

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Accident

An unexpected traumatic incident or unusual strain which is:

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

Some examples include: fracture or dislocation; sprain or strain; abrasion, laceration; contusion; embedded foreign body; burns; and concussion.

Accidental injury

An injury sustained as a result of an external force or forces that is/are sudden, direct and unforeseen and is/are exact as to time and place. A hernia of any kind will only be considered as an illness.

Active service

An employee is in service with the Participant Group on a day which is one of the Participant Group's regularly scheduled work days and that the employee is performing all of the regular duties of his/her employment with the Participant Group on a regular basis, either at one of the Participant Group's business establishments or at some location to which the Participant Group's business requires him/her to travel.

Adverse benefit determination

A denial, decrease or ending of a benefit. This includes a failure to provide or make payment (in whole or in part) for a benefit including claims based on medical necessity or experimental and investigational exclusions.

Advanced Practice Registered Nurse

A nurse who have additional professional education beyond the basic nursing degree required of a registered nurse and are considered Advanced Practice Registered Nurses by applicable state law. Advanced Practice Registered Nurses include nurse practitioners, nurse-midwives, nurse-anesthetists and clinical nurse specialists.

Affordable Care Act

A comprehensive law passed in 2010, aimed at reforming America's health care system to improve access and affordability for more Americans.

Air ambulance

Any form of aircraft equipped with medical supplies, equipment and qualified medical professionals that will provide mobile medical care to a patient during transport to a medical facility specialized in responding to the medical needs of the patient in transport. Air ambulances are largely used in emergency medical situations or situations where timing is of the essence in helping a patient receive treatment.

Allowable charge

The maximum amount a health care plan will reimburse a doctor or hospital for a given service.

Annual deductible

The amount you are required to pay annually before reimbursement by your health care benefits plan begins. The deductible requirement does not apply to preventive services.

Allowable Fee

The Allowable Fee is based on, but not limited to, the following:

1. Medicare RBRVS based 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. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the Medicare RBRVS system can be considerably less than the nonparticipating providers’ billed charge; or
2. Diagnosis-related group (DRGs) methodology is a system used to classify hospital cases into one of approximately 500 to 900 groups that are expected to have similar hospital resource use. Payment for each DRG is based on diagnoses, procedures, age, sex, expected discharge date, discharge status, and the presence of complications. The amount of payment for each DRG is generally within a fixed range because each patient is expected to use the same level of hospital resources for the given DRG regardless of the actual hospital resources used. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating providers under the DRG system can be considerably less than the nonparticipating providers’ billed charge; or
3. Billed charge is the amount billed by the provider; or
4. Case rate methodology is an all-inclusive rate for an episode of care for a specific clinical condition paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the case rate system can be considerably less than the nonparticipating providers’ billed charge; or
5. Per diem methodology is an all-inclusive daily rate paid to a facility. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the per diem system can be considerably less than the nonparticipating providers’ billed charge; or
6. Flat fee per category of service is a fixed payment amount for a category of service. For instance, a category of service could be a delivery, an imaging service, a lab service or an office visit. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to a nonparticipating providers under the flat fee per category of service system can be considerably less than the nonparticipating providers’ billed charge; or
7. Flat fee per unit of service fixed payment amount for a unit of service, For instance, a unit of service could be the amount of “work units” customarily required for a delivery, or an office visit, or a surgery. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the flat fee per unit system can be considerably less than the nonparticipating providers’ billed charge; or
8. Percent off of billed charge is a payment amount where a percentage is deducted from the billed charges; or
9. A percentage of Medicare allowance is a payment amount where a percentage is deducted to the amount that Medicare would allow as payment for the service; or
10. The amount negotiated with the pharmacy benefit manager or manufacturer or the actual price for prescription or drugs; or
11. The American Society of Anesthesiologists’ Relative Value Guide is a system established by the American Society of Anesthesiologists to pay anesthesiologists for a “work unit.” The payment value is determined by multiplying a “relative value” of the service by a “converter” to determine the value for a certain procedure. The amount of the payment is a fixed rate. Therefore, the amount paid by Blue Cross and Blue Shield of Montana to nonparticipating providers under the system can be considerably less than the nonparticipating providers’ billed charge.

12. For nonparticipating providers in Montana, the Allowable Fee is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Fee for nonparticipating providers will represent an average contract rate for Participating Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 80% of the average contract rates and will be updated not less than every 2 years. Blue Cross and Blue Shield of Montana will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by nonparticipating providers which may also alter the Allowable Fee for a particular service. In the event the Plan does not have any claim edits or rules, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Fee will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Plan within 90 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

In the event the nonparticipating Allowable Fee does not equate to the nonparticipating provider's billed charges, the Participant will be responsible for the difference, along with any applicable Copayment, Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the Plan's nonparticipating Allowable Fee for a particular service, Participants may call the customer service number shown on the back of their Identification Card. Montana law requires Blue Cross and Blue Shield of Montana to provide a summary of 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.

Annual limit

An insurance plan may limit the dollar amount it will pay during one year for a certain treatment or service, or for all benefits provided in a year.

Applied Behavior Analysis (ABA) – also known as Lovaas Therapy

Medically Necessary interactive therapies or treatment derived from evidence-based research. The goal of ABA is to improve socially significant behaviors to a meaningful degree, including:

- increase desired behaviors or social interaction skills
- teach new functional life, communication, or social, skills
- maintain desired behaviors, such as teaching self-control and self-monitoring procedures
- appropriate transfer of behavior from one situation or response to another
- restrict or narrow conditions under which interfering behaviors occur
- reduce interfering behaviors such as self-injury

ABA therapy and treatment includes Pivotal Response Training, Intensive Intervention Programs, and Early Intensive Behavioral Intervention, and the terms are often used interchangeably. The ABA benefit also includes Discrete Trial Training, a single cycle of behaviorally based instruction routine that is a companion treatment with ABA. Services must be provided by an appropriately certified provider.

Approved Clinical Trial

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

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

Authorized representative

An individual acting on behalf of the Participant or beneficiary claimant in obtaining or appealing a benefit claim. The authorized representative must have a signed form (specified by the Plan) by the claimant except for urgent care benefits or appeals. Once an authorized representative is selected, all information and notifications should be directed to that representative until the claimant states otherwise.

Benefit Period

Refers to a time period as shown in the Schedule of Benefits. For the Participant, it is the same as for the contract except if the Participant's effective date is after the effective date for the contract; the Benefit Period begins on the Participant's effective date and end on the same date the contract Benefit Period ends. The Participant's Benefit Period may be less than 12 months. Such Benefit Period will terminate on the earliest of the following dates:

- The last day of the time period so established, or
- The date the Plan terminates

Balanced billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A participating provider will not balance bill you for covered services.

Benefit

Services, supplies and medications that are provided to a Member and covered under this Contract as a Covered Medical Expense.

Blue Cross and Blue Shield of Montana (BCBSMT)

The Third-Party Administrator for the Plan's medical, dental and vision coverage.

Best evidence

Evidence based on

- Randomized Clinical Trials
- A Cohort Study or Case-Control Study, if randomized clinical trials are not available

- A Case Series, if Randomized Clinical Trials, Cohort Studies or Case-Control Studies are unavailable
- An Expert Opinion, if Randomized Clinical Trials, Cohort Studies, Case-Control Studies or Case Series are unavailable.

Brand-Name

A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand-Name drug. There may also be situations where a drug's classification changes from Generic to Preferred or Non-preferred Brand-Name due to a change in the market resulting in the Generic drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from Generic to Preferred or Non-preferred Brand-Name.

Calendar year

The 12-month period beginning January 1 and ending December 31 of the same year.

Care management

A process that assesses and evaluates options and services required to meet the Participant's health care needs. Care Management may involve a team of health care professionals, including Covered Providers, The Plan and other resources to work with the Participant to promote quality, cost-effective care.

Case-Control Study

A retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

Case series

An evaluation of a series of patients with a particular outcome, without the use of a control group.

Certificate of creditable coverage

A certificate issued by a group health plan that describes a person's prior period(s) of creditable health care coverage as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Chemical Dependency Condition

The uncontrollable or excessive use of addictive substances including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a licensed addition counselor or other appropriate medical practitioner.

Chemical dependency treatment center

A treatment facility that provides a program for the treatment of

Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician or addiction counselor licensed by the state. The facility must also be licensed or approved as a Chemical Dependency Treatment Center by the department of health and human services or must be licensed or approved by the state where the facility is located.

CHIP

The Children’s Health Insurance Program Reauthorization Act of 2009.

Claim

Any request for a Plan benefit made by you or your authorized representative. A Participant making a claim for benefits is a claimant.

Claim form

A form you or your doctor fill out and submit to your health care benefits plan for payment.

Clinical peer

A physician or other health care provider who:

- holds a nonrestricted license in a state of the United States, and
- is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review

COBRA

Refers to sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. 300bb-1 through 300bb-8] which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

This stands for Consolidated Omnibus Budget Reconciliation Act of 1985. This federal act requires group health care plans to allow employees and covered dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, termination of employment, a child becoming an over-aged dependent, Medicare eligibility, death or divorce of a covered employee.

COBRA Continuation of Coverage

Continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of COBRA.

Cohort study

Is a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

Coinsurance

The percentage of the Allowable Fee payable by the Participant for Covered Medical Expenses. The applicable Coinsurance for In-Network Covered Medical Expenses and Out-of-Network Covered Medical Expenses is stated in the Schedule of Benefits.

Concurrent care

Medical care:

- rendered concurrently with surgery during one Hospital admission by a Physician other than the operating surgeon for treatment of a medical condition different from the condition for which surgery was performed; or
- by two or more Physicians rendered concurrently during one Hospital admission when the nature or severity of the Participant’s condition requires the skills of separate Physicians.

Consultation services

Services of a consulting Physician requested by the attending Physician. These services include discussion with the attending Physician and a written report by the consultant based on an examination of the Participant.

Contracting hospital

A hospital that has contracted with a particular health care plan to provide hospital services to members of that plan.

Convalescent home

An institution, or distinct part thereof, other than a Hospital, which is licensed pursuant to state or local law. A convalescent home is a/n:

- skilled nursing facility
- extended care facility
- extended care unit
- transitional care unit

A Convalescent Home is primarily engaged in providing continuous nursing care by or under the direction and supervision of a registered nurse for sick or injured persons during the convalescent stage of their illness or injuries and is not, other than incidentally, a rest home or home for custodial care, or for the aged. **NOTE:** A Convalescent Home shall 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.

Copayment

The specific dollar amount payable by the Participant for covered medical expenses.

Coordination of benefits

A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

Covered medical expense

Expenses incurred for Medically Necessary services, supplies, and medications that are based on the Allowable Fee and are:

1. Covered under the Plan and not in excess of a benefit maximum
2. In accordance with BCBSMT Medical Policy, and
3. Provided to the Participant by and/or ordered by a covered provider for the diagnosis or treatment of an active illness or Injury or in providing maternity care or covered preventive services

In order to be considered a Covered Medical Expense, the Participant must be responsible for charges for such services, supplies, and medications.

Covered person

Any Participant or Dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.covered service.

A service that is covered according to the terms in your health care benefits plan.

Creditable Coverage

Coverage that the Participant had for medical benefits under any of the following plans, programs and coverages:

- a group health plan

- health insurance coverage
- Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1935c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4 (Medicare)
- Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s (Medicaid)
- Title 10, chapter 55, United States Code (TRICARE)
- a medical care program of the Indian Health Service or of a tribal organization
- the Montana Comprehensive Health Association provided for in 33-22-1503 (MCHA)
- a health plan offered under Title 5, chapter 89, of the United States Code (Federal Employee Health Benefits Program)
- a public health plan
- a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e)
- a high risk pool in any state

Creditable Coverage does not include coverage consisting solely of coverage of excepted Benefits.

Custodial Care

Any service, primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the Participant's condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

Deductible

The dollar amount each Participant must pay for Covered Medical Expenses incurred during the Benefit Period before the Plan will make payment for any Covered Medical Expense to which the Deductible applies. Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. Thus, Coinsurance, Copayment, noncovered services, and amounts billed by nonparticipating providers do not apply to the Deductible and are the Participant's responsibility.

If two or more Participants covered under the same Employee health plan satisfy the family Deductible as shown on the Schedule of Benefits in a single Benefit Period, the Deductible does not apply for the remainder of that Benefit Period for any Participant of the Employee's health plan.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, only one Deductible will be applied to that Hospital stay (facility charges only). If the Participant satisfied the Participant's Deductible prior to that Hospital stay, no Deductible will be applied to that stay.

Dentally Necessary

Treatment, tests, services or supplies provided by a Hospital, Physician or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

- Are to treat or diagnose a Dental condition or dental disease
- Are ordered by a Dentist or Licensed Health Care Provider and consistent with the symptoms or diagnosis and treatment of the dental condition or dental disease
- Are not primarily for the convenience of the covered Participant, Dentist or other Licensed Health Care Provider

- Are the standard or level of services most appropriate for good medical practice that can be safely provided to the covered Participant
- Are not of an Experimental/Investigational or solely educational nature
- Are not provided primarily for dental, medical or other research
- Do not involve excessive, unnecessary or repeated tests
- Are commonly and customarily recognized by the dental profession as appropriate in the treatment or diagnosis of the diagnosed condition, and
- Are approved procedures or guidelines by the Food and Drug Administration, Centers for Medicaid and Medicare Services (CMS) and the American Dental Association, pursuant to that entity's program oversight authority based upon the dental treatment circumstances

Dependent

- the beneficiary Participant's Spouse;
- the beneficiary Participant's unmarried or married child up to age 26, including an eligible foster child;
- children for whom the beneficiary Participant becomes legally responsible by reason of placement for adoption, as defined in Montana law; or
- an unmarried child of the beneficiary Participant who is 26 years of age or older and disabled.

For purposes of this contract the unmarried child will be considered disabled if the child:

- was covered under this Contract before age 26;
- Cannot support himself/herself because of intellectual disability or physical disability; and is legally dependent on the beneficiary Participant for support.

Proof of those qualifications must be supplied to the Plan within 31 days following the child's 26th birthday. Although there is no limiting age for disabled children, the Plan reserves the right to require periodic certification from the beneficiary Participant of such incapacity and dependency. Certification will not be requested more frequently than annually after the two-year period following the child's 26th birthday.

Domestic Partners

Two individuals, either opposite- or same-sex, who meet all of the following criteria:

- Are 18 years of age or older and each has the capacity to enter into a contract
- Has had joint ownership or joint tenancy of a residence together for at least the most recent 12 consecutive months, and such residence has served as the primary place of residence for each of them during the same period
- Neither party meets the MUST eligibility requirements of a Spouse or Dependent child
- Neither party is in a parental relationship with the other
- Neither party is related by blood or marriage to the other, and
- Have a financially-interdependent relationship with each other as evidenced by at least three (3) of the following:
 - Joint ownership or lease of a motor vehicle
 - Joint liability, such as a loan or credit card (at least one)
 - Mutually granted powers of attorney or mutually-granted health care powers of attorney, or
 - Designation of each other as primary beneficiaries in wills, life insurance policies or retirement annuities

Drug List

A list that identifies those Prescription Drug Products that are covered by the Plan for dispensing to Participants when appropriate. This list is reviewed quarterly and subject to modification. Details can be found on the pharmacy page at www.bcbsmt.com or by visiting www.myprime.com.

Drug formulary

A list of preferred drugs chosen by a panel of doctors and pharmacists. Both brand and generic medications are included on the formulary.

Effective date of coverage

The date your coverage begins. Please note: The effective date can also represent the date a change in your coverage takes effect. If you have questions, call the number on the back of your ID card.

Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent person acting reasonably to believe a health condition exists that requires immediate medical attention, and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Emergency medical condition

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

Emergency services

Services, medicines or supplies furnished or required to evaluate and treat an Emergency Medical Condition.

Employee contribution

The employee portion of the costs for a benefit plan.

Employer responsibility

Starting in 2015, if an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through a Health Insurance Marketplace, the employer must pay a fee to help cover the cost of tax credits.

Essential health benefits

Some benefits will be included in every insurance plan. Beginning in 2014, most insurance plans you can choose from — whether you buy on the Health Insurance Marketplace or go directly to the insurance company of your choice — will include many benefits that are meant to make sure basic health concerns are covered.

Evidenced-based standard

The conscientious, explicit, and judicious use of the current Best Evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

Exclusion

A provision which states that The Plan has no obligation under this Contract to make payment.

Explanation of benefits (EOB)

An EOB is created after a claim payment has been processed by your health care plan. It explains the actions taken on a claim such as the amount that will be paid, the benefit available, reasons for denying payment and the claims appeal process. EOBs are available both as a paper copy and online.

Experimental/Investigational/Unproven

A drug, device, biological product or medical treatment or procedure is Experimental, Investigation and /or Unproven if the Plan determines that:

- The drug, device, biological product or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product or medical treatment or procedure is furnished; or
- The drug, device, biological product or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials, or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- The prevailing opinion among peer-reviewed medical and scientific literature regarding the drug, device, biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis.

Expert opinion

A belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

Family coverage

Health care coverage for a primary policyholder/employee (called a "subscriber") and his or her spouse and any eligible dependents.

Federal Poverty Level (FPL)

A level of income issued annually by the Department of Health and Human Services – used to determine eligibility for certain programs and benefits. FPL will be used to determine the amount of tax credit you qualify for to offset the cost of purchasing health insurance.

FMLA refers to the Family and Medical Leave Act, as amended.

Fiduciary

A person or entity who exercises discretionary authority or control over the management of the plan or its assets or has discretionary authority or responsibility in Plan administration. The fiduciary for the MUST Plan is MSSF.

Freestanding inpatient facility

For treatment of Chemical Dependency means a facility which provides treatment for Chemical Dependency in a community-based residential setting for persons requiring 24-hour supervision and which is a Chemical Dependency Treatment Center. Services include medical evaluation and health supervision; Chemical Dependency education; organized individual, group and family counseling; discharge referral to Medically Necessary supportive services; and a client follow-up program after discharge.

For treatment of Mental Illness, it means a facility licensed by the state and specializing in the treatment of Mental Illness.

Generic

A drug that has the same active ingredient as a Brand-Name drug and is allowed to be produced after the Brand-Name drug's patent has expired. In determining the brand or generic classification for covered drugs, Blue Cross and Blue Shield of Montana uses the generic/brand status assigned by a nationally recognized provider of drug product database information. A list of Preferred Generic drugs is available at <http://mustbenefits.org/prime>.

Generic drug

A prescription drug that is the generic equivalent of a brand name drug listed on your health plan's formulary and costs less than the brand name drug.

Generic substitute

A prescription drug which is the generic equivalent of a drug listed on your health plan's formulary.

Group (or participant group)

A group of people covered under the same health care plan and identified by their relation to the same employer or organization.

Guaranteed issue

A requirement under the Affordable Care Act that health plans must permit you to enroll in some form of insurance coverage regardless of health status, age, gender or other factors.

Habilitative care services

When the Participant requires help to keep, learn or improve skills and functioning for daily living. Covered services include, but are not limited to:

- physical and occupational therapy;
- speech-language pathology; and
- 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.

Health Insurance Marketplace

The Health Insurance Marketplace, or Health Insurance Exchange, is a federal government website where you can shop, compare and buy plans offered by participating health insurance companies in your area. You can access the Marketplace via healthcare.gov or by phone.

Health Maintenance Organization (HMO)

An organization that provides health care coverage to its members through a network of doctors, hospitals and other health care providers.

Health reimbursement account (HRA)

Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account.

Health savings account (HSA)

A type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses if you have a high deductible health plan (HDHP).

Combining a HDHP with a HSA allows you to pay for certain medical expenses, like your deductible and copayments, with untaxed dollars. High-deductible plans usually have lower monthly premiums than plans with lower deductibles.

Unlike a flexible spending account (FSA), HSA funds roll over year to year if you don't spend them. You can take the funds with you if you change jobs or leave the work force. The HSA may also earn interest.

High deductible health plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. Usually the monthly premium is lower, but you have to pay more health care costs yourself (your deductible) before the insurance company starts to pay its share. A high deductible plan can be combined with a health savings account (HSA) or a health reimbursement arrangement. This allows you to pay for certain medical expenses with untaxed dollars. The IRS defines a high deductible health plan as any plan with a deductible of at least \$1,300 for an individual or \$2,600 for a family.

HIPAA

A federal law that outlines the rules and requirements employer-sponsored group insurance plans, insurance companies and managed care organizations must follow to provide health care insurance coverage for individuals and groups.

Home health agency

An agency licensed by the state which provides home health care to Members in the Member's home.

Home health aide

A nonprofessional worker who has been trained for home care of the sick and is employed by a Home Health Agency.

Home infusion therapy agency

A health care provider that provides home infusion therapy services.

Hospital

A facility providing, by or under the supervision of licensed Physicians, services for medical diagnosis, treatment, rehabilitation and care of injured, disabled, or sick individuals. 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.

Illness

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

Individual health insurance plan

Health care coverage for an individual with no covered dependents. Also known as individual coverage.

In-Network

Providers who are:

- Participating Blue Cross and Blue Shield of Montana (BCBSMT) Professional Providers
- Participating Blue Cross and Blue Shield of Montana (BCBSMT) Facility Providers Blue Cross and/or Blue Shield participating providers outside of Montana.

Inpatient services

Services provided when a member is registered as a bed patient and is treated as such in a health care facility such as a hospital.

Inclusive services/procedures

The portion of a service or procedure which is necessary for completion of the service or procedure or a service or procedure which is already described or considered to be part of another service or procedure.

Injury

Physical damage to an individual's body, caused directly and independent of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

Inpatient care

Care provided to a Participant who has been admitted to a facility as a registered bed patient and who is receiving services, supplies and medications under the direction of a Covered Provider with staff privileges at that facility. Examples of facilities to which a Participant might be admitted include:

- Hospitals;
- Transitional care units;
- Skilled nursing facilities;
- Convalescent homes;
- Freestanding inpatient facilities.

Inpatient Participant

A Participant who has been admitted to a facility as a registered bed patient for Inpatient Care.

Insurance carrier

The company that issues and assumes the risk of an insurance policy. MUST is an insurance carrier for its health benefit offerings. MUST contracts with other carriers for the life and long-term disability coverages.

Insured person

The person who a contract holder (an employer or insurer) has agreed to provide coverage for, often referred to as a member/subscriber.

Lifetime limit

A cap on the total lifetime benefits you may get from your insurance company for certain conditions. A health plan may have a total lifetime dollar limit on benefits (like a \$1 million lifetime cap) or limits on specific benefits (like a \$200,000 lifetime cap on organ transplants or one gastric bypass per lifetime), or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. Under the health care law, lifetime limits are no longer allowed on essential health benefits, such as emergency services and hospital stays.

Life-threatening condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medicaid

A joint federal and state funded program that provides health care coverage for low-income children and families, and for certain aged and disabled individuals.

Medical group

A licensed health care facility, program, agency, doctor or health professional that contracts with a health plan to deliver health care services to plan members.

Medically necessary

A medical service or supply that meets all the following criteria:

- It is required for the treatment or diagnosis of a covered medical condition
- It is the most appropriate supply or level of service that is essential for the diagnosis or treatment of the patient's covered medical condition
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards
- It is not furnished primarily for the convenience of the patient or provider of services, and
- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.

The fact that a service or supply is furnished, prescribed or recommended by a physician or other provider does not, of itself, make it Medically Necessary. A service or supply may be Medically Necessary in part only.

Medical or scientific evidence

Evidence found in the following sources:

1. peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's library of medicine for indexing in Index Medicus and Excerpta Medica, published by the Reed Elsevier group;
3. medical journals recognized by the Secretary of Health and Human Services under 42 U.S.C. 1395x(t)(2)(B) of the federal Social Security Act;
4. the following standard reference compendia:
 - a. the American Hospital Formulary Service Drug Information;
 - b. Drug Facts and Comparisons;
 - c. the American Dental Association Guide to Dental Therapeutics; and
 - d. the United States Pharmacopeia;
5. findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
 - a. the federal Agency for Healthcare Research and Quality;
 - b. the national Institutes of Health;
 - c. the National Cancer Institute;
 - d. the National Academy of Sciences;
 - e. the Centers for Medicare and Medicaid Services;
 - f. the Food and Drug Administration; and
 - g. any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6. Any other medical or scientific evidence that is comparable to the sources listed in subsection 4 or 5.

Medical Policy

The policy of the Plan which is 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:

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

Medically Necessary (for Down Syndrome)

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:

- Reduce or improve the physical, mental, or developmental effects of Down syndrome; or
- 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 (Medical Necessity)

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, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

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.

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

Medically Necessary (for Autism, Asperger's Disorder and Pervasive Developmental Disorder)

Any care, treatment, intervention, service, or item that is prescribed, provided or ordered by a Physician or psychologist and that will or is reasonably expected to:

- Prevent the onset of an Illness, condition, Injury, or disability;
- Reduce or improve the physical, mental, or developmental effects of an Illness, condition, or Injury, or disability; or
- 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.

Medicare

The federal program established to provide health care coverage for eligible senior citizens and certain eligible disabled persons under age 65.

Mental health treatment center

A treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by an interdisciplinary team, including a licensed Physician, psychiatric social worker and psychologist. The facility must be:

- licensed as a mental health treatment center by the state;
- funded or eligible for funding under federal or state law; or
- Affiliated with a Hospital under a contractual agreement with an established system for patient referral.

Mental illness

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

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

Mental Illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person. Mental Illness does not include:

- developmental disorders;
- speech disorders;
- psychoactive substance use disorders;
- eating disorders (except for bulimia and anorexia nervosa);
- impulse control disorders (except for intermittent explosive disorder and trichotillomania); or ☐ Severe Mental Illness.

Minimum Essential Coverage (MEC)

The type of health coverage an individual needs to maintain throughout the year in order to meet the individual responsibility requirement under the Affordable Care Act. Health plans that are considered MEC include individual and family plans bought through the Health Insurance Marketplace; qualified health plans bought directly through an insurance company; job-based coverage; Medicare; Medicaid; and certain other coverage. If you have minimum essential coverage throughout the year, you don't have to pay the tax penalty for being uninsured.

MSSF

Montana School Services Foundation

Multi-employer plan

In general, a group health plan that's sponsored jointly by 2 or more employers.

Multidisciplinary Team

A group of health service providers who are either licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. Members of the

Multidisciplinary Team may include, but are not limited to, a licensed psychologist, licensed speech therapist, registered physical therapist, or licensed occupational therapist.



INSURANCE TERMS GLOSSARY

MUST

Montana Unified School Trust

Network

The group of doctors, hospitals and other health care professionals that a managed care plan has contracted with to deliver medical services to its members.

Non-contracting hospital

A hospital that has not contracted with a particular health care plan to provide hospital services to members in that plan.

Non-Contracted Provider

Providers who are non-physician specialists that are not offered a contract to participate in Blue Cross and Blue Shield of Montana (BCBSMT) provider networks. Non-contracted providers do not accept the BCBSMT allowable fee as payment in full and can bill the Participant for deductibles, copayments and the difference between the BCBSMT allowable fee and the provider's charge. Non-contracted provider specialties include, but are not limited to, the following: acupuncturist, ambulance (ground), audiologist, denturist, Family Planning Clinic, Licensed Addiction Counselor (CCDC), optician, registered dietician, Student Health, Public Health Department and certain other facilities such as Alcohol/Drug Freestanding Facility, Alcohol/Drug/Mental Health Freestanding Facility, etc.

Occupational therapy

The treatment of neuromusculoskeletal and psychological dysfunction through the use of speech tasks or goal-directed activities designed to improve the functional performance of an individual.

Off-exchange health plan

A health insurance plan that meets the minimum essential coverage requirements under the Affordable Care Act. These plans are not offered on the Health Insurance Marketplace and are not eligible for the premium tax credit. If you qualify for a premium tax credit and want to use it, you must enroll in an on-exchange plan.

On-exchange health plan

A health insurance plan that meets the minimum essential coverage requirements under the Affordable Care Act and is purchased on a state or federal health exchange. If you qualify for a premium tax credit, you must enroll in an on-exchange plan in order to use it.

Orthopedic devices

Rigid or semirigid supportive devices which restrict or eliminate motion of a weak or diseased body part. Orthopedic Devices are limited to braces, corsets and trusses.

Open Enrollment period

A defined time when you are allowed to enroll yourself and/or your Dependents for benefit coverage.

Out-of-Network Providers

Providers who are:

- Nonparticipating professional providers
- Nonparticipating facility providers

Out-of-Pocket Amount

- **For the Member:** The total amount of Deductible, Coinsurance and Copayment a Participant must pay for Covered Medical Expenses incurred during the Benefit Period. Once the Participant has satisfied the Out of Pocket Amount, the Participant will not be required to pay the Participant's Deductible, Coinsurance and Copayment for Covered Medical Expenses for the remainder of that Benefit Period. The Out of Pocket Amount for the Participant is listed in the Schedule of Benefits.

If a Participant is in the Hospital on the last day of the Participant's Benefit Period and continuously confined through the first day of the next Benefit Period, the Deductible and Coinsurance for the entire Hospital stay (facility charges only) will only apply to the Out of Pocket Amount of the Benefit Period in which the inpatient stay

began. If the Participant satisfied the Out of Pocket Amount prior to that Hospital stay, no Deductible or Coinsurance will be applied to that stay.

Non-covered services, the 50% Coinsurance for Specialty Medications purchased at any pharmacy other than a participating Specialty Pharmacy, the amount the Participant pays for the difference between a Brand-Name drug and the Generic equivalent, and amounts over the allowed amount billed by a non-participating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

- **For the Family:** The total amount of Deductible, Coinsurance and Copayment for Covered Medical Expenses the family must pay for services incurred during that Benefit Period. Once the Deductible, Coinsurance and Copayment paid by the Participant during the Benefit Period for two or more family Participants covered under the

same group health plan total the Out of Pocket Amount for the family, the Participants covered under the same health plan will not be required to pay the Deductible, Coinsurance and Copayment for Covered Medical

Expenses the remainder of that Benefit Period. The Out of Pocket Amount for the family is listed on the Schedule of Benefits.

Non-covered services, the 50% Coinsurance for Specialty Medications purchased at any pharmacy other than a participating Specialty Pharmacy, the amount the Participant pays for the difference between a Brand-Name drug and the Generic equivalent, and amounts over the allowed amount billed by a non-participating provider do not accumulate to the Out of Pocket Amount and are the Participant's responsibility.

Outpatient

Services or supplies provided to the Participant by a Covered Provider while the Participant is not an Inpatient Participant.

Partial Hospitalization

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

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

Participant

Any eligible employee or other eligible individual enrolled in the Plan.

Participant Group

A Montana school district, districts and/or other school-related entities (as defined by the MUST Trustees) that have adopted this Plan for its Employees.

Participating Provider Option (PPO)

A health care plan that supplies services at a higher level of benefits when members use contracted health care providers. PPOs also provide coverage for services rendered by health care providers who are not part of the PPO network, however the plan member generally shares a greater portion of the cost for such services.

Participating Blue Cross and Blue Shield of Montana Facility Provider

A facility that has a contract with Blue Cross and Blue Shield of Montana (BCBSMT) and may include, but are not limited to, Hospitals, home health agencies, Convalescent Homes, skilled nursing facilities, Freestanding Inpatient Facilities and freestanding surgical facilities.

Participating Blue Cross and Blue Shield of Montana Professional Provider

A provider who has a contract with Blue Cross and Blue Shield of Montana (BCBSMT) and may include, but are not limited to, Physicians, physical assistants, nurse specialists, dentist, podiatrists, speech therapists, physical therapists, and occupational therapist.

Participating Pharmacy

A pharmacy which has entered into an agreement with the pharmacy benefit manager to provide Prescription Drug Products to Participants and has agreed to accept specified reimbursement rates.

Participating Provider

A Participating Blue Cross and Blue Shield of Montana (BCBSMT) Professional Provider or a Participating Blue Cross and Blue Shield of Montana (BCBSMT) Facility Provider.

Plan Administrator

The Plan Administrator for MUST is MSSF and/or its designee. The principal duty of the Plan

Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of eligible Participants and beneficiaries, without discrimination. The Plan Administrator has the power and exclusive authority necessary, at its discretion, to:

- Construe and interpret the Plan Document and to decide all questions of eligibility and participation
- Make all findings of fact for Plan administration, including payment of reimbursements
- Prescribe procedures to be followed and forms to be used by Participants and benefit
- Request and receive from all employees the information necessary for proper Plan administration
- Appoint and employ the individuals or entities to assist in Plan administration as necessary or advisable, including benefit consultants and legal counsel



INSURANCE TERMS GLOSSARY

Plan Document

The document that describes requirements for eligibility and enrollment, covered services, limitations and exclusions, and other terms and conditions that apply to participation in this Plan.

Plan

Montana Unified School Trust (MUST).

Plan Year

The 12 month period:

- Beginning July 1 and ending the last day of June of the next year for Participant Groups renewing on July 1 of each year, or
- Beginning September 1 and ending the last day of August of the next year for Participant Groups renewing on September 1 of each year
 - **Physical Therapy** means treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and pain relief.
 - **Physician** means a person licensed to practice medicine in the state where the service is provided.

Preauthorization

The process that determines in advance the Medical Necessity or Experimental, Investigational and/or Unproven nature of certain care and services under the Contract. Preauthorization is used to inform the Participant whether or not a proposed service, medication, supply, or on-going treatment is Medically Necessary and is a Covered Medical Expense of the Plan.

Preauthorization does not guarantee that the care and services a Participant receives are eligible for Benefits under the Plan Document. At the time the Member's claims are submitted, they will be reviewed in accordance with the terms of the Plan Document.

Pre-existing condition

A condition, disability or illness that you have been treated for before applying for new health coverage.

Preferred Brand-Name

A covered non-specialty Brand-Name drug product or other item that is identified on the Drug List as preferred and is subject to the Preferred Brand Name drug tier payment level.

Preferred Generic

A covered Generic drug product or other item that is identified on the Drug List as preferred and is subject to the Preferred Generic drug tier payment level.

Pre-notification

The process by which a plan member or their doctor notifies the plan, before the member undergoes a course of care, such as a hospital admission or a complex diagnostic test. Also called pre-authorization.

Premium

The ongoing amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly. The premium may not be the only amount you pay for insurance coverage. Typically, you will also have a co-payment or deductible amount in addition to your premium.

Premium tax credit

Based on your family size and income, you may qualify for a tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium costs. Sometimes called advanced premium tax credit (APTC), or tax credit. Use our premium tax credit estimator to see if you qualify.

Prescription Drug Product means a medication, product or device approved by the Food and Drug Administration.

Prescription drug list

A list of commonly prescribed drugs (also known as a drug formulary). Not all drugs listed in a plan's prescription drug list are automatically covered under that plan.

Preventive services

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary care physician (PCP)

The physician you choose to be your primary source for medical care. Your PCP coordinates all your medical care, including hospital admissions and referrals to specialists. Not all health plans require a PCP.

Professional call

An interview between the Participant and the professional provider in attendance. The professional provider must examine the Participant and provide or prescribe medical treatment. "Professional Call" does not include telephone calls or any other communication where the Participant is not examined by the professional provider, except as included in the Benefit section entitled Telemedicine.

Preferred Provider Organization (PPO)

A provider or group or providers that have contracted with The Plan to provide services to Participants under PPO Benefit Contracts.

Preferred Provider Organization (PPO) Network

A provider or group of providers that have a PPO contract with Blue Cross and Blue Shield of Montana (BCBSMT). The Participant may obtain a list of PPO providers from BCBSMT upon request.

Pre-service claim

Any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.

Proof of loss

Documentation accepted by the Plan upon which payment of Benefits is made.

Provider

Any person, organization, health facility or institution licensed to deliver or furnish health care services.

Qualified health plan

An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (deductibles, copayments, and out-of-pocket amounts) and meets other requirements.

Qualified Individual (for an approved clinical trial)

An individual with group health coverage or group or individual health insurance coverage who is eligible to participate in an Approved Clinical Trial according to the trial protocol for the treatment of cancer or other Life-Threatening Condition because:

1. The referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate, or
2. The individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

Qualifying Event

Under COBRA, the triggering event that causes a loss of coverage under a group health plan, including termination of employment, reduction in hours, death or divorce. (See the *COBRA* section)

Randomized clinical trial

A controlled, prospective study of patients who have been assigned at random to an experimental group or a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention. The term includes a study of the groups for variables and anticipated outcomes over time.

Reconstructive breast surgery

Surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Recovery care bed

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

Rehabilitation facility

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

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

Rehabilitation Therapy

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

- provided by a Rehabilitation Facility in an Inpatient Care or outpatient setting;
- provided under the direction of a qualified Physician and according to a formal written treatment plan with specific goals;
- designed to restore the patient's maximum function and independence; and
- Medically Necessary to improve or restore bodily function and the Participant must continue to show measurable progress.

Referral

As applicable to HMO or point of service (POS) coverage, a written authorization from a member's primary care physician (PCP) to receive care from a different contracted doctor, specialist or facility. If you don't get a referral first, the services may not be covered.

Residential Treatment Center

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Chemical Dependency. Requirements: the Plan requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by Blue Cross and Blue Shield of Montana as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Routine

Examinations or services provided when there is no objective indication of impairment of normal bodily function. Routine does not include the diagnosis or treatment of any Injury or Illness.

Routine patient costs

All items and services covered by a group health plan or a plan of individual or group health insurance coverage when the items or services are typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. The term does not include:

- An investigational item, device, or service that is part of the trial,
- An item or service provided solely to satisfy data collection and analysis need for the trial if the item or service is 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 the individual's diagnosis.

Severe mental illness

The following disorders as defined by the American psychiatric association:

- schizophrenia
- schizoaffective disorder
- bipolar disorder
- major depression
- panic disorder
- obsessive-compulsive disorder
- autism

Coverage for a child with autism who is 18 years of age or younger is provided under the Autism Spectrum Disorders Benefit if the child is diagnosed with:

- Autistic Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder not otherwise specified

Specialist

A health care professional whose practice is limited to a certain branch of medicine, including specific procedures, age categories of patients, specific body systems or certain types of diseases.

Special enrollment period

A time outside of the open enrollment period during which you can sign up for a health insurance plan. You generally qualify for a special enrollment period of 60 days following certain life events that changes your family status (for example, marriage or birth of a child) or loss of other health coverage.

Specialty Medications

High cost, hard to manage injectables, select orals, and/or infused therapies that are administered by the patient or Physician for the treatment of chronic illness.

Specialty Pharmacy

A pharmacy which has entered into an agreement with BCBSMT or its pharmacy benefit manager to provide Specialty Medications to Participants and which has agreed to accept specified reimbursement rates.

Speech Therapy

The treatment of communication impairment and swallowing disorders.

Spouse

The opposite sex or the same person to whom the eligible employee, trustee or retiree of the Plan is legally married, based upon the law in effect at the time of and in the state or appropriate jurisdiction in which the marriage was performed, recognized or declared.

Special enrollment

Under HIPAA, special mid-year enrollment rights that group health plans must offer to certain unenrolled employees and Dependents who experience a mid-year loss of other coverage or when there is a midyear birth, adoption or marriage.

Summary of Benefits and Coverage (SBC)

An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. Plan SBCs are available at mustbenefits.org.

Tax credits

Based on your family size and income, you may qualify for a tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly premium costs. Sometimes called advanced premium tax credit (APTC) or premium tax credit. Use the BCBSMT premium tax credit estimator to see if you qualify.

Telemedicine

The use of interactive audio, video, or other telecommunications technology that is:

1. Used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located, and
2. Delivered over a secure connections that complies with the requirements of the health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320D, et seq.

The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology. The term does not include the use of audio-only telephone, e-mail, or facsimile transmissions.

Third Party Administrator (TPA)

The organization providing services to this Plan's Administrator and Sponsor, including processing and payment of claims. For this Plan, BCBSMT is the TPA for the medical, dental, pharmacy and vision coverage. BCBSMT uses Prime Therapeutics as its pharmacy benefit manager.

Usual, Customary, and Reasonable (UCR) Dental

The dental program is designed to provide a fair and reasonable allowance toward charges for dental services. In general:

1. A dentist's fee is usual if it is the amount normally charged by that dentist for procedures commonly performed
2. A charge is customary, meaning it is in the 90th percentile of reported usual fees as determined by the TPA (also referred to as the Customary Maximum Allowance), and
3. Reasonable fee is established when we are unable to determine a customary fee because of the unusual or unique nature of the dental service. The service benefit amount allowed will be the lesser of the Usual, Customary, or Reasonable fee.

Wellness program

MUST's wellness program, Healthy Futures, is intended to improve and promote health. The program includes a blood screening and completion of the Total Health Management assessment form to help identify eligible participants' health risks.