

PROCEDURES FOR CLAIMING BENEFITS

Claims must be submitted to the Plan within twelve (12) months after the date services or treatments are received or completed. Non-electronic claims may be submitted on any approved claim form, available from the provider. The claim must be completed in full with all the requested information. A complete claim must include the following information:

- Date of service;
- Name of the Participant;
- Name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- Diagnosis [code] of the condition being treated;
- Treatment or service [code] performed;
- Amount charged by the provider for the treatment or service; and
- Sufficient documentation, in the sole determination of the Plan Administrator, to support the Medical Necessity of the treatment or service being provided and sufficient to enable the Plan Supervisor to adjudicate the claim pursuant to the terms and conditions of the Plan.

When completed, the claim must be sent to the Plan Supervisor, Allegiance Benefit Plan Management, Inc. (Allegiance), at P.O. Box 3018, Missoula, Montana 59806-3018, (406) 721-2222 or (800) 877-1122 or through any electronic claims submission system or clearinghouse to which Allegiance has access.

In no event will any claim be considered for payment of benefits if it is initially submitted to the Plan more than twelve (12) months from the date that such claim was incurred.

Upon termination of the Plan, final claims must be received within three (3) months of termination or such lesser time as is established by the Plan Administrator.

CLAIMS WILL NOT BE DEEMED TO BE SUBMITTED UNTIL RECEIVED BY THE PLAN SUPERVISOR.

The Plan will have the right, in its sole discretion and at its own expense, to require a claimant to undergo a medical examination, when and as often as may be reasonable, and to require the claimant to submit, or cause to be submitted, any and all medical and other relevant records it deems necessary to properly adjudicate the claim.

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims will be considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines and administrative practices not inconsistent with the terms of the Plan. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims decisions will be made within the time periods stated below. For purposes of this section, "Covered Person" will include the claimant and the claimant's Authorized Representative; "Covered Person" does not include a health care provider or other assignee, and said health care provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

"Authorized Representative" means a representative authorized by the claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization.

THE PLAN DOES NOT MAKE TREATMENT DECISIONS. ANY DECISION TO RECEIVE TREATMENT MUST BE MADE BETWEEN THE PATIENT AND HIS OR HER HEALTHCARE PROVIDER; HOWEVER, THE PLAN WILL ONLY PAY BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THIS PLAN.

1. **Urgent Care Claims** - An Urgent Care Claim is any claim for medical care or treatment with respect to which:
 - A. In the judgment of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
 - B. In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

There are no Urgent Care requirements under this Plan and therefore, there are no rights to appeal a pre-service Urgent Care claim denial.

2. **Pre-Service Claims** - Pre-Service Claims must be submitted to the Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Covered Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are procedures stated in the Plan Document which, the Plan recommends be utilized before a Covered Person obtains medical care.
3. **Post-Service Claims** - A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim.

4. **Concurrent Care Review** - For patients who face early termination or reduction of benefits for a course of treatment previously certified by the Plan, a decision by the Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the Plan's benefit maximums is not an Adverse Benefit Determination.) The Plan will notify the Covered Person sufficiently in advance to allow an appeal for uninterrupted continuing care before the benefit is reduced or terminated. Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time must be decided within twenty-four (24) hours of the Plan's receipt of the request. The appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially-prescribed period.

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim denial will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and

4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan Supervisor at the address or telephone number shown on the claim denial.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal or the information required by the Plan which was not initially provided and forward it to the Plan Supervisor within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. **First Level of Benefit Determination Review**

The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within fifteen (15) days following the date the Plan Supervisor receives the request for reconsideration.

If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Plan Supervisor, not later than sixty (60) days after receipt of the Plan Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. **Second Level of Benefit Determination Review**

The Plan Administrator will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Plan Administrator who is neither the original decisionmaker nor the decisionmaker's subordinate. The Plan Administrator cannot give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the Plan Administrator will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

INDEPENDENT EXTERNAL REVIEW FOR A PRE-SERVICE CLAIM

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Plan Supervisor will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan Supervisor at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal or the information required by the Plan which was not initially provided and forward it to the Plan Supervisor within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. **First Level of Benefit Determination Review**

The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within thirty (30) days following the date the Plan Supervisor receives the request for reconsideration.

If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Plan Supervisor, not later than sixty (60) days after receipt of the Plan Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. **Second Level of Benefit Determination Review**

The Plan Administrator will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Plan Administrator who is neither the original decisionmaker nor the decisionmaker's subordinate. The Plan Administrator cannot give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the Plan Administrator will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan at each level of review.

All claim payments are based upon the terms contained in the Plan Document, on file with the Plan Administrator and the Plan Supervisor. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

INDEPENDENT EXTERNAL REVIEW FOR A POST-SERVICE CLAIM

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Plan Supervisor will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.