MONTANA UNIVERSITY SYSTEM STUDENT INSURANCE PLAN

Effective August 1, 2014

Dental

BlueCross BlueShield
of Montana

STUDENTALMG2014

FOR CUSTOMER SERVICE, CALL 1-866-739-4090

FOR CLAIMS, SEND TO:
Blue Cross and Blue Shield of Montana
PO Box 6227
Helena, MT 59604-6227

FOR APPEALS, SEND TO:
Blue Cross and Blue Shield of Montana
PO Box 6227
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Certain terms in this Member Guide are defined in the Definitions section of this Member Guide. Defined terms are capitalized.

NO COVERAGE UNTIL DUES PAID

This Member Guide is being provided to you because your employer has agreed to purchase coverage from Blue Cross and Blue Shield of Montana. Your coverage will not be effective, and you will not be entitled to Benefits, until and unless your employer pays the required dues.

MEMBER GUIDE

This Member Guide is a summary of the Benefits available under the Group Plan. Nothing in this Member Guide will alter any of the terms, conditions, limitations, or Exclusions of the Group Plan. If questions should arise, the provisions of the Group Plan will prevail. Please refer to the Group Plan on file with your employer if you have any questions which aren't answered in the Member Guide or call your Blue Cross and Blue Shield of Montana representative.

PRIVACY OF INSURANCE AND HEALTH CARE INFORMATION

It is the policy of Blue Cross and Blue Shield of Montana to protect the privacy of Members through appropriate use and handling of private information. Further, appropriate handling and security of private information may be mandated by state and/or federal law.

The Group and Beneficiary Member may receive a copy of Blue Cross and Blue Shield of Montana's "Notice of Privacy Practices," or other information about privacy practices, by calling the telephone number or writing to the address shown on the inside cover of this Member Guide.

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SCHEDULE OF BENEFITS

Dental

Group Name:	Montana University System Student Insurance Plan
Group Number:	X58188-100
Effective Date:	August 1, 2014
Benefit Period:	August 1, 2014 to August 31, 2015

Additional days of coverage may be available for newly enrolled students, depending on the semester registration dates at each specific campus.

The Benefits are subject to the Benefit Period unless otherwise specified.

DENTAL SERVICES	**The Plan will pay Participating Providers**	**The Plan will pay Non-Participating Providers***
Diagnostic Evaluations (Deductible waived)	90%	90%
Preventive Services (Deductible waived)	90%	90%
Diagnostic Radiographs	90%	90%
Miscellaneous Preventive Services	90%	90%
Basic Restorative Services	70%	70%
Non-Surgical Extractions	70%	70%
Adjunctive Services	70%	70%
Non-Surgical Periodontal Services	70%	70%
Endodontic Services	50%	50%
Oral Surgery Services	50%	50%
Surgical Periodontal Services	50%	50%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%
Miscellaneous Restorative and Prosthodontic Services	50%	50%
Orthodontic Services – Deductible does not apply		
Pediatric Orthodontic Services: Coverage limited to Members under age 19 with an orthodontic condition meeting Medical Necessity criteria (e.g., severe, dysfunctional malocclusion) established by The Plan	50%	50%
Deductible (In and Out-of-Network accumulate together)		
Individual	$75	
Benefit Period Maximum - In and Out-of-Network accumulate together; the maximum does not apply to Orthodontic Services or to services provided to Members under the age of 19.	$1,000	

*The Member may be responsible for any amount by which the actual charges of an Out-of-Network Provider exceed the Allowable Fee.

PROVIDERS OF CARE FOR MEMBERS

Covered Providers may be Participating Providers or nonparticipating providers.

Participating Providers

Participating Providers include those providers who or which have a contract with Blue Cross and Blue Shield of Montana and are listed in the current provider directory. The providers include Participating Blue Cross and Blue Shield of Montana Professional Providers and Participating Blue Cross and Blue Shield of Montana Facility Providers.

Nonparticipating Providers

A nonparticipating professional or facility provider does not have a contract with Blue Cross and Blue Shield of Montana.

The Member will be responsible for a greater portion of the cost for any covered services received from the nonparticipating provider than if the Member had received the same covered services from a Participating Provider.

How Providers are Paid by The Plan and Member Responsibility

Payment by The Plan for Benefits is based on the Allowable Fee and is impacted by the participation or nonparticipation of the provider in the Blue Cross and Blue Shield of Montana provider network.

A **Participating Provider** agrees to accept payment of the Allowable Fee from Blue Cross and Blue Shield of Montana for covered services, together with any Deductible and Coinsurance from the Member, as payment in full. Generally, The Plan will pay the Allowable Fee for a covered service directly to a Participating Provider. In any event, The Plan may, in its discretion, make payment to the Member, the provider, the Member and provider jointly, or any person, firm, or corporation who paid for the services on the Member's behalf.

Nonparticipating providers do not have to accept Blue Cross and Blue Shield of Montana payment as payment in full. Blue Cross and Blue Shield of Montana reimburses a nonparticipating provider for covered services according to the Allowable Fee. The nonparticipating provider can bill the Member for the difference between payment by Blue Cross and Blue Shield of Montana and provider charges plus Deductible and Coinsurance. The Member will be responsible for the balance of the nonparticipating provider's charges after payment by Blue Cross and Blue Shield of Montana and payment of any Deductibles and Coinsurance.

The Plan will not pay for any services, supplies, or medications which are not covered services, or for which a Benefit maximum has been met, regardless of whether provided by a Participating Provider or a nonparticipating provider. The Member will be responsible for such services, supplies, or medications.

Pretreatment Estimate of Benefits and Treatment Plan

If the Member's Dentist recommends a Course of Treatment that will cost more than $300, the Dentist should prepare a claim form describing the planned treatment (called a "treatment plan"), copies of necessary x-rays, photographs and models and an estimate of the charges prior to beginning the Course of Treatment. The Plan will review the report and materials, taking into consideration any alternative adequate Course of Treatment, and will notify the Member and the Dentist of the estimated Benefits which will be provided under this Contract. This is not a guarantee of payment, but an estimate of the Benefits available for the proposed services to be rendered. The Plan's Pretreatment Estimates of Benefits are valid for 180 days, provided all eligibility and Contract requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, the Member is responsible for asking the Dentist to submit another request and treatment plan, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by The Plan.

COMPLAINTS, GRIEVANCES AND APPEALS

Complaints and Grievances

If a Member is dissatisfied with any aspect of The Plan's service or the care received and would like to notify The Plan of a Complaint or Grievance, the Member or the Member's designated representative may notify The Plan by telephone, in person, in writing, by fax, or electronic mail. Written Complaints and/or Grievances will be acknowledged within 10 days of receipt. The Member will be notified within 60 days of the disposition of the Complaint or Grievance. The telephone number, fax number and mailing address of The Plan appear on the inside cover of this Member Guide.

Appeals Process

If a Member does not agree with the denial or partial denial of a claim, the Member has the right to Appeal that decision.

The Member has 180 days from the date of receipt of notice of The Plan's action on a claim to request an Appeal. To request an Appeal, the Member must write to The Plan at the address listed on the inside cover of this Member Guide. Written requests will be acknowledged within 10 days of receipt. The Member must state the issue to be reviewed and provide all pertinent information (i.e., provider records, letters, etc.). The Member may also request a description of any records that The Plan used to make its original decision. The decision on the review will be made in writing within 60 days of receipt of all relevant dental records. Once the review has been completed, the Member will be notified of the outcome.

ELIGIBILITY AND ENROLLMENT

Who is Eligible

1. All students are eligible if they are:
   a. A fee-paying student attending credit courses at a participating campus; and
   b. A student enrolled for six credit hours or more at all campuses. A student enrolled for less than six credit hours is not eligible to enroll in the Student Health Plan.
2. Participation Requirements
   a. All students enrolled in school for six credit hours or more are automatically enrolled in the Student Health Plan for the entire semester unless proof of other coverage is submitted to the campus.

      The Student Health Plan fee will be assessed each Fall and Spring/Summer semester at registration.
   b. Enrollment in the Student Health Plan is required for all International Students (residing within the United States), at all campuses regardless of the number of credit hours, unless proof of other coverage in the United States is submitted to the campus.

      The Student Health Plan fee will be assessed each Fall and Spring/Summer semester at registration.
   c. Summer only students may enroll in The Plan on an optional basis. Enrollment and payment must be made within the first 5 class days of the summer semester.
   d. Waiver of coverage must be made within the first 15 class days of the semester, Fall and Spring/Summer. Only students with proof of other coverage will be allowed to waive coverage.

Enrollment/Waiver Process

The Effective Date of coverage (for those who apply within the periods of eligibility) will be the date assigned by the Group.

A specific period of time is allowed at the beginning of each semester for enrolling in The Plan or waiving coverage. For the Fall and Spring/Summer semesters, the enrollment/waiver period begins on the first day of scheduled classes each semester and ends 15 class days later. New summer students must visit the Insurance Office on their campus within 5 class days to enroll.

Effective Date of Coverage

1. For the Student.

a. The effective date of coverage for eligible students shall be the first day of the applicable coverage period.

b. If a student becomes eligible after the beginning of the applicable coverage period, the student's effective date will be the first day of the applicable coverage period after the required premium is paid.

2. For Newborn Children.

For a newborn born to a Member, the date of birth. Coverage will continue for 31 days only. Coverage for the newborn will be provided only if the Beneficiary Member remains covered on the health plan during the 31 day period. If the Beneficiary Member does not remain covered for 31 days, the newborn will only be covered for the amount of time (during the 31 days) that the Beneficiary Member is covered.

3. For Adoption or Placement for Adoption.

In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption. In the event the placement is disrupted prior to legal adoption and the child is removed from placement, coverage shall cease upon the date the placement is disrupted. Coverage will continue for 31 days only. Coverage for the child will be provided only if the Beneficiary Member remains covered on the health plan during the 31 day period. If the Beneficiary Member does not remain covered for 31 days, the child will only be covered for the amount of time (during the 31 days) that the Beneficiary Member is covered.

Special Enrollment for Loss of Eligibility

Eligible students will not be allowed to enroll in The Plan after the applicable enrollment/waiver period unless proof is furnished that the student became ineligible for coverage under another group insurance plan during the 31 days immediately preceding the date of the request for late enrollment. The coverage will be for the entire semester.

Conditions for Special Enrollment for Loss of Eligibility

1. When the student declined enrollment for the student, the student stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment; and

a. The student had COBRA continuation coverage and the COBRA continuation coverage has expired; or

b. The student had other coverage that was not under a COBRA continuation provision and the other coverage has been terminated because of:

1. A loss of eligibility for the coverage. Loss of eligibility for coverage includes a loss coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the forgoing. However, loss of eligibility does not include a loss of coverage due to failure of the individual or the Beneficiary Member to pay premiums on a timely basis or termination of coverage for cause; or
2. Employer contributions towards the other coverage have been terminated; or
3. A situation in which The Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

c. The student loses eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the student becomes eligible for financial assistance for group health coverage, under either the Children's Health Insurance Program or the Medicaid Program.

2. The student must request enrollment not later than 31 days after the exhaustion of the COBRA continuation coverage or termination of the other coverage because of loss of eligibility or termination of employer contributions.

3. The student must request enrollment not later than 60 days after the date of termination of coverage under either the Children's Health Insurance Program or the Medicaid Program.
4. The student must request enrollment not later than 60 days after the date the student is determined to be eligible for financial assistance under the Children's Health Insurance Program or the Medicaid Program.
5. Enrollment during a special enrollment period is subject to all other applicable enrollment requirements of The Plan and the provisions of this Member Guide.

Effective Date of Enrollment

Enrollment due to loss of eligibility will be the first day of the applicable semester after the required premium is paid.

When Benefits Begin

The Member is entitled to the Benefits of this Member Guide beginning on the Member's Effective Date.

Change of Status

Change of Status forms should be completed and returned to The Plan for:

1. Name changes; or
2. Address changes.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMSCO)

Beneficiary Members and Family Members can obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from Blue Cross and Blue Shield of Montana.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

1. The Family and Medical Leave Act of 1993 (FMLA) requires employers, who employ at least 50 workers within a 75 mile radius of the workplace, to provide eligible employees with up to 12 weeks of leave during any 12-Month period for any of the following reasons:
   a. To care for a newborn child;
   b. Because a child has been placed with the employee for adoption or foster care;
   c. To care for a spouse, child, or parent of the employee;
   d. The employee's own serious health condition makes the employee unable to perform his or her job.
2. Eligible employees are those who have been employed by the employer for at least 12 Months and who have worked at least 1,250 hours for that employer during the previous 12-Month period.
3. The health Benefits of an employee and Dependents, if any, will be maintained during FMLA leave on the same terms and conditions as if the employee had not taken leave.
4. The health Benefits of an employee and Dependents, if any, may lapse at the employer's discretion during FMLA leave because the employee does not pay his or her share of the premiums in a timely manner or the employee does not elect health Benefits during the FMLA leave. Upon return from leave, the employee and dependents, if any, will be reenrolled in the health benefit plan as if the coverage had not lapsed.
5. The employee's reenrollment in the health plan will be effective upon the date on which the employee returns to work.
6. An employee who takes FMLA leave and fails to pay any required premium contribution or fails to return from leave will be entitled to COBRA coverage for the maximum COBRA coverage period beginning when the FMLA coverage terminated.

TERMINATION OF COVERAGE

Termination When No Longer Eligible for Coverage

When No Longer Eligible for Coverage

Your membership will terminate on the earlier of:

1. The last day of the period for which payment has been made; or
2. The date the university is no longer participating in the Student Health Plan; or
3. The date of entry into military service, except for temporary duty of thirty (30) days or less.

In the event the covered student withdraws from the university within the 100 percent refund period, the following action may take place:

> If an unexpected illness or accident forces the student to drop classes, and there was intent by the individual to finish the course of study during the coverage period, he/she may be covered for the remainder of the coverage period. (In this case, the Director of the Student Health Center would make the decision on whether a medical release is in order.) Students who intend to pursue this option should contact the Health Center within the 100 percent refund period.

Benefits after Termination of Coverage

When the membership of a Beneficiary Member is terminated for any reason listed in this section or any other section, Benefits will no longer be provided and The Plan will not make payment for services provided to them after the date on which cancellation becomes effective, except in the following instances:

If the Member is receiving Inpatient Care at a health care facility on the day coverage terminates, the Benefits of this Member Guide shall be provided:

1. Until the maximum amount of Benefits has been paid.
2. Until the inpatient stay ends.
3. Until the end of a 90-day period from the day coverage terminates.
4. Until the Member becomes covered without limitation as to the condition for which the Member is receiving Inpatient Care under any other group coverage.
5. Or whichever occurs first.

DENTAL SERVICES

The Benefits of this section are subject to all the terms and conditions of this Member Guide. Benefits are available only for services and supplies that are determined by The Plan to be Medically Necessary, unless otherwise specified.

All Dental Services listed in this section are subject to the Exclusions and Limitations section of this Member Guide, which lists services, supplies, situations or related expenses that are not covered.

The Schedule of Benefits indicates what the Deductible, Coinsurance and Benefit Period Maximum will be for a Dental Service.

Dental Benefits include coverage for the following Dental Services as long as these services are rendered by a Dentist or a Physician. When the term “Dentist” is used in this Member Guide, it will mean Dentist or Physician.

Diagnostic Evaluations

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

D0120 Periodic oral evaluation - Limited to 1 every 6 months
D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months
D0150 Comprehensive oral evaluation - Limited to 1 every 6 months
D0160 Detailed and extensive oral evaluation - problem focused, by report
D0180 Comprehensive periodontal evaluation - Limited to 1 every 6 months
D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)

Benefits will not be provided for tests and oral pathology procedures, or for re-evaluations.

Preventive Services

Preventive services are performed to prevent dental disease. Dental Services include:

D1120 Prophylaxis - Child - Limited to 1 every 6 months
D1203 Topical application of fluoride (excluding prophylaxis) - child - Limited to 2 every 12 months
D1204 Topical application of fluoride (excluding prophylaxis) - Age 15 to 19 - 2 every 12 months

Diagnostic Radiographs

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

D0210 Intraoral - complete series (including bitewings) 1 every 60 (sixty) months
D0220 Intraoral - periapical first film
D0230 Intraoral - periapical - each additional film
D0240 Intraoral - occlusal film
D0277 Vertical bitewings - 7 to 8 films - Adult - 1 set every calendar year / Children - 1 set every 6 months
D0330 Panoramic film - 1 film every 60 (sixty) months
D0340 Cephalometric x-ray
D0350 Oral / Facial Photographic Images

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

Miscellaneous Preventive Services

Miscellaneous preventive services are other services performed to prevent dental disease and include:

D1351 Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months
D1352 Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months.
D1510 Space maintainer - fixed - unilateral - Limited to children under age 19
D1515 Space maintainer - fixed - bilateral - Limited to children under age 19
D1520 Space maintainer - removable - unilateral - Limited to children under age 19
D1525 Space maintainer - removable - bilateral - Limited to children under age 19
D1550 Re-cementation of space maintainer - Limited to children under age 19

Benefits are not available for nutritional, tobacco and oral hygiene counseling.

Basic Restorative Services

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Dental Services include:

D2140 Amalgam - one surface, primary or permanent
D2150 Amalgam - two surfaces, primary or permanent
D2160 Amalgam - three surfaces, primary or permanent
D2161 Amalgam - four or more surfaces, primary or permanent
D2330 Resin-based composite - one surface, anterior
D2331 Resin-based composite - two surfaces, anterior

D2332 Resin-based composite - three surfaces, anterior
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)

Benefits will not be provided for restorations placed within 12 months of the initial placement by the same Dentist.

Non-Surgical Extractions

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Non-Surgical Periodontal Services

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

D4341 Periodontal scaling and root planning-four or more teeth per quadrant - Limited to 1 every 24 months
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant - Limited to 1 every 24 months
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - Limited to 1 per lifetime

Benefits will not be provided for chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.

Adjunctive Services

Adjunctive general services include:

D9110 Palliative treatment of dental pain - minor procedure
D9220 Deep sedation/general anesthesia - first 30 minutes
D9221 Deep sedation/general anesthesia - each additional 15 minutes
D9241 Intravenous conscious sedation/analgesia - first 30 minutes
D9242 Intravenous conscious sedation/analgesia - each additional 15 minutes
D9610 Therapeutic drug injection, by report

Benefits will not be provided for local anesthesia, nitrous oxide analgesia, therapeutic parenteral drugs, or other drugs or medicaments and/or their application.

Endodontic Services

Endodontics is the treatment of dental disease of the tooth pulp and includes:

D3220 Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
D3410 Apicoectomy/periradicular surgery - anterior
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
D3425 Apicoectomy/periradicular surgery - molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3450 Root amputation - per root
D3920 Hemisection (including any root removal) - not including root canal therapy

Pulpal debridement is considered part of endodontic therapy when performed by the same Dental Provider and not associated with a definitive emergency visit.

Benefits will not be provided for the following “Endodontic Services”:

- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal.
- Endodontic therapy if the Member discontinues endodontic treatment.

Oral Surgery Services

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth - partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva
D9930 Treatment of complications (post-surgical) unusual circumstances, by report

Benefits will not be provided for the following Oral Surgery procedures:

- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.

Surgical Periodontal Services

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

D4210 Gingivectomy or gingivoplasty - four or more teeth - Limited to 1 every 36 months
D4211 Gingivectomy or gingivoplasty - one to three teeth
D4240 Gingival flap procedure, four or more teeth - Limited to 1 every 36 months
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant - Limited to 1 every 36 months
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure (including donor site surgery)
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - Limited to 1 per lifetime

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

Major Restorative Services

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

D2510 Inlay - metallic - one surface - An alternate benefit will be provided
D2520 Inlay - metallic - two surfaces - An alternate benefit will be provided
D2530 Inlay - metallic - three surfaces - An alternate benefit will be provided
D2542 Onlay - metallic - two surfaces - Limited to 1 per tooth every 60 months
D2543 Onlay - metallic - three surfaces - Limited to 1 per tooth every 60 months
D2544 Onlay - metallic - four or more surfaces - Limited to 1 per tooth every 60 months
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
D2751 Crown - porcelain fused to predominately base metal - Limited to 1 per tooth every 60 months
D2752 Crown - porcelain fused to noble metal - Limited to 1 per tooth every 60 months
D2780 Crown - 3/4 cast high noble metal - Limited to 1 per tooth every 60 months
D2781 Crown - 3/4 cast predominately base metal - Limited to 1 per tooth every 60 months
D2783 Crown - 3/4 porcelain/ceramic - Limited to 1 per tooth every 60 months
D2790 Crown - full cast high noble metal - Limited to 1 per tooth every 60 months
D2791 Crown - full cast predominately base metal - Limited to 1 per tooth every 60 months
D2792 Crown - full cast noble metal - Limited to 1 per tooth every 60 months
D2794 Crown - titanium - Limited to 1 per tooth every 60 months
D2940 Protective Restoration

Benefits will be provided for the replacement of a lost or defective crown. However, Benefits will not be provided for the restoration of occlusion or incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 months whether placement was provided under this Member Guide or under any prior dental coverage, even if the original crown was stainless steel. Crowns placed over implants will be covered.

Prosthodontic Services

Prosthodontics involve procedures necessary for providing artificial replacements for missing natural teeth and includes:

D4910 Periodontal maintenance - 4 in 12 months after the completion of active periodontal therapy
D5110 Complete denture - maxillary - Limited to 1 every 60 months
D5120 Complete denture - mandibular - Limited to 1 every 60 months
D5130 Immediate denture - maxillary - Limited to 1 every 60 months
D5140 Immediate denture - mandibular - Limited to 1 every 60 months
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 months

BENEFIT
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 months
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 months
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) - Limited to 1 every 60 months
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) - Limited to 1 every 60 months
D5410 Adjust complete denture - maxillary
D5411 Adjust complete denture - mandibular
D5421 Adjust partial denture - maxillary
D5422 Adjust partial denture - mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth - complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5740 Reline maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
Note: An implant is a covered procedure only if determined to be a dental necessity. Claim review is conducted by The Plan who reviews the clinical documentation submitted by the treating Dentist. If The Plan determines an arch can be restored with a standard prosthesis or restoration, no Benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate Benefit provision of The Plan.
D6010 Endosteal Implant - 1 every 60 months
D6012 Surgical Placement of Interim Implant Body - 1 every 60 months
D6040 Eposteal Implant - 1 every 60 months
D6050 Transosteal Implant, Including Hardware - 1 every 60 months
D6053 Implant supported complete denture
D6054 Implant supported partial denture
D6055 Connecting Bar - implant or abutment supported - 1 every 60 months
D6056 Prefabricated Abutment - 1 every 60 months
D6058 Abutment supported porcelain ceramic crown - 1 every 60 months
D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 months
D6060 Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months
D6061 Abutment supported porcelain fused to noble metal crown - 1 every 60 months
D6062 Abutment supported cast high noble metal crown - 1 every 60 months
D6063 Abutment supported cast predominately base metal crown - 1 every 60 months

D6064 Abutment supported cast noble metal crown - 1 every 60 months
D6065 Implant supported porcelain/ceramic crown - 1 every 60 months
D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months
D6067 Implant supported metal crown - 1 every 60 months
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months
D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months
D6080 Implant Maintenance Procedures -1 every 60 months
D6090 Repair Implant Prosthesis - 1 every 60 months
D6091 Replacement of Semi-Precision or Precision Attachment - 1 every 60 months
D6095 Repair Implant Abutment - 1 every 60 months
D6100 Implant Removal - 1 every 60 months
D6190 Implant Index - 1 every 60 months
D6210 Pontic - cast high noble metal - Limited to 1 every 60 months
D6211 Pontic - cast predominately base metal - Limited to 1 every 60 months
D6212 Pontic - cast noble metal - Limited to 1 every 60 months
D6214 Pontic - titanium - Limited to 1 every 60 months
D6240 Pontic - porcelain fused to high noble metal - Limited to 1 every 60 months
D6241 Pontic - porcelain fused to predominately base metal - Limited to 1 every 60 months
D6242 Pontic - porcelain fused to noble metal - Limited to 1 every 60 months
D6245 Pontic - porcelain/ceramic - Limited to 1 every 60 months
D6519 Inlay/onlay - porcelain/ceramic - Limited to 1 every 60 months
D6520 Inlay - metallic - two surfaces - Limited to 1 every 60 months
D6530 Inlay - metallic - three or more surfaces - Limited to 1 every 60 months
D6543 Onlay - metallic - three surfaces - 1 every 60 months
D6544 Onlay - metallic - four or more surfaces - 1 every 60 months
D6545 Retainer - cast metal for resin bonded fixed prosthesis - 1 every 60 months
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis - 1 every 60 months
D6740 Crown - porcelain/ceramic - 1 every 60 months
D6750 Crown - porcelain fused to high noble metal - 1 every 60 months
D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months
D6752 Crown - porcelain fused to noble metal - 1 every 60 months
D6780 Crown - 3/4 cast high noble metal - 1 every 60 months
D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months
D6782 Crown - 3/4 cast noble metal - 1 every 60 months
D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months
D6790 Crown - full cast high noble metal - 1 every 60 months
D6791 Crown - full cast predominately base metal - 1 every 60 months
D6792 Crown - full cast noble metal - 1 every 60 months
D6973 Core buildup for retainer, including any pins - 1 every 60 months
D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older

Prosthetics placed over implants will be covered.

Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

Benefits will not be provided for the following Prosthodontic Services:

- Treatment to replace teeth which were missing prior to the Effective Date, except those teeth missing due to congenital malformation.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

Miscellaneous Restorative and Prosthodontic Services

Other restorative and prosthodontics services include:

D0470 Diagnostic Models
D2910 Re-cement inlay
D2920 Re-cement crown
D2930 Prefabricated stainless steel crown - primary tooth - Under age 15 - Limited to 1 per tooth in 60 months
D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
D2950 Core buildup, including any pins- Limited to 1 per tooth every 60 months
D2951 Pin retention - per tooth, in addition to restoration
D2954 Prefabricated post and core, in addition to crown- Limited to 1 per tooth every 60 months
D2980 Crown repair, by report
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report

Orthodontic Services

Orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Members. Coverage for orthodontic services is shown on the Schedule of Benefits. Covered services include:

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit
D8670 Periodic orthodontic treatment visit (as part of contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)

Special Provisions Regarding Orthodontic Services:

- Pediatric Orthodontic Services – Coverage is limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria established by The Plan (e.g., severe, dysfunctional malocclusion.
- Orthodontic services are paid over the Course of Treatment, up to the maximum Benefit Period orthodontic Benefit. Benefits cease when the Member is no longer covered, whether or not the entire Benefit has been paid out.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the Benefit Period maximum for orthodontic services.
- If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
- If the Member's coverage is terminated prior to the completion of the orthodontic treatment plan, the Member is responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Member is not covered.
- Benefits are not available for replacement or repair of an orthodontic appliance.

- For services in progress on the Effective Date, Benefits will be reduced based on the benefits paid prior to this coverage beginning.

EXCLUSIONS AND LIMITATIONS

All Benefits provided under this Member Guide are subject to the Exclusions and Limitations in this section and as stated under the Benefit section.

Important Information About the Member's Dental Benefits

1. Dental Procedures Which Are Not Medically Necessary

Please note that in order to provide dental care Benefits at a reasonable cost, this Member Guide provides Benefits only for those covered Dental Services and eligible dental treatment that are determined by The Plan to be Medically Necessary.

No Benefits will be provided for procedures which are not Medically Necessary. Medically Necessary generally means that a specific procedure provided to the Member is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to the Member, as determined by The Plan.

The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

2. Care By More Than One Dentist

If the Member changes Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if the Member had stayed with the same Dentist until treatment was completed. There will be no duplication of Benefits.

3. Non-Compliance with Prescribed Care

Any additional treatment and resulting liability which is caused by the lack of a Member's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Member.

The Plan will not pay for:

1. Services or supplies not specifically listed as a Dental Service, or when they are related to a non-covered service.
2. Amounts which are in excess of the Allowable Fee, as determined by The Plan.
3. Dental Services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve aesthetics.
4. Dental Services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders or to increase vertical dimension.
5. Dental Services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in the mouth is not considered an accidental injury.
6. Services and supplies for any illness or injury suffered after the Member's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
7. Services or supplies that do not meet accepted standards of dental practice.
8. Experimental, investigational and/or unproven services and supplies and all related services and supplies.
9. Hospital and ancillary charges.
10. Services or supplies for which the Member is not required to make payment or would have no legal obligation to pay if the Member did not have this or similar coverage.

11. Services or supplies for which “discounts” or waiver of Deductible or Coinsurance amounts are offered.

12. Services or supplies received from someone other than a Dentist or Denturist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.

13. Services or supplies received for behavior management or consultation purposes.

14. All services, supplies, drugs and devices which are provided to treat any illness or injury arising out of employment when the Member’s employer has elected or is required by law to obtain coverage for illness or injury under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This Exclusion applies to all services and supplies provided to treat such illness or injury even though:

- **a.** Coverage under the government legislation provides benefits for only a portion of the services incurred.
- **b.** The employer has failed to obtain such coverage required by law.
- **c.** The Member waives his or her rights to such coverage or benefits.
- **d.** The Member fails to file a claim within the filing period allowed by law for such benefits.
- **e.** The Member fails to comply with any other provision of the law to obtain such coverage or benefits.
- **f.** The Member was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

This Exclusion will not apply if the Member is permitted by statute not to be covered and the Member elects not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws.

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

15. Any services or supplies to the extent payment has been made under Medicare or would have been made if the Member had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).

16. Charges for nutritional, tobacco or oral hygiene counseling.

17. Charges for local, state or territorial taxes on Dental Services or procedures.

18. Charges for the administration of infection control procedures as required by local, state or federal mandates.

19. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.

20. Orthodontic services, except Pediatric Orthodontic Services are covered when Medically Necessary.

21. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.

22. Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.

23. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.

24. Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.

25. Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to the Member’s Effective Date under this Member Guide; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after the Member’s Effective Date.

26. Any services, treatments or supplies included as Dental Services under other hospital, medical and/or surgical coverage.

27. Case presentations or detailed and extensive treatment planning when billed for separately.

28. Any services and supplies which are not listed as a Benefit of the Member Guide.

CLAIMS

How to Obtain Payment for Benefits

1. If a Member obtains benefits from a participating provider, the participating provider will submit claims to The Plan for the Member. If a Member obtains benefits from a nonparticipating provider, the Member may be required to submit all claims to The Plan. All claims for services must be submitted no later than 12 months after the date on which the services were received after the end of the Benefit Period in which Dental Services were provided. All claims must provide enough information about the services for The Plan to determine whether or not they are a Benefit. Submission of such information is required before payment will be made. In certain instances, Blue Cross and Blue Shield of Montana may require that additional documents or information including, but not limited to, accident reports, medical records, and information about other insurance coverage, claims, payments and settlements, be submitted within the timeframe requested for the additional documentation before payment will be made.

   NOTE: The Member must submit all claims for Dental Services provided outside of the state of Montana.

2. Claims must be submitted to the address listed on the inside cover of this Member Guide.

GENERAL PROVISIONS

Modification of Group Plan

The Plan may make administrative changes or changes in dues, terms or Benefits in the Group Plan by giving written notice to the Group at least 60 days in advance of the effective date of the changes. Dues may not be increased more than once during a 12-month period, except as allowed by Montana law.

No change in the Group Plan will be valid unless in writing and signed by the President of Blue Cross and Blue Shield of Montana. No other agent or representative or employee of The Plan may change any part of this Member Guide.

Clerical Errors

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

Notices Under Contract

Any notice required by the Group Contract may be given by United States mail, postage paid. Notice to the Beneficiary Member will be mailed to the address appearing on the records of The Plan. Notice to The Plan must be sent to Blue Cross and Blue Shield of Montana at the address listed on the inside cover of this Member Guide. Any time periods included in a notice shall be measured from the date the notice was mailed.

A Beneficiary Member or Family Member may reasonably request, in writing, that any communication of the Member's health information be sent to an alternate address or by alternative means should disclosure of any of the Member's health information endanger the Member.

Contract Not Transferable by the Member

No person, other than the Beneficiary Member listed on the subscriber application for membership and accepted by The Plan, is entitled to Benefits under the Group Contract. The Contract is not transferable to any other person.

Rescission of Member Guide

This Member Guide is subject to rescission if the Member commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, concerning a Member's health, claims history, or current receipt of health care services.

Validity of Contract

If any part, term, or provision of the Group Contract is held by the courts to be illegal or in conflict with or not in compliance with any applicable law of the state of Montana or the United States, the Group Contract shall not be rendered invalid but shall be construed and applied in accordance with such provisions as would have applied had the Contract been in conformance with applicable law and the validity of the remaining portions or provisions shall not be affected. The rights and obligations of the parties shall be construed and enforced as if the Contract did not contain the particular part, term, or provision held to be invalid.

Waiver

The waiver by The Plan of any breach of any provision of the Group Plan will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure of The Plan to exercise any right hereunder will not operate as a waiver of such right. All rights and remedies provided herein are cumulative.

Payment by the Plan

Payment under the Group Contract is not assignable by the Member to any third party. Payment made by The Plan shall satisfy any further obligation of The Plan.

Conformity With State Statutes

The provisions of this Member Guide conform to the minimum requirements of Montana law and have control over any conflicting statutes of any state in which the insured resides on or after the Effective Date of the Group Plan.

Forms for Proof of Loss

The Plan shall furnish, upon written request of a Member claiming to have a loss under the Group Plan, forms of proof of loss for completion by the Member. The Plan shall not, by reason of the requirement to furnish such forms, have any responsibility for or with reference to the completion of such form or the manner of any such completion or attempted completion.

Members Rights

Members have only those rights as specifically provided in the Group Plan.

Alternate Benefits

In all cases in which there is more than one Course of Treatment possible, the Benefit will be based upon the most efficient Course of Treatment, as determined by The Plan.

If the Member and Dentist or Physician decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the standard procedures for Dental Services, as determined by The Plan.

Benefit Maximums

Once The Plan pays the maximum amount for a specific Benefit, no further payment will be made for that specific condition under any other provisions of the Group Plan.

Pilot Programs

The Plan reserves the right to develop and enter into pilot programs under which health care services not normally covered under the Group Plan will be paid. The existence of a pilot program does not guarantee any Member the right to participate in the pilot program or that the pilot program will be permanent.

Fees

The Plan reserves the right to charge the Member a reasonable fee for providing information or documents to the Member which were previously provided in writing to the Member. Fees may be charged for the costs of copying labor, supplies and postage. Fees will not be charged for searching for and retrieving the requested information.

Subrogation

1. To the extent that Benefits have been provided or paid under the Group Plan, The Plan may be entitled to subrogation against a judgment or recovery received by a Member from a third party found liable for a wrongful act or omission that caused the Injury requiring payment for Benefits.
2. The Member will take no action through settlement or otherwise which prejudices the rights and interest of The Plan under the Group Plan.
3. If the Member intends to institute an action for damages against a third party, the Member will give The Plan reasonable notice of intention to institute the action. Reasonable notice will include information reasonably calculated to inform The Plan of facts giving rise to the third party action and of the prospects for recovery.
4. The Member may request that The Plan pay a proportional share of the reasonable costs of the third-party action, including attorney fees. If The Plan elects not to participate in the cost of the action, The Plan waives 50 percent of its subrogation interest.
5. The right of subrogation may not be enforced until the Member has been completely compensated for the injuries.

Statements are Representations

All statements and descriptions in any application shall be considered representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the Member Guide unless:

1. Fraudulent;
2. Material either to the acceptance of the risk or to the hazard assumed by The Plan; or
3. The Plan in good faith would not have issued the Member Guide, would not have issued the Member Guide in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to The Plan as required either by the application for the Member Guide or otherwise. No statement made for the purpose of effecting coverage shall avoid such coverage or reduce Benefits unless contained in a written instrument signed by the Member, a copy of which has been furnished to such Member.

When the Member Moves Out of State

If the Member moves to an area served by another Blue Cross or Blue Shield plan, the Member's coverage will be transferred to the plan serving the new address. The new plan must offer coverage that is in compliance with the conversion laws of that state. This coverage is that which is normally provided to Members who leave a group and apply for new coverage as individuals. Although subject to the conversion laws of that state, such coverage is usually provided without a medical examination or health statement. If the Member accepts the conversion coverage, the new plan will credit the Member for the length of time of enrollment with Blue Cross and Blue Shield of Montana toward any of its own waiting periods. Any physical or mental conditions covered by The Plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage. The premium rate and benefits available from the new plan may vary significantly from those offered by The Plan.

The new plan may also offer other types of coverage that are outside of the transfer program. This coverage may require a medical examination or health statement to exclude coverage for preexisting conditions and may not apply time enrolled in Blue Cross and Blue Shield of Montana to waiting periods.

Right to Audit

The Plan reserves the right to audit a Group's employment records to determine whether all employees of the Group are eligible. The Plan further reserves the right to correspond directly with employees to obtain affidavits certifying such eligibility.

Independent Relationship

Participating Providers furnishing care to a Member do so as independent contractors with The Plan; however, the choice of a provider is solely the Member's. Under the laws of Montana, The Plan cannot be licensed to practice medicine or surgery and The Plan does not assume to do so. The relationship between a provider and a patient is personal, private, and confidential. The Plan is not responsible for the negligence, wrongful acts, or omissions of any providers, or provider's employees providing services, or Member receiving services. The Plan is not liable for services or facilities which are not available to a Member for any reason.

Blue Cross and Blue Shield of Montana as an Independent Plan

The Group, on behalf of itself and its employees, hereby expressly acknowledges its understanding that the Group Contract constitutes a contract solely between the Group and Blue Cross and Blue Shield of Montana, that Blue Cross and Blue Shield of Montana is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting Blue Cross and Blue Shield of Montana to use the Blue Cross and Blue Shield Service Mark in the state of Montana, and that Blue Cross and Blue Shield of Montana is not contracting as the agent of the Association. The Group further acknowledges and agrees that it has not entered into the Group Contract based upon representations by any person other than Blue Cross and Blue Shield of Montana and that no person, entity, or organization other than Blue Cross and Blue Shield of Montana shall be held accountable or liable to the Group for any of Blue Cross and Blue Shield of Montana's obligations to the Group created under the Group Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Montana other than those obligations created under other provisions of the Group Contract.

DEFINITIONS

This section defines certain words used throughout this Member Guide. These words are capitalized whenever they are used as defined.

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.

Montana law requires Blue Cross and Blue Shield of Montana to provide a summary of a Member's 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.

APPEAL

Request for review of a denied or partially denied claim and/or services.

BENEFICIARY MEMBER

The student who has applied for, been accepted as a Member, and maintains membership in The Plan under the terms of this Member Guide.

BENEFIT

Services, supplies and medications that are provided to a Member and covered under this Member Guide as a covered Dental Service.

BENEFIT PERIOD

For the Member Guide - Is the period of time shown in the Schedule of Benefits.

For the Member - Is the same as for the Member Guide except if the Member's Effective Date is after the Effective Date of the Member Guide, the Benefit Period begins on the Member's Effective Date and ends on the same date the Member Guide Benefit Period ends. Thus, the Member's Benefit Period may be less than 12 months.

COINSURANCE

The percentage of the Allowable Fee payable by the Member for covered Dental Services. The applicable Coinsurance for In-Network covered Dental Services and Out-of-Network covered Dental Services is stated in the Schedule of Benefits.

COMPLAINT

Any communication from the Member or on the Member's behalf which expresses:

1. Dissatisfaction;
2. Disagreement;
3. Lack of action; or
4. Threats.

CONTRACT

This Group Contract, the Group application and any amendments, endorsements, riders, or modifications to the Contract made to it by The Plan.

COURSE OF TREATMENT

Any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERED PROVIDER

A participating or nonparticipating provider which has been recognized by Blue Cross and Blue Shield of Montana as a provider of services for Benefits described in this Member Guide. A provider may, because of the limited scope of practice, be covered only for certain services provided. To determine if a provider is covered, The Plan looks to the nature of the services rendered, the extent of licensure and The Plan's recognition of the provider.

DEDUCTIBLE

The dollar amount each Member must pay for Dental Services incurred during the Benefit Period before The Plan will make payment for any Dental Services to which the Deductible applies. Only the Allowable Fee for Dental Services is applied to the Deductible. Thus, Member responsibility for Coinsurance, noncovered services, or amounts billed by nonparticipating providers, does not apply to the Deductible.

DENTAL PROVIDER

A Dental Provider may be participating or nonparticipating. A participating Dental Provider is a provider who has a contract with Blue Cross and Blue Shield of Montana. These providers agree to accept payment directly from Blue Cross and Blue Shield of Montana for covered dental benefits. This payment, together with the Member's Deductible and Coinsurance described in the Schedule of Benefits, is accepted as payment in full. The Member may obtain a list of participating Dental Providers from Blue Cross and Blue Shield of Montana upon request.

If a Member receives services from a nonparticipating Dental Provider, the Member is responsible for the balance of the nonparticipating provider's bill after payment by Blue Cross and Blue Shield of Montana.

DENTAL SERVICES

Dental services for which allowances are provided in this Contract.

DENTIST

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

DENTURIST

A person licensed as a Denturist in the state where the service is provided.

EFFECTIVE DATE

For a Member - the Effective Date of a Member's coverage means the date the Member:

1. has met the requirements of The Plan stated in this Member Guide; and
2. is shown on the records of The Plan to be eligible to receive Benefits.

For the Member Guide - the Effective Date of the Member Guide is the date shown on the face of this Member Guide

For any endorsement, rider, or amendment - the Effective Date is the date shown on the Member Guide unless otherwise shown on the endorsement, rider and amendment.

EXCLUSION

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

GRIEVANCE

A Complaint about the quality of care, or services rendered by a provider or provider officer.

GROUP

The organization, employer, or trust to which the Contract has been issued and includes the Beneficiary Members.

GROUP PLAN

The Contract between Blue Cross and Blue Shield of Montana and the Group.

INCLUSIVE SERVICES/PROCEDURES

A 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.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

A specific procedure or supply provided to you that is reasonably required, in the judgment of The Plan, for the treatment or management of the Member's specific dental symptom, injury, or condition and is the most efficient and economical procedure that can safely be provided to the Member. The fact that a Dentist or Physician may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and where the procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants, retained by The Plan. These consultants review the claim and diagnostic materials submitted in support of the claim, and based upon their professional opinions, determine the necessity and propriety of treatment.

MEMBER

The Beneficiary Member.

MEMBER GUIDE

The summary of Benefits issued to a Member that describes the Benefits available under the Group Plan.

MONTH

For the purposes of this Member Guide, a Month has 30 days even if the actual calendar Month is longer or shorter.

PLAN - THE PLAN

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

BlueCross BlueShield
of Montana

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