

ALLEGIANCE MANAGED CARE OPTION PLAN DESCRIPTION

A SUPPLEMENT TO THE [Employer] EMPLOYEE BENEFITS SUMMARY PLAN DOCUMENT

This Supplement replaces corresponding medical benefit sections of the [Employer] Employee Benefits Summary Plan Document for Members Enrolled in the Managed Care Option (MCO) Plan administered by Allegiance Benefit Plan Management.

For purposes of this Supplement:

“**Employer**” means [Employer]

“**TPA**” means Allegiance Benefit Plan Management

“**Allegiance Managed Care Option (MCO) Plan**” means the plan of benefits defined by this Supplement, applicable provisions of the Employer’s Employee Benefits Summary Plan Document and the current Schedule of Benefits.

Other capitalized terms are defined in Section 3, Definitions.

Employer Contact:

[Employer customized]

TPA Contact:

Allegiance Customer Services at 1-877-778-8600 or visit their web site at www.abpmtpa.com/mus

Utilization Management Company:

StarPoint at 1-800-342-6510

Effective January 2008

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HOW TO OBTAIN BENEFITS

Payment of benefits under this Allegiance Managed Care Option (MCO) Plan will be made on the basis of your submission of required information to the TPA. You must also be eligible under the Employer’s Employee Benefit Plan.

*“Service Area” for the Allegiance MCO Plan is defined by zip code and by city for Hospitals as listed in the annual informational materials the Employer provides on medical insurance plan options for the upcoming Benefit Year.

SECTION 1: OBTAINING BENEFITS

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1.0 AVAILABILITY OF THE ALLEGIANCE MCO PLAN

The Allegiance MCO Plan is available to the following eligible Members:

1. Any Member whose primary residence is within the state of Montana and is also within the Service Area* for this Allegiance MCO Plan. **Please note that even if primary residence is within the state of Montana, in order to receive the In-Network Level of Benefits, use of an In-Network Provider (including Hospitals and Surgical Centers) is required, except services for an Emergency Medical Condition and facility/Professional Services for an Urgent Medical Condition.**
2. Members who temporarily travel or reside outside of the state of Montana, but whose primary residence is within the state of Montana and is also within the Service Area* for this Allegiance MCO Plan. **Please note that even though You temporarily reside outside the state of Montana, in order to receive the In-Network Level of Benefits, use of an In-Network Provider (including Hospitals and Surgical Centers) is required, except for services for an Emergency Medical Condition and facility/ Professional services for an Urgent Medical Condition.**

The Allegiance MCO Plan is not available to the following eligible Members:

1. Any Member whose primary residence is not within the state of Montana; and
2. Any Member whose primary residence is within the state of Montana, but not within the Service Area for the Allegiance MCO Plan*.

1.1 STEPS TO TAKE IN ADVANCE OF RECEIVING SERVICES

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1. Make sure you have a current Identification Card from the TPA. Make sure it contains the correct Identification Number, name(s), Dependent Coverage information, and date(s) of birth. If you need services before you receive your card or have lost it, ask Your Provider to verify Your Coverage by calling the TPA or the Employer at the numbers located on the Cover Page. Replacement cards can also be ordered by calling the TPA.
2. The Allegiance MCO Plan encourages you to seek an In-Network Provider to coordinate all your health care services. However, you are permitted to self-refer to any Allegiance In-Network Provider and still receive the highest level (the In-Network Level) of benefits. You may search for In-Network Providers statewide or in Your area by using the Allegiance website at www.abpmtpa.com/mus.

If You need care not available in the state of Montana, You may also search this website for National Network Providers, whose Covered Medical Services will qualify for the In-Network Level of Benefits only if delivered with a referral by an In-Network Provider. **Note: If an In-Network Provider refers You to another Provider (another Physician, specialist, facility, lab, therapist, etc) it is Your responsibility to ensure that this Provider is either an In-Network Provider or, for services not available within the state, a National Network Provider in order to receive the In-Network Level of Benefits. If You receive services (other than Emergency Medical Care or facility/Professional Urgent Care) from an Out-of-Network Provider, You will receive the Out-of-Network Level of Benefits regardless of whether it is referred by an In-Network provider.**

For all referrals it is the responsibility of the Member to check Allegiance's website at www.abpmtpa.com/mus to see if the Provider is either an In-Network Provider (under the in-state MultiProvider search) or, for care not available within the State, a National Network Provider (under the National Network search).

3. In advance of receiving services, know and optimize your benefits:

a. Obtain Pre-Certification for in-patient Hospital stays. All non-Emergency inpatient Hospital stays should be Pre-Certified (prior to admission) by calling the Utilization Management Company to make sure the stay meets Medical Necessity requirements for inpatient benefits. All Emergency admissions should be Certified within 72 hours after admission, or at the first opportunity, to make sure any continued stay meets Medical Necessity criteria for inpatient benefits. The Hospital will typically make this call to assure payment, but since you are responsible for all charges that are not for Covered Medical Services, You should call as well for your own protection. You should also call to confirm that the Hospital is an In-Network facility if you are unsure. *Pre-Certification is especially critical for any inpatient facility admissions/stays for: transplants, treatment of Mental Illness or Chemical Dependency, and Rehabilitation Services or recovery, as indicated for these services in Section 2.*

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

- 1) Infertility treatment;
- 2) Obesity management (non-surgical)
- 3) DME over \$1,000,
- 4) Transplants
- 5) TMJ - surgical treatment
- 6) Orthognathic surgery
- 7) Non-Emergency oral surgery
- 8) Home Health Services
- 9) Hospice
- 10) Home Infusion Services

- 11) Growth hormone therapy
- 12) Outpatient Rehabilitation Services – Physical, Occupational & Speech Therapy

c. Identify services for which Prior Authorization is recommended. These include:

- 1) Dialysis for renal disease
- 2) PET scans
- 3) Reconstructive breast surgery.

Identify other services for which Medical Necessity may be in doubt. Any and all such services are subject to medical review, and adjudication of claims can only be completed after services have been rendered and submitted to the TPA. However, You may call Allegiance's customer service to obtain a Prior Authorization for services that are new or outside standard medical practice, or that are only Covered under some circumstances (as described in Section 2).

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

- 1) obtaining Covered Medical Services from an In-Network Provider;
- 2) obtaining Covered Medical Services, not available within the state, from a National Network Provider when referred by an In-Network Provider
- 3) obtaining from any Provider Covered Medical Services for treatment of an Emergency Medical Condition or obtaining Covered facility/ Professional Services for Urgent Care (care of an Urgent Medical Condition). In the case of a medical Emergency You are encouraged to obtain services from the closest appropriate Provider. You will receive the In-Network Level of Benefits for immediate treatment of an Emergency Medical Condition by any Covered Provider, including an Out-of-Network Provider. However, you will only receive the In-Network Level of Benefits for any Out-of-Network follow

up care (after the medical Emergency has ended) if the above Pre-Certification requirements are met.

Other Covered Services from an Out-of-Network Provider will receive the Out-of-Network Level of Benefits (also described in the Schedule of Benefits) with some exceptions. The medical services identified in 2.1.3 are not Covered Out-of-Network.

- e. Determine if there are frequency, duration, or dollar limits on services you plan to receive so you can consider alternatives, if needed (see Section 2 and the Schedule of Benefits).

1.2 STEPS TO TAKE TO RECEIVE BENEFITS AND PAYMENT

1. Present Your Identification Card to the Physician, Hospital, or other health care Provider when you or any Covered Dependents receive services, and pay any required Copayments.
2. Make sure the Provider has your current Identification Number and address. If you change your address, notify the TPA and the Employer at the numbers or location on the Cover Page.
3. Most Providers will file a claim for you; however, you are responsible for making sure a claim has been filed. A CLAIM MUST BE FILED WITH THE HEALTH PLAN WITHIN TWELVE MONTHS OF THE DATE OF SERVICE TO RECEIVE BENEFITS. You may need to complete a standard claim form (which should be available from the Provider) if you use a Provider who does not submit claims on your behalf. See 1.3 on filing a claim.
4. Payment will automatically be sent directly to Providers whose bills include an assignment of benefits from you. You will receive payment directly for services for which no assignment of benefits has been made. For In-Network Providers, You will not be responsible for paying charges for Covered Medical Services above Allowable Fees.

5. Respond to requests for information about accidents, Pre-Existing Conditions, other insurance Coverage, additional information for Prior Authorization or Pre-Certification or any other information requests from the TPA. Your claim will not be adjudicated until and unless the required information is received within the time frame required by the Health Plan.
6. Monitor invoices from the Provider and Explanations of Benefits from the Health Plan to make sure the Health Plan received and adjudicated a claim for services and that the Provider received any payment due.

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

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

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

If a claimant does not understand the reason for any adverse benefit determination, he or she should contact the TPA at the address or telephone number shown on the EOB. See the Employer's Summary Plan Document for Appeal procedures.

1.4 SELF-AUDIT AWARD

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

- a. The over-charges may not have already been detected by the Health Plan TPA or reported

- by the Provider.
- b. The over charges must be \$50 or more, and
- c. The over-charges must be within Allowable Fees for Covered Medical Expenses

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

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

MEDICAL BENEFITS

SECTION 2: PLAN BENEFITS

2.1 COVERED MEDICAL EXPENSES AND SERVICES, GENERALLY

2.1.0 COVERED MEDICAL EXPENSES
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Covered Medical Expenses of the Allegiance MCO Plan are:

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

2.1.1 COVERED MEDICAL SERVICES
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Covered Medical Services are services, procedures, and supplies:

- a. listed in this Supplement as Covered Medical Services, and not specified as exclusions in this Supplement or in the Schedule of Benefits.
- b. determined by the TPA to be Medically Necessary for the diagnosis or treatment of:
 - 1) Injury;
 - 2) Illness;
 - 3) maternity care; or
 - 4) are preventive services specified in this section.
- c. provided in accordance with the terms of this MCO Plan including any Prior Authorization requirements, and any time and service limits.
- d. provided to a Member by a licensed Provider; and
- e. provided and coded appropriately (in accordance with industry standards).

Covered Medical Expenses are paid or credited to the Member’s Deductible, Copayment and Co-insurance obligations for the applicable level of benefits as described below.

2.1.2 IN-NETWORK LEVEL OF BENEFITS
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You receive the In-Network Level of Benefits (described in the Schedule of Benefits) for Covered Medical Services that are:

- a. provided by an In-Network Provider;
- b. not available within the state and provided by a National Network Provider with referral by an In-Network Provider
- c. for treatment of an Emergency Medical Condition or facility/Professional services for Urgent Care (care of an Urgent Medical Condition) by any Provider.

You will be responsible for any Deductible, Copayment and Coinsurance amounts, which the current Schedule of Benefits specifies for the In-Network Level of Benefits. See 2.2 – 2.11 and 2.12 for any special requirements for receiving the In-Network Level of Benefits for particular Covered Medical Services or services with limited Coverage.

2.1.3 OUT-OF-NETWORK LEVEL OF BENEFITS

.....

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

- a. Infertility treatment;
 - b. Obesity management (non-surgical)
 - c. Transplants
- (Note that the above require Prior Authorization for any benefits.)

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

2.2 DIAGNOSTIC/LAB

2.2.0 DIAGNOSTIC LABORATORY SERVICES

.....

Prior Authorization of PET scans is strongly recommended.

1. Coverage includes radiology, laboratory and tissue diagnostic examinations, and diagnostic machine tests (such as EKGs) made for the purpose of diagnosing Injury or Illness when Hospital confinement is not required and benefits are not provided elsewhere in this Supplement.
2. Radiology and laboratory benefits shall not be provided for the following:
 - a. dental examinations or treatments, except for dental x-rays resulting from injuries sustained in an accident (Covered under 2.12., provision 3);
 - b. visual examinations; and

- c. premarital examinations and routine physical checkups, including examinations made as a requirement of employment or governmental authority, except as provided in 2.8.0.

2.3 EMERGENCY

2.3.0 AMBULANCE

.....

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

2.3.1 EMERGENCY CARE

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

The emergency room Copayment (as identified in the Schedule of Benefits) only includes the facility charges. Any lab fees, diagnostic fees or Professional Service charges are subject to Deductible and Coinsurance.

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

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

If an Emergency Medical Condition is determined to exist that requires Hospital admission or any follow-up services, You must notify the Utilization Management Company within 24 hours of (or the next working day after) the initial Emergency care so the Utilization Management Company can coordinate the subsequent follow-up care and assure continued In-Network Benefits. If You are incapable of calling or having a representative call the Utilization Management Company within 24 hours (or on the next working day), You should contact the Utilization Management Company as soon as medically possible. Once medical stabilization is achieved, the Utilization Management Company may recommend transfer to an In-Network Hospital for the In-Network Level of Benefits to continue.

2.4 HOSPITAL

2.4.0 INPATIENT HOSPITAL CARE

.....
Pre-Certification of non-Emergency Hospital admissions is strongly recommended. See 2.3.1 for Emergency admissions.

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

2.4.1 OUTPATIENT HOSPITAL SERVICES

.....
Hospital services and supplies described in 2.4.0 are Covered if a Member is treated at a licensed Hospital, but not admitted for bed patient care. Charges for Observation Beds/Rooms are Covered when Medically Necessary for services of less than 24 hours and for charges not exceeding the room rate that would be charged for an inpatient stay of one day. See 10.0 for information on outpatient surgical services.

2.5 MATERNITY, GYNECOLOGY AND NEWBORN CARE

2.5.0 OBSTETRICS AND GYNECOLOGY/GYN

.....
Coverage includes Medically Necessary obstetrical and gynecological services.

If you enroll in the employer's prenatal wellness program within the first trimester of pregnancy, the following will be waived:

1. Copayments for in-network prenatal and post-natal office visits and deductible and coinsurance on routine labs (that have not already been assessed before enrollment); and
2. Deductible and coinsurance on in-network professional charges for the delivery.

See the Employer's Summary Plan Document for information on the Employer's prenatal wellness program and how to enroll. Without timely enrollment in the prenatal wellness program, charges are subject to deductible and coinsurance as described in the current Schedule of Benefits.

Ultrasounds will be subject to standard Deductible and Coinsurance with the first one exempted if the Member Enrolls in the Employer's prenatal wellness program as described above.

2.5.1 FACILITY OBSTETRICAL DELIVERY CARE AND SERVICES

.....
Pre-Certification of non-Emergency Hospital Admissions is strongly recommended. See 2.3.1 for Emergency Admissions.

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

2.5.2 ROUTINE NEWBORN CARE

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Coverage includes the initial routine care of a newborn at birth provided by a Physician, standby

care provided by a pediatrician at cesarean section, and facility nursery care of newborn infants. Facility and Professional Service charges are exempt from Deductible.

2.6 MISCELLANEOUS
2.6.0 CONGENITAL ANOMALY

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

2.6.1 DIALYSIS

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

2.6.2 HOME INFUSION THERAPY

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

2.6.3 INBORN ERRORS OF METABOLISM (including PKU)

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

2.6.4 INJECTIBLE BENEFIT

Coverage includes injectible medications administered at the Provider's office or facility, when not able to be self injected, including but not limited to: contraception, pain control, and administration of antibiotics.

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

2.7 PHYSICIAN

2.7.0 INPATIENT PROVIDER CARE

.....
Pre-Certification of all Hospital admissions is strongly recommended. See 2.3.1 for Emergency admissions.

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

2.7.1 OUTPATIENT OFFICE VISIT SERVICES

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

The In-Network office visit Copayment only covers the office visit Allowable Fee. Any laboratory, x-ray, radiation, tests, or other ancillary procedures are subject to Deductible and Coinsurance unless Covered under the preventive benefits described in 2.80 and 2.81 below.

2.8 PREVENTIVE

2.8.0 ADULT PREVENTIVE SERVICES

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

- 1. Nineteen (19) years through thirty nine (39)

years of age:

- a. one physical exam every two years, including history, screening for high-risk behavior, urinalysis, Hemoglobin OR Hematocrit, basic metabolic panel and cholesterol and lipid screening (Covered preventive labs are included in the In-Network office visit Copayment);
- b. for female Members, the physical exam also includes a gynecological exam and pap test, which are Covered annually (Covered preventive labs are included in In-Network office visit Copayment);
- c. For female Members, one baseline mammogram between thirty five (35) and thirty nine (39) years of age; for female Members with a documented family history of disease risk, annual mammograms when Prior Authorized (Paid at 100% if In-Network; see Schedule of Benefits for Out-of-Network benefit).

2. Forty (40) years and older:

- a. one physical exam every year, including history, screening for high-risk behavior, urinalysis, Hemoglobin OR Hematocrit, basic metabolic panel, cholesterol and lipid screening and stool occult blood colorectal screening (Covered preventive labs are included in office visit Copayment);
- b. for female Members, the physical exam also includes a gynecological exam and pap test (included in office visit Copayment);
- c. for male Members, the physical exam also includes PSA screening (included in office Copayment);
- d. one ECG/EKG per lifetime (subject to Coinsurance & Deductible);
- e. for female Members, one mammogram every year (paid at 100% In-Network; see Schedule of Benefits for Out-of-Network benefit).

- f. beginning at age 50, a flexible sigmoidoscopy and double-contrast barium enema every five years; a colonoscopy every ten years (subject to Coinsurance & Deductible);
- g. Bone density scan every five years (subject to Coinsurance & Deductible) for female Members age 60 and over and male Members age 70 and over.

- 3. **Immunizations & allergy shots:** Allergy shots and adult immunizations recommended by the Centers for Disease Control Immunization Guidelines are Covered excluding immunizations recommended because of increased risk due to type of employment or travel, such as, but not limited to: malaria, yellow fever, hepatitis B, and tuberculosis (included in In-Network office visit Copayment). *In-Network immunizations and allergy shots billed without an office visit are exempt from Deductible and only subject to Coinsurance up to a maximum of \$10.*

2.8.1 WELL CHILD BENEFITS

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Well-child Care Benefits Include:

- 1. A history, physical examination, developmental assessment, and anticipatory guidance by a Physician, as those terms are defined in 33-33-303 MCA, and laboratory tests according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in MCA 53-6-101 from birth through age seven (7). Visits are Covered at the following approximate ages:
 - A visit for any newborn who did not receive a newborn exam in a Hospital or birthing facility or who was discharged from a Hospital in less than 36 hours;
 - 1 month;
 - 2 months;
 - 4 months;
 - 6 months;
 - 9 months;
 - 12 months;
 - 15 months;
 - 18 months;

- 24 months;
 - and one per year thereafter, through the child's seventh (7th) year of age;
2. An age and gender appropriate physical examination every two years from age 8 through age eighteen (18) including a gynecological examination and pap test for pubescent girls at the discretion of the Physician; and
 3. Routine immunizations (according to the schedule of immunizations recommended by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services) and allergy shots.

In-Network allergy shots and Covered laboratory tests and immunizations are included in the office visit Copayment. In-Network immunizations and allergy shots received without an office visit are exempt from Deductible and only subject to Coinsurance up to a maximum of \$10.

2.9 SEVERE MENTAL ILLNESS

2.9.0 SEVERE MENTAL ILLNESS CARE

Pre-Certification of all non-Emergency Hospital admissions is strongly recommended. See 2.3.1 for Emergency admissions.

Coverage includes Medically Necessary care and treatment of Severe Mental Illness as defined in 33-22-706 MCA and this Supplement Section 3 Definitions.

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

2.10 SURGERY

2.10.0 SURGICAL CENTER AND OUTPATIENT HOSPITAL SURGERY SERVICES

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

2.10.1 MASTECTOMY

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

2.10.2 RECONSTRUCTIVE BREAST SURGERY

Prior Authorization is strongly recommended.
 Coverage provides reconstructive surgery after a mastectomy, which resulted from disease, Illness, or Injury.

Coverage is provided for:

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

2.10.3 ORAL SURGERY

Prior Authorization of orthognathic surgery, non-Emergency oral surgery and surgical treatment of TMJ disorders is required.

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

ORTHOGNATHIC SURGERY (RECONSTRUCTIVE JAW SURGERY)

Coverage is provided only for the treatment of

congenital conditions of the jaw that may be demonstrated to cause actual significant deterioration of the Member's physical condition because of inadequate nutrition when Prior Authorized.

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

2.10.4 RECONSTRUCTIVE SURGERY

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

2.11 URGENT CARE

2.11.0 URGENT CARE

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

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

The In-Network office visit Copayment (specified in the Schedule of Benefits) is applied to Allowed facility and Professional Fees for Urgent Care from any licensed Provider.

Any laboratory, x-ray, radiation or other tests or procedures are subject to Deductible and Coinsurance.

2.12 SERVICES WITH LIMITED COVERAGE

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The following are health care services and supplies that are Covered as described in 2.1 – 2.11, but with special limitations.

Some of these services have no Out-of-Network

Level of Benefits, as specified next (and as listed in 2.1, provision 3). They are only Covered when provided by an In-Network Provider or, for services not available in the state, by a National Network Provider with referral by an In-Network Provider. Some services require Prior Authorization (in advance of the service) for any benefits (either In-Network or Out-of-Network). Some have dollar or service limits, or require a Physician's order.

2.12.1 CHEMICAL DEPENDENCY TREATMENT

Pre-Certification of all non-Emergency Hospital admissions is strongly recommended. See 2.3.1 for Emergency admission.

Coverage is provided for inpatient and outpatient treatment for alcoholism and drug addiction (excluding costs for medical detoxification, which are Covered under 2. 4.0). Coverage is limited to a maximum combined (inpatient and outpatient) amount for a 12-month period and to a lifetime maximum inpatient amount (See the Schedule of Benefits). After that, a small annual benefit for inpatient and outpatient treatment may be available (See Schedule of Benefits).

2.12.2 CHIROPRACTIC SERVICES

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

2.12.3 DENTAL SERVICES FOR ACCIDENTAL INJURY

Coverage is provided for the treatment of accidental dental Injury only. It is limited to the restorative services and supplies necessary for the treatment of a fractured jaw or other accidental Injury to sound natural teeth completed within twelve (12) months after the date of the accidental Injury.

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

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

Prior Authorization is required for DME expenses in excess of \$1,000. Coinsurance does not count toward annual Coinsurance Maximum.

Coverage is provided for the following services and supplies for medical purposes only, or for therapeutic use in a Member's home:

- a. rental (up to purchase price) or purchase which ever meets the therapeutic purpose for less, of a Hospital-type bed, wheelchair, walker or other Durable Medical Equipment and repair of purchased equipment (provided the Equipment is designed for prolonged use, serves a specific therapeutic purpose in the treatment of an Illness or Injury, is primarily and customarily used for a medical purpose, is appropriate for use in the home, and is not generally useful to a person in the absence of Illness or Injury). *Requests for computerized and "deluxe" equipment, like motor-driven wheelchairs, are reviewed on an individual basis. Coverage does not include maintenance, replacement due to loss, or duplication. Replacement can occur when equipment or prosthetics are no longer repairable or when DME has been out-grown.*
- b. foot orthotics (limited to a dollar amount per foot per year specified in the Schedule of Benefits, and excluding Coverage of orthotics for the sole purpose of treating sports-related activities);
- c. oxygen services and supplies; and
- d. prosthetic appliances, including the purchase and fitting of breast prostheses and the purchase and fitting of artificial limbs, larynx, eyes, and other prosthetic appliances or permanent internally implanted devices that are not Experimental. Repair, maintenance, replacement due to loss, and duplication are not Covered. Replacement can occur when the item is no longer repairable.

2.12.5 DISEASE PROCESS EDUCATION & DIETARY NUTRITIONAL COUNSELING

See the current Schedule of Benefits for benefit maximum.

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

2.12.6 HOME HEALTH SERVICES

Prior Authorization is required.

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

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

Home health services are limited to the number of visits per Benefit Year specified in the Schedule of Benefits, where a day with any Home Health Service is counted toward the maximum.

The following services are not Covered:

- a. services and supplies not part of the Home Health Care Plan;
- b. domestic or housekeeping services such as Meals on Wheels;
- c. services for mental or nervous conditions;
- d. transportation; and

- e. disposable supplies self-administered in the home (gauze, bandages, etc.) unless Covered elsewhere and DME and prostheses, which are Covered elsewhere.

2.12.7 HOSPICE SERVICES

Hospice care is Covered for Members who are diagnosed as having a terminal Illness with a life expectancy of six months or less when the care is ordered by a Physician. The following Hospice services are Covered:

- a. facility expenses of a Hospice facility, Hospital, or Skilled Nursing Facility for board, room, and other services and supplies furnished to a person while inpatient for pain control and other acute and chronic symptom management (*Expenses for a private room are Covered only up to the regular daily expense for a semi-private room unless a private room is Medically Necessary or a semi-private room is unavailable*); and
- b. Hospice expenses for:
 - 1) nursing care provided by a registered nurse or licensed practical nurse, and services of a home health aide;
 - 2) medical social services provided under the direction of a Physician;
 - 3) psychological and dietary counseling;
 - 4) consultation or Case and Disease Management services;
 - 5) Medically Necessary Physical and Occupational Therapy;
 - 6) medical supplies, drugs, and medicines prescribed by a Physician; and
 - 7) expenses for consultant or Case and Disease Management services, or Physical or Occupational Therapy by health care Providers who are not Employees of the Hospice - but only when the Hospice retains responsibility for the care.

2.12.8 INFERTILITY TREATMENT

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

Benefits include diagnostic and evaluation services to determine if treatment for infertility is necessary. Follow-up treatment is limited to

Members who have been diagnosed as biologically infertile in accordance with accepted medical practice. Artificial insemination attempts per Member per lifetime are limited to the number specified in the Schedule of Benefits. Medically indicated fertility drugs that are authorized by the Health Plan must be obtained through the Employer's Prescription Drug Plan under the terms of that Plan. Infertility benefits do not include in-vitro fertilization, and are not provided to Members who have undergone a voluntary sterilization procedure.

2.12.9 MENTAL ILLNESS

Pre-Certification of all non-Emergency Hospital admissions is strongly recommended. See 2.3.1 for Emergency admissions.

Coverage is provided for Medically Necessary inpatient and outpatient treatment of Mental Illness. Inpatient services are limited to the maximum number of days specified in the Schedule of Benefits. Two Partial Hospitalization days can be received in lieu of one inpatient day. Outpatient benefits are limited to the maximum number of visits specified in the Schedule of Benefits. There are no inpatient or outpatient maximums for Severe Mental Illness defined in 33-22-706, MCA. See Section 3 Definitions.

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

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

2.12.10 OBESITY MANAGEMENT

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

Coverage includes non-surgical treatment for reducing or controlling weight under a Prior-Authorized treatment plan. The Member must meet the definition of Morbid Obesity in Section 3 Definitions of this Supplement to begin receiving benefits and must make timely progressive weight loss for benefit continuation, as defined in the

Prior Authorization. Medically indicated drugs that are authorized by the Health Plan must be obtained through the Employer's Prescription Drug Plan under the terms of that Plan.

Non-surgical treatment includes the following services:

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

Bariatric and other surgeries to reduce weight, dietary supplements, and exercise programs are not included in this benefit.

2.12.11 REHABILITATIVE SERVICES

Please refer to Your Schedule of Benefits for inpatient and outpatient maximums. Prior Authorization is required.

Coverage includes pulmonary, cardiac, respiratory, Physical, and Occupational Therapy that is ordered by a licensed Physician and determined to show proven gain in function. For therapies to be eligible for Coverage, the Member must meet one or more of the following criteria:

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

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

- a. There is a documented condition or delay in development that can be expected to improve with therapy within a reasonable time.

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

Speech Therapy is not Covered if:

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

2.12.12 SKILLED NURSING FACILITY CARE

Please refer to Schedule of Benefits for maximum days Covered.

Coverage is provided for Medically Necessary care by a licensed Skilled Nursing Facility, or part of an institution that offers Skilled Nursing Care (as defined in Section 3 Definitions of this Supplement).

2.12.13 TRANSPLANTS

No Out-of-Network Level of Benefits is available. Benefits (the In-Network Level) are only available through the designated Transplant Network or when an Allegiance In-Network Provider is authorized due to unavailability of a designated Transplant Network Provider. Prior Authorization is required.

The TPA has designated certain Hospitals to perform Covered transplants. These Hospitals have been selected for their experience in performing transplants and no benefits are available from other Hospitals (except under rare circumstances approved in advance by the TPA. In some instances, the designated Hospital may not be located in the Service Area, therefore requiring travel. Contact the TPA for a list of designated transplant facilities. Please refer to the Summary of Benefits for benefit maximums.

a. Covered Transplant Services

Coverage includes the following for Covered transplants:

- 1) evaluation;
- 2) pre-transplant care;
- 3) transplant and certain specific donor-related services; and
- 4) follow-up treatment.
- 5) a travel, reimbursement benefit up to the maximum in the Schedule of Benefits, (subject to Federal guidelines) during the dates for which a transplant contract is in effect, or up to one year after the date of the transplant, whichever is longer.

b. Covered Transplants

The following human organ/ tissue transplants are Covered:

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

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

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

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

2). Autologous Bone Marrow Transplants

- a) acute lymphocytic leukemia and non-acute lymphocytic
- b) leukemia
- c) Burkitts Lymphoma
- d) large-cell lymphoma

- e) non-Hodgkin's lymphoma
- f) Hodgkin's Disease
- g) neuroblastoma

3). Stem cell transplants in conjunction with high-dose chemotherapy are Covered, when Medically Necessary. Prior authorization is recommended (a retrospective review will be done if services are not Prior Authorized). The TPA will consider high-dose chemotherapy with either allogenic or autologous stem-cell transplant on an individual case basis.

c. Donor Benefits

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

d. No Coverage for the Following:

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

2.13 PLAN EXCLUSIONS

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The following are exclusions of this MCO Plan:

2.13.1 NON-COVERED SERVICES

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

2.13.2 SERVICES WHICH ARE NOT MEDICALLY NECESSARY

2.13.3 NON-AUTHORIZED SERVICES

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

2.13.4 PRESCRIPTION DRUGS

Exclusions include outpatient prescription drugs, which are Covered by a separate Prescription Drug Plan (see Section 3 Definitions of this Supplement).

2.13.5 PRE-EXISTING CONDITIONS

Pre-Existing Conditions are excluded for up to one year from a Member's Coverage Effective Date. However, the period of exclusion may be reduced by Creditable Coverage as described in Section 3 Definitions of this Supplement. Also see the Employer's Summary Plan Document.

2.13.6 HEARING AID SERVICES

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

2.13.7 COMPLICATIONS FROM INELIGIBLE PROCEDURE

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

2.13.8 ELECTIVE, COSMETIC, AND

VOLUNTARY HEALTH SERVICES

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

- a. Surgery and any related services for the sole intent to improve appearance.
- b. Services and supplies for cosmetic purposes, including the restoration of hair, appearance of skin, and/or body shape.
- c. Personal hygiene and convenience items including, but not limited to: air conditioners, humidifiers, or physical fitness equipment.
- d. Lifestyle improvements, such as physical fitness programs.
- e. Services and/or memberships provided through facilities including, but not limited to: health clubs, fitness centers, or spas.
- f. Dietary regimen supplements and/or exercise programs for the controlling or reduction of weight, except the limited obesity treatment benefit (described in 2.12, provision 10).
- g. Dietary supplements, except medical foods required for the treatment of inborn errors of metabolism (described in 2.6.3).
- h. Procedures, services, drugs, and supplies related to elective abortions, except when the pregnancy is the result of an act of rape or incest.
- i. Treatment leading to (or in connection with) sexual reassignment including, but not limited to: surgery and mental health counseling.
- j. Services and supplies for (or related to) conception by artificial means, except as provided in 2.12, provision 8.
- k. Services and supplies needed to reverse a sterilization procedure, including tubal ligations and vasectomies.

1. Treatment of sexual dysfunction.
- m. Pastoral, financial, or legal counseling.
- n. Counseling services for adolescent behavior problems, learning delays, self discovery and improvement, and family and marital problems
- o. All services related to routine, non-Medically Necessary foot care including, but not limited to: the treatment or removal of corns, calluses, or nails; hypertrophy; hyperplasia of skin or subcutaneous tissues; cutting or trimming of nails; treatment of weak, strained, or flat feet; fallen arches; orthotic appliances, lifts, and orthopedic shoes (except the foot orthotic benefit provided in 2.12, provision 4); padding and strapping; and fabrication.
- p. Physical examinations and other services required for obtaining or maintaining employment, insurance, or government licensing, unless they are a portion of an annual physical assessment Covered as an adult preventive service (as defined in 2.8.0).
- q. School, sports, and camp physicals, unless they are part of an annual physical assessment Covered as preventive services (as defined in 2.8.0 or 2.8.1).
- r. Over-the-counter supplies including, but not limited to: bandages, splints, and medications.
- s. Any device for the sole purpose of enhancing sports-related activities.
- t. Immunizations for foreign travel.
- u. Education or tutoring services, except as provided in 2.12, provision 5.
- a. Confinement in a Skilled Nursing Facility, convalescent Hospital, other facility or that part of any such facility used for:
 - 1) convalescent, custodial, or rest care;
 - 2) Mental Illness or Chemical Dependency care; or
 - 3) training or schooling.
- b. Services or articles for custodial, convalescent, or maintenance care; domiciliary care; rest care; or care designed primarily to assist in the activities of daily living.
- c. Long-term care services.

2.13.10 EXPERIMENTAL PROCEDURES

Exclusions include Experimental Procedures (as defined in Section 3 Definitions of this Supplement) and/or medical treatments, procedures, drugs, devices, or biologics that are Experimental, investigational, or used for research.

2.13.11 NON-STANDARD OR SELF PRESCRIBED SERVICES AND SUPPLIES

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

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

2.13.9 NURSING HOME AND RELATED CONVALESCENT CARE

Except as specifically provided in this Supplement, exclusions include:

2.13.12 INJURY OR SICKNESS RELATED TO ILLEGAL ACTIVITIES

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

illegal act or occupation.

2.13.13 INJURY OR SICKNESS RELATED TO A RIOT

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

2.13.14 LEGALLY-ORDERED SERVICES

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

2.13.15 ADMINISTRATIVE CHARGES

Exclusions include charges for missed appointments or other administrative sanctions.

2.13.16 INJURIES OR SICKNESS RELATED TO MILITARY SERVICE

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

2.13.17 SERVICES INCURRED OUTSIDE THE COVERAGE PERIOD

Exclusions include services incurred outside the Coverage period including:

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

2.13.18 TRAVEL

Travel is excluded, except transportation of the patient in an Emergency to the nearest facility qualified to treat the Injury or disease, or as

otherwise provided in the ambulance benefit (2.3.0) or transplant benefit (2.12, provision 13).

2.13.19 CERTAIN PRIVATE ROOM CHARGES

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

2.13.20 DUPLICATE SERVICES OR SERVICES COVERED UNDER ANOTHER BENEFIT PLAN

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

a. Government-Covered Services and Supplies

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

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

b. Workers' Compensation-Covered Services

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

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

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

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

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

c. Expenses Covered by Other Insurance Policies

Exclusions include expenses that a Member is entitled to have Covered (or that are paid) under an automobile insurance policy, a

premise liability policy, or other liability insurance policy (such as a home owners or business liability policy). Exclusions also include expenses the Member would be entitled to have Covered under such policies if not Covered by the Allegiance MCO Plan, unless applicable law requires the MCO Plan to provide primary Coverage.

2.13.21 CHARGES MEMBERS ARE NOT OBLIGATED TO PAY

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

2.13.22 THIRD PARTY LIABILITY

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

2.13.23 UNUSUAL CIRCUMSTANCES

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

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

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

labor dispute.

2.13.24 VOCATIONAL REHABILITATION

2.13.25 DENTAL COVERAGE

Exclusions include dental Coverage (see 2.12, provision 3, for limited Coverage due to accidental Injury).

2.13.26 VISION SERVICES AND APPLIANCES

Exclusions include vision services and appliances including eye exams, glasses, contact lenses, radial keratotomy or other surgery to correct vision, and orthoptic or vision training (These may be Covered by a separate Employer vision plan).

2.13.27 TREATMENT FOR MALOCCLUSION OF THE JAW

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

2.13.28 ORGAN OR TISSUE TRANSPLANTS

Organ and tissue transplants are excluded, except as provided in 2.12, provision 13.

2.13.29 SPEECH THERAPY

Developmental Speech Therapy is excluded from Coverage except as Covered in 2.12, 11.

2.13.30 RESIDENTIAL CARE PROGRAMS FOR MENTAL ILLNESS TREATMENT

2.13.31 ANY ADDITIONAL CHARGES FOR INCLUSIVE PROCEDURES OR SERVICES

Exclusions include additional charges for Inclusive Procedures or services (as defined in Section 3 Definitions of this Supplement).

2.13.32 SERVICES OR SUPPLIES NOT PROVIDED BY A LICENSED PROVIDER OR WHICH ARE NOT LISTED AS A

BENEFIT IN THIS SUPPLEMENT.

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