclusive services and procedures because the Allowable Fee for the anesthesia performed during the surgery includes the anesthesia consultation; or
IV. Anesthesia for dental services.

In compliance with the federal No Suprises Act, when You receive care by an Out-Of-Network Anesthesiologist at an In-Network hospital facility, You are protected from surprise/balance billing. See “Surprise Billing” in this Policy for additional information.

APPROVED CLINICAL TRIAL

Clinical Trials Charges for unproven medical practices or care, treatment, devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined by the CO-OP and our Third-Party Administrator.

The CO-OP does not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in approved clinical trials. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Patient costs do not include the investigational item, device, or service, itself; items and services that are provided to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

AUTISM SPECTRUM DISORDER COVERAGE

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

I. Autistic Disorder;
II. Asperger's Disorder; or
III. Pervasive Developmental Disorder not otherwise specified. Coverage will include:
    I. Habilitative or rehabilitative care that is prescribed, provided, or ordered by a Physician or a licensed psychologist, including but not limited to:
    II. professional, counseling, and guidance services; and
    III. Treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
    IV. Medications prescribed by a Physician;
    V. Psychiatric or psychological care; and
    VI. Therapeutic care that is provided by:
        a. a speech-language pathologist;
        b. audiologist;
        c. occupational therapist; or
        d. physical therapist licensed in this state.

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including:

I. applied behavior analysis
II. discrete trial training;
III. pivotal response training;
IV. intensive intervention programs; and (5) early intensive behavioral intervention.

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

When Continued Services Are Required

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

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

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

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

BLOOD TRANSFUSIONS

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

CENTERS OF EXCELLENCE (COE)

Our Centers of Excellence (COE) program promotes the CO-OP's high standards for quality and value of care, which results in improved patient outcomes. COE partners must demonstrate rigorous quality control measures, positive patient outcomes, and cost efficient healthcare delivery.

Our COE medical categories include, but are not limited to: knee, hip, back, cardiac, cancer, transplants, tertiary care, and other specialty care outside Member's geographic area.

The criteria to qualify for our COE program includes:

I. Be referred by your physician and have prior approval for a qualified COE procedure;
II. Tertiary care where COE provider(s) has demonstrated excellence in a particular medical front and care is delivered in a unique, focused manner to patients; and
III. Medical Management referral.

The use of Our COE program is directed through the Medical Management preauthorization process.

Things you need to know before accessing a COE:

I. To access the CO-OP's travel benefit, you must meet the following criteria:
    I. Members must be pre-approved to use a designated COE facility or practitioner.
    II. Standard preauthorization requirements still apply.
II. Designated COE providers may be located out of the CO-OP's primary service area, and Members may be eligible for travel benefits. All travel-related reimbursement requires preauthorization, which can be obtained by calling (800) 299-6080. Travel expenses related to the Member will only be reimbursed for medical care done at the CO-OP's approved COE and meet the distance requirements of the Travel policy.
III. When Member is pre-approved for services at Our COE facilities and receives preapproved care at one of Our COE facilities, Member's deductible may be waived for that episode for care.

If you have questions, please contact Customer Service at 855-447-2900.

CHEMICAL DEPENDENCY

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

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

Chemical Dependency Treatment Center means a treatment facility that:

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

Inpatient Treatment Services

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

I. A Hospital;
II. A Physician;
III. Prescribed by a Physician; or
IV. A Freestanding Inpatient Facility which is a part of a Chemical Dependency Treatment Center. Such facility must be approved by the Department of Public Health and Human Services.

Coverage will be provided under this Policy for:

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

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

Outpatient Treatment Services

I. Benefits will be payable for Outpatient Treatment of Chemical Dependency when such Treatment is provided in or by a facility that is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities and such Treatment is provided by:

:

I. A Hospital;
II. An accredited Chemical Dependency Treatment Center;
III. A Physician or prescribed by a Physician or by a licensed covered provider;
IV. A licensed psychiatrist;
V. A psychologist;
VI. A licensed social worker;
VII. A licensed professional counselor; or

VIII. An addiction counselor licensed by the state and accredited.
IX. Prescribed by a licensed provider
X. The Provider is A provider providing a covered benefit under this Policy

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

I. The Treatment must be reasonably expected to improve or restore the level of functioning that has been affected by the Chemical Dependency;
II. The Treatment must be provided to diagnose and treat recognized Chemical Dependency;
III. Chemical dependency services rendered through a facility or provider such as (a) boarding school (b) wilderness program (c) sheltered living provided by a school or halfway house (d) educational or correctional services (e) Psychoanalysis or Psychotherapy received as part of the educational or training programs, regardless of diagnosis or symptoms that may be present, (f) A court ordered sex offender treatment program (g) support group (h) marriage counseling; (i) hypnotherapy; or (j) services given by a staff member of a school or halfway house will not be covered.

CHIROPRACTIC SERVICES

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

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

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

CHRONIC DISEASE MANAGEMENT

Coverage will be provided for chronic disease management services for: (a) diabetes; (b) hypertension (high blood pressure); (c) high cholesterol; and (d) any other chronic disease required by the federal Affordable Care Act defined as those that have lasted or are expected to last for one year of more, and that result in a functional limitation or the need for ongoing medical care. The Member must be diagnosed and receiving treatment for the chronic disease, and the Chronic Disease Management may be prescribed by a Physician or Member may obtain the services without a prescription.

CONVALESCENT HOME SERVICES/SKILLED NURSING

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

I. Prescribed by a Physician; and
II. Preauthorization is obtained.

Coverage will be provided for Convalescent Home Physician visits.

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

This Policy does not pay for custodial care services.

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

DENTAL ACCIDENT SERVICES

Dental services provided by:

I. A Physician;
II. A Dentist;
III. An Oral surgeon; and/or
IV. Any other Covered Provider;

will not be covered under this Policy except Medically Necessary services for the initial repair or replacement of sound natural teeth which are damaged as a result of an Accident will be covered under this Policy. The following will not be covered under this Policy, even if they are related to an Accident:

I. orthodontics;
II. dentofacial orthopedics;
III. Orthognathic surgery; or
IV. related appliances.

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

DENTAL EXAM

Your plan provides up to a $100 reimbursement towards one routine dental examination per enrollee each calendar year. Reimbursable services include exams, cleanings and fluoride treatment. Any licensed dental office may be used.

For instructions on how to be reimbursed for this benefit, please visit our website at https://www.mountainhealth.coop/

DOWN SYNDROME

Coverage will be provided for medically necessary care, treatment, intervention, services, or items that are prescribed, provided, or ordered by a physician licensed in Montana and that will or is reasonably expected to reduce or improve the physical, mental, or developmental effects of Down syndrome; or assist in achieving maximum functional capacities that are appropriate for a child of the same age. “Medically necessary” means

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

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

DURABLE MEDICAL EQUIPMENT

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

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

Durable Medical Equipment must be:

I. prescribed by a Physician;
II. be able to withstand repeated use (consumables are not covered);
III. primarily used to serve a medical purpose rather than for comfort or convenience; and
IV. generally not useful to a person who is not ill or Injured.

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

Durable Medical Equipment includes, but is not limited to:

I. canes;
II. crutches;
III. walkers;
IV. standard manual or electric wheelchairs; and
V. standard hospital beds.

No benefits will be payable for the following:

I. exercise equipment;
II. car lifts or stair lifts;

III. biofeedback equipment;
IV. self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition;
V. air conditioners and air purifiers;
VI. whirlpool baths, hot tubs, or saunas;
VII. waterbeds;
VIII. other equipment which is not always used for healing or curing;
IX. computerized and "deluxe" equipment life motor-driven wheelchairs or beds when standard equipment is adequate. We will have the right to determine when standard equipment is adequate;
X. durable medical equipment required primarily for use in athletic activities;
XI. replacement of lost or stolen durable medical equipment;
XII. repair to rental equipment;
XIII. duplicate equipment purchased primarily to the Member's convenience when the need for duplicate equipment is not medical in nature.
XIV. electronic devices such as laptops, smart phones, software applications
XV. monthly fees such as Internet, cellular phones/data
XVI. experimental and investigational equipment

Durable Medical Equipment is reimbursed on a rental, rental to purchase or capped rental. Rental to purchase is a time period where reimbursement is based on a monthly fee up to the amount that the item will be considered purchased. Capped rental is the amount reimbursed on a monthly rental basis, which will not exceed the applicable number of continuous months. If the service is billed beyond the maximum number of rental months, no additional reimbursement will be allowed.

Preauthorization is recommended for the original purchase or replacement of durable medical equipment. Please refer to Section 6, Utilization Review Management Program.

EDUCATION SERVICES

Coverage will not be provided for education services other than diabetic education that are related to the Member's medical condition.

EMERGENCY CARE SERVICES

Coverage will be provided for Emergency Care Services provided in a Hospital's emergency room for an Emergency Medical Condition. No Preauthorization is required for Emergency Care Services; however, the Member must notify Us within 48 hours of the Emergency Service as provided in Section 6, Utilization Review Management Program.

HABILITATIVE CARE AND REHABILITATIVE CARE

Coverage will be provided for habilitative care services when the Member requires help to keep, learn or improve skills and functioning for daily living. These services include, but are not limited to:

I. physical and occupational therapy;
II. speech-language pathology; and
III. other services for people with disabilities.

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

Coverage will be provided for rehabilitative care services when the Member needs help to keep, get back or improve skills and functioning for daily living that have been lost or impaired because a the Member was sick, hurt or disabled. These services will include, but are not limited to:

I. physical and occupational therapy;
II. speech-language pathology; and
III. psychiatric rehabilitation.

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

Coverage for habilitative care and rehabilitative care are subject to the Limitation found on the SBC under habilitative and rehabilitative services.

HEARING SERVICES

Coverage will be provided for the diagnosis and treatment of hearing loss for a covered child Member 18 years of age or younger. Treatment must be:

I. Medically Necessary; and
II. Prescribed, provided or ordered by a licensed health care provider to treat hearing loss of the covered child.

Treatment will be limited to one (1) hearing or amplification device with required accessories per ear every 3 years, or as required by a licensed audiologist.

Amplification Device means a hearing device, hearing aid, or a wearable, nondisposable, nonexperimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold. Batteries and cords are excluded.

HOME HEALTH CARE SERVICES

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

Services for home health care include:

I. nursing services;

II. home health aide services;
III. hospice services;
IV. physical therapy;
V. occupational therapy;
VI. speech-language pathology;
VII. medical social worker;
VIII. medical supplies and equipment suitable for use in the home; and
IX. Medically Necessary personal hygiene, grooming, and dietary assistance.

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

No benefits will be payable for:

I. Maintenance or custodial care visits;
II. Domestic or housekeeping services;
III. "Meals-on-Wheels" or similar food arrangements;
IV. Visits, services, medical equipment, or supplies not approved or included as part the Member's treatment plan for Home Health Care;
V. Services for mental or nervous conditions; or
VI. Services provided in a nursing home or skilled nursing facility.

HOME AND OUTPATIENT INFUSION THERAPY SERVICES

The preparation, administration, or delivery of parenteral medications, or parenteral or enteral nutritional services to a Member by a Home Infusion Therapy Agency or an Outpatient Infusion Pharmacy with infusion suites.

Services provided include, but are not limited to:

I. Therapy and drug administration education for the Member, the Member's caregiver, or a family Member.
II. Drugs and other diluents necessary for injection or infusion.
III. Supplies.
IV. Equipment.
V. Skilled nursing services when billed by a Home Infusion Agency or Outpatient Infusion Pharmacy. (Please note: Skilled Nursing Services billed by a Home Health Agency will be covered under the Home Health Care Benefit.) Home infusion therapy services must be ordered by a Physician and provided by a licensed Home Infusion Agency or Outpatient Infusion Pharmacy.

Member cost-share may be lower or waived for Members using CO-OP Preferred Home Infusion or CO-OP Preferred Outpatient Infusion Pharmacy providers.

Preauthorization is required for the infusion therapy benefit and related services. Please refer to the section on Preauthorization.

HOSPICE CARE SERVICES

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

I. Inpatient and Outpatient care;
II. Home care;
III. Skilled nursing care;
IV. Counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally-ill Member; and
V. Instructions for care of the Member, counseling and other support services for the Member's Immediate Family.

HOSPITAL SERVICES – FACILITY AND PROFESSIONAL

INPATIENT CARE SERVICES BILLED BY A FACILITY PROVIDER

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

I. Room and Board Accommodations:
II. Room and board, which includes special diets and nursing services;
III. Intensive care and cardiac care units which include special equipment and concentrated nursing services provided by nurses who are Hospital employees.
IV. Miscellaneous Hospital Services:
    a. Laboratory procedures;
    b. Operating room, delivery room, and recovery room;
    c. Anesthetic supplies;
    d. Surgical supplies;
    e. Oxygen and use of equipment for the administration;
    f. X-rays;
    g. Intravenous Injections and setups for intravenous solutions;
    h. Special diets when Medically Necessary;
    i. Respiratory therapy, chemotherapy, radiation therapy, dialysis therapy;
    j. Physical therapy, speech-language pathology, and occupational therapy;
V. Drugs and medicines which:
    a. Are appointed for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed;
    b. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
    c. Require a Physician's written prescription.
VI. Inpatient Hospital Physician visits. Inpatient Care is subject to Plan Notification and Preauthorization. Please refer to Section 6, Utilization Review Management Program.
VII. Inpatient Care Services are subject to the following conditions:
    a. Days of care:
        i. The number of days of Inpatient Care provided is 365 days.

ii. In computing the number of Inpatient Care days available, days will be counted according to the standard midnight census procedure used in most Hospitals. The day the Member is admitted to a Hospital is counted, but the day the Member is discharged is not. If a Member is discharged on the day of admission, one day is counted.

iii. The day the Member enters a Hospital is the day of admission. The day the Member leaves a Hospital is the day of discharge.

b. The Member will be responsible to the Hospital for payment of its charges if the Member remains as an Inpatient when Inpatient Care is not Medically Necessary. No benefits will be provided for a bed reserved for the Member. No benefits will be paid for Inpatient Care provided primarily for diagnostic or therapy services.

INPATIENT CARE MEDICAL SERVICES BILLED BY A PROFESSIONAL PROVIDER

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

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

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

OBSERVATION BEDS/ROOMS

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

OUTPATIENT HOSPITAL SERVICES

Coverage will be provided for ambulatory patient services rendered in the Hospital's outpatient facilities and equipment for:

I. surgery;
II. respiratory therapy;
III. chemotherapy;
IV. radiation therapy; and
V. dialysis therapy.

Outpatient Hospital facilities include a licensed Hospital's Ambulatory Care Facility or licensed Free-Standing Surgical Facility.

"Inborn Errors of Metabolism. Coverage will be provided for the treatment of inborn errors of metabolism that are Medicallly Necessary:

Coverage for inborn errors of metabolism include expenses of:

I. diagnosing;
II. monitoring; and
III. controlling the disorders by nutritional and medical assessment, including but not limited to:
    a. clinical services;
    b. biochemical analysis;

c. medical supplies;
d. prescription drugs;
e. corrective lenses for conditions related to the inborn error of metabolism;
f. nutritional management; and
g. medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

"Medical foods" means nutritional substances in any form that are:

I. formulated to be consumed or administered entirely under supervision of a physician;
II. specifically processed or formulated to be distinct in one or more nutrients present in natural food;
III. intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
IV. essential to optimize growth, health, and metabolic homeostasis.

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

INFERTILITY TREATMENT – DIAGNOSIS AND TREATMENT

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

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

The Plan will not pay for:

I. Prescription drugs used to treat infertility.
II. Services, supplies, drugs and devices related to invitro fertilization.

LABORATORY SERVICES

Coverage will be provided for:

I. Diagnostic x-ray examinations;
II. Laboratory and tissue diagnostic examinations; and
III. Medical diagnostic procedures (machine tests such as EKG, EEG). Laboratory services include, but are not limited to, the following:
IV. Laboratory X-ray Examinations;
V. Other Radiology Tests, including but not limited to:
VI. computerized tomography scan (CT Scan);
VII. MRIs;
VIII. nuclear medicine; and
IX. Ultrasound;

X. Laboratory Tests, including but not limited to: (a) urinalysis; (b) blood tests; and (c) throat cultures;

XI. Diagnostic Testing, including but not limited to: (a) Electroencephalograms (EEG); and Electrocardiograms (EKG or ECG). Such laboratory services must be;

i. Prescribed by a Covered Provider;

ii. Medically Necessary

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

MAMMOGRAM (PREVENTATIVE AND MEDICAL)

Preventive:

Coverage for Mammography examinations is provided under the Preventative Health Care Services benefit.

The following minimum mammography examinations are covered:

I. one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

II. a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

III. a mammogram each year for a woman who is 50 years of age or older.

In-Network Providers: Preventive Mammograms within the above recommendations will be covered under the Preventive Health Care Services section of this Policy and will be at no charge.

Out-of-Network Providers: For non-QHDHP's We will pay at least $70, or the actual charge if less, for each minimum mammography examination. After the $70 payment Deductibles, Copayments, and/or Coinsurance will apply. If your Plan is a QHDHP Your Deductible with apply. Once met, We will pay at least $70, or the actual charge if less, for each minimum mammography examination, and then Deductibles, Copayments, and/or Coinsurance will apply.

Medical:

Diagnostic Breast Examination means a Medically Necessary and clinically appropriate examination of the breast that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination. This term includes examinations using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound.

Supplemental Breast Examinations means a Medically Necessary and appropriate examination of the breast that is used to screen for breast cancer when there is no abnormality seen or suspected, and is based on personal or family medical history or other factors that may increase a person's risk for breast cancer. This term includes examination using breast magnetic resonance imaging or breast ultrasound.

For non-QHDHP's medical mammograms will be covered at no charge. If your Plan is a QHDHP Your Deductible will apply. Once met a medical mammogram will be covered at no charge for both an In-Network and Out-of-Network Provider.

MATERNITY AND NEWBORN CARE SERVICES

Coverage for maternity and newborn care services will be treated as any other illness. Coverage will be provided for maternity services, including:

I. prenatal care;
II. delivery of one or more newborn children;
III. postpartum care and benefits for childbirth; and
IV. Hospital Inpatient Care for conditions related directly to pregnancy.

Coverage will include at least:

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

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

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

Under Federal law, benefits may not be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than:

I. 48 hours following a vaginal delivery; or
II. 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending Covered Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, under Federal law, Covered Providers may not be required to obtain Preauthorization from the Utilization Review Management Program for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Payment for any maternity services by the professional Covered Provider is limited to the Allowable Fee for total maternity care, which includes:

I. delivery;
II. prenatal care; and
III. postpartum care.

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

NEWBORN INITIAL CARE

Coverage will be provided for the following:

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

MEDICAL SUPPLIES

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

I. Supplies for insulin pumps, syringes and related supplies for conditions such as diabetes. It is recommended that the Member purchase insulin pumps, syringes and related supplies under the Prescription Drug Benefit.
II. Injection aids, visual reading and urine test strips, glucagon emergency kits for treatment of diabetes. One insulin pump for each warranty period is covered under the Durable Medical Equipment Benefit;
III. Sterile dressings for conditions such as cancer or burns;
IV. Catheters;
V. Splints;
VI. Colostomy bags and related supplies; and
VII. Supplies for renal dialysis equipment or machines.

Medical supplies will be covered only when:

I. Medically Necessary to treat the Member's condition for which benefits are payable under this Policy; and
II. prescribed by Physician.

MENTAL HEALTH

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

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

IV. The provider is providing a covered benefit under this Policy
V. The Facility is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities

"Mental Illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

I. present distress or a painful symptom;
II. a disability or impairment in one or more areas of functioning; or
III. a significantly increased risk of suffering:
    a. death;
    b. pain;
    c. disability; or
    d. an important loss of freedom.

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

"Mental Illness" means the following as defined by the American Psychiatric Association:

I. schizophrenia;
II. schizoaffective disorder;
III. bipolar disorder;
IV. major depression;
V. panic disorder;
VI. obsessive-compulsive disorder; and
VII. autism.

"Mental Health Treatment Center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written individualized treatment plan approved and monitored by an interdisciplinary team, including a licensed physician medical director, psychiatric social worker, and psychologist, and a treatment facility that is: (1) licensed as a Mental Health Treatment Center by the state; (2) funded or eligible for funding under federal or state law; or (3) affiliated with a hospital under a contractual agreement with an established system for patient referral (4) accredited by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities

The Treatment must be reasonably expected to improve or restore the level of functioning.
The Treatment must be provided to diagnose and treat mental illness;
Mental Illness services rendered through a facility or provider such as (a) boarding school (b) wilderness program (c) sheltered living provided by a school or halfway house (d) educational or correctional services (e) Psychoanalysis or Psychotherapy received as part of the educational or training programs, regardless of diagnosis or symptoms that may be present, (f) A court ordered sex offender treatment program (g) support group (h) marriage counseling; (b) hypnotherapy; or (c) services given by a staff member of a school or halfway house will not be covered.

Coverage will be provided for Inpatient Acute Care , Residential Treatment, Partial Hospitalization, Intensive Outpatient and Outpatient Treatment of Mental Illness. Benefits will be paid on the same basis as any other Illness.

INPATIENT, RESIDENTIAL TREATMENT, PARTIAL HOSPITALIZATION, INTENSIVE OUTPATIENT AND OUTPATIENT CARE SERVICES

Coverage for Inpatient Care Acute Care, Residential Treatment, Partial Hospitalization, Intensive Outpatient and Outpatient Treatment Services of Mental Illness, while the Member is insured under this Policy, when such Inpatient Care Services are provided in:

I. a Hospital;
II. a Freestanding Inpatient Facility; or
III. prescribed by a Physician.
IV. Inpatient Care Services must be Preauthorized; refer to Section 6, Utilization Review Management Program. Medically monitored and medically managed intensive Inpatient Care services and clinically managed high-intensity residential services are covered under this Policy. Medically monitored and medically managed intensive Inpatient Care Services and clinically managed high-intensity residential services provided at a Residential Treatment Center are covered under this benefit.

PARTIAL HOSPITALIZATION

Partial Hospitalization coverage will be provided for care and treatment of Mental Illness when Partial Hospitalization services are rendered by:

I. a Freestanding Outpatient Facility; or
II. a prescribed by a Physician. Partial Hospitalization is considered to be Outpatient Care and must be Preauthorized; refer to Section 6, Utilization Review Management Program.

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

The Treatment must be reasonably expected to improve or restore the level of functioning.
The Treatment must be provided to diagnose and treat mental illness;
Mental Illness services rendered through a facility or provider such as (a) boarding school (b) wilderness program (c) sheltered living provided by a school or halfway house (d) educational or correctional services (e) Psychoanalysis or Psychotherapy received as part of the educational or training programs, regardless of diagnosis or symptoms that may be present, (f) A court ordered sex offender treatment program (g) support group (h) marriage counseling; (b) hypnotherapy; or (c) services given by a staff member of a school or halfway house will not be covered.

OUTPATIENT CARE SERVICES

Outpatient care and treatment of Mental Illness will be covered under this Policy if the Member is not receiving Inpatient Mental Illness treatment and the Outpatient care and treatment is provided by:

I. a Physician or prescribed by a Physician;
II. a Mental Health Treatment Center;
III. a Chemical Dependency Center;
IV. a psychologist;

V. a licensed psychiatrist;
VI. a licensed social worker;
VII. a licensed professional counselor; or
VIII. a licensed addiction counselor.

Outpatient Mental Illness Treatment must be:

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

No benefits will be payable for: Mental Illness services rendered through a facility or provider such as (a) boarding school (b) wilderness program (c) sheltered living provided by a school or halfway house (d) educational or correctional services (e) Psychoanalysis or Psychotherapy received as part of the educational or training programs, regardless of diagnosis or symptoms that may be present, (f) A court ordered sex offender treatment program (g) support group (h) marriage counseling; (b) hypnotherapy; or (c) services given by a staff member of a school or halfway house will not be covered.

ORTHOPEDIC DEVICES/ORTHOTIC DEVICES

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

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

PEDIATRIC SERVICES

Coverage will be provided for Pediatric preventive care services for Covered Dependent Children up to age eighteen (18). Benefits include but are not limited to:

I. appropriate immunizations as defined by Standards of Child Health Care issued by the American Academy of Pediatrics or other guidelines required by the state;
II. developmental assessments, which includes Physician visits for child health supervision services;
III. laboratory services;
IV. topical fluoride varnish; and
V. any other care and services mandated by the federal Affordable Care Act.

PEDIATRIC VISION CARE PROGRAM

Coverage will be provided for vision care services for Covered Dependent Children up to age eighteen (18). Benefits will be provided for the covered services shown in the SBC for the stated frequency of services. The frequency of service for each covered service is once every 12 months, unless otherwise stated in the SBC.

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

EYE EXAMINATIONS

Benefits will be provided for one eye examination for each eligible Covered Dependent Child during the Calendar Year. The eye examination may be used for one of the following:

I. eyeglasses;
II. contact lenses; or
III. for both eyeglasses and contact lenses during one examination.

No benefits will be payable for another eye examination performed during the Calendar Year. No benefits will be payable for separate eye examinations for eyeglasses and contact lenses during the Calendar Year.

VISION CARE MATERIALS: EYEGLASS LENSES, COATINGS, AND FRAMES

Benefits will be provided for:

I. eyeglass lenses;
II. eyeglass coatings; and
III. eyeglass frames.

The benefits payable are shown in the SBC.

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

CONTACT LENSES

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

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

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

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

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

I. Other insurance policies or service agreements;
II. Artistically painted or non-prescription lenses;
III. Additional office visits for contact lens pathology;
IV. Contact lens modification, polishing or cleaning; and
V. Orthoptics, vision training, supplemental testing.

PAYMENT OF BENEFITS

Benefits will be paid as shown in the SBC.

The CO-OP does not have a provider network established for these services. Services will be covered at the In-Network benefit level.

EXCLUSIONS AND LIMITATIONS

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

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

PHYSICIAN MEDICAL SERVICES

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

PRESCRIPTION DRUG BENEFIT

Preventive, Preferred Generic, Preferred Brand, Non-Preferred Brand, and Specialty Prescription Drugs are covered under this Policy, as provided in this Covered Benefit provision. Covered prescription drugs must be prescribed by a licensed provider.

Covered Prescription Drugs are provided in the Prescription Drug Formulary (PDL) for this Policy. The formulary may be obtained on Our website, https://www.mountainhealth.coop/pharmacy , or by calling the Customer Service number on the back of your ID card.

Prescription drug benefits described in the SBC are arranged by Tiers to provide a structure for Member cost-sharing in each category. Generally, the relationship is as follows: Tier 1 = Preferred Generic; Tier 2 = Preferred Brand; Tier 3 = Non-Preferred Brand and Non-Preferred Generic; Tier 4 = Preferred Specialty Drugs; and Tier 5 = Preventive Drug.

DEFINITIONS

The following definitions apply to this Covered Prescription Drug Benefit Section:

Brand Name Drug is a drug that has a trade name and is protected by patent, meaning it can only be manufactured and produced by the company holding the patent. Brand name drugs may require step therapy or preauthorization. If a brand name drug has a generic equivalent, a brand-generic charge will apply.

Brand Generic Drug Charge is applied if you receive a Brand name drug, regardless of reason or medical necessity, when a generic is available. A Brand-Generic charge is the difference in cost between the generic and the brand name drug. This charge is added to the regular cost sharing outlined in your benefit summary. The Brand-Generic charge does not apply towards your Deductible or Out-of-Pocket Maximum.

Designated Pharmacy means you must use the pharmacy designated by the Plan for that particular pharmacy benefit to apply.

Generic Drug is a drug that has the same active ingredients compared to a brand name drug with regard to its dosage, strength, quality, performance, outcome, and intended use, but is manufactured by a generic drug manufacturer after the brand name drug patent has expired.

Prescription Drug means a drug or medicine which may only be obtained by a Prescription Order and is approved by the US Food and Drug Administration. These products typically bear the legend “Caution, Federal Law prohibits dispensing without a prescription”.

Prescription Order means a written, electronic, or oral order for a medication or device Prescription Drug issued by a licensed prescriber within the scope of his or her practice to be administered to an individual.

Preauthorization is a process used by health plans to assure drug benefits are administered as designed, that members receive medications that are safe and effective for the condition being treated, and the medications used have the greatest value. Preauthorizations require the prescriber to receive pre-approval for prescribing a particular medication in order for the drug to be covered by the health plan benefit.

Quantity Limits is a limitation that is placed on daily dose, days' supply, or maximum quantity. Quantity limits help assure FDA-approved doses or durations are not exceed for the safety of the patient. Exceptions may be approved when the benefits outweigh the risks to the patient.

Specialty Drugs are high risk, high-cost drugs that are used to treat complex conditions that may require special handling and administration. Specialty drugs generally require preauthorization and are limited to a 30-day supply. All Specialty drugs must be filled through a designated Specialty Pharmacy. Please call Pharmacy Customer Service at the number found on the back of your ID Card for additional information.

Step Therapy is a process designed to assure that first line drugs which have been proven safe and effective and that demonstrate greater value are used before second line and potentially more costly alternatives. Most brand medications with generic alternatives require ST with the generic product before the brand will be authorized.

PRESCRIPTION DRUGS WITH ENHANCED PREVENTIVE BENEFITS

Preventive Drug (PREV): Certain prescription drugs are considered preventive under the ACA. ACA preventive drugs are covered at 100 percent by the Plan (no patient responsibility); although limits may apply. Drugs available under this benefit are listed as PREV under the 3rd column of the PDL list. For more information about your preventive drug benefits, please contact Pharmacy Customer Service at the number listed on the back of your ID Card.

Value Preventive Drug List (VAL): The Value Preventive Drug List provides coverage for designated prescription drugs in specific categories even before you meet your deductible or out-of-pocket expenses. Members will not have any cost-share for prescription drugs listed in our value-based preventive drug list. This is in addition to the no-cost share coverage for preventive drugs listed in the (ACA) and expands preventive drug coverage. Drugs available under this benefit are listed as VAL under the 3rd column of the PDL list.

Prescribed Contraceptive Services: Covered Benefits for contraceptive services identified by the FDA include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling as prescribed by a health care provider. Barrier methods, implanted devices and hormonal methods are covered in accordance with the medical or pharmacy benefits. There is no coverage for contraception for men.

The contraceptive methods for women currently identified by the FDA include:

I. sterilization surgery for women;
II. surgical sterilization implant for women:
III. implantable rod;
IV. IUD copper;
V. IUD with progestin;
VI. shot/injection;
VII. oral contraceptives (combined pill);
VIII. oral contraceptives (progestin only);
IX. oral contraceptives extended/continuous use;
X. patch;
XI. vaginal contraceptive ring;
XII. diaphragm;
XIII. sponge;
XIV. cervical cap;
XV. female condom;
XVI. spermicide; and
XVII. emergency contraception.

Contraceptives are covered is accordance with the ACA; certain types and brands may have no out-of-pocket cost. A prescription for a 12-month supply of covered contraceptive drugs may be renewed and refilled a minimum of 60 days prior to expiration of the prescription. A Member may receive a 12-month supply at one time unless the Member requests less than a 12-month supply or a health care provider specifically prescribes less than a 12-month supply.

Insulin: A Member will pay no more than $35 for up to a 30-day supply of insulin covered on Our formulary with no deductible. The $35 will count towards the Member's Deductible and Out-of-Pocket Maximum.

PRESCRIPTION DRUG LIMITS AND REQUIREMENTS

Age: Some prescription drugs have a minimum or maximum age limit requirement under the Plan. Only members within those limits are able to fill those prescription drugs.

Brand-Generic Charge (Ancillary Charge): A Brand-Generic Charge is applied to your cost if you receive a brand name prescription drug, regardless of reason or medical necessity, if your provider prescribes a brand name drug when a generic is available. A Brand-Generic Charge is the difference between the cost of the generic and the cost of the brand name prescription drug. This penalty is in addition to the regular cost-sharing outlined in your benefits summary. The Brand-Generic does not apply towards Deductibles or Out-of-Pocket Maximum.

Preauthorization (PA): To ensure appropriate utilization, some generic and brand prescription drugs and all specialty drugs require Preauthorization to be eligible for coverage under the prescription drug benefit. In addition, prescription drugs with anticipated costs over $1000 require preauthorization. The Pharmacy and Therapeutics (P&T) Committee establishes the PA criteria. Your provider will be required to complete a PA form and provide clinical documentation to show why this prescription drug is needed for treatment of your disease state or medical condition. A letter of medical necessity is also recommended. Your provider should also include your diagnosis and previous therapies that have failed in the letter. If a PA is not received or if the prescription drug is filled prior to approval, the cost of the prescription drug. Preauthorization is required for any quantities that exceed Plan limits. For a list of medications requiring PA visit https://www.mountainhealth.coop/pharmacy.

Quantity Limit (QL): Quantity Limit is a program that ensures members do not receive a prescription for a quantity that exceeds recommended Plan or safety limits. Limits are set because some prescription drugs have the potential to be abused, misused, shared, or have a manufacturer's limit on the recommended maximum dose. Quantity limits are based on FDA approved dosing, current medical practices, evidence-based clinical guidelines, and peer-reviewed medical literature related to a particular prescription drug. Preauthorization is required for any quantities that exceed Plan limits.

Step Therapy (ST): Step therapy is a program for prescription drugs that are taken on a regular basis to treat an ongoing medical condition. The program is developed around effectiveness, safety, and value. In ST, the covered prescription drugs are arranged in a series of "steps". The program typically starts with generic prescription drugs as the "first step". These generics are rigorously tested and approved by the FDA and allow you to have safe, effective treatment with prescription drug that is more affordable. More expensive brand-name prescription drugs are usually considered in the "second step". Step Therapy is developed under the guidance and direction of the P&T Committee. They review the most current research on thousands of drugs tested and approved by the FDA for safety and efficacy. The first time you submit a prescription that is not for a first-step drug, your pharmacist will receive a message to tell you that the Plan requires ST. This means if you don't want to pay full price for your prescription drug, your doctor needs to write a new prescription for a "first-step" drug. With ST, if you've already tried and failed the "first-step" drug, can't take the "first-step" drug (because of an allergy, etc.), and/or your provider can show medical necessity for the second step products, your provider can submit a request for Preauthorization review.

Additional Policies and Processes

Lost/Damaged/Stolen: Prescription replacements are not covered by the plan. The member will have access to the network discounts, but the cost for replacement will be member responsibility. If a medication is stolen, the plan will review for replacement only when accompanied by a police report and if the provider is

willing to write a new prescription. In the case a stolen replacement is approved, it will be limited to one incident per year.

Mail Order: Mail order is when a 90 day supply of a generic or brand name prescription drug (Tier 1, 2, and 5) is mailed directly through a designated Mail Order Pharmacy. Not all prescription drugs are available through Mail Order. Contact Pharmacy Customer Service at the number listed on the back of your ID card for more information or to get started on the Mail Order program.

Mandatory Generic: The plan mandates generic prescription drugs wherever available. If a brand-name prescription drug is requested when a generic is available, the generic will be available without Preauthorization. If brand is still desired, PA will be required, even if not indicated on the PDL below. If brand is approved through the PA process, the Brand-Generic penalty will still be applied (see Brand-Generic Change under the Prescription Drug Limits & Requirements section above).

Off-Label Use of Prescription Drugs: The FDA requires that prescription drugs used in the U.S. be safe and effective. The label information of a prescription drug outlines use for "approved" doses and specific conditions or disease states. The use of a prescription drug for a disease state or condition not listed on the label, or in a dose or therapy not listed on the label, is considered to be a "non-approved" or "off-label" use of the prescription drug. Off-label use of a prescription drug is not covered unless it meets the Plan's off-label use policy. A Preauthorization is required when a prescription drug is used outside of its FDA indication, dosage, or treatment, or it may not be covered. Coverage will be reviewed under the off-label use policy;, and subject to the same conditions and limitations as any other prescription drug. Therapies deemed investigational or experimental or that do not meet the off-label criteria are not a covered benefit.

Non-Formulary (not covered) or Exception Requests for Prescription Drugs: For prescription drugs that are not covered by the Plan (non-formulary), you or your provider can may submit a formulary exception request. Your provider will be required to complete a formulary exception form and provide clinical documentation to show why these requested prescription drug is needed/required for treatment of your disease state or medical condition and to provide evidence that you cannot use a formulary alternative. A letter of medical necessity is also recommended. Your provider should also include in his/her letter your diagnosis and previous therapies that have been tried and failed. If an exception request approval is not received or the prescription drug is filled prior to approval, the cost of the prescription drug will be full member responsibility. Contact Pharmacy Customer Service at the number listed on the back of your ID card for more information.

Specialty Medications: Specialty medications are generally prescribed for individuals with complex or ongoing medical conditions such as multiple sclerosis, hemophilia, hepatitis C, rheumatoid arthritis, autoimmune disorders, dermatological disorders, or certain types of cancer. These are high-cost medications that can be taken by mouth, injection, or infusion and have special handling or storage requirements and may not be stocked by retail pharmacies. They often require additional specific education and support from a health care professional than most retail medications.

Coverage for specialty medications is provided through your pharmacy benefit plan and may require use of one of the plan’s designated specialty pharmacies to receive coverage.

Specialty medications are Tier 4 medications in the PDL. Tier 4 specialty medications may require preauthorization or have quantity limits. Those requirements may be found on our website at https://www.mountainhealth.coop/pharmacy , or by calling the Pharmacy Customer Service number appearing on the back of your ID Card.

Therapeutic Interchange (TI): Therapeutic Interchange is the practice of replacing, with your physician's approval, a prescription drug originally prescribed with a chemically different but therapeutically equivalent

prescription drug. Prescription drugs used in therapeutic interchange programs are expected to produce similar levels of effectiveness and results. Therapeutic interchange programs are based on scientific evidence. These programs are developed under the guidance of the P&T Committee. The program is designed to work along with other tools that medical professionals use to promote safe and effective drug therapy. If therapeutic interchange is required on a prescription drug, your pharmacist will receive a message to request a therapeutic interchange from your provider. If you or your provider feel the interchange is not right for you and you do not want to pay full price for your prescription, your provider can submit a request for Preauthorization review.

DRUG FORMULARY, PREAUTHORIZATION, AND PRESCRIPTION DRUG SUPPLY LIMITS

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

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

If the Member does not obtain Preauthorization for a Prescription Drug listed in the Prescription Drug Preauthorization List, reimbursement may be denied. For reimbursement consideration, the Member must submit a claim with supporting documentation to Pharmacy Customer Service.

Up to a 30-day supply of a non-specialty prescribed medication is allowed at a retail network pharmacy. In addition, up to a 90-day supply of a non-specialty prescribed medication is allowed at certain In-Network Pharmacies (retail) and certain In-Network Mail Order Pharmacies, as allowed by applicable state or federal law. Specialty medications must be filled through a designated specialty pharmacy and are only allowed for up to a 30-day supply.

The supply limits for Prescription Drugs are as follows:

I. Per prescription or refill at a retail In-Network Pharmacy or an Out-of-Network Pharmacy is limited to a maximum of a 30-day supply;
II. Per prescription or refill received from certain In-Network 90-day retail pharmacies or Mail Order Pharmacies is limited to a maximum of a 90-day supply based on the FDA-approved dosage regardless of the manufacturer packaging.
III. Specialty medications are limited to a 30-day supply from a designated specialty pharmacy.

Prescription Drug Benefit Exclusions and Limitations

Specific medications may not be a covered benefit under The Plan. Some prescriptions drugs, though FDA approved, have failed to show meaningful efficacy toward treating any condition, may have a suitable over-the-counter alternative, may be solely used for conditions not covered by the plan, or have significant safety

concerns which outweigh the benefit of the therapy. These may include drugs used to treat cosmetic conditions or for weight loss. This drug list is subject to change as new drugs becoming available and others are removed from the market. For a complete list of covered and non-covered medications and plan limitations, refer to The Plan's website at https://www.mountainhealth.coop/pharmacy to access the retail drug formulary.

The following exclusions and limitations apply to your Prescription Drug Benefits:

I. Anabolic Steroids
II. Biological Sera, Blood, or Blood Plasma
III. Compounded Products; unless prior approval received for medical necessity. Compounded products are limited and may not be covered if a commercial product is available.
IV. Diabetic infusion sets, which include: (a) a cassette; (b) needle and tubing; and (3) one insulin-pump during the warranty period. Diabetic-infusion sets, pumps and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit.
V. Experimental Trial medications
VI. Eyedrop Refills unless the following is met:
    a. The eyedrop is a covered medication;
    b. The prescriber indicates on the original prescription that additional quantities are needed;
    c. The Member's refill request does not exceed the number of additional quantities needed; and
    d. An amount of time has passed in which the Member should have used 70% of the dosage unit according to the prescriber's instruction; or
        i. 21 days have passed since a 30-day supple of the eyedrop was dispensed;
        ii. 42 days have passed since a 60-day supply of the eyedrop was dispensed; or
        iii. 63 days have passed since a 90-day supply of the eyedrop was dispensed.
VII. Food Supplements, Special Formulas, and Special Diets
VIII. Homeopathic Medications
IX. Infertility Medications to treat or enhance fertility
X. Investigational, Experimental, Clinical Trial, or Unproven Drugs: Drugs labeled "Caution – limited by federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
XI. Medications for Cosmetic purposes (for example, but not limited to, cosmetic hair growth and removal Products).
XII. Medications or immunizations administered for the purpose of prevention of disease when traveling to other countries.
XIII. Medication Taken or Administered While in a provider office or facility: Medication which is taken by or administered to an individual, in whole or in part, while he or she is a patient in a doctor's office, hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
XIV. Medications that cannot be self-administered
XV. Medications that are therapeutically the same as an over-the-counter medication
XVI. Medications that are covered under a per diem or daily rate for a Skilled Nursing, Long-term Care, or Acute Rehab facility contract

XVII. No Charge Medications received under worker's compensation laws, federal, state, or local programs
XVIII. Medications to treat sexual dysfunction or impotence
XIX. Medication samples, including any corresponding administration requirements such as intravenous infusion therapy and office visits for administration.
XX. Medications used to treat weight loss.
XXI. Medications whose primary purpose is to correct vision.
XXII. Non-Formulary Medications.
XXIII. Off-label use of Medication; except as outlined in the Plan Off-label Use Policy.
XXIV. Other Party Liability, Prescription Drugs which an eligible person is entitled to receive without charge under any workers compensation laws, or any other municipal, state, or federal program.
XXV. Over-the-Counter Medication (OTC) or other items purchased at a pharmacy other than Prescription Drugs whether or not there is a Prescription order for the item(s), except as required under the ACA
XXVI. Pigmenting/De-pigmenting Agents, except as required to treat photosensitive conditions, such as psoriasis
XXVII. Prescription Drugs in excess of a 90-day supply or the Plan day or quantity limit
XXVIII. Refills in excess of the number specified by the Physician or any refill dispensed after one year from the Physician's original Prescription order
XXIX. Synagis outside of state-designated Respiratory Syncytial Virus (RSV) Season
XXX. Testopel pellets
XXXI. Therapeutic devices or appliances, including hypodermic needles, syringes (excluding insulin syringes), support garments, and other non-medicinal substances, regardless of intended use. (In some cases, items may be covered under the Medical Benefits portion of the Plan.)
XXXII. Vitamins and Minerals, except as required under the ACA, listed as PREV. Please note vitamins may be limited to coverage by age and specific dosing requirements.

PURCHASE AND PAYMENT OF PRESCRIPTION DRUGS

To maximize Your benefits, Prescription Drugs may be obtained using a retail In-Network Pharmacy or In-Network Mail Order Pharmacy. Prescription drugs can also be obtained by using a retail Out-of-Network Pharmacy or Out-of-Network Mail Order Pharmacy at a higher cost to the Member. The Prescription Drug Coinsurance and/or Copayment, if any, is shown in the SBC. The Prescription Drug Coinsurance and Copayments apply towards the satisfaction of the Annual Out-of-Pocket Maximum required under the Policy.

If Prescription Drugs are purchased at a retail In-Network Pharmacy, the Member must present the Member's Identification Card (ID) at the time of purchase and pay the required Prescription Drug Deductible, Coinsurance and/or Copayment as shown in the SBC.

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

If Prescription Drugs are purchased at an Out-of-Network Pharmacy, retail or mail order, the Member must pay out-of-network coinsurance for the prescription at the time of purchase.

THIRD PARTY PAYMENTS FOR PRESCRIPTION DRUGS

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

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

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

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

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

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

POSTMASTECTOMY CARE AND RECONSTRUCTIVE BREAST SURGERY

POSTMASTECTOMY CARE

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

I. A mastectomy;
II. A lumpectomy; or
III. A lymph node dissection; for the Treatment of breast cancer.

RECONSTRUCTIVE BREAST SURGERY

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

I. All stages of reconstruction of the breast on which a mastectomy has been performed;

II. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
III. Prostheses and physical complications of all stages of mastectomy and breast reconstruction, including lymphedemas; and
IV. Chemotherapy.

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

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

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

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

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

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

PREVENTIVE HEALTH CARE SERVICES BENEFIT

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

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

I. Services that have an "A" or "B" rating* in the United States Preventive Services Task Force's current recommendations. Additional information is provided by accessing (http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browserecommendations) ; and
II. Immunizations recommended by the Advisory Committee of Immunizations Practices of the Centers for Disease Control and Prevention; and
III. Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children, Adolescents and Women;
IV. Lactation Services: Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period. In addition, the plan will reimburse the Member the actual cost for the purchase of a breast pump once per birth event. Hospital-grade pumps can be rented, per Medical Policy criteria.

V. Contraceptives: Food and Drug Administration approved contraceptive methods, including certain contraceptive products, sterilization procedures for women, and patient education and counseling for all women with reproductive capacity.
VI. Current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued prior to November 2009; and
VII. Any other Preventive Health Care Services required by federal and state law.
VIII. Educational training for Preventive Health Care Services that is necessary and prescribed by a Physician will be covered.

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

For more detailed information on Preventive Health Care Services, contact Customer Service at the telephone number or website shown on page 5, Important Information.

PROSTHETIC DEVICES (NON-DENTAL)

Coverage will be provided for appropriate non-dental prosthetic devices used to replace a body part missing because of an Accident, Injury or Illness. Such non-dental prosthetic devices include:

I. artificial limbs;
II. eyes; or
III. other prosthetic appliances.

Replacement of such devices will be covered only if:

I. functionally necessary; or
II. as required by a change in the Member's physical structure.

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

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

No benefits will be paid for:

I. Computer-assisted communication devices; and
II. Replacement of lost or stolen prosthesis.
III. Preauthorization is required for the original purchase or replacement of prosthetics over $1,500. Please refer to Section 7, Utilization Review Management Program.

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

RADIATION THERAPY SERVICES

Coverage will be provided for these services which include:

I. Chemotherapy. Coverage includes the use of drugs to approved for use in humans by the U.S. Food and Drug Administration (FDA);
II. X-rays;
III. Radium therapy; and
IV. Radioactive isotope therapy;

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

REHABILITATION – FACILITY AND PROFESSIONAL SERVICES

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

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

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

I. Custodial care;
II. Diagnostic admissions;
III. Maintenance, nonmedical self-help, or vocational educational therapy;
IV. Social or cultural rehabilitation;
V. Learning and developmental disabilities; and
VI. Visual, speech, or auditory disorders because of learning and developmental disabilities.

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

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

REHABILITATION FACILITY INPATIENT CARE SERVICES BILLED BY A FACILITY PROVIDER

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

I. Room and Board Accommodations. Such room and board accommodations include, but are not limited to:
   a. dietary and general; and
   b. medical and rehabilitation nursing services.
II. Miscellaneous Rehabilitation Facility Services (whether or not such services are Rehabilitation Therapy or are general, medical or other services provided by the Rehabilitation Facility during the Member's admission), including but not limited to:

a. Rehabilitation Therapy services and supplies, including but not limited to Physical Therapy, Occupational Therapy, and speech-language pathology.
b. Laboratory procedures;
c. Diagnostic testing;
d. Pulmonary services and supplies, including but not limited to oxygen, and use of equipment for its administration;
e. X-rays and other radiology;
f. Intravenous injections and setups for intravenous solutions;
g. Special diets when Medically Necessary;
h. Operating room, recovery room;
i. Anesthetic and surgical supplies;
j. Drugs and medicines which:
    i. Are approved for use in humans by the U.S. Food and Drug Administration for the specific diagnosis for which they are prescribed;
    ii. Are listed in the American Medical Association Drug Evaluation, Physicians' Desk Reference, or Drug Facts and Comparisons; and
    iii. Require a Physician's written prescription.

Rehabilitation Facility Inpatient Care Services do not include services, supplies or other items for any period during which the Member is absent from the Rehabilitation Facility for purposes not related to rehabilitation, including, but not limited to, intervening Inpatient admissions to an acute care Hospital.

Preauthorization is required for Rehabilitation Facility Inpatient Care. Refer to Section 6, Utilization Review Management Program.

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

I. A facility that primarily provides Rehabilitation Therapy, regardless of whether the facility is also licensed as a Hospital or other facility type;
II. A freestanding facility or facility associated with or located within a Hospital or other facility;
III. A designated rehabilitation unit of a Hospital;
IV. For purposes of the Rehabilitation Therapy Benefit, any facility providing Rehabilitation Therapy to a Member, regardless of the category of facility licensure.

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

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

Rehabilitation Facility Inpatient Care is subject to the following conditions:

I. The Member will be responsible to the Rehabilitation Facility for payment of the Facility's charges if the Member remains as an Inpatient when Rehabilitation Facility Inpatient Care is not Medically Necessary. No benefits will be provided for a bed reserved for the Member.

II. The term "Rehabilitation Facility" does not include:
   a. A Hospital when the Member is admitted to a general medical, surgical or specialty floor or unit (other than a rehabilitation unit) for acute Hospital care, even though rehabilitation services are or may be provided as a part of acute care;
   b. A nursing home;
   c. A rest home;
   d. Hospice;
   e. A skilled nursing facility;
   f. A Convalescent Home;
   g. A place for care and treatment of Chemical Dependency;
   h. A place for treatment of Mental Illness;
   i. A long-term, chronic-care institution or facility providing the type of care listed above in this subparagraph.

REHABILITATION FACILITY INPATIENT CARE SERVICES BILLED BY A PROFESSIONAL PROVIDER

Coverage will be provided for all Professional services provided by a Covered Provider who is a physiatrist or other Physician directing the Member's Rehabilitation Therapy. Such professional services include:

I. care planning and review;
II. patient visits and examinations;
III. consultation with other Physicians, nurses or staff; and
IV. all other professional services provided with respect to the Member. Professional services provided by other

Covered Providers (i.e., who are not the Physician directing the Member's Rehabilitation Therapy) are not included in this Rehabilitation benefit, but are included to the extent provided in and subject to the terms, conditions and limitations of other Covered Benefits under this Policy.

OUTPATIENT REHABILITATION SERVICES

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

RENAL DIALYSIS

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

ROUTINE FOOT CARE

Coverage will be provided for routine foot care if You have diabetes-related nerve damage and need Medically Necessary treatment.

SURGICAL SERVICES

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

SURGICAL SERVICES BILLED BY A PROFESSIONAL PROVIDER

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

SURGICAL SERVICES BILLED BY AN OUTPATIENT SURGICAL FACILITY OR FREESTANDING SURGERY CENTERS

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

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

SURGICAL SERVICES BILLED BY A HOSPITAL (INPATIENT AND OUTPATIENT)

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

TELEHEALTH

Coverage will be provided for Telehealth. Health care services administered via Telehealth must be deemed medically necessary and administered by a licensed health care provider. Telehealth is reimbursed at the same benefit level as brick and mortar office visits. Coinsurance, deductible and copays may apply.

THERAPEUTIC SERVICES – OUTPATIENT

Coverage will be provided for the following Outpatient therapeutic services:

I. Physical Therapy;
II. Speech-language pathology;
III. Cardiac Therapy;
IV. Occupational Therapy; and
V. Rehabilitation Therapy.

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

TRANSPLANT BENEFITS

Coverage will be provided for Medically Necessary non-experimental transplants for the following:

I. kidney;
II. pancreas;
III. heart;
IV. heart/lung;
V. single lung;
VI. double lung;
VII. liver;
VIII. cornea;
IX. bone marrow/stem cell;
X. small bowel transplant;
XI. simultaneous pancreas/kidney; and
XII. renal transplant.

Preauthorization is required for organ transplants; refer to Section 6, Utilization Review Management Program.

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

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

I. Organ procurement including transportation of the surgical/harvesting team, surgical removal of the donor organ, evaluation of the donor organ and the transportation of the donor or donor organ to the location of the transplant operation.
II. Donor services, including the pre-operative services, transplant related diagnostic lab and x-ray services, and the transplant surgery hospitalization. Transplant related services are covered for up to six months after the transplant surgery.
III. Hospital Inpatient Care.
IV. Surgical services.
V. Anesthesia.
VI. Professional Covered Providers and diagnostic Outpatient services.
VII. Licensed ambulance travel or commercial air travel for the Member receiving the Transplant to the nearest Hospital with appropriate facilities.

Benefits will be payable subject to the following conditions:

I. When both the transplant recipient and donor are Members, both will receive benefits.
II. When the transplant recipient is a Member and the donor is not, both will receive benefits to the extent that benefits for the donor are not provided under other hospitalization coverage.
III. When the transplant recipient is not a Member and the donor is a Member, the donor will receive benefits to the extent that benefits are not provided to the donor by hospitalization coverage of the transplant recipient.

No benefits will be payable for:

I. Experimental or investigational procedures;
II. Transplants of a nonhuman organ or artificial organ transplant; and
III. Donor searches.

URGENT CARE

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

If a condition requiring urgent care develops, We recommend that You go to the nearest

In-Network urgent care center or physician's office. This treatment may be subject to a Copayment and/or Coinsurance as shown in the SBC.

VISION EXAM

Your plan provides up to a $60 reimbursement towards one routine vision examination per enrollee each calendar year. Any licensed optometrist or ophthalmologist may be used. This allowance may be used towards the following services routine eye exam services:

I. Examination of the outer and inner parts of the eye
II. Evaluation of vision sharpness (refraction)
III. Binocular function testing
IV. Routine tests of color vision, peripheral vision, and intraocular pressure
V. Case history, recommendations, and prescriptions

LENSES: no benefits for contact lenses, eyeglass lenses, or frames are available with this benefit.

For instructions on how to be reimbursed for this benefit, please visit our website at https://www.mountainhealth.coop/

WELL-CHILD CARE

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

I. Histories;
II. Physical examinations;
III. Developmental assessments;
IV. Anticipatory guidance;
V. Laboratory tests; and
VI. Routine immunizations.

WELLNESS SERVICES

Coverage will be provided for Wellness Services. Benefits include, but are not limited to, the following:

I. Smoking Cessation;
II. Weight Management;
III. Stress Management; or
IV. Nutrition and Exercise.

SECTION 6—UTILIZATION REVIEW MANAGEMENT PROGRAM

Our Utilization Review Management Program provides for Prospective Utilization Review to assure that certain prescribed Treatments and elective procedures are Medically Necessary and appropriate.

Prospective Utilization Review requires the Member to obtain Preauthorization for certain prescribed Treatments and elective procedures before the Treatments and procedures are rendered. The Member must contact the Utilization Review Management Program representative to obtain the Preauthorization. The Utilization Review Management Program representative is shown on page 5, Important Information.

HOW TO USE THE UTILIZATION REVIEW PROGRAM

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

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

I. The name and social security number of the Member for whom Treatment has been prescribed and requires Preauthorization;
II. The Policyowner's name and this Policy's Policy Number which is shown on the Outline of Coverage.
III. The name and telephone number of the attending Physician;
IV. The name of the Covered Facility where the Member will be admitted, if applicable;
V. The proposed date of admission, if applicable; and
VI. The proposed Treatment.

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

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

UTILIZATION REVIEW DEADLINES

I. For prospective determinations (service not yet occurred): seven (7) business days;
II. For retrospective determinations (service has already occurred): thirty (30) days;
III. For expedited determinations (urgent care): as soon as possible (48-hour maximum)

The insurer may seek a 7-day deadline extension for prospective and retrospective determinations.

PLAN NOTIFICATION

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

MEDICAL TREATMENTS REQUIRING PREAUTHORIZATION

Preauthorization must be obtained for:

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

Members are responsible for obtaining preauthorization. Failure to obtain the required Preauthorization prior to receiving services will result in pended claims and a review for medical necessity. If We find the services not medically necessary, You may be responsible for the full cost of the services.

To request a preauthorization Member or Member's provider must call the Preauthorization phone number provided on the back of the ID Card. Preauthorization does not guarantee that services/supplies/medications Member receives are Covered Medical Expenses or that those medical expenses will be paid.

PREAUTHORIZATION MEDICAL TREATMENT LIST

Preauthorization is prior approval for certain Services and is considered a Preservice Claim. Preauthorization is not required when your plan is secondary to another primary commercial and documentation of primary coverage is verified.

Preauthorization is required for injectable drugs and inpatient services when Medicare is your primary insurance.

Obtaining Preauthorization does not guarantee coverage. Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions and all other provisions of the Plan.

GENERAL SERVICES REQUIRING PREAUTHORIZATION

The following services require preauthorization for elective circumstances; notification is required for urgent /emergent circumstances within 48 hours of admission or provision of the service. These include:

I. Inpatient Acute Care Hospitals
II. Observation stays, Acute Care Hospitals
III. Long-Term Acute Care Hospitals
IV. Inpatient Behavioral Health and Substance Use

V. Inpatient Hospice
VI. Acute Rehabilitation
VII. Skilled Nursing Facility
VIII. Home Health/Outpatient Hospice Services
IX. Air Medical Transport

SPECIFIC SERVICES REQUIRING PREAUTHORIZATION

In addition to general Services requiring preauthorization, certain procedures and specific Services may also require preauthorization in addition to the general authorizations above. The following partial list of Services requiring preauthorization for coverage is outlined below. This list reflects some Services which may be covered if preauthorization is obtained. A full list of these services can be found at online at https://mountainhealth.coop/.

Common Services Requiring Preauthorization

I. Durable medical equipment with total price or individual components exceed $1000.00
II. Gender Reassignment Surgery
III. Certain Genetic Tests or Therapies
IV. Certain outpatient behavioral health services
V. Joint Replacement Procedures
VI. Certain Arthroscopic Procedures
VII. Spine Surgeries
VIII. Certain Diagnostic and Therapeutic Cardiac Procedures
IX. Certain Medical Drugs
X. Proton/Neutron Beam/Stereotactic Radiosurgery Therapy
XI. Neurostimulation
XII. Out-of-Network Services
XIII. Reconstructive/Cosmetic Surgeries
XIV. Solid organ and Stem Cell Transplants and associated services
XV. This list does not reflect those services which are excluded from coverage due to benefit exclusion or not covered as they are considered investigational.

UTILIZATION REVIEW PROCESS

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

UTILIZATION REVIEW FOR MENTAL HEALTH TREATMENT

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

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

I. Personal and family history; or
II. Current and diagnosis of a mental disorder;

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

Request for Information

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

DISCLSOURE OF PERSONAL INFORMATION

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

I. Personal and family history; or
II. Current and past diagnosis of a mental disorder;

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

DETERMINATIONS MADE ON APPEAL OR RECONSIDERATION

A Utilization Review determination that is:

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

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

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

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

SECTION 7—COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when the Member has health care coverage under more than one Plan. Plan is defined below. If You are covered by more than one health benefit plan, You should file all Your claims with each plan.

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

DEFINITIONS

I. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   a. "Plan" includes: group and nongroup health insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
   b. "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, if determined by the commissioner to be "excepted benefits" as defined in 33-22-140, MCA; school accident type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

IV. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.
When This Plan is Primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

V. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable

Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable expense. The following are examples of expenses that are not Allowable expenses:

a. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
b. If a person is covered by two or more Plans that compute their benefit payments on the basis of relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
c. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
d. If a person is covered by one Plan that calculates its benefits or services on the basis of relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.
e. The amount of any benefit reduction by the Primary Plan because a Member has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and In-Network arrangements.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

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

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

IX. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

X. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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

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

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

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

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

    a. The Plan covering the Custodial parent;
    b. The Plan covering the spouse of the Custodial parent;
    c. The Plan covering the non-custodial parent; and then
    d. The Plan covering the spouse of the non-custodial parent.

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

XVII. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid- off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

OTHER INSURANCE

If no other coordination of benefit rules are applicable, We will credit Member's deductible, copayment, or coinsurance, as applicable, for any payment made by a casualty or property insurer for Covered Medical Expenses as long as You notify Us of the payment within 12 months of the date of service.

SECTION 8 – EXCLUSIONS AND LIMITATIONS

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

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

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

III. Services, supplies, drugs, and devices which the Member is entitled to receive or does receive TRICARE, the Veteran's Administration (VA), and Indian Health Services but not Medicaid.

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

IV. War, or act of war, whether declared or not, rebellion, armed invasion, or insurrection.

V. Service in the Armed Forces or any auxiliary units of the Armed Forces.

VI. Any loss for which a contributing cause was commissioned by the Member if found guilty of a felony.

VII. Dental care and treatment except for such care or treatment due to accidental Injury to sound natural teeth and except for dental care or treatment necessary due to congenital disease or anomaly.

VIII. Vision services, including, but not limited to:
    a. fitting of eyeglasses or contact lenses
    b. purchase of eyeglasses and contact lenses
    c. Lasik surgery
    d. radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism).

This exclusion DOES NOT apply to the Pediatric Vision Care benefit provided in this Policy or to the Preventive Eye Exam Benefit, if any, provided in this Policy.

IX. Hearing aids and examinations for the prescription or fitting of hearing aids except as specified as a Covered Service in the Policy.

X. Cosmetic Surgery unless it is either
   a. Medically Necessary; or
   b. reconstructive surgery. Such reconstructive surgery must be: incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part because of congenital disease or anomaly of a covered Dependent Child which has resulted in a functional defect.

XI. Services, supplies, drugs, and devices for the treatment of illness, injury or complications resulting from services that are not Covered Benefits, except for any services, supplies, drugs, and devices which are incurred in connection with an Approved Clinical Trial.

XII. Foot care, including but not limited to:
   a. treatment or removal of corns and callosities
   b. hypertrophy, hyperplasia of the skin or subcutaneous tissues
   c. cutting or trimming toenails
   d. any Treatment of congenital flat foot
   e. injections and nonsurgical Treatment of acquired flat foot, fallen arches, or chronic foot strain
   f. any Treatment of flat foot purely for the purpose of altering the foot's contour where no medicine or functional impairment exists
   g. orthotic appliances
   h. impression casting for orthotic appliances
   i. padding and strapping
   j. fabrication.

Note: This exclusion does not apply to those with diabetes. See Routine Foot Care under the Covered Service section of this policy for more information.

XIII. Foot orthotic appliance provided for the treatment of any medical condition except diabetic related.

XIV. Behavioral Health and Substance Abuse or Addiction services and treatment not recognized by the American Psychiatric and American Psychological Association or provided in facilities that are not accredited for the particular level of care for which reimbursement is being requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities.

XV. TENS and supplies units.

XVI. Treatment provided in a government hospital, except Montana residents who are confined in state medical institutions; benefits provided under Medicare or another governmental program (except Medicaid).

XVII. Services rendered and separately billed by employees of hospitals, laboratories, or other institutions.

XVIII. Services performed by the Member or a member of the Member's Immediate Family.

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

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

XXI. Custodial Care.

XXII. Private duty nursing.

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

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

XXV. Reversal of an elective sterilization.

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

XXVII. Outpatient prescription drugs dispensed from a medical provider for which benefits are provided under the Prescription Drug Benefit in this Policy.

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

XXIX. Transplants of a non-human organ or artificial organ transplant.

XXX. Any services, supplies, drugs, and devices which are: (a) an investigational/Experimental Service/Technology (b) not accepted medical practice (c) not a Covered Medical Expense (d) not Medically Necessary (e) not covered under our Medical Policy. We may consult with physicians or national medical specialty organizations for advice determining whether the service or supply is an accepted medical practice.

XXXI. For travel by the Member or a provider except as allowed under this Policy.

XXXII. Orthodontics.

XXXIII. Services, supplies and devices relating to:

a. Holistic Medicine
b. Holistic Healing
c. Reiki
d. Medical Herbalism
e. Natural Healing
f. acupressure
g. homeopathic treatments
h. Rolfing; and other forms of Complementary and Alternative Medical treatments or therapy.
i. Services, supplies and devices relating to any of the following treatments or related procedures:
j. religious counseling
k. self-help programs.

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

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

XXXVI. . Services, supplies, drugs and devices for weight reduction or weight control, whether rendered for weight control or any other condition. This Exclusion does not include intensive behavioral dietary counseling for adult patients when services are provided by a physician, physician assistant or advanced nurse practitioner.

XXXVII. Education services, boarding schools, , or tutoring services.

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

XXXIX. Computerized items including, but not limited to, the following:

a. durable medical equipment
b. prosthetic limbs
c. communication devices.

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

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

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

XLII. All services, supplies, drugs, and devices provided to treat any Illness or Injury arising out of employment as an athlete.

XLIII. For any of the following:

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

XLIV. Services, supplies, drugs, or devices provided before the Policy Effective Date of coverage or after the termination of coverage.

XLV. Any service, supply, drug, or devices excluded in any other section of this Policy.

XLVI. Charges associated with health clubs.

XLVII. Any service, supply, drug, device, or medical expense not provided by a Covered Provider.

XLVIII. Non-Emergent services, supplies, drugs, devices, or medical expense provided outside the United States.

XLIX. Services, supplies, drugs, devices, or medical expenses which are not Covered Benefits, not Covered Medical Expenses, or for which benefit maximums have been reached.

L. Foreign Prescriptions, except when associated with an Emergency Medical Condition while You are traveling outside the United States unless covered under the international sourcing program.

LI. Services, supplies, drugs, devices, or medical expenses not submitted within twelve (12) months after received or provided.

LII. Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to the treatment of painful physical conditions: Mental Health Conditions; Substance Use Disorders; Smoking; Weight Loss; Dental Care; or Anesthesia purposes.

LIII. Illegal Services, Substances and Supplies.

LIV. Sexual Dysfunction.

LV. Varicose Vein Treatment except in the following situations: (a) When there is an associated venous ulceration(s); or (b) A persistent OR recurrent bleeding from ruptured veins.

SECTION 9 – CLAIM PROVISIONS

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

HOW TO FILE A CLAIM

When a Member receives services from of an In-Network, no claim form is required to be submitted to Us. However, if the Member uses the services of a Out-of-Network, the Member should file a claim with Us only if the Out-of-Network Provider does not file one for the Member. Instructions on how to file a claim are found on our website at https://mountainhealth.coop/

In-Network Providers will automatically file a claim directly to Us on behalf of the Member for whom they provide services. Therefore, the Member is not required to complete and submit a claim to Us.

NOTICE OF CLAIM

Written notice of claim must be given to Us within twelve (12) months after the occurrence or commencement of any loss covered by this Policy or as soon as is reasonably possible. Notice given by or on behalf of the Member or the beneficiary to Us at Our Claims Administration office address is shown on page 4, Important Information.

CLAIM FORMS

We will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss upon request. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant will be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proofs of loss, written proof of covering the occurrence, the character, and the extent of the loss for which claim is made. For immediate receipt of a claim form, You can visit our website at https://mountainhealth.coop/

PROOF OF LOSS

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

TIME PAYMENT OF CLAIMS

Covered Benefits payable under this Policy for any covered loss will be processed in the time period required under this Policy upon receipt of due written proof of such loss.

Timely Settlement of Claims

We will pay or deny a claim within 30 days of receipt of all the necessary documents to process the claim. We make a reasonable request for additional information or documents in order to evaluate the claim. Payment cycles will not exceed thirty (30) days. If We make a reasonable request for additional information or

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

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

PAYMENT OF CLAIMS

Benefits payable under this Policy will be paid to Member.

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

PHYSICAL EXAMINATIONS AND AUTOPSY

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

RIGHT TO RECOVER

After We pay any claim under this Policy, We have the right to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim within twelve (12) months. The twelve (12)-month period for Our review or audit will not begin until:

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

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

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

PRESCRIPTION DRUG RECOVERY

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

SUBROGATION

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

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

Third-Party Liability Provision

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

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

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

SECTION 10—COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS AND GRIEVANCES

We, the CO-OP, have established a Complaint and Grievance process. Important Information appears on page 5 to process claims, handle complaints, grievances and appeals Customer Service and Appeals and Grievances Department, respectively. A complaint involves a communication from the Member expressing discontent or dissatisfaction with services. A grievance involves a complaint of unfair treatment or quality of care received from a provider's staff.

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

The Member may also file a written complaint. The mailing address of Customer Service appears on page 5, Important Information. Written complaints or grievances will be acknowledged within three (3) working days of receipt. The Member will be notified of the response to or resolution of this matter within thirty (30) days of the Member's written complaint or grievance.

CLAIMS PROCEDURES

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

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

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

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

An Appointment of Authorized Representative form may be obtained from, and completed forms must be submitted to Customer Service Department at the address listed on page 4, Important Information. An

assignment for purposes of payment does not constitute appointment of an authorized representative under these claims procedures. Once an Authorized Representative is appointed, the We will direct all information, notification, etc., regarding the claim to the authorized representative. The Claimant will be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise.

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

NOTIFICATION OF ADVERSE CLAIM DETERMINATION

I. Adverse benefit determination on a claim is "adverse" if it is:
II. a rescission or a denial, reduction, or termination of; or
III. a failure to provide or make payment (in whole or in part) for a Policy benefit.
IV. Notification of adverse benefit determination, , in writing or electronically,, will be provided to the Claimant of the adverse benefit determination on a claim and will include the following, in a manner calculated to be understood by the Claimant:
V. A statement of the specific reason(s) for the decision. If the adverse benefit determination is a rescission, the notice, sent at least thirty (30) days in advance of implementing the rescission decision will include (a) clear identification of the fraudulent act, practice, or omission or the intentional misrepresentation of material fact; (b) an explanation of why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact; (c) the date when the advance notice period ends and the date to which coverage is to be retroactively rescinded;
VI. Reference(s) to the specific Policy provision(s) on which the decision is based
VII. If applicable, a description of any additional material or information necessary to perfect the claim and why such information is necessary;
VIII. A description of this Policy's procedures and time limits for appeal of the decision, and the right to obtain information about those procedures, contact information for a consumer appeal assistance program, and if applicable, a statement of the right to sue in federal court;
IX. If applicable, a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
X. If the decision involves scientific or clinical judgment, either:
XI. an explanation of the scientific or clinical judgment applying the terms of the Policy to the Claimant's medical circumstances; or
XII. a statement that such explanation will be provided at no charge upon request;
    A. In the case of an urgent care claim, an explanation of the expedited review methods available for such claims, and
    B. A statement that reasonable access to and copies of all documents and records and other information relevant to the adverse benefit determination will be provided, upon request and free of charge.

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

YOUR RIGHT TO APPEAL

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

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

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

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

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

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

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

I. The identity of the Claimant;
II. A specific medical condition or symptom;
III. A specific treatment, service, or product for which approval or payment is requested; and
IV. Any reasons why the appeal should be processed on a more expedited basis.
V. If a physician with knowledge of the Claimant's medical condition determines the claim involves urgent care, We will treat the claim as an urgent care claim.

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

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

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

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

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

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

TIME PERIOD FOR NOTIFICATION OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATIONS

Urgent Care Claims. Urgent Care Claims Appeals will be completed as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt by the Appeals and Grievances Department of the written appeal or completed Request for Review form. The Appeals and Grievances

Department will notify the Claimant and/or the Member's Authorized Representative verbally and provide a follow-up written notice no later than seventy-two (72) hours after receipt of the appeal request.

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

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

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

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

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

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

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

NOTIFICATION OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

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

I. The specific reason(s) for the final internal adverse benefit determination, including a discussion of the decision. If the final internal adverse benefit determination upholds a

rescission, the notice will include: (1) the basis for the fraud; or (2) intentional misrepresentation of a material fact;

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

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

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

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

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

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

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

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

EXTERNAL REVIEW PROCEDURES

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

I. Rescissions of coverage; and

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

If the Plan has failed to strictly adhere to the internal appeals processes the Member is deemed to have exhausted the internal claims and appeals process and may request and external review or pursue available remedies under section 502(a) of ERISA or under State Law.

STANDARD EXTERNAL REVIEW

A Claimant (or someone acting on the Claimant's behalf) may request external review of an adverse benefit determination within 120 days after the date of receipt of a notice of an adverse benefit determination or a final internal adverse benefit determination. The request for external review must be made in writing or orally to the Appeals and Grievances Department at the address indicated on page 5 of this Policy or by calling (800)

299-6080. Within five (5) business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether:

I. The Claimant is (or was) covered under this Policy at the time the health care item or service was requested or, in the case of retrospective review, the Claimant was covered under this Policy at the time the health care item or service was provided;
II. The adverse benefit determination or final internal adverse benefit determination is not based on the fact that the Claimant was not eligible for coverage under this Policy;
III. The Claimant has exhausted this Policy's internal appeal process (unless exhaustion is not otherwise required); and
IV. The Claimant has provided all the information, forms and fee required to process an external review, including the release of medical records form.

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

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

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

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

EXTERNAL REVIEW PROCESS

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

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

Reconsideration. On receiving any information submitted by the Claimant, the IRO must forward the information to the Appeals and Grievances Department within one (1) business day. The Appeals and

Grievances Department may then reconsider its adverse benefit determination or final internal adverse benefit determination. If the Appeals and Grievances Department decides to reverse its adverse benefit determination or final internal adverse benefit determination, it must provide written notice to the Claimant, Commissioner and the IRO within one (1) business day after making the decision. On receiving this notice, the IRO will end its external review.

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

I. The Claimant's medical records;
II. The Claimant's treating provider's or providers' recommendations;
III. Reports from appropriate health care professionals and other documents, opinions, and recommendations submitted by Us, Appeals and Grievances Department, and the Claimant;
IV. The terms and conditions of this Policy, including specific coverage provisions, to ensure that the IRO's decision is not contrary to the terms and conditions of this Policy, unless the terms and conditions do not comply with applicable law;
V. Appropriate practice guidelines, which must include applicable evidence-based standards;
VI. Any applicable clinical review criteria developed and used by Us unless the criteria:
VII. are inconsistent with the terms and conditions of this Policy; and
VIII. do not comply with applicable law;
IX. The applicable medical policies of this Policy;
X. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider them appropriate.

Notice of Decision. The IRO will send written notice of its decision to the Claimant and the Appeals and Grievances Department within 45 days after the IRO receives the request for external review. The notice will include:

I. A general description of the reason for the external review request, including:
II. information sufficient to identify the claim; and
III. the reason for the prior denial;
IV. The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
V. References to the evidence or documentation considered in reaching the decision, including:
VI. specific coverage provisions; and
VII. evidence-based standards;
VIII. A discussion of the principal reason(s) for the IRO's decision, including:
IX. the rationale for its decision; and
X. any evidence-based standards relied on in making the decision;
XI. A statement that the IRO's determination is binding, unless other remedies are available to the Plan or the claimant under state or federal law;
XII. A statement that judicial review may be available to the claimant and this Policy; and
XIII. Contact information for Montana's Consumer Assistance Program.

Compliance with IRO Decision: If the IRO reverses the Appeals and Grievances Department's adverse benefit determination or final internal adverse benefit determination, We will process the approval within five (5) days of the decision and according to the written terms and benefits of this Policy.

EXPEDITED EXTERNAL REVIEW

Expedited External Review may be requested when:

I. An adverse benefit determination involves: (1) a medical condition with regard to which the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health, or ability to regain maximum function; and (2) a request for an expedited internal appeal has been filed; or
II. A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Claimant's treating health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, and a request for an expedited internal appeal has been filed.
III. A final internal adverse benefit determination involves:
IV. A medical condition where the timeframe for completing a standard external review under the interim final regulations would seriously jeopardize the Claimant's: (a) life; or (b) ability to regain maximum function; or
V. An admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility; or
VI. A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Claimant's treating health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

The request for an expedited external review must be made in writing to the Appeals and Grievances Department at the address indicated on page 5, Important Information. Immediately upon receipt of the request for an expedited external review, a determination will be made as to whether the request meets the requirements earlier set forth above in Standard External Review. The Claimant will be notified of the determination, and an IRO will be assigned as described above in Standard External Review. The Appeals and Grievances Department will provide all necessary documents and information considered in making the denial of the claim to the assigned IRO.

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

SECTION 11—GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

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

MISSTATEMENT OF AGE

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

REPRESENTATIONS

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

COORDINATION WITH MEDICARE

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

TIME LIMIT ON CERTAIN DEFENSES

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

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

CHANGE OF BENEFICIARY

Unless the Member makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the Member. The consent of the beneficiary or beneficiaries will not be requisite to surrender or

assignment of this Policy, or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

ASSIGNMENT

Member may not assign any rights they may have under this Policy. No person, other than a Member, is entitled to Covered Benefits under this Contract. This Contract is not assignable or transferable to any other person.

LEGAL ACTIONS

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

NONPARTICIPATING

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

CONFORMITY WITH MONTANA STATUTES

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

Rescission: This Policy is subject to rescission if a Member commits an act or omission that constitutes fraud or intentional misrepresentation of a material fact following a 30 day notification.

Validity of Contract: This Policy shall not be rendered invalid if any provision is held by a court to be illegal or in conflict with applicable law but this Policy shall be construed without the invalid provision.

Benefit Discretion: We may agree to make payments for services, supplies, drugs , devices or medical expenses which are not listed as Covered Benefits in order to provide quality care at a lesser cost.

In-Network Providers: In-Network Providers are independent contractors and We are not responsible for any of In-Network Providers' actions or omissions.

Notices: We will send notices required by this Policy using the United States mail, postage prepaid. Notices will be mailed to the address appearing on our records. Member must send notices to Us at the address listed on our website, https://mountainhealth.coop/. Any required time periods will be measured from the date the notice was mailed.

Term: The term of this Policy is set in the SBC.

SECTION 12-REQUIRED NOTICES

NOTICE OF PRIVACY PRACTICES

This notice describes how Medical Information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how protected health information (PHI) may be used or disclosed by your health plan to carry out payment, health care operations and for other purposes that are permitted by law. This Notice of Privacy Practices also explains your health plan's legal obligations concerning your PHI, and describes your rights to access, amend, and manage your PHI.

PHI is individually identifiable information, including demographic information, collected from your or created and received by a health care provider, a health plan, your employer, (when functioning on behalf of a group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices has been drafted to be consistent with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Any terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule. If you have any questions about this Notice or the policies and procedures described herein, please contact Mountain Health CO-OP Privacy Office at (406) 447-9510.

Effective Date: This Notice of Privacy Practices is effective January 1, 2020.

Your Rights

You have the right to:

I. Get a copy of your health and claims records
II. You can ask to see or get a copy of your health and claims records and other health information we have about you.
III. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request.
IV. Correct your health and claims records
V. You can ask us to correct your health and claims records if you think they are incorrect or incomplete
VI. We may say "no" to your request, but we will tell you why in writing within 60 days.
VII. Request confidential communication
VIII. You can ask us to contact you in a specific way
IX. We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.
X. Ask us to limit the information we share
XI. You can ask us to use or share certain health information for treatment, payment, or our negotiations
XII. We are not required to agree to your request, and we may say "no" if it would affect your care.
XIII. Get a list of those with whom we've shared your information
XIV. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why

XV. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures.
XVI. Get a copy of this privacy notice
XVII. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Please contact the Privacy Office at 406-324-7022 by phone or sent your request to The Privacy Office, Mountain Health Co-op, PO Box 5358 Helena MT, 59604.
XVIII. Choose someone to act for you
XIX. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
XX. We will make sure the person has this authority and can act for you before we take action.
XXI. File a complaint if you believe your privacy rights have been violated
XXII. You can complain if you feel we have violated your rights by contacting us at the Privacy Office at 406-324-7022 by phone or sent your request to The Privacy Office, Mountain Health Co-op, PO Box 5358 Helena MT, 59604.
XXIII. You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW Washington, DC. 20201 or visiting www.hhs.gov/ocr/privacy/hippa/complaints
XXIV. We will not retaliate against you for filing a complaint.

Your Choices

You have some choices in the way that we use and share information as we:

I. Answer coverage questions from your family and friends
II. Provide disaster relief
III. Market out services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

I. Help manage the health care treatment you receive
II. Run our organization
III. Pay for your health services
IV. Administer your health plan
V. Help with public health and safety issues
VI. Do research
VII. Comply with the law
VIII. Respond to organ and tissue donation requests and work with a medical examiner or funeral director
IX. Address workers' compensation, law enforcement, and other governmental requests
X. Respond to lawsuits and legal actions

Mountain Health CO-OP (the CO-OP) is required by law to maintain the privacy of all medical information within its organization; provide this Notice of Privacy Practices to all Policyholders and Certificateholders Persons; inform Policyholders and Certificateholders of our legal obligations; and advise Policyholders and

Certificateholders of additional rights concerning their medical information. The CO-OP must follow the privacy practices contained in this notice and continue to do so until this notice is changed or replaced.

Potential Impact of State Law:

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, the extent state law applies, the privacy laws of state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which the CO-OP will be required to operate. For example, where such laws have been enacted, the CO-OP will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

HEALTH PLAN NOTICES 2023

Women's Health & Cancer Rights Act

The Women's Health & Cancer Rights Act (WHCRA) requires health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

I. Covered under the employer-sponsored medical plan, and
II. All stages of reconstruction of the breast on which the mastectomy was performed;
III. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
IV. Prostheses; and
V. Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Your plans comply with these requirements.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length or their hospital stays following childbirth. Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Health Insurance Portability & Accountability Act Non-discrimination Requirements

The Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals with respect to premiums, eligibility or benefits based on an individual's health factors.

These health factors include: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

Special Enrollment rights

The Health Plan Portability & Accountability Act (HIPAA) provides rights and protections for participants and beneficiaries in group health plans that allow a special opportunity to enroll in a new plan in certain circumstances.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicare or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact our office.

HIPAA Special Enrollment Opportunities include:

I. COBRA (or state continuation of coverage) exhaustion.
II. Loss of other health insurance coverage.
III. Acquisition of a dependent through marriage, birth, adoption or place for adoption.
IV. Becoming eligible for a State Medicaid or premium assistance subsidy (CHIPRA).

Non-Discrimination Statement and Notice-Discrimination is Against the Law

Mountain Health Co-Op ("the CO-OP") complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, disability, age, sex, gender, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations. The CO-OP does not exclude people or treat them differently because of race, color, national origin, disability, age, sex, gender, sexual orientation, or health status.

The CO-OP:

I. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
II. Qualified sign language interpreters
III. Written information in other formats (large print, audio, accessible electronic formats, other formats)
IV. Provides free language services to people whose primary language is not English, such as:

V. Qualified interpreters
VI. Information written in other languages

If you need these services, contact the CO-OP: 855-447-2900

If you believe that the CO-OP has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, age, sex, gender, sexual orientation, or health status, you can file a grievance with Mountain Health Coop.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

SECTION 13-YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing, except when using ground ambulance services.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or be required to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. Out-of-Network Providers may be permitted to bill you for the difference between Our plan Allowable Amount and the full amount charged for a service. This is called "balance billing." This amount is likely more than In-Network costs for the same service and might not count toward your annual Out-of-Pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when You can't control who is involved in your care—like when You have an emergency or when You schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network provider.

You are protected from balance billing for: Emergency Care Services If you have an Emergency Medical Condition and get Emergency Care Services from an Out-of-Network Provider or facility, the most the provider or facility may bill you is your plan's In-Network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these Emergency Care Services. This includes services You may get after you're in stable condition, unless You give written consent and give up Your protections not to be balanced billed for these post-stabilization services.

When You receive services from an In-Network hospital or ambulatory surgical center, certain providers there may be Out-of-Network. In these cases, the most those providers may bill You your plan's In-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill You and may not ask You to give up your protections not to be balance billed. If You get other services at these In-Network facilities, Out-of-Network providers can't balance bill You, unless You give written consent and give up Your protections.

You're never required to give up Your protections from balance billing. You also aren't required to get care Out-of-Network. You can choose a provider or facility in Your plan's network. When balance billing isn't allowed, You also have the following protections:

I. You are only responsible for paying Your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).
II. We will pay Out-of-Network providers and facilities directly.
III. We generally must:
    a. Cover Emergency Care Services without requiring you to get approval for services in advance (preauthorization).
    b. Cover Emergency Care Services by out-of-network providers.

c. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
d. Count any amount you pay for Emergency Care Services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk (NSHD) at 1-800-985-3059 or visit https://www.cms.gov/nosurprises for more information on your protections under federal law.