# Request for Proposals

# For

# Pharmacy Benefit Management Services for the City of Billings

**Deadline for Questions:** September 9, 2022

**Deadline for RFP Submission:** September 23, 2022

**Request For Proposals**
**Table of Contents**

## Section 1: General Information

The City of Billings ("City") has retained Granite Peak Analytics, LLC. ("GPA") to assist in preparing and evaluating submittals received via this Request for Proposal ("RFP") for Pharmacy Benefit Management (PBM) Services.

GPA will issue responses to inquiries and any necessary corrections or amendments in addenda prior to the proposed submission deadline. Respondents should not rely on any representations, statements or explanations other than those made in this RFP or in formal addenda. It is the respondent's responsibility to ensure receipt of all addenda. Addenda to the RFP will be sent via email only to those firms that request those directly from Trevor Daer with GPA.

Any alterations to this RFP made by the respondent may be grounds for rejection of the proposal, cancellation of any subsequent award, or any other legal remedies available to the City.

**From the date this RFP is issued until the award of the contract, any and all communication related to this RFP should be directed only to Trevor Daer at Granite Peak Analytics, LLC.** Current providers may discuss ongoing business with the City but should not discuss any aspects of this RFP. All questions or requests for clarification must be in writing, sent by email, and directed to the attention of**:**

Trevor Daer, President
Granite Peak Analytics, LLC.
P.O. Box 80846
Billings, MT 59108
td@granitepeakrx.com

There should be no communication, either in person, in writing, or by phone, between any respondent and any (1) City of Billings employee, (2) elected officials or their staff members, or (3) any other person in a position to influence the decision of the City at any time during the RFP process. Direct communication with any person who falls within the descriptions in this section in an attempt to influence the awarding of the RFP may be grounds for disqualification.

**Request For Proposals** (RFP) – Pharmacy Benefit Management Services

THE ABOVE DESCRIPTION MUST APPEAR ON ALL PROPOSALS AND RELATED CORRESPONDENCE.

**THIS IS NOT AN ORDER.**

| PROPOSALS MUST BE RECEIVED NO LATER THAN: | RFP INITIATIVE: |
|---|---|
| **Friday, September 23, 2022, at 5:00 pm (MST)** | **Pharmacy Benefit Management Services RFP** |

- **All suppliers must respond in detail to each element of this RFP in order to be considered for contract award.**
- **All proposals must be emailed to contact person at the address below.**
- **Attachment B, Pricing, must be emailed under separate cover and "Pharmacy Benefit Management Services RFP Confidential Pricing" as the subject line.**

SEND ALL CORRESPONDENCE TO THE CONTACT BELOW:

**Trevor Daer, President**

**Email: td@granitepeakrx.com**

**PHONE: (406) 868-2761**

## Section 2: Objectives

Introduction and Objectives

This RFP is issued by GPA on behalf of the City for the purpose of obtaining information and pricing regarding Pharmacy Benefit Management Services. It is the intent of the City to review and assess the RFP responses to determine which proposal best meets the needs of the City.

Suppliers are expected to provide their best and most competitive proposal.

**Attachment E, the Intent to Respond form, must be completed and emailed at least fourteen (14) days prior to the advertised RFP due date.**

## Section 3: Information for Suppliers

Disclaimer

This RFP does not form or constitute a contractual document. The City shall not be liable for any loss, expense, damage or claim arising out of the advice given or not given or statements made or omitted to be made in connection with this RFP. The City also will not be responsible for any expenses which may be incurred in the preparation of this RFP. This RFP is not to be construed as a contract or commitment of any kind.

Instructions to Proposers

EXAMINATION OF DOCUMENTS

Before submitting the proposals, the proposer shall:

(a) Carefully examine the Standards and Specifications as well as all other attached documents;

(b) Fully inform yourself of the existing conditions and limitations;

(c) Include with the proposal sufficient information to cover all items required in the specifications.

PROPOSAL MODIFICATIONS

In addition to any other information and documentation requested in this RFP, any forms provided herein shall be included in the submitted proposal. Modifications, additions or changes to the terms and conditions of this request for proposals may be cause for rejection of the proposal. Proposals submitted without required forms may be rejected.

WITHDRAWAL OF PROPOSALS

Proposers may withdraw their proposal by written request at any time prior to the due date set for receiving proposals.

PRICES HONORED

By responding to this RFP, Proposer acknowledges that no contractual relationship with the Proposer exists until execution of the resulting contract following City Administration or City Council approval. Because contract approval can be delayed due to scheduling or unforeseen circumstances, the Proposer must honor their pricing and any other terms set forth in the proposal for at least ninety (90) days after the RFP due date.

The prices established from this RFP may be extended to other political subdivisions within the State of Montana solely at the vendor's discretion.

CERTIFICATION

The proposer certifies that the proposal has been arrived at independently and has been submitted without any collusion designed to limit competition. The proposer further certifies that the materials, products, services and/or goods offered herein meet all

requirements of the stated specifications and are equal in quality, value and performance with highest quality, nationally advertised brand and/or trade names.

INSURANCE REQUIREMENTS

**The proposer certifies that it/they can comply with the City insurance requirements of :**

1. **Workers' compensation and employer's liability coverage as required by Montana law.**
2. **Commercial general liability, including contractual and personal injury coverage's - $750,000 per claim and $1,500,000 per occurrence.**
3. **Automobile liability - $1,500,000 per accident.**
4. **Professional liability in the amount of $1,500,000 per claim.**

**Each policy of insurance required by this Section shall provide for no less than 30 days' advance written notice to the City prior to cancellation.**

**The City shall be listed as an additional insured on all policies except Professional Liability and Worker's Compensation Policies.**

**In addition, all policies except Professional Liability and Worker's Compensation shall contain a waiver of subrogation against the City.**

**Proposer shall comply with the applicable requirements of the Workers' Compensation Act, Title 39, Chapter 71, MCA, and the Occupational Disease Act of Montana, Title 39, Chapter 71, MCA. Proposer shall maintain workers' compensation insurance coverage for all members and employees of Proposer's business, except for those members who are exempted as independent contractors under the provisions of §39-71-401, MCA.**

The successful proposer will be required to purchase a City business license and complete the new vendor forms in order to be eligible for payment.

DISPOSITION OF PROPOSALS

All materials submitted in response to this RFP become public records under Article II, Section 9 of the Montana Constitution and § 2-6-102 and may be distributed by written request pursuant to Montana's Constitutional Right to Know or Public Records Acts.

Information provided in response to this RFP will be held in confidence and will not be revealed or discussed with competitors prior to award of Contract by Council. However, one copy of each proposal submitted shall be retained for the official files of the Department and will become public record after award of the Contract. Fee or Price schedules submitted, but not reviewed by the City, do not become a public record and shall only be retained for official files.

Records and materials that are constitutionally protected from disclosure are not subject to the provisions of this section.

The Proposer understands that, if selected, the City reserves the right to provide its opinion publicly and privately regarding the Proposer's performance.

QUESTIONS

Questions regarding the Request for Proposals contents must be sent to the contact person listed in Section 1 no later than 5:00 p.m. (MST) on September 9, 2022. GPA will make every effort to provide a written response within 2 business days. Whenever responses to inquiries would constitute a modification or addition to the original RFP, the reply will be made in the form of an addendum to the Request for Proposals, a copy of which will be posted on the City's website and forwarded to all Suppliers who have submitted an "Intent to Respond" form (Attachment E).

Supplier must submit their questions via email using the "Master Q & A" form found in **Attachment D**, and provide, at a minimum, the following:

- Supplier's name, requester, and appropriate contact information.
- The question, clearly stated.
- Specific reference to the applicable Request for Proposals section(s).

RFP Response Submission

Upon the submission of the RFP response, the supplier acknowledges that all information is accurate and complete.

**All proposals must be emailed to contact person listed in Section 1.**

**Pricing must be emailed under separate cover with "Pharmacy Benefit Management Services RFP Confidential Pricing" as the subject line.**

## Section 4: RFP Evaluation and Selection Processes

Initial Evaluation

Proposals received will undergo an initial review to determine:

- Compliance with instructions stated in the RFP
- Compliance with proposal submittal date

Phase II Evaluation

PBM bidders will be evaluated on the following criteria. These criteria will be the basis for review of the written proposals and interview session, if necessary. Based on results of the initial evaluation, the City will select finalists for consideration. Any or all proposals may be rejected by the City. The finalists may be asked to make formal presentations of their proposals, as well as to demonstrate their systems and procedures for providing pharmacy benefit management services.

The evaluation of supplier's proposals may include, but is not limited to, the following criteria:

- Experience of Supplier with goods/services required by the City
- Capacity to assume new business
- Perceived ability to meet the City requirements
- Total Cost Competitiveness
- Breadth of services available
- Company's stability
- Ongoing support and customer service
- Reporting capability
- Compliance with the City Terms and Conditions
- Demonstrated ability to deliver low net-cost prescription programs
- Flexibility to administer unique City plan components (i.e. limited maintenance network)

The City reserves the right to conduct interviews with all or some of the Proposers at any point during the evaluation process. However, the City may determine that interviews are not necessary. In the event interviews are conducted, information provided during the interview process shall be taken into consideration when evaluating firms using the above-stated criteria.

The City also reserves the right to make such additional investigation as it deems necessary to establish the competence and financial stability of any firm submitting a proposal.

## Section 5: Scope of Work

Below is a general outline of the anticipated scope of work. However, the final scope of work will be negotiated with the successful proposer.

The City seeks a qualified Pharmacy Benefit Management partner to:

1. Effectively address rising specialty medication costs while positively impacting patients
2. Achieve full transparency and alignment of City's interests
3. Understand and optimize effective clinical programs
4. Balance cost-control with patient intervention/disruption
5. Provide forward-thinking and market-leading programs in a rapidly changing industry

Eligible Employees

The City has approximately 913 employees and 1,300 covered dependents with health benefits (2,213 total covered lives). Benefits are provided for all full and 20 + hour part-time employees in permanent positions. The City also has 85 retirees on one of the current plans for coverage. 84 are Pre-Medicare and 1 grandfathered Medicare retiree.

Third Party Administrator & Plans

The City currently uses Imagine360/EBMS as their third-party administrator for the Standard and High Deductible Health plans (See Attachment H).

Prescription Plan Metrics (1/1/2021 – 12/31/2021)

-Total Cost (Plan + Patient) = $2.86 Million

-Total Net Prescriptions = 16,008

## Section 6: Qualifications

The following is preferred:

1. Current governmental entity customers
2. Understanding of and/or direct experience with Montana (rural) healthcare access and care delivery
3. Proposals shall be accepted on a fee only "pass-through" basis. The City of Billings will not consider traditional/spread, hybrid, or any other structure wherein the PBM is compensated in any way other than fully-disclosed administrative fees (network/transaction fees paid by pharmacies are acceptable).

# ATTACHMENT A

## VALIDATION QUESTIONS FOR SUPPLIER

### 1. Organizational Alignment

a. What do you believe is the primary differentiator, specifically in the Montana pharmacy marketplace, that separates your organization from others providing similar services?
b. How many full service PBM lives do you currently serve today and under which lines of business are they arranged (Commercial, Government, Discount Card Etc.)
c. What is your average client size?
d. What is your largest client size? Smallest?
e. How many members do you currently serve for public-sector/ governmental customers?

### 2. Implementation

a. Describe your implementation process (include timeline) and provide detailed materials that showcase how your organization will manage the implementation process.
b. Will your organization provide a single point of contact for implementation? Will this be the same contact for ongoing service and support (i.e. Account Manager). If not, please describe your "hand-off" process.
c. What do you offer in the form of "disruption mitigation" to ensure patients do not feel the impact of a PBM change (i.e. grandfathering members with current formulary copay tier for x amount of time).
d. Do you provide daily post-implementation updates as a standard for the first 30 days after go-live (i.e. Number of claims paid, rejected, reject reasons etc.)?
e. Client Accounts: Do you require clients to pre-fund? If yes, what are the terms (i.e. 15 days worth of estimated claims etc.) If no, what are your standard payment terms?
f. Implementation Guarantee: Do you offer an implementation guarantee? If yes, please provide the details of your offer.

### 3. Benefit & Plan Design Setup / Testing Process

a. The City needs to ensure their PBM can implement a wide range of plan design options. Please confirm your ability to administer the pharmacy plans outlined in Attachment H.
b. Describe your organization's process around testing the benefits that have been built in your system.
c. Should initial implementation setup errors or existing benefit errors be identified, outline the step by step process for which the issues are identified, communicated, remedied, and resolved.

### 4. Specialty Pharmacy Management

a. Please describe your approach to specialty pharmacy management in the following areas:
    i. Prior-Authorization
    ii. Specialty Pharmacy Partners
    iii. Plan design (i.e. recommended specialty copays, full specialty exclusion etc.)
    iv. Manufacturer Coupon Maximization (please provide proposed plan design and any pharmacy restrictions)
    v. Foundational Assistance Options
    vi. International Sourcing
    vii. Clinical Patient Support
    viii. "Mandatory specialty"
    ix. Other products/services that might differentiate your organization in its' approach to specialty pharmacy (i.e. medical specialty/J-Codes etc.)
b. Please list and describe any specialty pharmacy management vendors you use to support your proposed solutions. What is your level of integration?
c. Please provide an estimated percentage of your current book of business that utilize the following: Mfg Coupon Maximization, Foundation Assistance, International Sourcing, Full Specialty Exclusion.
d. Clearly outline any requirements or limitations to these programs (i.e. pharmacy restrictions).

**5. Cost-Containment**

a. Based on your review of the City's prescription utilization (Attachment G), are there other programs that have generated positive ROI for your clients that you would recommend? Please provide your proposed solution, estimated savings, and associated fees (if any).
b. The City is interested in reducing and managing costs on a PMPM basis. Are you willing to offer a **net-cost reduction guarantee**? If so, please detail your guarantee, requirements, and caveats.

**6. Pharmacy Network Contracting**

a. Do you contract with pharmacies directly (i.e. own pharmacy network)? If no, who do you outsource this to?
b. The City currently utilizes an exclusive network for maintenance medications (pharmacies outlined in Attachment H) Please propose your discount guarantees with this in mind.
c. Do you have the ability to implement single pharmacy contracts as directed by the City? Please explain your ability (and process) to adjust rates for individual pharmacies and across the network.
d. Please describe whether your network assesses DIR or "clawbacks" to network pharmacies.

**7. Rebate & Formulary Management**

a. Provide an overview of the number of formulary options you offer clients and the basic differences between them.
b. Please confirm the timing of rebate payments and how these payments are facilitated (i.e. bulk check, individual check by client, ACH, admin. credit etc.)
c. Do you hold your own rebate contracts or contract with an “aggregator?” If you utilize an aggregator, please identify the percentage of rebate(s) they retain.
d. Do you retain any portion of rebates, manufacturer administrative fees, or any other revenue derived from manufacturers or aggregators?
e. Do you offer overrides for members using non-formulary medications at the City’s direction?

**8. Account Management**

a. Describe to us your proposed Account Service Team and their experience.
b. Account Management Responsiveness: In order to effectively provide a positive experience for City members, they require prompt and accurate responses from their PBM partner. Please provide your standard turnaround time for inquiries (i.e. expectation is response/acknowledgement within 24 hours). Are you willing to offer a guarantee?
c. Clinical expertise: Do you provide a pharmacist account management contact for more clinically focused questions/needs/recommendations?
d. Reporting: Please provide your standard reporting package, frequency of delivery, and ability to customize. Are there additional fees for customized reporting needs?

**9. Customer Service / Member Support**

a. Describe your organization’s approach to member support and the customer care experience
b. What differentiates your organization from other competing PBM solutions?
c. How do you measure quality in your call centers?
d. Can the City have designated agents taking their specific calls?

**10. Web / Mobile Technology Services**

a. Describe your web/mobile services in detail
    i. Do you have single sign on capability?
b. Do you offer any other tech solutions that differentiate you from others in the market and may benefit City patients?

**11. Data & Claims Integration**

a. Provide your experience exchanging claims, eligibility, and accumulator data with Imagine360/EBMS (current TPA).
b. Please confirm your ability to set up EDI feeds (eligibility and claims) with City directed entities without additional fees (i.e. Deerwalk, Granite Peak

Analytics). Do you have any limit to the number of EDI feeds you will provide at no additional cost?

c. Please advise if you require a certain file layout for claims and eligibility.

**12. Repricing Parameters**

a. Attachment G “RX CLAIM FILE” will ONLY be provided once Attachment E “INTENT TO RESPOND” has been delivered.
b. Your repricing analysis must be done at the individual claim NDC-11 level. It must provide your price for that medication on the exact date of service and channel (i.e. do not apply retail 90 pricing to retail 30 claims). If your reprice deviates from these parameters, it must be clearly outlined in this section of the questionnaire.
c. Your rebate analysis must be based on actual brand and specialty medications in the claim file without considering conversion to your formulary. You may provide separately what the additional rebates would be with formulary conversion.
d. Please estimate the total of any ancillary fees you intend to charge (i.e. Prior Authorization) based on utilization.
e. If you are not contracted with miRx pharmacy, please clearly identify what pricing you apply (i.e. Retail 90 chain, Retail 90 independent, Mail etc.). Please only apply one pricing methodology.

**13. Specialty Pharmacy**

a. Do you own your specialty pharmacy? If yes, do you require use of that pharmacy? If no, who are your preferred specialty pharmacy partners?
b. Can the City partner with other specialty options outside of your preferred/owned option(s)? If yes, what are the impacts to your pricing proposal?
c. Please clearly outline any caveats/adjustments to your pricing (guarantees, rebates etc.) proposal between exclusive specialty pharmacy vs. open specialty pharmacy.

**14. Mail Order Fulfillment**

a. Do you own your mail-order pharmacy? If yes, do you require use of that pharmacy? If no, who are your preferred mail-order pharmacy partners?
b. Can the City partner with other mail-order options outside of your preferred/owned option(s)? If yes, what are the impacts to your pricing proposal?
c. Please clearly outline any caveats/adjustments to your pricing (guarantees, rebates etc.) proposal between mandatory mail-order vs. open network.

**15. Outsourcing**

a. Please identify any PBM functions you outsource (outside of previously mentioned network contracting, specialty management partners and rebate management), the service they provide, and the name of the vendor.

### 16. Other compensation/ID Cards/Transition Costs

a. The City is requesting a one-time **$3.50 Per Member** implementation credit to be paid from the chosen PBM's general assets as not to impact the financial terms offered. The City will utilize this fund to off-set the following expenses:
    i. Printing and mailing new ID cards
    ii. PBM Consulting/RFP Expenses
    iii. Technology integration
    iv. Communication to membership
    v. Other expenses directly related to the work effort required for this transition.

b. Please identify any additional Pharmacy Management Funds/Allowances that may be offered annually.

*Detail how the applicable credit/allowances will be calculated, when it will be paid, and confirm the amount of the credit in the financial proposal form.*

### 17. Key Contract Definitions

Please indicate your understanding, agreement, or proposed deviation from the following contract requirements. No response will be considered agreement with the proposed language.

The City is seeking a 3 year contract with annual market check provision(s) and 90-day termination rights without cause, after year 1.

Client termination for any cause or no cause after the initial 12 month period shall incur no fees or penalties of any kind to the client. For the avoidance of doubt, the PBM may not retain any earned rebates, require administration fees through the term of agreement, or require repayment of any implementation / setup fees or credits.

The City may retain a third-party to monitor pharmacy program performance relative to the contract and marketplace. Monitoring is not an audit and will focus on contractual compliance, clinical guidance, marketplace rates/trends, and plan design adherence. PBM understands and agrees to allow for Client Monitoring. Third-party fee may be collected by PBM and passed through to third-party for administrative efficiency only. PBM agrees to send full detail claims file, in the format requested, on a daily basis to up to 6 recipients, including third-party monitor, free of charge.

**Financial guarantees** may not be off-set, even within channel. Zero-balance due claims may be included but only for the amount of the actual network discount applied to the claim (i.e. not 100%).

Your financial proposal must be based on the following contract definitions. Any deviations must be included in your initial response and redlined.

**"AWP"** means for individual claims will be the actual reported AWP from Medi-Span for the specific NDC11 on the day of service for all channels (i.e. Retail, Mail, and

Specialty). Claims will not use an average AWP and will not, in any way be calculated, altered, adjusted, or assigned an alternate NDC number. Claims at Mail and Specialty will use the AWP of the actual package size, NDC11, used to dispense (not the package size of the prescription dispensed). PBM will not assert a proprietary source of AWP calculation, algorithm, or other means for calculating the benchmark AWP.

**"Brand Drug"** shall mean a drug with the multisource code field in Medi-Span of "M" or "N"; or "O". When a drug is identified as a Brand Drug, it shall always be considered a Brand Drug for all purposes, guarantees, and reconciliations. A Brand Drug may be dispensed and treated as a Generic Drug for the sole purpose of Member Cost Share.

**"Generic Drug"** shall mean a drug with the multisource code field in Medi-Span of "Y.". When a drug is identified as a Generic Drug, it shall always be considered a Generic Drug for all purposes, guarantees, and reconciliations.

**"Ingredient Cost"** means the cost of the covered drug (not including dispense fee) which is used to calculate the AWP discount guarantees. The ingredient cost will be calculated as the lesser of a MAC price, discounted AWP, or Usual & Customary.

**"Paid Claim"** means a Claim that is approved for payment, in whole or in part, and has not been reversed within the same invoice period. Administrative fees paid on a per net Paid Claim basis, where the total amount of administrative fees paid by Client will not include payment for any Paid Claims that were reversed or rejected.

**"Rebates"** means all remuneration the PBM receives from pharmaceutical manufacturers and/or intermediaries (including aggregators) for utilization of designated Prescription Drugs by Members under the applicable rebate agreement with PBM in return for Formulary placement of covered products and/or access. This would include rebates, discounts, data feed reimbursement, research and development compensation, administrative fees and any other compensation or remuneration received by PBM that is directly related to the use of a Covered Pharmaceutical by a Member during the term of this Agreement.

**"Pass Through"** means PBM shall invoice the Client the same amounts reimbursed by PBM to Participating Pharmacies for any Covered Item dispensed from such retail Participating Pharmacy. This pricing model will bill Client the exact Ingredient Cost, Dispensing Fee and taxes paid less member cost share to the Participating Pharmacy. PBM receives no other revenue and derives no other value from any Paid Claim adjudicated at the Participating Pharmacy, either directly or indirectly, in the aggregate or otherwise, except for the fee(s) charged by PBM to a Participating Pharmacy for administrative services related to dispensing Covered Products to Members. PBM shall pass through 100% of pharmaceutical manufacturer or other third-party remuneration that is attributable to the purchase or utilization of covered drugs, including but not limited to incentive rebates, rebates, market share incentives, market share of utilization, rebate submission fees, and administrative or management fees**.**

**"Specialty Drug"** means certain pharmaceuticals and/or biotech or biological drugs that are used in the management of chronic or genetic disease, including but not limited to injectable, infused, or oral Medications, or that otherwise require special handling. Specialty drugs shall be defined at the GPI level, meaning if a single NDC within the GPI is considered Specialty, all NDCs within the GPI shall be considered Specialty (whether

or not all NDCs are listed on the specialty list). Drug-by-drug guaranteed minimum pricing, by NDC to be provided on a quarterly basis or upon request.

**"Lower of Pricing Logic"** means the minimum of the following: Submitted Usual and Customary, MAC + Dispense Fee, AWP Discount (or alternative metrics such as WAC, NADAC, AAC, etc.)+ Dispense Fee, and Submitted Ingredient Cost(if allowed) + Dispense Fee.

**"Lower of Member Cost Logic"** means the minimum of Copay/ Coinsurance or 'Lower of Pricing Logic.'

**"Biosimilar Product"** means an FDA-approved type of biological product that is highly similar to and has no clinically meaningful differences in terms of safety and effectiveness from its respective FDA-approved biological reference product.

**"Drug Classification"** means the agreed upon methodology to classify Brand Drugs and Generic Drugs as set forth in this Agreement. For clarity, the Drug Classifications shall be incorporated into the Agreement and any future amendments and renewals entered into between the Parties unless expressly otherwise agreed to in writing.

**"New-To-Market"** means a drug or product that is newly introduced for sale by pharmaceutical manufacturers and made available for dispense at pharmacies after the Effective Date.

# ATTACHMENT B

# PRICING

See Attachment B – Financial Proposal Form.xls

## ATTACHMENT C

## CONDITIONS AND NON-COLLUSION FORM

To receive consideration, this form must be signed in full by a responsible, authorized agent, officer, employee or representative of your firm.

CONDITIONS AND NON-COLLUSION AGREEMENT

We have read and agree to the conditions and stipulations contained herein and to the Standard Terms and Conditions contained on the attached.

We further agree to furnish the services specified at the prices stated herein, to be delivered to the location and on that date set forth herein.

In signing this proposal, you also certify that you have not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition; that no attempt has been made to induce any other person or firm to submit or not to submit a proposal; that this proposal has been independently arrived at without collusion with any other proposer, competitor or potential competitor; that this proposal has not been knowingly disclosed prior to the due date and time to any other proposer or competitor; that the above statement is accurate under penalty of perjury.

**I/We acknowledge _____ addendum.**

#

| | |
|---|---|
| Legal Name of Firm/Corporation | Authorized Signature |
| Address | Printed Name |
| City/State/Zip | Title |
| Date | Telephone Number |

By signing the above, I certify that I am authorized by the Company named above to respond to this request.

# ATTACHMENT D

## MASTER Q & A FORM

### PROJECT: PHARMACY MANAGEMENT BENEFIT SERVICES RFP

| | |
|---|---|
| **Master Q&A** | Any questions regarding this Request for Proposals should be submitted according to the process outlined below. The City will make every effort to answer within two (2) days of receiving the questions. |
| | |
| **Q&A Process** | 1. Prepare questions or concerns on the template provided.<br>2. Complete the table in full, providing a date for each question and a section of the RFP to reference (if applicable).<br>3. Submit the completed form via email to td@granitepeakrx.com. Attach associated documents as necessary.<br><br>Please contact Trevor Daer with any questions regarding this process. |

**Questions from: _____ Company: _____**

**Email Address: _____**

| # | Date | Reference Section | Question or Comment | City Response |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |

**ATTACHMENT E**

**INTENT TO RESPOND FORM**

**RFP: PHARMACY BENEFIT MANAGEMENT SERVICES**

**Dated_____**

Email the following Intent to Respond form within fourteen (14) days of the RFP due date even if your company chooses NOT to participate in the RFP.

**To: Granite Peak Analytics, LLC**
Attn: Trevor Daer
Email: td@granitepeakrx.com

From: _____ Contact Name
_____ Company Name
_____ Company Address
_____
_____ Phone Number
_____ Fax Number
_____ Email Address

---

We intend to respond to this RFP by the specified due date:

Yes _____ No _____

_____ _____
Company Name Date

_____ _____
Contact Name (please print) Title

_____
Signature of Contact Person

By signing the above, I certify that I am authorized by the Company named above to respond to this request.

## ATTACHMENT F

## PROPOSER CONTACT INFORMATION

### *A. Company Contacts*

| | |
|---|---|
| Primary Contact Person (Name): | |
| Title/Function: | |
| Address | |
| Business Hours Phone: | |
| Fax: | |
| Internet E-mail Address: | |
| Name of Person Responding to Request: | |
| Title/Function: | |
| Address: | |
| Phone: | |
| Fax: | |
| Internet E-mail Address: | |

### *B. General Company and Financial Information*

| | |
|---|---|
| Company Name: | |
| Headquarters Address: | |
| City, State, ZIP | |
| Headquarters Phone: | |
| Headquarters FAX: | |
| Company Owned By: | |
| Percent % Ownership: | |
| Years In Business | |
| Name of CIO | |
| Name of CEO/President: | |

# Attachment B - Financial Proposal

| Pharmacy Network Rates- Pass Through / Transparent | Year 1 | Year 2 | Year 3 | Notes/Caveats |
|---|---|---|---|---|
| **Retail 30** Brand Minimum Guaranteed Discount | | | | |
| **Retail 30** Brand Minimum Guaranteed Dispensing Fee | | | | |
| **Retail 30** Generic Minimum Guaranteed Discount | | | | |
| **Retail 30** Generic Minimum Guaranteed Dispensing Fee | | | | |
| **Retail 90** Brand Minimum Guaranteed Discount | | | | |
| **Retail 90** Brand Minimum Guaranteed Dispensing Fee | | | | |
| **Retail 90** Generic Minimum Guaranteed Discount | | | | |
| **Retail 90** Generic Minimum Guaranteed Dispensing Fee | | | | |
| **Mail Order** Brand Minimum Guaranteed Discount | | | | |
| **Mail Order** Brand Minimum Guaranteed Dispensing Fee | | | | |
| **Mail Order** Generic Minimum Guaranteed Discount | | | | |
| **Mail Order** Generic Minimum Guaranteed Dispensing Fee | | | | |
| **Specialty** Brand Minimum Guaranteed Discount | | | | |
| **Specialty** Brand Minimum Guaranteed Dispensing Fee | | | | |
| **Specialty** Generic Minimum Guaranteed Discount | | | | |
| **Specialty** Generic Minimum Guaranteed Dispensing Fee | | | | |

| Pharmaceutical Manufacturer Rebates - Open Formulary | Year 1 | Year 2 | Year 3 | Year 3 |
|---|---|---|---|---|
| Retail (1-83 DS) Per Brand Guarantee | | | | |
| Retail (84+ DS) Per Brand Guarantee | | | | |
| Mail Order Per Brand Guarantee | | | | |
| Specialty Per Brand Guarantee | | | | |

| Pharmaceutical Manufacturer Rebates - Managed Formulary | Year 1 | Year 2 | Year 3 | Year 3 |
|---|---|---|---|---|
| Retail (1-83 DS) Per Brand Guarantee | | | | |
| Retail (84+ DS) Per Brand Guarantee | | | | |
| Mail Order Per Brand Guarantee | | | | |
| Specialty Per Brand Guarantee | | | | |

| Administrative Fees | | | | |
|---|---|---|---|---|
| **Proposed Administrative Fees (Pass Through / Transparent Offering)** | **Year 1** | **Year 2** | **Year 3** | **Year 3** |
| All-In Administrative Fee - PMPM | | | | |
| All-In Administrative Fee - Per Paid Claim | | | | |
| Clinical Prior Authorization | | | | |
| Copay Maximization/PAP/Importation | | | | |

| Miscelaneous Credits & Allocations | | | | |
|---|---|---|---|---|
| | **Year 1** | **Year 2** | **Year 3** | **Year 3** |
| Implementation Credit - PM (One time per member credit) | | | | |
| Pharmacy Management Fund - PMPM | | | | |
| Other | | | | |

# PLAN DOCUMENT AND

# SUMMARY PLAN DESCRIPTION

# FOR

# CITY OF BILLINGS EMPLOYEE BENEFIT PLAN

**EFFECTIVE: JANUARY 1, 2006**

**REVISED RESTATED: JANUARY 1, 2022**

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## INTRODUCTION

This document is a description of the **City of Billings Employee Benefit Plan (the Plan).** No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing claims, or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, Injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Charges incurred before termination, amendment, or elimination.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

The Claims Administrator utilizes Aetna's Clinical Policy Bulletins (CPBs) to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The CPBs are based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals and guidelines from nationally recognized health care organizations. These CPBs are reviewed on a regular basis based upon a review of currently available clinical information.

**This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:**

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Care Management Services.** Explains the methods used to curb unnecessary and excessive charges.

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Plan Exclusions.** Shows what charges are **not** covered.

**How to Submit A Claim.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person because of injuries sustained.

**COBRA Continuation Coverage.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

## ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements.

### ELIGIBILITY

**Eligible Classes of Employees.**

**(1)** All Active Employees of the Employer.

**(2)** All Retired Employees of the Employer.

**(3)** All elected city officials.

**Eligibility Requirements for Employee Coverage.** A person is eligible for Employee coverage from the first day that he or she:

**(1)** Is employed in a permanent position as a full-time, Active Employee of the Employer. An Employee is considered to be full-time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

**(2)** Is employed in a permanent position as a part-time, Active Employee of the Employer. An Employee is considered part-time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer for that work.

**(3)** Is a Retired Employee of the Employer. An Employee is eligible for service retirement when an Employee meets the requirements for Retirement according to MPERA - Montana Public Employees Retirement Administration. Refer to www.mpera.mt.gov for group specific Handbook PERS (Teamster & Non-Bargaining), MPORS (Police) or MFURS (Fire) on these details or the City of Billings Human Resources Benefits Coordinator at (406) 657-8265.

**(4)** Is in a class eligible for coverage.

**(5)** Completes the employment Waiting Period of a full calendar month as an Active Employee. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan.

If a non-permanent, seasonal short-term or temporary Employee is employed by the Employer into a non-bargaining position and is not designated eligible for coverage at the time of hire, the Employer may use a 12-month benefit measurement period to determine the eligibility of such an Employee. The Employee must average or be expected to average the required minimum hours of service established by the Employer each week in the Employee's initial 12-month measurement period to be eligible for coverage.

This Employee's initial measurement period begins the first day of the month coinciding with or following the date of hire, with an initial stability period commencing the first day of the second full calendar month following the initial measurement period. If there is a gap between the end of the Employee's first stability period and the start of the Employer's standard stability period, the Employee will remain eligible until the first day of the standard stability period as long as the Employee is actively working for the Employer.

The Employer's standard 12-month measurement period for non-permanent, seasonal short-term or temporary Employees begins each November 1st, with a standard stability period commencing each January 1st. Coverage is effective the first day of the stability period following the applicable measurement period. To remain eligible for coverage, they must average the required minimum hours of service each week during the subsequent measurement period.

If an Employee is hired into a permanent, benefit eligible position, the Employer calculates eligibility for coverage on the basis of the hours worked during the prior month. The Employee must average or be expected to average the required minimum hours of service established by the Employer during the prior month of employment to maintain eligibility for coverage.

If an Employee changes from a non-benefit eligible position to a benefit eligible position, the Employee will be credited with any time worked in the non-benefit eligible position for the employment Waiting Period.

For more information on benefit measurement periods, contact the Employer's Human Resources Department.

**Note:** All 20+ hour Employees in permanent positions with the Employer are required to enroll for coverage under the Medical and Prescription Drug benefits under this Plan. This requirement does not apply to the following elected officials: Mayor or City Council members.

**Note: Effective January 1, 2006:** A covered Retiree or his or her Spouse who reaches age 65 and/or becomes eligible for Medicare on or after January 1, 2006, will no longer be eligible for coverage under this Plan.

This provision does not apply to those retired Employees who were grandfathered on to the plan prior to the **January 1, 2001,** Plan change.

Under no circumstances will a covered Dependent child(ren) of a covered Retiree remain on the Plan after the Retired Employee reaches age 65.

**Eligibility Requirements for Elected Official Coverage**. A person is eligible for elected official coverage from the first day and throughout the time that he or she:

**(1)** Is officially sworn into the office to which he or she was elected. For purposes of this Plan, such an elected official may opt in or opt out of the Plan;

**(2)** Is a Retired elected official. An Employee is eligible for service retirement when an Employee meets the requirements for retirement according to MPERA- Montana Public Employees Retirement Administration. Refer to www.mpera.mt.gov for group specific Handbook PERS(Teamster & Non-Bargaining), MPORS(Police) or MFURS (Fire) on these details or the City of Billings Human Resources Benefits Coordinator at 657-8265;

**(3)** Is in a class eligible for coverage; and

**(4)** Completes the employment Waiting Period of a full calendar month as an elected official. A "Waiting Period" is the time between the first day the elected official is sworn into office and the first day of coverage under the Plan.

**Eligible Classes of Dependents.**

A Dependent is any one of the following persons:

**(1)** A covered **Employee's Spouse** and **children** from birth to the limiting age of 26 years. When the child reaches the limiting age, coverage will end on the last day of the child's birthday month.

The term **"Spouse"** shall mean an individual of the same or opposite sex recognized as the covered Employee's husband or wife under the laws of the state in which the marriage was formalized. This definition ***does not*** include domestic partners or common law marriage. **The Plan Administrator may require documentation proving a legal marital relationship.**

The term **"children"** shall include natural children, adopted children or children placed with a Covered Employee in anticipation of adoption. Step-children or Foster Children may also be included.

If a covered Employee is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase **"child placed with a covered Employee in anticipation of adoption"** refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A participant of the Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

**The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.**

**(2)** A covered Dependent child who is **Totally Disabled**, incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

**These persons are excluded as Dependents:** Other individuals living in the covered Employee's, Retired Employee's or elected official's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee, Retired Employee, or elected official; or any person who is covered under the Plan as an Employee, Retired Employee, or elected official.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both husband and wife, including same-sex married couples, are Employees, Retired Employees or elected officials, their children may be covered as Dependents of either the father or the mother, but not of both.

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

## FUNDING

### Cost of the Plan.

City of Billings shares the cost of Employee and Dependent coverage under this Plan with covered Employees.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

## ENROLLMENT

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application. If Dependent coverage is desired, the covered Employee is required to enroll for Dependent coverage.

**Enrollment Requirements for Newborn Children.** A newborn child of a covered Employee who has Dependent children coverage is automatically enrolled in this Plan; however, an enrollment card must be completed and submitted to the Plan Administrator.

A newborn child of a covered Employee who has Single or Employee/Spouse coverage must enroll the newborn child as defined in the section "Timely Enrollments" following this section. If this newborn child is not enrolled in this Plan on a timely basis, the enrollment will be considered a Late Enrollment, there will be no payment from the Plan, and the covered parent will be responsible for all costs.

Charges for covered routine nursery and Physician care will be applied toward the Plan of the newborn child.

## TIMELY OR LATE ENROLLMENT

**(1)** **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent child terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

An Employee who fails to enroll on a timely basis will be defaulted to single coverage on a plan which is determined each year based on the Employer's discretion.

An Employee who fails to enroll on a timely basis as a result of a qualified family status change during the Plan Year (see "Changes in Family Status" section), may be able to enroll during the next yearly re-enrollment period (see "Yearly Re-enrollment" section).

**(2)** **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. An Employee or their qualifying Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during the open annual enrollment period.

*Coverage begins as stated in the Open Annual Enrollment provision below.*

**(i) Open Annual Enrollment for Employees and Qualifying Dependents**

Each year there is an annual open enrollment period designated by the Employer during which eligible Employees may enroll themselves and any qualifying Dependents under the Plan, or covered Employees may change their and their covered Dependents' benefit elections under the Plan.

The annual open enrollment is also an opportunity for Retirees to add qualifying Dependents to existing coverages.

A Plan Participant who fails to make an election during open enrollment will automatically retain present coverage.

Benefit choices for Late Enrollees made during the open enrollment period will become effective **January 1st**.

## NON-BENEFIT EMPLOYEES – ENROLLMENT FOLLOWING BENEFIT MEASUREMENT PERIOD

Employees who were determined to be part-time or full-time during the 12-month look-back measurement period and their eligible Dependents may enroll in the Plan the first day of the first full calendar month of the stability period that follows the benefit measurement period. To the extent previously satisfied the employment Waiting Period will be considered satisfied.

## HOW TO DROP COVERAGE

Pre-tax benefit elections may not be revoked during the Plan Year except as permitted by IRS regulations. If the Employee's Dependent is enrolled in this Plan and wishes to drop coverage for him or herself this may only be done when a qualifying special event has occurred.

The Employee's Dependent may also drop coverage if the Dependent becomes eligible under another group health plan or health insurance.

For more information regarding dropping coverage for a Dependent, please contact the Human Resources Department within 31 days of the eligibility date for other coverage or qualifying special event date.

## CHANGES IN FAMILY STATUS

IRS regulations require that a covered Employee's benefit elections remain in force for the full **Plan Year** (January 1 – December 31). The only exception that permits the covered Employee to change his or her election during the year occurs when he or she experiences a qualified change in family status (as defined under the Internal Revenue Code) that directly affects the covered Employee and his or her Dependent's participation in the Plan. The benefit election is irrevocable, except as allowed in the IRS temporary proposed and final regulations.

Under current Federal tax rules, the following situations are examples of qualified family status changes:

- Change in marital status, including marriage, divorce, legal separation, annulment or death of spouse.
- Change in number of dependents, including birth, death, adoption, and placement for adoption. This extends to dependents that become newly eligible for plan coverage because of a plan amendment.
- Change in employment status of the Employee, Spouse or Dependent, including commencement or termination of employment, change in worksite, commencement or return from leave of absence, change to a part-time or full-time Active Employee permanent position as defined under the Plan, strike or lockout,-or change from salaried to hourly pay.
- Change in residence of the Employee, Spouse or Dependent. Dependent meeting or ceasing to meet the Plan's definition of Dependent, such as attainment of a specified age.
- Mid-year eligibility for or loss of Medicare or Medicaid.
- A judgment, decree or order requiring dependent coverage (e.g., QMCSO). For dependent care spending accounts, if there is a change in provider or cost mid-year or the dependent ceases to be eligible mid-year, the spending account election can be changed.

A consistency requirement applies to change in status events for mid-year election changes and consists of three parts:

- The change in status event must cause an individual to gain or lose eligibility for benefits under one of the underlying plans or the cafeteria plan, or under another employer's plans or for one of the benefit options under a plan; and

- The mid-year election change must be "on account of" the change in status; and

- The mid-year election change must "correspond with" the change in status that caused a gain or loss of plan eligibility.

If the covered Employee experiences a family status change, please contact Human Resources of the Employer immediately for further information needed to make any changes allowed. These changes must be made within 31 days of the event.

**SPECIAL ENROLLMENT RIGHTS**

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for his or her dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. **To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.**

**SPECIAL ENROLLMENT PERIODS**

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

**(1)** **Losing other coverage may create a Special Enrollment right.** A Dependent who is eligible, but not otherwise enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

**(a)** The Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

**(b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

**(c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

**(d)** The Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, as described above. Coverage will begin no later than the first day of the first calendar month following the date of loss.

For purposes of these rules, a loss of eligibility occurs due to one of the following:

**(i)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time employees).

**(ii)** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

**(iii)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

**(iv)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

**(2) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:**

**(a)** The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

**(b)** A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then, the Dependent may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may also be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Employee must request enrollment during this 31-day period.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

**(a)** In the case of marriage, as of the date of marriage;

**(b)** In the case of a Dependent’s birth, as of the date of birth; or

**(c)** In the case of a Dependent’s adoption or placement for adoption, the date of the adoption or placement for adoption.

**Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)**

Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within sixty (60) days from the date of the following loss of coverage or gain in eligibility:

**(a)** The eligible person ceases to be eligible for Medicaid or State Children’s Health Insurance Program (SCHIP) coverage; or

**(b)** The eligible person becomes newly eligible for a premium subsidy under Medicaid or SCHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or SCHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or SCHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. *The effective date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer and its Employees. **For more information regarding special enrollment rights, contact the Plan Administrator.**

**EFFECTIVE DATE**

**Effective Date of Employee Coverage**. An Employee will be covered under this Plan as of the first day of the first calendar month following the date that the Employee satisfies all of the following:

**(1)** The Eligibility Requirement.

**(2)** The Active Employee Requirement.

**(3)** The Enrollment Requirements of the Plan.

**Note:** In the case of weekends and holidays, if the covered Employee starts on the first business day of the calendar month, he or she will be treated as having been hired on the first day of the calendar month.

**Active Employee Requirement.**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirement is met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

**TERMINATION OF COVERAGE**

**The Employer or Plan has the right to rescind any coverage of the Employee/Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee/Retiree and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's/Retiree's and/or Dependent's paid contributions.**

**When Employee Coverage Terminates.** Employee coverage will terminate on the earliest of these dates:

**(1)** The date the Plan is terminated;

**(2)** The date the covered Employee's employer ceases to be a covered Employer, if applicable;

**(3)** The date the covered Employee's Eligible Class is eliminated;

**(4)** The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes, or as applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action;

**(5)** In the event coverage under the Plan is terminated for an Employee who goes active duty, the effective date of termination will be the last working day prior to military leave or as otherwise set by the Employer and Employee;

**(6)** The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;

**(7)** If an Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage; or

**(8)** As otherwise specified in the Eligibility section of this Plan.

**Note:** Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

**Continuation During Periods of Employer-Certified Leave of Absence or Layoff.** A person may remain eligible for a limited time if Active, full-time work ceases due to leave of absence or layoff. This continuance will end as follows:

**For leave of absence or layoff only:** the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

**Continuation During Family and Medical Leave.** Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor if, in fact, FMLA is applicable to the Employer and all of its Employees.

If applicable, during any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

**Rehiring a Terminated Employee.** A terminated Employee who is rehired *under a benefit eligible position* and prior to the end of a 13 consecutive week period after the date of termination will be credited with time met toward the employment waiting period as of the date of termination. Coverage will begin the first day of the first month following the date of rehire, or the first day of the first month following completion of the waiting period.

Otherwise, a terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA Continuation Coverage. This Employee does not have to satisfy the employment Waiting Period.

**Employees on Military Leave.** Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

**(1)** The maximum period of coverage of a person under such an election shall be the lesser of:

**(a)** The 24-month period beginning on the date on which the person's absence begins; or

**(b)** The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

**(2)** A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

**(3)** An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

**Montana National Guard Members.** Participants performing State active duty as a Montana National Guard member may elect to continue Plan coverage subject to the terms of the Montana Military Service Employment Rights Act (MMSERA) under the following circumstances:

**(1)** The period of coverage of a person under such an election shall be the period of time beginning on the date on which the person’s absence for State active duty begins, and ending:

**(a)** The next regularly scheduled day of employment following travel time plus 8 hours, if State active duty is 30 days or less; or

**(b)** The next regularly scheduled day of employment following 14 days after termination of State active duty, if State active duty is not more than 180 days; or

**(c)** The next regularly scheduled day of employment following 90 days after termination of State active duty, if State active duty is more than 180 days.

**(2)** A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except that a person on State active duty for less than 180 days may not be required to pay more than the regular Participant’s share, if any, for the coverage.

**(3)** An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State active duty.

**When Retiree Coverage Terminates.** Retiree coverage will terminate on the earliest of these dates:

**(1)** The date the Plan is terminated;

**(2)** The date the covered Retired participant's Plan ceases to be an active Plan;

**(3)** The date the covered Retiree's participant's Eligible Class is eliminated;

**(4)** The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

**(5)** If a Retiree commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Retiree for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates:

**(1)** The date the Plan or Dependent coverage under the Plan is terminated;

**(2)** The date that the Plan Participant's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.);

**(3)** The last day of the calendar month in which a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.);

**(4)** On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled COBRA Continuation Coverage.);

**(5)** The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;

**(6)** If a Dependent commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

**(7)** As otherwise specified in the Eligibility section of this Plan.

**Note:** Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

If the Retiree's coverage under the Plan terminates for any reason including death, the Spouse of a covered Retired Employee may remain a member of the Plan until he or she reaches age 65 and/or becomes eligible for Medicare.

A surviving Spouse of a deceased Employee or Retiree may remain a Plan Participant under this Plan as long as the spouse is eligible for retirement benefits accrued by the deceased Employee or Retiree.

**SCHEDULE OF BENEFITS**
**STANDARD HEALTH PLAN**

**Verification of Eligibility** (406) 245-3575

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

**Active Permanent City Employees:** The Wellness Committee & Health Insurance Committee are committed to helping covered Employees achieve their best health. Rewards for participating in a results based wellness program are available to all active, permanent city Employees. City of Billings reserves the right to alter the Wellness Program at any time. Covered Employees should contact the Human Resources Department for additional information regarding these programs.

## MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are reasonable and customary (as defined as an Allowable Charge); that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services or supplies. *A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are received by the Plan Participant. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Claims Procedure section.*

## PROVIDER INFORMATION

**This Plan has entered into agreements with the following providers. Plan Participants who receive services from these providers will receive a better benefit than when a Non-Network Provider is used:**

### PREFERRED NETWORK PROVIDERS:

- Rocky Mountain Health Network (www.rmhn.org)
- Riverstone Health

### NETWORK PROVIDERS:

- First Choice Health

To access a list of Preferred Network Providers or Network Providers, please refer to the Provider website and/or toll free number listed on the **City of Billings Employee Benefit Plan identification card**. Prior to receiving medical care services, the Plan Participant should confirm with the provider that the provider is a participant in the applicable network.

**Please note the following Non-Network Provider exceptions that apply under this Plan:**

- Services for Mental Disorders or Substance Abuse treatment rendered at the Billings Clinic will be subject to the Preferred Network Provider benefit level.

- If there is not a specific specialty provider available through *either* a Preferred Network Provider *or* a Network Provider, services received from a Non-Network specialty provider will be subject to the Preferred Network Provider benefit level.

- Laboratory services performed by a Non-Network Provider when referred by a Preferred Network Provider will be subject to the Preferred Network Provider benefit level.

- For Plan Participants who reside outside Yellowstone County and who utilize a Non-Network Provider in their community, Non-Network Provider services will be subject to the Preferred Network Provider benefit level. *(This does not include Plan Participants who reside outside Yellowstone County who travel to Yellowstone County to receive services. They must utilize a Rocky Mountain Health Preferred Network Provider in order to receive the highest Preferred Network Provider benefit level.)*

Covered Charges will be reimbursed based on the Allowable Charge. The Plan Participant may be balanced billed by a Non-Network Provider for any amount over the Allowable Charge.

**NO SURPRISES ACT (NSA)**

For Non-Network Provider charges subject to the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), the Plan Participant cost-sharing will be the applicable *Preferred Network Provider* or Network Provider benefit level which will be calculated as if the Allowable Charge was the Recognized Amount. Cost-sharing amounts will also accrue toward the *Preferred Network Provider* or the Network Provider maximum out-of-pocket amount. The NSA prohibits Non-Network Providers from pursuing payment from the Plan Participant for the difference between the Allowable Charge and the Non-Network Provider's billed charge for services, except for any applicable cost-sharing.

Non-Network Provider charges subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a *Preferred Network Provider* or Network Provider Facility:
    - Provided the Plan Participant has not provided Notice and Consent (as explained below) to waive the applicability of the NSA;
    - Including the furnishing of equipment/devices, labs, imaging, telehealth, pre-operative and post-operative services regardless of being physically located at the *Preferred Network Provider* or Network Provider Facility; and
- Covered Charges for air ambulance services.

Benefit determinations for Non-Network Provider claims subject to the NSA will be made within 30 days of the Claims Administrator's receipt of the claim and if applicable, reimbursement will be submitted directly to the Non-Network Provider.

**Notice and Consent.** Exceptions to the NSA balance billing protections may apply when the Plan Participant receives non-emergency services (other than ancillary services) from a Non-Network Provider and gives written consent to receive those services as Non-Network Provider benefits. Ancillary services include anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and items and services related to emergency medicine.

**PROVIDER DIRECTORIES**

If a Plan Participant seeks care based on incorrect information indicating that the provider was a *Preferred Network Provider* or a Network Provider at the time the treatment or service was received, the Plan Participant's cost share will be limited to the applicable *Preferred Network Provider* or Network Provider benefit level if the Plan Participant can provide proof within 30 days that they sought care based on the incorrect information.

## CONTINUING CARE PROVISION

In accordance with the Consolidated Appropriations Act of 2021, when a Plan Participant is a receiving treatment from a *Preferred Network Provider* or Network Provider, and that provider's relationship with the Plan is terminated, not renewed, or otherwise ends for any reason (other than the Provider's failure to meet applicable quality standards or for fraud), the Plan Participant has rights to elect Continuing Care from the former *Preferred Network Provider* or Network Provider.

The Plan shall notify the Plan Participant in a timely manner that the *Preferred Network Provider* or Network Provider's contractual relationship with the Plan has terminated. If the Plan Participant **elects in writing** to receive Continuing Care, benefits will apply under the same terms and conditions as would have applied had the termination not occurred. This Continuing Care Provision becomes available as of the date of the letter received by the Plan Participant that the former *Preferred Network Provider* or Network Provider is no longer associated with the Plan. The Continuing Care Provision will cease 90 days after that date or when the Plan Participant ceases to receive Continuing Care, whichever occurs first.

Under the Continuing Care Provision, the former *Preferred Network Provider* or Network Provider: (i) must accept reimbursement from the Plan and any applicable cost sharing from the Plan Participant as payment in full; and (ii) must continue to adhere to all policies, procedures, and standards of care imposed by the Plan in the same manner as if the *Preferred Network Provider* or Network Provider termination had not occurred.

For purposes of this provision, a "Continuing Care" Plan Participant is:

**(1)** undergoing a course of treatment for a serious and complex condition from a specific *Preferred Network Provider* or Network Provider;

**(2)** undergoing a course of institutional or inpatient care from a specific *Preferred Network Provider* or Network Provider;

**(3)** scheduled to undergo non-elective surgery from a specific *Preferred Network Provider* or Network Provider, including postoperative care;

**(4)** pregnant and undergoing a course of treatment for the Pregnancy from a specific *Preferred Network Provider* or Network Provider; or

**(5)** terminally ill and receiving treatment for such illness from a specific *Preferred Network Provider* or Network Provider.

## DEDUCTIBLES/COPAYMENTS/COINSURANCE PAYABLE BY PLAN PARTICIPANTS

**Deductibles** are dollar amounts that the Plan Participant must pay before the Plan pays.

*Deductibles will accrue toward the maximum out-of-pocket amount.*

A **copayment** is an amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

*Copayments, excluding Prescription Drug copayments, will accrue toward the maximum out-of-pocket amount.*

**Coinsurance** is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Schedule of Benefits and is the Plan Participant's responsibility. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

Coinsurance is payable by the Plan Participant until the maximum out-of-pocket amount, as shown in the Schedule of Benefits, is reached. Then Covered Charges incurred will be payable by the Plan at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the remainder of the Calendar Year.

**STANDARD HEALTH PLAN**
**MEDICAL BENEFITS SCHEDULE**

| STANDARD HEALTH PLAN | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | **Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health** | **First Choice Health** | |
| Claims should be received by the Claims Administrator within *365 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.<br><br>The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion. | | | |
| **MAXIMUM CALENDAR YEAR BENEFIT AMOUNT** | Unlimited | | |
| **DEDUCTIBLE, PER CALENDAR YEAR** | | | |
| Per Plan Participant | $1,000 | | |
| Per Family Unit | $2,000 | | |
| **INPATIENT HOSPITAL COPAYMENT** | | | |
| Per Confinement until the maximum out-of-pocket amount is met | $200 | | |
| **MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR** | | | |
| Per Plan Participant | $2,250 | $6,000 | $6,000 |
| Per Family Unit | $5,750 | $17,000 | $17,000 |
| ***The Preferred Network Provider maximum out-of-pocket amount does not cross accumulate with the Network Provider and Non-Network Provider maximum out-of-pocket amounts, however the Network Provider and the Non-Network Provider maximum out-of-pocket amounts cross-accumulate with each other.*** | | | |
| The Plan will pay the designated percentage of Covered Charges until the maximum out-of-pocket amount is reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. | | | |
| The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%:<br>➢ Prescription drug deductibles, copayments, out of pocket charges and coinsurance amounts<br>➢ Prescription drug Dispense As Written (DAW) penalties, discounts, coupons, Pharmacy discount programs or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.<br>➢ Amounts over the Allowable Charge | | | |
| **COVERED SERVICES** | | | |
| **Note: The maximums listed below are the total for Preferred Network Provider, Network Provider and Non-Network Provider expenses. For example, if a maximum of 60 days is listed more than once under a service, the Calendar Year maximum is 60 days total which may be split between Preferred Network, Network, and Non-Network Providers.** | | | |

| STANDARD HEALTH PLAN | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | **Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health** | **First Choice Health** | |
| Inpatient Hospital Services<br>Room and Board | 80% after deductible and Inpatient Hospital Copayment* (limited to the semiprivate room rate) | 60% after deductible and Inpatient Hospital Copayment* (limited to the semiprivate room rate) | 60% after deductible and Inpatient Hospital Copayment* (limited to the semiprivate room rate) |
| Intensive Care Unit (ICU) | 80% after deductible and Inpatient Hospital Copayment* (limited to the Hospital's ICU rate) | 60% after deductible and Inpatient Hospital Copayment* (limited to the Hospital's ICU rate) | 60% after deductible and Inpatient Hospital Copayment* (limited to the Hospital's ICU rate) |
| *The Inpatient Hospital Copayment applies per confinement until the maximum out-of-pocket amount is met. | | | |
| Outpatient Hospital Services/Ambulatory Surgical Center | 80% after deductible | 60% after deductible | 60% after deductible |
| Emergency Room Services | 80% after deductible | | |
| **Skilled Nursing Facility** | 80% after deductible (limited to the semiprivate room rate) | | |
| **Rehabilitation Services**<br>Inpatient facility | 80% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* |
| Outpatient (includes occupational therapy, physical therapy and speech therapy) | 80% after deductible | 60% after deductible | 60% after deductible |
| *The Inpatient Hospital Copayment applies per confinement until the maximum out-of-pocket amount is met. | | | |
| Urgent Care Services<br>Facility | 80% after deductible | 60% after deductible | 60% after deductible |
| Office visit | 100% after $25 copayment per visit deductible waived | 100% after $50 copayment per visit deductible waived | 100% after $50 copayment per visit deductible waived |
| **Note:** The copayment will be applied to the office visit only. Any associated charges will be paid per normal Plan provisions. | | | |
| Physician Services<br>Inpatient visits | 80% after deductible | 60% after deductible | 60% after deductible |
| Office visits | 100% after $25 copayment per visit deductible waived | 100% after $50 copayment per visit deductible waived | 100% after $50 copayment per visit deductible waived |
| Surgery | 80% after deductible | 60% after deductible | 60% after deductible |
| **Note:** The copayment will be applied to the office visit only. Any associated charges will be paid per normal Plan provisions. | | | |
| **SCL Health Right Care –** Video Visits | 100% after $25 copayment per visit, deductible waived | | |

| STANDARD HEALTH PLAN | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | **Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health** | **First Choice Health** | |
| **Note:** Refer to the SCL Health Right Care benefit shown in the Covered Charges section for more information regarding this benefit. | | | |
| **Ambulance Service** | 80% after deductible | | |
| **Chemotherapy and Radiation Treatment** | 80% after deductible | 60% after deductible | 60% after deductible |
| **Wig** (after chemotherapy or radiation treatment) | 80% after deductible $500 Lifetime maximum | 60% after deductible $500 Lifetime maximum | 60% after deductible $500 Lifetime maximum |
| **Diagnostic X-ray and Lab** | 80% after deductible | 60% after deductible | 60% after deductible |
| **Imaging Services** (CT/PET scans, MRIs) | 80% after deductible | 60% after deductible | 60% after deductible |
| **Note:** Charges in connection with 3-D mammography will be a Covered Charge. | | | |
| **Durable Medical Equipment, Orthotics and Prosthetics** | 80% after deductible | | |
| **Home Health Care** | 80% after deductible | | |
| **Hospice Care** | 80% after deductible | | |
| **In Vitro Fertilization** | 80% after deductible Lifetime maximum of two implantation attempts | 60% after deductible Lifetime maximum of two implantation attempts | 60% after deductible Lifetime maximum of two implantation attempts |
| **Jaw Joint/TMJ** | 80% after deductible | 60% after deductible | 60% after deductible |
| **Mental Disorders and Substance Abuse Treatment** | | | |
| Inpatient Services | | | |
| Facility | 80% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* |
| Physician | 80% after deductible | 60% after deductible | 60% after deductible |
| Outpatient Services | | | |
| Facility | 80% after deductible | 60% after deductible | 60% after deductible |
| Physician | 80% after deductible | 60% after deductible | 60% after deductible |
| Office visits | 100% after $25 copayment per visit deductible waived | 100% after $50 copayment per visit deductible waived | 100% after $50 copayment per visit deductible waived |
| *The Inpatient Hospital Copayment applies per confinement until the maximum out-of-pocket amount is met. **Note:** The Office visit copayment will be applied to the office visit only. Any associated charges will be paid per normal Plan provisions. | | | |
| **Organ Transplants** | 80% after deductible | | |

| STANDARD HEALTH PLAN | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | **Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health** | **First Choice Health** | |
| **Pregnancy** | | | |
| Initial Office Visit | 100% after $25 copayment deductible waived | 100% after $50 copayment deductible waived | 100% after $50 copayment deductible waived |
| Prenatal / postnatal care | 80% after deductible | 60% after deductible | 60% after deductible |
| Routine prenatal office visits | 40% of Covered Charges of the global maternity fee will be payable at 100%, deductible waived; thereafter, 80% after deductible; **OR** if billed separately, 100% of the routine prenatal office visits will be payable at 100%, deductible waived | 60% after deductible | 60% after deductible |
| Inpatient Hospitalization | 80% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* |
| All other related services | Payable per normal Plan provisions | Payable per normal Plan provisions | Payable per normal Plan provisions |
| *The Inpatient Hospital Copayment applies per confinement until the maximum out-of-pocket amount is met. **Note:** Refer to the Coverage of Pregnancy benefit listed in the Covered Charges section for more information regarding routine prenatal office visits. | | | |
| **Routine Well Newborn Nursery Care** (while Hospital confined at birth) | 80% after deductible | 60% after deductible | 60% after deductible |
| **PREVENTIVE CARE** | | | |
| **Please note: Preventive care is care by a Physician that is not treatment for an Illness or Injury. The preventive care benefits as shown below will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.**<br><br>**Please consult with your attending Physician at the time services are rendered as to whether or not the services provided will be considered preventive care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) grades a and b recommendations or the Women's Preventive Services as required by the Health Resources and Services Administration (HRSA).**<br><br>**Otherwise, services rendered which are not considered or billed by the attending Physician as preventive care (as stated above) will be payable under normal Plan provisions at the same benefit level as any other Illness or Injury.** | | | |
| **Preventive Well Adult Care** [1] Age 18 and over | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |

[1] **Preventive care services** will be subject to frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF), *unless otherwise specifically stated in this Schedule of Benefits,* and which can be located using the following website:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

| STANDARD HEALTH PLAN | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health | First Choice Health | |

**Preventive Well Care services will include, but will not be limited to, the following preventive services:** Physical exams; office visits; lab and x-ray services.

**Note**: If applicable, this Plan may comply with a state vaccine assessment program.

**Women's Preventive Services** will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Schedule of Benefits,* and which can be located using the following websites:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/; and
http://www.hrsa.gov/womens-guidelines

**Women's Preventive Services, will include, but will not be limited to, the following routine services:** Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity ***(and does not include birthing classes)***, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

*Note: Charges in connection with 3-D mammography will be a Covered Charge.*

| | | | |
|---|---|---|---|
| **Preventive Well Child Care**[4] Birth through 7 years | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |

[4] The Allowable Charges for preventive Well Child Care: Coverage includes one visit per provider at the intervals stated below.

**Preventive Well Child Care means Physician-delivered or Physician-supervised services for:** History, physical exam, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule according to the U.S. Preventive Services Task Force (USPSTF) and which can be located using the following website:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

and not to exceed 10 visits from birth up to age 2, and one visit annually thereafter up to age 8.

The benefits described above are limited to one visit payable to one provider for all of the services provided at each visit and must be delivered by a Physician or a health care professional supervised by a Physician.

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

| | | | |
|---|---|---|---|
| **Preventive Well Child Care**[5] Age 8 through 17 years | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |

[5] Preventive care services will be subject to frequency limitations as determined by the U.S. Preventive Services Task Force and Health Resources (USPSTF) as *specifically stated in this Schedule of Benefits,* and which can be located using the following website:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

**Preventive Well Child Care services will include, but will not be limited to, the following preventive services:** Physical exams, office visits, Pap smears, lab and x-ray services.

| STANDARD HEALTH PLAN | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health | First Choice Health | |
| **Other Preventive Care** | | | |
| **(Preventive) Colonoscopy/ Sigmoidoscopy** | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |
| **Diabetic Education** | 100%, deductible and copayment waived 10 visits maximum per Calendar Year | 60% after deductible 10 visits maximum per Calendar Year | 60% after deductible 10 visits maximum per Calendar Year |
| **Immunizations – All ages** | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |
| **Nutritional Education Counseling** | 100%, deductible and copayment waived 10 visits maximum per Calendar Year | 60% after deductible 10 visits maximum per Calendar Year | 60% after deductible 10 visits maximum per Calendar Year |
| **Obesity Interventions** (Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m2 or higher) | 100%, deductible and copayment waived 26 visits maximum per Calendar Year | 60% after deductible 26 visits maximum per Calendar Year | 60% after deductible 26 visits maximum per Calendar Year |
| **Note:** Refer to the Obesity Interventions benefit listed in the Covered Charges section for more information regarding Obesity Interventions. | | | |
| **Prostate Screening**[2] | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |
| [2]Frequency limits for prostate screening: Age 50 and over.....annually | | | |
| **Tobacco/Nicotine Cessation Counseling** | 100%, deductible and copayment waived | 60% after deductible | 60% after deductible |
| **Freedom from Smoking** | 100% after $50 copayment*, deductible waived Limited to one course per Calendar Year per Plan Participant | | |
| *The Freedom from Smoking copayment will be reimbursed by the Plan after completion of the course. Refer to the Covered Charges section for more information regarding reimbursement and the Freedom from Smoking benefit. | | | |
| **Private Duty Nursing - Outpatient** *(only available through Home Health Care)* | 80% after deductible | | |
| **Spinal Manipulation/ Chiropractic Care and Massage Therapy** | 50% after deductible 24 visits combined maximum per Calendar Year | | |
| **All Other Covered Charges** | 80% after deductible | 60% after deductible | 60% after deductible |

**PRESCRIPTION DRUG BENEFIT STANDARD HEALTH PLAN**

**RETIREES AGE 65 AND/OR ELIGIBLE FOR MEDICARE ARE NOT ELIGIBLE FOR THIS PRESCRIPTION DRUG BENEFIT**

***The Coordination of Benefits provision will not apply to the Prescription Drug Benefits.***

If applicable, this Plan will make a retroactive adjustment to a claim based on a discount, coupon, Pharmacy discount program or similar arrangement provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.

**PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT**

***Applies to Mail Order Prescription Drug Program, Specialty Pharmacy Program and Retail Pharmacy Program***

| | |
|---|---|
| Per Calendar Year, per Plan Participant | $2,250 |
| Per Calendar Year, per Family Unit | $6,750 |

**Mandatory - *mi*Rx MAIL ORDER PHARMACY PROGRAM**

***miRx Pharmacy copayments for maintenance medications – 30, 60, or 90-day supply per prescription***

| | |
|---|---|
| Generic drugs | $5/30 days, $10/90 days |
| Preferred Brand Name drugs | $30/30 days, $60/60 days, $90/90 days |
| Non-Preferred Brand Name drugs | $45/30 days, $90/60 days, $135/90 days |

Prescriptions requiring compounding will need to be utilized under the Retail Pharmacy Program, at specific compounding Pharmacies.

**PRESCRIPTION DRUG DEDUCTIBLES**

***Applies only to Specialty Pharmacy Program and Retail Pharmacy Program***

*Note: The Prescription Drug deductible does not apply when using the miRx Pharmacy for maintenance medications through the miRx Mail Order Program.*

| | |
|---|---|
| Deductible per Calendar Year, per Plan Participant | $100 |
| Deductible per Calendar Year, per Family Unit | $200 |

**Mandatory – *mi*Rx SPECIALTY PHARMACY PROGRAM**

***miRx Specialty Pharmacy copayments - Limited to a 30 day supply per prescription***

| | |
|---|---|
| Generic | $75 after prescription drug deductible |
| Preferred Brand Name | $125 after prescription drug deductible |
| Non-Preferred Brand Name | $125 after prescription drug deductible |

**RETAIL PHARMACY PROGRAM** - ***Administered by Magellan Rx***

***Retail Pharmacy copayments - Limited to a 30 day supply per prescription***

| | |
|---|---|
| Generic | $5 after prescription drug deductible |
| Preferred Brand Name | 20% after prescription drug deductible ($30 minimum and $60 maximum) |
| Non-preferred Brand Name | 40% after prescription drug deductible ($50 minimum and $100 maximum) |

**Please Note:** Plan Participants are encouraged to utilize the *mi*Rx Pharmacy, as a community Pharmacy, for retail medications that are prescribed for short-term acute conditions; but it is not mandatory. However, for convenience, if the Plan Participant utilizes the *mi*Rx community Pharmacy for retail medications, they will process based on the copayment and deductibles for retail Pharmacy.

**All medications will be dispensed as a Generic Drug, if available, instead of its brand name product.** *If a Brand Name Drug is dispensed when a Generic Drug equivalent is available, the Plan Participant will be responsible for the Brand Name Drug copayment plus the difference in cost between the Brand Name Drug and the Generic Drug. If there is no Generic Drug available or the Physician prescribes a Brand Name Drug over the Generic Drug* ***due to medical necessity****, the applicable Brand Name Drug copayment will apply. Prescription drug DAW (Dispense As Written) penalties do not apply toward the maximum out-of-pocket amount.*

**For more information regarding the Prescription Drug benefits, refer to the separate Prescription Drug Benefit section under this Plan.**

**SCHEDULE OF BENEFITS**
**HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**

**Verification of Eligibility** (406) 245-3575

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

***Only those Participants covered under a High Deductible Health Plan (HDHP) are eligible to contribute to a Health Savings Account (HSA).***

***If a Participant is covered under this Plan and another plan, the other plan would also need to be a HDHP in order for the Participant to contribute to an HSA.***

**Active Permanent City Employees:** The Wellness Committee & Health Insurance Committee are committed to helping covered Employees achieve their best health. Rewards for participating in a results based wellness program are available to all active, permanent city Employees. City of Billings reserves the right to alter the Wellness Program at any time. Covered Employees should contact the Human Resources Department for additional information regarding these programs.

**MEDICAL BENEFITS**

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are reasonable and customary (as defined as an Allowable Charge); that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services or supplies. *A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are received by the Plan Participant. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Claims Procedure section.*

**PROVIDER INFORMATION**

**This Plan has entered into agreements with the following providers. Plan Participants who receive services from these providers will receive a better benefit than when a Non-Network Provider is used:**

**PREFERRED NETWORK PROVIDERS:**

- Rocky Mountain Health Network (www.rmhn.org)
- Riverstone Health

**NETWORK PROVIDERS:**

- First Choice Health

To access a list of Preferred Network Providers or Network Providers, please refer to the Provider website and/or toll free number listed on the **City of Billings Employee Benefit Plan identification card**. Prior to receiving medical care services, the Plan Participant should confirm with the provider that the provider is a participant in the applicable network.

**Please note the following Non-Network Provider exceptions that apply under this Plan:**

- Services for Mental Disorders or Substance Abuse treatment rendered at the Billings Clinic will be subject to the Preferred Network Provider benefit level.

- If there is not a specific specialty provider available through *either* a Preferred Network Provider *or* a Network Provider, services received from a Non-Network specialty provider will be subject to the Preferred Network Provider benefit level.

- Laboratory services performed by a Non-Network Provider when referred by a Preferred Network Provider will be subject to the Preferred Network Provider benefit level.

- For Plan Participants who reside outside Yellowstone County and who utilize a Non-Network Provider in their community, Non-Network Provider services will be subject to the Preferred Network Provider benefit level. *(This does not include Plan Participants who reside outside Yellowstone County who travel to Yellowstone County to receive services. They must utilize a Rocky Mountain Health Preferred Network Provider in order to receive the highest Preferred Network Provider benefit level.)*

Covered Charges will be reimbursed based on the Allowable Charge. The Plan Participant may be balanced billed by a Non-Network Provider for any amount over the Allowable Charge.

**NO SURPRISES ACT (NSA)**

For Non-Network Provider charges subject to the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), the Plan Participant cost-sharing will be the applicable *Preferred Network Provider* or Network Provider benefit level which will be calculated as if the Allowable Charge was the Recognized Amount. Cost-sharing amounts will also accrue toward the *Preferred Network Provider* or the Network Provider maximum out-of-pocket amount. The NSA prohibits Non-Network Providers from pursuing payment from the Plan Participant for the difference between the Allowable Charge and the Non-Network Provider's billed charge for services, except for any applicable cost-sharing.

Non-Network Provider charges subject to the NSA are those which are submitted for:

- Emergency Services;

- Non-emergency services rendered by a Non-Network Provider at a *Preferred Network Provider* or Network Provider Facility:

    - Provided the Plan Participant has not provided Notice and Consent (as explained below) to waive the applicability of the NSA;

    - Including the furnishing of equipment/devices, labs, imaging, telehealth, pre-operative and post-operative services regardless of being physically located at the *Preferred Network Provider* or Network Provider Facility; and

- Covered Charges for air ambulance services.

Benefit determinations for Non-Network Provider claims subject to the NSA will be made within 30 days of the Claims Administrator's receipt of the claim and if applicable, reimbursement will be submitted directly to the Non-Network Provider.

**Notice and Consent.** Exceptions to the NSA balance billing protections may apply when the Plan Participant receives non-emergency services (other than ancillary services) from a Non-Network Provider and gives written consent to receive those services as Non-Network Provider benefits. Ancillary services include anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and items and services related to emergency medicine.

## PROVIDER DIRECTORIES

If a Plan Participant seeks care based on incorrect information indicating that the provider was a *Preferred Network Provider* or a Network Provider at the time the treatment or service was received, the Plan Participant's cost share will be limited to the applicable *Preferred Network Provider* or Network Provider benefit level if the Plan Participant can provide proof within 30 days that they sought care based on the incorrect information.

## CONTINUING CARE PROVISION

In accordance with the Consolidated Appropriations Act of 2021, when a Plan Participant is a receiving treatment from a *Preferred Network Provider* or Network Provider, and that provider's relationship with the Plan is terminated, not renewed, or otherwise ends for any reason (other than the Provider's failure to meet applicable quality standards or for fraud), the Plan Participant has rights to elect Continuing Care from the former *Preferred Network Provider* or Network Provider.

The Plan shall notify the Plan Participant in a timely manner that the *Preferred Network Provider* or Network Provider's contractual relationship with the Plan has terminated. If the Plan Participant **elects in writing** to receive Continuing Care, benefits will apply under the same terms and conditions as would have applied had the termination not occurred. This Continuing Care Provision becomes available as of the date of the letter received by the Plan Participant that the former *Preferred Network Provider* or Network Provider is no longer associated with the Plan. The Continuing Care Provision will cease 90 days after that date or when the Plan Participant ceases to receive Continuing Care, whichever occurs first.

Under the Continuing Care Provision, the former *Preferred Network Provider* or Network Provider: (i) must accept reimbursement from the Plan and any applicable cost sharing from the Plan Participant as payment in full; and (ii) must continue to adhere to all policies, procedures, and standards of care imposed by the Plan in the same manner as if the *Preferred Network Provider* or Network Provider termination had not occurred.

For purposes of this provision, a "Continuing Care" Plan Participant is:

**(1)** undergoing a course of treatment for a serious and complex condition from a specific *Preferred Network Provider* or Network Provider;

**(2)** undergoing a course of institutional or inpatient care from a specific *Preferred Network Provider* or Network Provider;

**(3)** scheduled to undergo non-elective surgery from a specific *Preferred Network Provider* or Network Provider, including postoperative care;

**(4)** pregnant and undergoing a course of treatment for the Pregnancy from a specific *Preferred Network Provider* or Network Provider; or

**(5)** terminally ill and receiving treatment for such illness from a specific *Preferred Network Provider* or Network Provider.

## HIGH DEDUCTIBLE HEALTH PLAN

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) provides coverage for high cost medical events, and in a tax-advantaged way to help build savings for future medical expenses. The Plan gives a covered Employee greater control over how health care benefits are used. An HDHP satisfies certain statutory requirements with respect to minimum deductibles and maximum out-of-pocket expenses for both Single Coverage and Family Unit coverage. These minimum deductibles and limits for out-of-pocket expenses limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

*Only those Employees covered under a qualified HDHP are eligible to contribute to an HSA.*

*If a Plan Participant has coverage under this Plan and another plan, the other plan would also need to be a qualified HDHP in order for the Plan Participant to contribute to an HSA.*

## DEDUCTIBLES/COPAYMENTS/COINSURANCE PAYABLE BY PLAN PARTICIPANTS

Deductibles/Copayments/Coinsurance are dollar amounts that the Plan Participant must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Plan Participant. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges (except for charges that are not subject to the deductible). All deductibles are based on a Calendar Year beginning January 1 and ending on December 31. Each **January 1st**, a new deductible amount is required.

*Note: Deductibles will apply towards the maximum out-of-pocket amount.*

### Non-Embedded Deductible

This Plan has a "**non-embedded deductible"** which means:

**Single Coverage:** Covered Employees **with Employee only coverage** must meet the Single Coverage deductible amount as shown in the Schedule of Benefits.

**Family Coverage:** Covered Employees **with covered Dependents** must meet the Family Coverage deductible amount, as shown in the Schedule of Benefits, without regard to which covered family member incurred the expenses.

A "Copayment" is a set fee paid by a Plan Participant each time a particular service is used. Not all services have copayments, and copayments only apply if expressly stated.

*Copayments, including Prescription Drug copayments, will accrue toward the maximum out-of-pocket amount.*

**Coinsurance** is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Schedule of Benefits and is the Plan Participant's responsibility. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

Coinsurance is payable by the Plan Participant until the maximum out-of-pocket amount, as shown in the Schedule of Benefits, is reached. Then Covered Charges incurred will be payable by the Plan at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the remainder of the Calendar Year.

**HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**
**MEDICAL BENEFITS SCHEDULE**

| HIGH DEDUCTIBLE HEALTH PLAN (HDHP) | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health | First Choice Health | |
| Claims should be received by the Claims Administrator within *365 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.<br><br>The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion. | | | |
| **MAXIMUM CALENDAR YEAR BENEFIT AMOUNT** | Unlimited | | |
| **DEDUCTIBLE, PER CALENDAR YEAR** | | | |
| Single Coverage | $1,500 | | |
| Family Coverage | $3,000 | | |
| This Plan has a "**non-embedded deductible"** which means:<br>**Single Coverage:** Covered Employees **with Employee only coverage** must meet the Single Coverage deductible amount as shown above.<br>**Family Coverage:** Covered Employees **with covered Dependents** must meet the Family Coverage deductible amount, as shown above, without regard to which covered family member incurred the expenses. | | | |
| **INPATIENT HOSPITAL COPAYMENT** | | | |
| Per Confinement until the maximum out-of-pocket amount is met | $200 | | |
| **MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR** | | | |
| Single Coverage | $3,750 | $6,500 | $6,500 |
| Family Coverage<br>per Plan Participant * | $7,500<br>$3,750 | $13,000<br>$6,500 | $13,000<br>$6,500 |
| * *Note: The maximum out-of-pocket amount for any one individual with Family Coverage will not exceed $3,750 per Calendar Year for Allowable Charges when utilizing a Preferred Provider, or $6,500 per Calendar Year for Allowable Charges when utilizing a Network or Non-Network Provider.* | | | |
| ***The Preferred Network Provider maximum out-of-pocket amount does not cross accumulate with the Network Provider and Non-Network Provider maximum out-of-pocket amounts, however the Network Provider and the Non-Network Provider maximum out-of-pocket amounts cross-accumulate with each other.*** | | | |
| This Plan is an "**embedded maximum out-of-pocket amount"** which means:<br>**Single Coverage:** Covered Employees **with Employee only coverage** must meet the Single Coverage maximum out-of-pocket amount as shown above.<br>**Family Coverage:** Covered Employees **with covered Dependents** must meet the Family Coverage amount as shown above, without regard to which covered family member incurred the expenses. | | | |
| The Plan will pay the designated percentage of Covered Charges until the maximum out-of-pocket amount is reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. | | | |
| The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%.<br>➢ Amounts over the Allowable Charge<br>➢ Prescription drug Dispense As Written (DAW) penalties, discounts, coupons, Pharmacy discount programs or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs. | | | |

| HIGH DEDUCTIBLE HEALTH PLAN (HDHP) | PREFERRED NETWORK PROVIDERS (highest reimbursement level)<br>Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health | NETWORK PROVIDERS<br>First Choice Health | NON-NETWORK PROVIDERS |
|---|---|---|---|
| **COVERED SERVICES** | | | |
| **Note: The maximums listed below are the total for Preferred Network Provider, Network Provider and Non-Network Provider expenses. For example, if a maximum of 60 days is listed more than once under a service, the Calendar Year maximum is 60 days total which may be split between Preferred Network, Network, and Non-Network Providers.** | | | |
| Inpatient Hospital Services<br>Room & Board | 80% after deductible and Inpatient Hospital Copayment* (limited to the semiprivate room rate) | 60% after deductible and Inpatient Hospital Copayment* (limited to the semiprivate room rate) | 60% after deductible and Inpatient Hospital Copayment* (limited to the semiprivate room rate) |
| Intensive Care Unit (ICU) | 80% after deductible and Inpatient Hospital Copayment* (limited to the Hospital's ICU rate) | 60% after deductible and Inpatient Hospital Copayment* (limited to the Hospital's ICU rate) | 60% after deductible and Inpatient Hospital Copayment* (limited to the Hospital's ICU rate) |
| *The Inpatient Hospital Copayment applies per confinement until the maximum out-of-pocket amount is met. | | | |
| Outpatient Hospital Services/ Ambulatory Surgical Center | 80% after deductible | 60% after deductible | 60% after deductible |
| Emergency Room | 80% after deductible | | |
| **Skilled Nursing Facility** | 80% after deductible (limited to the semiprivate room rate) | | |
| **Rehabilitation Services**<br>Inpatient | 80% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* |
| Outpatient (includes occupational therapy, physical therapy and speech therapy) | 80% after deductible | 60% after deductible | 60% after deductible |
| *The Inpatient Hospital Copayment applies per confinement until the maximum out-of-pocket amount is met. | | | |
| **Urgent Care Services**<br>Facility | 80% after deductible | 60% after deductible | 60% after deductible |
| Office Visits | 100% after deductible and $25 copayment per visit | 100% after deductible and $50 copayment per visit | 100% after deductible and $50 copayment per visit |
| **Note:** The copayment will be applied to the office visit only. Any associated charges will be paid per normal Plan provisions. | | | |
| **Physician Services**<br>Inpatient | 80% after deductible | 60% after deductible | 60% after deductible |
| Office visits | 100% after deductible and $25 copayment per visit | 100% after deductible and $50 copayment per visit | 100% after deductible and $50 copayment per visit |
| Surgery | 80% after deductible | 60% after deductible | 60% after deductible |
| **Note:** The copayment will be applied to the office visit only. Any associated charges will be paid per normal Plan provisions. | | | |
| **SCL Health Right Care –** Video Visits | 100% after deductible and $25 copayment per visit | | |
| **Note:** Refer to the SCL Health Right Care benefit shown in the Covered Charges section for more information regarding this benefit. | | | |
| **Ambulance Service** | 80% after deductible | | |

| HIGH DEDUCTIBLE HEALTH PLAN (HDHP) | PREFERRED NETWORK PROVIDERS (highest reimbursement level)<br>Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health | NETWORK PROVIDERS<br>First Choice Health | NON-NETWORK PROVIDERS |
|---|---|---|---|
| **Chemotherapy and Radiation Treatment** | 80% after deductible | 60% after deductible | 60% after deductible |
| **Wig** (after chemotherapy or radiation treatment) | 80% after deductible<br>$500 Lifetime maximum | 60% after deductible<br>$500 Lifetime maximum | 60% after deductible<br>$500 Lifetime maximum |
| **Diagnostic X-ray and Lab** | 80% after deductible | 60% after deductible | 60% after deductible |
| **Imaging Services** (CT/PET scans, MRIs) | 80% after deductible | 60% after deductible | 60% after deductible |
| **Note:** *Charges in connection with 3-D mammography will be a Covered Charge.* | | | |
| **Durable Medical Equipment, Orthotics and Prosthetics** | 80% after deductible | | |
| **Home Health Care** | 80% after deductible | | |
| **Hospice Care** | 80% after deductible | | |
| **In Vitro Fertilization** | 80% after deductible<br>Lifetime maximum of two implantation attempts | 60% after deductible<br>Lifetime maximum of two implantation attempts | 60% after deductible<br>Lifetime maximum of two implantation attempts |
| **Jaw Joint/TMJ** | 80% after deductible | 60% after deductible | 60% after deductible |
| **Mental Disorders and Substance Abuse Treatment**<br>Inpatient Services<br>Facility | 80% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* |
| Physician | 80% after deductible | 60% after deductible | 60% after deductible |
| Outpatient Services<br>Facility services | 80% after deductible | 60% after deductible | 60% after deductible |
| Physician visits | 80% after deductible | 60% after deductible | 60% after deductible |
| Office visits | 100% after deductible and $25 copayment per visit | 100% after deductible and $50 copayment per visit | 100% after deductible and $50 copayment per visit |
| *The Inpatient Hospital Copayment applies per confinement until the maximum out-of-pocket amount is met.<br><br>**Note:** The Office visit copayment will be applied to the office visit only. Any associated charges will be paid per normal Plan provisions. | | | |
| **Organ Transplants** | 80% after deductible | | |

| HIGH DEDUCTIBLE HEALTH PLAN (HDHP) | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | **Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health** | **First Choice Health** | |
| **Pregnancy**<br>Initial office visit | 100% after deductible and $25 copayment | 100% after deductible and $50 copayment | 100% after deductible and $50 copayment |
| Prenatal / postnatal care | 80% after deductible | 60% after deductible | 60% after deductible |
| Routine prenatal office visits | 40% of Covered Charges of the global maternity fee will be payable at 100%, deductible waived; thereafter, 80% after deductible, **OR** if billed separately, 100% of the routine prenatal office visits will be payable at 100%, deductible waived | 60% after deductible | 60% after deductible |
| Inpatient Hospitalization | 80% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* | 60% after deductible and Inpatient Hospital Copayment* |
| All other related services | Payable per normal Plan provisions | Payable per normal Plan provisions | Payable per normal Plan provisions |
| *The Inpatient Hospital Copayment applies per confinement until the maximum out-of-pocket amount is met.<br><br>**Note:** Refer to the Coverage of Pregnancy benefit listed in the Covered Charges section for more information regarding routine prenatal office visits. | | | |
| **Routine Well Newborn Nursery Care** (while Hospital confined at birth) | 80% after deductible | 60% after deductible | 60% after deductible |
| **PREVENTIVE CARE** | | | |
| **Please note: Preventive care is care by a Physician that is not treatment for an Illness or Injury. The preventive care benefits as shown below will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.**<br><br>**Please consult with your attending Physician at the time services are rendered as to whether or not the services provided will be considered preventive care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) grades a and b recommendations or the Women's Preventive Services as required by the Health Resources and Services Administration (HRSA).**<br><br>**Otherwise, services rendered which are not considered or billed by the attending Physician as preventive care (as stated above) will be payable under normal Plan provisions at the same benefit level as any other Illness or Injury.** | | | |
| **Preventive Well Adult Care** [1]<br>Age 18 and over | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |
| [1] **Preventive care services** will be subject to frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) *unless otherwise specifically stated in this Schedule of Benefits,* and which can be located using the following website:<br><br>http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/; | | | |

| HIGH DEDUCTIBLE HEALTH PLAN (HDHP) | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health | First Choice Health | |

**Preventive Well Care services will include, but will not be limited to, the following preventive services:**
Physical exams; office visits; and lab and x-ray services.

**Note**: If applicable, this Plan may comply with a state vaccine assessment program.

**Women's Preventive Services** will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Schedule of Benefits,* and which can be located using the following websites:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/; and
http://www.hrsa.gov/womens-guidelines

**Women's Preventive Services, will include, but will not be limited to, the following routine services:**
Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity ***(and does not include birthing classes)***, preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

*Note: Charges in connection with 3-D mammography will be a Covered Charge.*

| | | | |
|---|---|---|---|
| **Preventive Well Child Care**[4] Birth through 7 years | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |

[4] The Allowable Charges for preventive Well Child Care. Coverage includes one visit per provider at the intervals stated below.

**Preventive Well Child Care means Physician-delivered or Physician-supervised services for:** History, physical exam, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule according to the U.S. Preventive Services Task Force (USPSTF) and which can be located using the following website:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

and not to exceed 10 visits from birth up to age 2, and one visit annually thereafter up to age 8.

The benefits described above are limited to one visit payable to one provider for all of the services provided at each visit and must be delivered by a Physician or a health care professional supervised by a Physician.

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

| | | | |
|---|---|---|---|
| **Preventive Well Child Care**[5] Age 8 through 17 years | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |

[5] Preventive services will be subject to frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and which can be located using the following websites:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

**Preventive Well Child Care services will include, but will not be limited to, the following routine services:**
Physical exams, office visits, Pap smears, and lab and x-ray services.

| HIGH DEDUCTIBLE HEALTH PLAN (HDHP) | PREFERRED NETWORK PROVIDERS (highest reimbursement level) | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|---|
| | Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health | First Choice Health | |
| **Other Preventive Care** | | | |
| **(Preventive) Colonoscopy/ Sigmoidoscopy** | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |
| **Diabetic Education** | 100%, deductible and copayment waived 10 visits maximum per Calendar Year | 60% after deductible 10 visits maximum per Calendar Year | 60% after deductible 10 visits maximum per Calendar Year |
| **Immunizations – All ages** | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |
| **Nutritional Education Counseling** | 100%, deductible and copayment waived 10 visits maximum per Calendar Year | 60% after deductible 10 visits maximum per Calendar Year | 60% after deductible 10 visits maximum per Calendar Year |
| **Obesity Interventions** (Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m2 or higher) | 100%, deductible and copayment waived 26 visits maximum per Calendar Year | 60% after deductible 26 visits maximum per Calendar Year | 60% after deductible 26 visits maximum per Calendar Year |
| **Note:** Refer to the Obesity Interventions benefit listed in the Covered Charges section for more information regarding Obesity Interventions. | | | |
| **Prostate Screening**[2] | 100%, deductible and copayment waived | 60%, deductible waived | 60%, deductible waived |
| [2]Frequency limits for prostate screening: Age 50 and over..... annually | | | |
| **Tobacco/Nicotine Cessation Counseling** | 100%, deductible and copayment waived | 60% after deductible | 60% after deductible |
| **Freedom from Smoking** | 100% after $50 copayment*, deductible waived Limited to one course per Calendar Year per Plan Participant | | |
| *The Freedom from Smoking Copayment will be reimbursed by the Plan after completion of the course. Refer to the Covered Charges section for more information regarding reimbursement and the Freedom from Smoking benefit. | | | |
| **Private Duty Nursing - Outpatient** *(only available through Home Health Care)* | 80% after deductible | | |
| **Spinal Manipulation Chiropractic and Massage Therapy** | 50% after deductible 24 visits combined maximum per Calendar Year | | |
| **All Other Covered Charges** | 80% after deductible | 60% after deductible | 60% after deductible |

**PRESCRIPTION DRUG BENEFIT HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**

**RETIREES AGE 65 AND/OR ELIGIBLE FOR MEDICARE ARE NOT ELIGIBLE FOR THIS PRESCRIPTION DRUG BENEFIT**

***The Coordination of Benefits provision will not apply to the Prescription Drug Benefits.***

If applicable, this Plan will make a retroactive adjustment to a claim based on a discount, coupon, Pharmacy discount program or similar arrangement provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.

**Prescription Drug expenses under the HDHP Plan are subject to the HDHP Plan medical deductible amount *(except Preventive prescriptions),* and apply to the medical maximum out-of-pocket amount.**

**Mandatory - *mi*Rx MAIL ORDER PHARMACY PROGRAM**
***miRx Pharmacy copayments for maintenance medications – 30, 60, or 90-day supply per prescription***

| | |
|---|---|
| Generic drugs | $5/30 days, after medical deductible<br>$10/90 days, after medical deductible |
| Preferred Brand Name drugs | $30/30 days, after medical deductible<br>$60/60 days, after medical deductible<br>$90/90 days, after medical deductible |
| Non-Preferred Brand Name drugs | $45/30 days, after medical deductible<br>$90/60 days, after medical deductible<br>$135/90 days, after medical deductible |
| Preventive medications | Subject to the above copayments;<br>*medical deductible does not apply* |

Prescriptions requiring compounding will need to be utilized under the Retail Pharmacy Program, at specific compounding Pharmacies.

**Mandatory – *mi*Rx SPECIALTY PHARMACY PROGRAM**
***miRx Specialty Pharmacy copayments - Limited to a 30 day supply per prescription***

| | |
|---|---|
| Generic | $75 after medical deductible |
| Preferred Brand Name | $125 after medical deductible |
| Non-Preferred Brand Name | $125 after medical deductible |

**RETAIL PHARMACY PROGRAM - *Administered by Magellan Rx***
***Retail Pharmacy copayments - Limited to a 30 day supply per prescription***

| | |
|---|---|
| Generic | $5 after medical deductible |
| Preferred Brand Name | 20% after medical deductible<br>($30 minimum and $60 maximum) |
| Non-preferred Brand Name | 40% after medical deductible<br>($50 minimum and $100 maximum) |

**Please Note:** Plan Participants are encouraged to utilize the *mi*Rx Pharmacy, as a community Pharmacy, for retail medications that are prescribed for short-term acute conditions; but it is not mandatory. However, for convenience, if the Plan Participant utilizes the *mi*Rx community Pharmacy for retail medications, they will process based on the copayment and deductibles for retail Pharmacy.

**All medications will be dispensed as a Generic Drug, if available, instead of its brand name product.** *If a Brand Name Drug is dispensed when a Generic Drug equivalent is available, the Plan Participant will be responsible for the Brand Name Drug copayment plus the difference in cost between the Brand Name Drug and the Generic Drug. If there is no Generic Drug available or the Physician prescribes a Brand Name Drug over the Generic Drug **due to medical necessity**, the applicable Brand Name Drug copayment will apply. Prescription drug DAW (Dispense As Written) penalties do not apply toward the maximum out-of-pocket amount.*

**For more information regarding the Prescription Drug benefits, refer to the separate Prescription Drug Benefit section under this Plan.**

## MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

Claims should be received by the Claims Administrator within *365 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

**DEDUCTIBLE – (Applicable only to the Standard Health Plan)**

**Deductible Amount.** This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Plan Participant must meet the deductible shown in the Schedule of Benefits.

*This amount will apply toward the maximum out-of-pocket amount.*

**Deductible Three Month Carryover.** Covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

The Three Month Carryover provision will not apply to the Prescription Drug deductible.

**Family Unit Limit**. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

**DEDUCTIBLES/COPAYMENTS/COINSURANCE PAYABLE BY PLAN PARTICIPANTS –**

**(Applicable only to the High Deductible Health Plan (HDHP))**

**Deductible Amount.** This is an amount of Covered Charges for which no benefits will be paid. In a Calendar Year, a covered Employee with Employee only coverage must meet the *Single Coverage* deductible, as shown in the Schedule of Benefits, before benefits will be paid. For covered Employees with covered Dependents, the *Family Coverage* deductible, as shown in the Schedule of Benefits, must be met before benefits will be paid.

The deductible *will apply* to the maximum out-of-pocket amount.

**BENEFIT PAYMENT AND COINSURANCE**

Each Calendar Year, benefits will be paid for the Covered Charges of a Plan Participant after the Plan Participant has met his or her Calendar Year deductible and any applicable copayment(s).

Benefit payment made by the Plan will be at the percentage rate shown in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

Once the Plan has made the applicable benefit payment, the remaining percentage owed is the Plan Participant's "Coinsurance" responsibility. For example, if the Plan's reimbursement rate is 80%, the Plan Participant's responsibility (or coinsurance) is 20%. Coinsurance *does not* include any deductible or copayment amounts. Coinsurance *will apply* to the maximum out-of-pocket amount.

## MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable by the Plan at the percentages shown each Calendar Year until the maximum out-of-pocket amount shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

Before benefits can be paid at 100%, a covered Employee with Employee only coverage must meet the *Single Coverage* maximum out-of-pocket amount shown in the Schedule of Benefits. For covered Employees with covered Dependents, the *Family Coverage* maximum out-of-pocket amount must be met before benefits will be paid. However, if the maximum out-of-pocket amount is embedded, a covered family member only needs to satisfy per Plan Participant maximum out-of-pocket amount, not the entire Family Coverage amount

## COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

**(1)** **Hospital Care**. The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be payable at the average private room rate of that facility.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

**(2)** **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness, and will be payable as stated in the Schedule of Benefits.

**Note: Routine prenatal office visits will be payable as stated under the Pregnancy benefit as shown in the Schedule of Benefits section.**

The following services will continue to be payable per normal Plan provisions:

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of Pregnancy (as defined under this Plan), delivery, and post-partum care.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**(3)** **Skilled Nursing Facility Care**. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

**(a)** The patient is confined as a bed patient in the facility;

**(b)** The confinement starts immediately following a Hospital confinement or a period of Home Health Care Utilization;

**(c)** The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

**(d)** The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

**(4)** **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for multiple surgical procedures are subject to the following provisions in the absence of a negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement:

**(a)** If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed each additional procedure performed through the same incision or during the same operative session. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

**(b)** If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge percentage allowed for that procedure; and

**(c)** If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed **25%** of the surgeon's Allowable Charge.

**(5)** **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

**(a)** **Inpatient Nursing Care**. Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

**(b)** **Outpatient Nursing Care**. Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a shift-basis is not covered.

**(6)** **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

**(7)** **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

**(8)** **Other Medical Services and Supplies**. These services and supplies not otherwise included in the items above are covered as follows:

**(a)** **Acupuncture.** Acupuncture services by a licensed acupuncturist.

**(b)** **Ambulance.** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided.

**(c)** **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

**(d)** **Breast pump, breast pump supplies, lactation support and counseling**.

**Breast pump, breast pump supplies**
A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.

- For female Plan Participants using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.

- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered every three Calendar Years following a subsequent Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Schedule of Benefits section.

**Note:** *Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable at the Preferred Network Provider benefit level only for the purposes of this benefit.*

*The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.*

**Lactation support and counseling**
Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Plan Participants for the duration of the breast feeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

**Note:** *Payment will be made for Covered Charges for lactation support and counseling under the Preventive Care benefits in the Schedule of Benefits section at the higher Preferred Network Provider payment for Non-Network Provider services for the purposes of this benefit.*

**(e)** **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery or other cardiac condition; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

**(f)** **Chemotherapy or radiation treatment with radioactive substances**. The materials and services of technicians are included.

Pre-notification of services, by the Plan participant, for cancer treatment services is strongly recommended. The pre-notification request must include the Plan participant's plan of care and treatment protocol. Pre-notification of services should occur at least 7 days prior to the initiation of treatment.

For pre-notification of services, call CareLink at the following numbers:
Toll Free in the United States: (866) 894-1505

*A pre-notification of services by CareLink is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan, including but not limited to medical necessity, exclusions and limitations in effect when services are received. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Claims Procedure section.*

**(g)** **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained web site www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial.
- The Plan Participant meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
- The Plan Participant has signed an Informed Consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent;
- The trial is approved by the Institutional Review Board of the institution administering the treatment.
- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Plan Participant would receive whether or not he or she were participating in a clinical trial.

***Routine patient services do not include, and reimbursement will not be provided for:***

- The investigational service, supply, or drug itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Plan Participant (e.g. monthly CT scans for a condition usually requiring only a single scan);
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g. device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

**(h)** Initial **contact lenses** or glasses required following cataract surgery.

**(i)** **Contraceptives.** All Food and Drug Administration approved contraceptive methods when prescribed by a Physician, including but not limited to, intrauterine devices (IUDs), implants, and injections, and any related Physician and facility charges (including complications), and will be payable under the Preventive Care benefits as shown in the Schedule of Benefits section.

Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Plan Participants.

**(j)** **Diabetic Education.** Inpatient and outpatient self-management training and education for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, up to the limits stated in the Schedule of Benefits.

**(k)** **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Plan Participant;
- Does NOT have significant non-medical uses (i.e. air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Plan Participant's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Plan Participant.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Plan Participant if the Plan Participant were to purchase the item directly. The acquisition cost of the item may be prorated over a six-month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every four Calendar Years.

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Plan Participant's medical condition occurs sooner than the four Calendar Year period.

- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Plan Participant's medical condition occurs sooner than the four Calendar Year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the four Calendar Year limit.

*The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support medical necessity.*

**(l)** **Freedom from Smoking.** This is a professionally led seven-week, eight session course (two sessions in week four). The first session will help the Plan Participant make the decision as to whether this course is for them. Manuals and fees are included in this $50 course. *Refer to the following website for more information regarding this course:*

https://www.svh-mt.org/calendar/community-event/freedom-from-smoking/

***Proof of completion of the course must be provided to the Claims Administrator in order to receive reimbursement of the copayment amount as shown in the Schedule of Benefits.***

**(m)** **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and are required for the administration of a home infusion therapy regimen when ordered by and are part of a formal written plan prescribed by a Physician. The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor a response to therapy.

**(n)** **Infertility.** Care, supplies and services for the diagnosis and treatment of Infertility. Covered Charges for In Vitro Fertilization will be payable up to the limits as stated in the Schedule of Benefits.

**(o)** **Injury to or care of the mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth. This repair must be made within six months from the date of an accident.

  Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

**(p)** **Jaw joint conditions.** Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome.

**(q)** **Laboratory studies.** Covered Charges for diagnostic lab testing and services.

**(r)** **Massage therapy.** Care and treatment in connection with massage therapy by a health care provider acting within the scope of his or her license, and will be payable up to the combined limits as stated in the Schedule of Benefits.

**(s)** **Mental Disorders and Substance Abuse.** Covered Charges will be payable for care, supplies and treatment of Mental Disorders and Substance Abuse.

**(t)** **Naturopathy.** Naturopathic services by a licensed naturopath or Naturopathic Doctor (N.D.)

**(u)** **Nutritional Education Counseling.** Care, treatment, and services when provided by a healthcare provider acting within the scope of his or her license, up to the limits as stated in the schedule of benefits.

This benefit will not include weight loss medications or nutritional supplements whether or not prescribed by a Physician.

**(v)** **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act preventive services requirement. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Plan Participants age 18 and older with a body mass index (BMI) of 30 kg/m2 or higher.

Intensive, multicomponent behavioral interventions for weight management will include group and individual sessions of high intensity (limited up to 26 visits maximum per Calendar Year) encompassing the following:

- Behavioral management activities such as setting weight loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes

Non-surgical care and treatment and Physician prescribed weight loss medications **will not** be a Covered Charge except as may be specifically described as a benefit by this Plan.

This Plan **will not** cover nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

**(w)** **Occupational therapy** by a health care provider acting within the scope of his or her license. Therapy must be ordered by a Physician, result from an Injury or Sickness that occurred while covered under the Plan and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

**(x)** **Organ transplants.** Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant that is not considered experimental or investigational, subject to the following criteria:

- The transplant must be performed to replace an organ or tissue.

- **Organ transplant benefit period.** A period of 365 continuous days beginning five days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.

- **Organ procurement limits.** Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Plan participant. When the donor has medical coverage, his or her Plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's Plan. Donor charges include those for:

  **(i)** Evaluating the organ or tissue;

  **(ii)** Removing the organ or tissue from the donor; and

**(iii)** Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed.

**Note:** Expenses related to the purchase of any organ will not be covered.

**As soon as reasonably possible, but in no event more than ten days after a Plan participant's attending Physician has indicated that the Plan participant is a potential candidate for a transplant, the Plan participant or his or her Physician must contact CareLink at (866) 894-1505.**

There is no obligation to the Plan Participant to use a Center of Excellence facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Preferred Network Provider, Network Provider or a Non-Network Provider and whether or not a Center of Excellence facility is utilized.

A **Center of Excellence** is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Plan participant may contact CareLink to determine whether or not a facility is considered a Center of Excellence.

**Special Transplant Benefits**

Under certain circumstances, there may be special transplant benefits available when the group health Plan and/or a Plan participant participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact CareLink at (866) 894-1505 as soon as reasonably possible so that the Plan can advise the Plan participant or his or her Physician of the transplant benefits that may be available.

**Transplant Exclusions**

Coverage for the following procedures, when Medically Necessary, may be provided under the regular medical benefits provision under this Plan, subject to all Plan provisions and applicable benefit limitations as stated in the Schedule of Benefits:

- Cornea transplantation
- Skin grafts
- Artery
- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

**(y)** **Orthotic appliances.** The initial purchase, fitting, repair and replacement of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness that occurred while covered under the Plan.

**(z)** **Physical therapy** by a health care provider acting within the scope of his or her license. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function.

**(aa)** **Prescription** Drugs (as defined).

**(bb)** **Preventive Care/Routine Well Care.** Covered Charges under Medical Benefits are payable for Preventive Care/Routine Well Care as described in the Schedule of Benefits.

Preventive Care/Routine Well Care is care by a Physician that is not for an Injury or Illness and will only apply in the absence of a diagnosis for a medical condition, including a recurring condition or for medication.

Consult with your Physician at the time services are rendered as to whether or not the services provided will be considered Preventive Care/Routine Well Care as mandated under the Affordable Care Act (ACA), U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations or the Women's Preventive Services as required by the Health Resources and Services Administration (HRSA).

Otherwise, services rendered which are not considered or billed by the Physician as Preventive Care/Routine Well Care (as stated above) will be subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

**(cc)** **Prosthetic devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices which replace body parts provided that the loss occurred while covered under the Plan.

**(dd)** **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

**(i)** reconstruction of the breast on which a mastectomy has been performed,

**(ii)** surgery and reconstruction of the other breast to produce a symmetrical appearance, and

**(iii)** coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the Plan Participant.

**(ee)** **SCL Health Right Care – Video Visits.** SCL Health Right Care Video Visits, available to any covered Employee or covered Spouse in Colorado and Montana, are the most convenient way to get quick, affordable care for many common health issues like allergies, coughs, rashes, and pink eye.

For video visits, the Plan Participant will meet an SCL Health Physician from his or her smartphone or tablet and will receive additional care instructions as if they were in the provider's office. Video visits can be scheduled with the Plan Participant's established care provider or with the next available provider.

*Note: This benefit allows for video visits only, "e-visits" are not a Covered Charge.*

For more information, visit: *https://www.sclhealth.org/rightcare/video-visit/*, or log into https://mychart.sclhealth.org.

**(ff)** **Sleep disorders.** Medically Necessary care and treatment for sleep disorders.

**(gg)** **Speech therapy** by a health care provider acting within the scope of his or her license. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person born while covered under the Plan; (ii) an Injury; or (iii) a Sickness.

**(hh)** **Spinal Manipulation/Chiropractic services** by a health care provider acting within the scope of his or her license, subject to the combined limits stated in the Schedule of Benefits.

**(ii)** **Sterilization** procedures. Sterilization procedures for female Plan Participants will be payable as shown under the Preventive Care benefits as shown in the Schedule of Benefits section.

The following charges will be payable per normal Plan provisions:

- Hysterectomies; and
- Sterilization procedures for male Plan Participants.

**(jj)** **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

**(kk)** **Telehealth.** Telehealth services will be a Covered Charge subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person, *except SCL Health Right Care services payable as specified in the Schedule of Benefits.*

**(ll)** **Tobacco/Nicotine Cessation Counseling**. Covered Charges include tobacco/nicotine cessation counseling visits when rendered by a Physician to aid nicotine withdrawal and will be payable up to the limits as stated in the Schedule of Benefits. *Tobacco/nicotine cessation products are covered under the Prescription Drug Benefits of this Plan.*

**(mm)** **Well Newborn Nursery/Physician Care.**

**Charges for Routine Nursery Care**. Routine well newborn nursery care is room, board and other normal care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent is a Plan Participant who was covered under the Plan at the time of the birth.

The benefit is limited to the Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth. **Coverage of routine nursery care will be applied toward the Plan of the newborn child.**

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Charges for Routine Physician Care.** The benefit is limited to the Allowable Charges made by a Physician, including circumcision, for the newborn child while Hospital confined as a result of the child's birth.

**Charges for covered routine Physician care will be applied toward the Plan of the newborn child.**

**(nn)** **Wig.** Covered Charges for the ***purchase*** of a wig following chemotherapy treatment or radiation treatment, payable up to the limits as stated in the Schedule of Benefits.

**(oo)** **X-rays**. Charges for diagnostic x-rays and imaging services.

## CARE MANAGEMENT SERVICES

### UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Plan Participants in understanding and becoming involved with their diagnosis and medical plan of care, and advocates patient involvement in choosing a medical plan of care. Utilization Management begins with the pre-notification process.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Plan Participant receives treatment, services and/or supplies. *A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Claims Procedure section.*

**Examples of when the Physician and Plan Participant should contact CareLink prior to treatment include:**

- Inpatient admissions to a Hospital
- Inpatient admissions to free-standing chemical dependency, mental health, and rehabilitation facilities
- Cancer treatment plan of care, administered on an inpatient or outpatient basis
- Inpatient or outpatient surgeries relating to, but not limited to, hysterectomies, back surgery, or bariatric surgery.
- Outpatient services as follows:
    - Dialysis;
    - Genetic testing;
    - Injectables;
    - Home Health Care;
    - Hospice;
    - Durable Medical Equipment (DME) over $2,000

***All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.***

The Physician or Plan Participant should notify CareLink at least seven days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number and address of the Plan Participant
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The plan of care, treatment protocol and/or informed consent, if applicable

If there is an emergency admission to the Hospital, the Plan Participant, Plan Participant's family member, Hospital or attending Physician should notify CareLink within two business days after the admission.

Hospital Observation Room stays in excess of 23 hours are considered an admission for purposes of this program, therefore CareLink should be notified.

**Contact the Care Management administrator at:**

CareLink (406) 245-3575 or (866) 894-1505

## PRE-ADMISSION AND POST DISCHARGE CARE CALLS

A CareLink nurse will contact the Plan Participant to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan and post-discharge follow-up.

## PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

The Plan Administrator or its designee, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within 15 days of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Plan Administrator or its designee will notify the Plan Participant or the Physician. The time for making a determination on the request will be deferred from the date that the additional information is requested until the date that the information is received.

The Physician and Plan Participant will be provided notice of the Plan's determination. If the pre-authorization request is denied, written notice will provide the reason for the adverse pre-notification determination.

As a reminder, a pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within 30 days of the receipt of the adverse pre-notification determination and include a statement as to why the Plan Participant disagrees with the adverse pre-notification determination. The Plan Participant may include any additional documentation, medical records, and/or letters from the Plan Participant's treating Physician(s). The request for reconsideration should be addressed to:

CareLink
Attn: Appeals
7400 West Campus Rd.
New Albany, OH 43054

The Plan Administrator or its designee will perform the reconsideration review. The Plan Administrator or its designee will review the information initially received and any additional information provided by the Plan Participant, and determine if the pre-notification determination was appropriate. If the adverse pre-notification determination was based upon the medical necessity, the Experimental/ Investigational nature of the treatment, service or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. Written or electronic notice of the determination upon reconsideration will be provided within 30 days of the receipt of the request for reconsideration.

## CASE MANAGEMENT

If a Plan Participant has an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor this Plan Participant, and to work with the attending Physician and Plan Participant to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the

Plan Participant, the family, and the attending Physician in order to assist in coordinating the plan of care approved by the Plan Participant's attending Physician and the Plan Participant.

This plan of care may include some or all of the following:

- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

**Case Management is not a requirement of the Plan. There are no reductions of benefits or penalties if the Plan Participant and family choose not to participate.**

**Each treatment plan is individualized to a specific Plan Participant and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Plan Participant and the attending Physician.**

## DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is a permanent 20+ hour Employee who performs all of the duties of his or her job with the Employer on a regular basis.

**Allowable Charge**. Allowable Charge means the amount for a treatment, service or supply that is the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement.

For Covered Charges rendered by a Physician, Hospital or ancillary provider in a geographic area where applicable law or a governmental authority directs the amount to be paid, the Allowable Charge will mean the amount established by applicable law or governmental authority for the Covered Charge.

In the absence of such network arrangement, negotiated arrangement, controlling law or governmental directive that establishes the amount to be paid, the Allowable Charge will mean: (i) an amount that does not exceed billed charges for the same treatment, service or supply furnished in the same geographic area by a provider of like services; and (ii) a reasonable amount established solely and exclusively by the Plan Administrator or its designee; and (iii) For out-of-network air ambulance claims, an amount equivalent to 250% of the Medicare reimbursement for transportation provided; and (iv) (except in circumstances where a provider network arrangement, other discounting or negotiated arrangement is established), an amount that does not exceed 200% of the Medicare allowed amount, if any.

In the event the Non-Network Provider disputes the Plan's Allowable Charge for any claim subject to the No Surprises Act (NSA) through the Independent Dispute Resolution (IDR) process, the Allowable Charge may be determined by a Certified IDR Entity.

**Ambulatory Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Calendar Year** means January 1st through December 31st of the same year.

**Certified Independent Dispute Resolution (IDR) Entity** means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Complications of Pregnancy.**

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

**Covered Charge(s)** means those Medically Necessary services or supplies that are covered under this Plan.

**Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Dentist** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

**Emergency Services** means the following:

**(1)** An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency; and

**(2)** Within the capabilities of the staff and facilities available at the Hospital (including Hospital outpatient department that provides emergency services) or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to a Medical Emergency, Emergency Services shall also include an item or service provided by a Non-Network Provider (regardless of the department of the Hospital in which items or services are furnished) after the Plan Participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Plan Participant is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Network Provider.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

**Employer** is City of Billings.

**Enrollment Date** is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

**Experimental and/or Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan.

The Plan Administrator will be guided by the following principles:

**(1)** If the drug or medical device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or medical device is furnished; or

**(2)** If the drug, medical device, medical treatment or procedure, or the patient informed consent document utilized with the drug, medical device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

**(3)** Except as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Charges section, if Reliable Evidence shows that the drug, medical device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

**(4)** If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, medical device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

A medical device approved by the Food and Drug Administration may require post-approval study for 3 to 5 years to evaluate long-term safety and effectiveness and will continue to be considered Experimental and/or Investigational until the study period has been completed and results published.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

**Family Unit** is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

**Foster Child** means a child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation.

A covered Foster Child is <u>not</u> a child temporarily living in the covered Employee’s home; one placed in the covered Employee’s home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

**Home Health Care Agency** is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis;; and it must specify the type and extent of home health care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

**Hospital** is an institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it has received accreditation from the Commission of Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC), or if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

**Independent Freestanding Emergency Department** means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Centers or Clinics.

**Infertility** means incapable of producing offspring.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Intensive Care Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Late Enrollee** means an Employee or qualifying Dependent who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person of and managing the property and rights of a minor child.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medically or Dentally Necessary** care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**Medicare** is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

**Morbid Obesity** is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a Body Mass Index (BMI) of 40+. The BMI is a factor produced by dividing a person’s weight (in kilograms) by his or her height squared (in meters).

**Network Provider and *Preferred Network Provider*/Network Facility and *Preferred Network Facility*** means a healthcare institution or healthcare provider who have by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Non-Network Provider/Non-Network Facility** means a healthcare institution or healthcare provider who do not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

**Outpatient Care** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Naturopathic Doctor (N.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means City of Billings Employee Benefit Plan, which is a benefits plan for certain employees of City of Billings and is described in this document.

**Plan of Care** is a written plan that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

**Plan Participant** is any Employee, Retiree or Dependent who is covered under this Plan.

**Plan Year** is the 12-month period beginning on January 1st and ending December 31st.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Qualifying Payment Amount (QPA)** means the median of the contracted rates recognized by the Plan or recognized by all Plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a QPA, said amount will be determined by referencing an applicable state all-payer claims database or any eligible third-party database in accordance with applicable law.

**Recognized Amount**, except for Non-Network Provider air ambulance services, means an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable, and for Non-Network Provider air ambulance services, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

**Retired Employee (Retiree)** is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retiree.

Effective January 1, 2001, a Retiree or the spouse of a Retiree who reaches 65 years of age on or after January 1, 2001, and/or become eligible for Medicare on or after January 1, 2006, will no longer be eligible for coverage under this Plan.

**Sickness** is a person's illness, disease or Pregnancy (including complications).

**Skilled Nursing Facility** is a facility that fully meets all of these tests:

**(1)** It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

**(2)** Its services are provided for compensation and under the full-time supervision of a Physician.

**(3)** It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

**(4)** It maintains a complete medical record on each patient.

**(5)** It has an effective utilization review plan.

**(6)** It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the handicapped or disabled, Custodial or educational care or care of Mental Disorders.

**(7)** It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar nomenclature.

**Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Substance Abuse** is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco/nicotine and ordinary caffeine-containing drinks.

**Temporomandibular Joint** (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

**Urgent Care Services** means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

## PLAN EXCLUSIONS

**Note: All exclusions related to Dental are shown in the Dental Plan.**
**For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:**

**(1)** **Abortion.** Services, supplies, care or treatment in connection with an abortion, except in the case of rape, incest or when the life of the mother is endangered.

**(2)** **Coding Guidelines.** Charges for inappropriate coding in accordance to the industry standard guidelines in effect.

**(3)** **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

**(4)** **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

**(5)** **Educational or vocational testing.** Services for educational or vocational testing or training, except as specifically stated as a benefit of this Plan.

**(6)** **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.

**(7)** **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

**(8)** **Experimental or not Medically Necessary.** Care and treatment that is either Experimental / Investigational or not Medically Necessary.

**(9)** **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

**(10)** **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet or metatarsalgia and treatment of corns, calluses, or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease or when deemed Medically Necessary).

**(11)** **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

**(12)** **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except as specifically stated as a benefit under this Plan.

**(13)** **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except for audiometric testing or as specifically stated as a benefit under this Plan.

**(14)** **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

**(15)** **Illegal Acts.** Charges for services received as a result of an Injury, Illness and/or Sickness resulting from or occurring during the commission of a violation of law by the Plan Participant, including but not limited to, a felony, a misdemeanor, and/or engaging in an illegal occupation, riot, or public disturbance. This exclusion does not apply to minor traffic violations. The Plan Administrator has full discretion to determine what constitutes a minor traffic violation.

Under no circumstances will operating a motor vehicle while under the influence of alcohol or drugs, or a combination thereof, or operating a motor vehicle with a blood alcohol content (BAC) above the legal limit, be considered a minor traffic violation. For this exclusion to apply, it is not necessary that a fine be imposed or criminal charges be filed, or if filed, that a conviction result or that a sentence be imposed. This exclusion does not apply if the Injury, Illness, and/or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

**(16)** **Incarcerated.** Care, treatment, services, and supplies incurred and/or provided to a Plan Participant by a government entity while housed in a governmental institution.

**(17)** **Mailing Charges.** Mailing charges for prescription or laboratory specimens or examinations.

**(18)** **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

**(19)** **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

**(20)** **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

**(21)** **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

**(22)** **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except as allowed under the separate Nutritional Education benefit and Obesity Interventions benefit listed under this Plan, or unless determined by the Plan to be Medically Necessary treatment of Morbid Obesity. This exclusion will again apply once an individual does not meet the definition of Morbid Obesity.

**(23)** **Occupational Injury.** Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit and for which the Plan participant is eligible to receive benefits under any Workers' Compensation or occupational disease law. This exclusion will apply if the Plan participant was eligible to receive such benefits and failed to properly file a claim for such benefits or to comply with any other provision of the law to obtain such benefits.

**(24)** **Personal comfort items.** Personal comfort items, patient convenience or other equipment, such as, but not limited to, patient convenience, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

**(25)** **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

**(26)** **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

**(27)** **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

**(28)** **Shipping and handling.** Charges for shipping, handling, postage, conveyance and sales tax.

**(29)** **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

**(30)** **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit of this Plan.

**(31)** **War.** Any loss that is due to a declared or undeclared act of war.

Claims should be received by the Claims Administrator within *365 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Before filing a lawsuit, the Plan Participant must exhaust all available levels of review as described in the Internal and External Claims Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

## PRESCRIPTION DRUG BENEFITS

The Coordination of Benefits provision will not apply to Prescription Drug Benefits.

**RETIREES AGE 65 AND/OR ELIGIBLE FOR MEDICARE ARE NOT ELIGIBLE FOR THIS PRESCRIPTION DRUG BENEFIT**

Maintenance medications are **mandatory** to be filled through the *mi*Rx Pharmacy mail-order Pharmacy. *Only the first fill will be eligible through the retail Pharmacy option*.

Specialty medications are **mandatory** to be filled through the *mi*Rx Specialty Pharmacy. These are medications for certain chronic Illnesses or complex diseases.

**Please note:** Plan Participants are encouraged to utilize the *mi*Rx Pharmacy, as a community Pharmacy, for retail medications that are prescribed for short-term acute conditions; but it is not mandatory. However, for convenience, if the Plan Participant utilizes the *mi*Rx community Pharmacy for retail medications, they will process based on the copayment and deductibles for retail Pharmacy.

All Prescription Drugs will be payable subject to the applicable dispensing limits, copayment amounts, deductible amounts, and maximum out-of-pocket amounts as shown in the applicable Schedule of Benefits sections for either the Standard Plan or HDHP option.

**All medications will be dispensed as a Generic Drug, if available, instead of its brand name product.** *If a Brand Name Drug is dispensed when a Generic Drug equivalent is available, the Plan Participant will be responsible for the Brand Name Drug copayment plus the difference in cost between the Brand Name Drug and the Generic Drug. If there is no Generic Drug available or the Physician prescribes a Brand Name Drug over the Generic Drug **due to medical necessity**, the applicable Brand Name Drug copayment will apply.*

Prescriptions requiring compounding will need to be utilized under the Retail Pharmacy Program, at specific compounding pharmacies.

**MANDATORY *mi*Rx MAIL ORDER PHARMACY PROGRAM, Administered by miRx**

The *mi*Rx Mail Order Pharmacy is **mandatory** for all Prescription Drugs considered to be a **maintenance medication**. Only the first fill will be eligible through the retail Pharmacy option. Maintenance medications are those medications taken for long periods such as high blood pressure, heart disease, cholesterol, asthma, etc. Because of volume buying, the mail order Pharmacy is able to offer Plan Participants significant savings on their prescriptions.

Please contact the *mi*Rx Pharmacy at (406) 869-6551 or toll-free 1 (866) 894-1496 for more information concerning the mail order Pharmacy.

(Note: The *mi*Rx Mail Order Prescription Drug Option is available in certain states only. Please contact the Claims Administrator for more information regarding this benefit.)

### *mi*Rx MAIL ORDER PHARMACY COPAYMENT

The *mi*Rx Mail Order copayment is applied to each covered maintenance mail order Prescription Drug charge and is shown in the Schedule of Benefits.

*Any one prescription is limited to a 90-day or 300-unit supply.*

*Preventive* medications – to determine if your medication is considered *preventive*, please see the preventive formulary on your miBenefits website.

**COMMUNITY PHARMACY PRESCRIPTION DRUG PROGRAM – Administered by *mi*Rx Pharmacy**

You *may* also utilize *mi*Rx Pharmacy as a **community Pharmacy** for medications that are prescribed on an acute, short-term, or as needed (e.g. antibiotics, pain medication, anti-inflammatories, etc.) basis as well. Please contact the *mi*Rx Pharmacy at (406) 869-6551 or toll-free at 1 (866) 894-1496 for more information concerning the *mi*Rx Pharmacy. **Note:** The Plan Participant will have the option of having these Prescription Drugs mailed directly to their home or to pick up directly from the *mi*Rx Pharmacy.

**COMMUNITY PHARMACY PROGRAM COPAYMENT**

The Community Pharmacy copayment is applied to each covered Prescription Drug charge when purchased through the *mi*Rx Pharmacy and is shown in the Schedule of Benefits. *Any one prescription is limited to a 30-day supply.*

**MANDATORY SPECIALTY PHARMACY PROGRAM, Administered by *mi*Rx Specialty Pharmacy**

Use of Specialty Pharmacy Services contracted through the *mi*Rx Specialty Pharmacy will be **mandatory** for Plan Participants using injectable biopharmaceuticals and other medication therapies for conditions such as cystic fibrosis, growth hormone deficiency, hepatitis, Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS), multiple sclerosis, Respiratory Syncytial Virus (RSV), rheumatoid arthritis and solid organ transplants.

In the event the *mi*Rx Specialty Pharmacy is not able to fill a prescription, the *mi*Rx Specialty Pharmacy will re-direct the Plan Participant to a retail or specialty Pharmacy that can fill the Prescription Drug request.

**To enroll in the program or for more information, Plan Participants can contact the *mi*Rx Specialty Pharmacy at (406) 869-6551 or toll-free 1 (866) 894-1496 or visit the following website at www.ebms.com.**

**SPECIALTY PHARMACY PROGRAM COPAYMENT**

The copayment is applied to each covered specialty Pharmacy drug charge and is shown in the Schedule of Benefits.

Benefits are limited to a 30-day supply unless the Federal Drug Administration recommended guidelines or the drug manufacturer's packaging limits the supply in another manner.

Any requests for quantities above the recommended FDA or manufacturer packaging guidelines will require a letter from the prescribing Physician demonstrating medical necessity and will be subject to medical review. An additional copayment will be charged for any amount over the 30-day dispensing limit.

**RETAIL PHARMACY PROGRAM,** Administered by Magellan Rx

Retail Pharmacy medications are medications that *are not* considered maintenance medications (those that are taken for long periods of time) and are prescribed for acute conditions (a condition with a rapid onset and/or of short duration and generally urgent in nature, such as antibiotics). Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. **Magellan Rx** is the administrator of the Retail Pharmacy Program.

**For Retail Pharmacy Program Prescription Drug claims questions or to obtain a claim form please call:**

Magellan Rx toll-free 1 (800) 424-7908 or visit www.ebms.com.

**Note:** If a Prescription Drug is purchased from a Non-Participating Pharmacy or a Participating Pharmacy when the Plan Participant's ID card is not used**,** the Plan Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to **Magellan Rx,** the Pharmacy benefit manager, for reimbursement (minus any applicable deductible or copayments as shown in the Schedule of Benefits).

**RETAIL PHARMACY PROGRAM COPAYMENT**

The copayment is applied to each covered Pharmacy drug charge and is shown in the Schedule of Benefits. *Any one prescription is limited to a 30-day supply.*

**COVERED PRESCRIPTION DRUGS**

Note: Some prior authorizations and/or quantity limitations may apply.

**(1)** All drugs prescribed by a Physician that require a prescription either by federal or state law, except any drugs not covered under this Plan.

**(2)** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. Compounded prescriptions are not available through the mail order Pharmacy. Compound prescriptions can be purchased through the Retail Pharmacy Program and will be payable subject to the non-preferred Brand Name drug benefit as shown in the Schedule of Benefits.

**(3)** Insulin and diabetic supplies and syringes (not including glucometer) when prescribed by a Physician.

**(4)** Drugs to treat Attention Deficit Disorder.

**(5)** Fertility drugs.

**(6)** Retin-A up to age 25; thereafter, prior authorization is required.

**(7)** Migraine products. Chronic condition migraine products will process as maintenance medications under this Plan.

**(8)** Potassium supplements.

**(9)** Dermatologicals.

**(10)** Anti-viral medications.

**(11)** Injectable drugs and delivery devices.

**(12)** Impotence / sexual dysfunction medications. Prior authorization and quantity limits will apply.

**The following will be covered at 100 %, no copayment required for formulary drugs.**

*Benefits may be subject to prescription formulary and/or quantity limitations. Non-formulary prescriptions may be payable subject to the applicable prescription copayment as shown in the Schedule of Benefits.* ***Contact Magellan Rx toll-free 1 (800) 424-7908 to request coverage of the medication as a non-formulary medical exception.***

**(1)** Tobacco/nicotine cessation agents, including over-the-counter when prescribed by a Physician.

**(2)** Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Plan Participants with reproductive capacity.

*Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.*

**(3)** Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance or deductible will be required, and will only be available when utilizing a Participating Pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact *Magellan Rx toll-free 1 (800) 424-7908 for more information regarding which medications are available. Note: Age and/or quantity limitations may apply*:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

**LIMITS TO THIS BENEFIT**

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

**(1)** Refills only up to the number of times specified by a Physician.

**(2)** Refills up to one year from the date of order by a Physician.

**EXPENSES NOT COVERED**

This benefit will not cover a charge for any of the following:

**(1)** **Administration.** Any charge for the administration of a covered Prescription Drug.

**(2)** **Appetite suppressants.** A charge for appetite suppressants, dietary supplements, vitamin supplements, fluoride supplements, and prescription vitamin supplements containing fluoride.

**(3)** **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

**(4)** **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, blood glucose monitoring machines, insulin pumps and pump supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*

**(5)** **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)

**(6)** **FDA.** Any drug not approved by the Food and Drug Administration.

**(7)** **Hair loss.** Rogaine and Propecia for hair loss.

**(8)** **Immunization.** Immunization agents or biological sera.

**(9)** **Inpatient medication.** A drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

**(10)** **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

**(11)** **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

**(12)** **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs. In addition, discounts, coupons, Pharmacy discount programs or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs will not be a Covered Charge under this Plan.

**(13)** **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin and syringes.

**(14)** **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

## HOW TO SUBMIT PHARMACY CLAIMS

When obtaining a prescription, a Plan Participant should show his or her **City of Billings Employee Benefit Plan** identification card to the pharmacist. Participating Pharmacies may submit claims on a Plan Participant's behalf. If the Pharmacy provider is unable to submit the claim, the Plan Participant should request a receipt.

**For prescription claims questions or to obtain a claim form contact:**

Magellan Health Services
Attention: Claims Department
11013 W. Broad Street, Suite 500
Glen Allen, Virginia 23060

Toll free: (800) 424-7908
Fax: (888) 656-3607
Or visit www.ebms.com.

## HOW TO SUBMIT MEDICAL CLAIMS

When services are received from a health care provider, a Plan Participant should show his or her EBMS/**City of Billings Employee Benefit Plan** identification card to the provider. Participating Providers may submit claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill **which includes procedure (CPT) and diagnostic (ICD) codes** from his or her health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number (**City of Billings,** Group **#00086**)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

***Note:*** *A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at http://www.ebms.com.*

## WHERE TO SUBMIT CLAIMS

Employee Benefit Management Services, LLC is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

## WHEN CLAIMS SHOULD BE FILED

***Note: For Dental Claims Procedures, refer to Appendix A.***

Claims should be received by the Claims Administrator within *365 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

## INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain services is strongly recommended, but not required by the Plan. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits, and cannot be appealed. Please refer to the Care Management Services section.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are two types of claims:

**Concurrent Care Determination**

> A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services Section.*

**Post-Service Claim**

> A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. 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 involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

**Initial Benefit Determination**

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits**. If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45 day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information. Under the No Surprises Act, the Plan would have up to 30 calendar days to send a notice of denial of payment or an initial payment to the Non-Network Provider from the time the Claim is resubmitted with additional information.

**Notice of Determination**

If a Claim is denied in whole or in part, the Plan shall provide written or electronic notice of the determination that will include the following:

- Information to identify the claim involved.
- Specific reason(s) for the denial, including the denial code and its meaning.
- Reference to the specific Plan provisions on which the denial was based.
- Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

- Description of the Plan's Internal Appeal Procedures and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once Claimant has exhausted all available internal and external review procedures.

- Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

- Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.

- If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

- Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan participant's failure to timely pay required premiums.

**Claims Review Procedure - General**

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

**Note:** When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Non-Network Provider, and the provider has no recourse against the Plan Participant under the No Surprises Act, the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with a Non-Network Provider's payment dispute through the IDR process.

## Internal Appeal Procedure

### First Level of Internal Review

The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
℅ Employee Benefit Management Services, LLC (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

**An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.**

The First Level of Internal Review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

### Second Level of Internal Review

If the Claimant does not agree with the Claims Administrator's determination from the First Level of Internal Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review (or 15 days for an appeal of a Concurrent Care Determination), along with any additional supporting information to:

Plan Administrator
℅ Employee Benefit Management Services, LLC (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review, unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the first level of review. In certain circumstances as described below, the Claimant may also request an expedited External Review.

**External Review Procedure**

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within four months from the date of receipt of the notice of the final internal adverse benefit determination or the first day of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

*A request for external review may be granted only for Adverse Benefit Determinations that involve a:*

- Determination that a treatment or service is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.
- Violation of cost-sharing and surprise billing protections as identified within the NSA.
- Application of treatment limits to a Claim for a Mental Disorder.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law. ***Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies***. ***A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable***.

## COORDINATION OF BENEFITS

**Coordination of the benefit plans.** The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

**Benefit plan**. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- Group or nongroup insurance contracts and subscriber contracts;
- Uninsured arrangements of group or group-type coverage;
- Group and nongroup coverage through closed panel plans;
- Group-type contracts;
- The medical components of long-term care contracts, such as skilled nursing care;
- Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;
- The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

**Allowable Charge(s)**. For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Allowable Charge" in the Defined Terms section.)

In the case of Health Maintenance Organization (HMO) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Plan Participant does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Plan Participant used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

**Automobile limitations.** When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

**Benefit plan payment order**. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

**(A)** Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

**(B)** Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:

**(1)** The benefits of the plan which covers the person directly (that is, as a Member/Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay first.

**(2)** Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

**i.** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

**ii.** If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's spouse does, the plan of that parent's spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.

- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);

- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

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

**1st** The plan covering the custodial parent,
**2nd** The plan covering the spouse of the custodial parent,
**3rd** The plan covering the non-custodial parent, and
**4th** The plan covering the spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (5) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

**(3)** The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or as a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Member/Employee. This rule does not apply if Rule (1) can be used to determine the order of benefits If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

**(4)** The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.

**(5)** If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

**(C)** Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

**(D)** If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

**(E)** The Plan will pay primary to Tricare to the extent required by federal law.

**Claims determination period**. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

**Right to receive or release necessary information**. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

**Facility of payment**. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of recovery**. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

**Exception to Medicaid.** The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan.

## THIRD PARTY RECOVERY PROVISION

To the extent necessary for reimbursement of benefits paid to or on behalf of a Plan Participant, the Plan is entitled to subrogation as provided herein, against a judgment or recovery received by the Plan Participant from a Third Party found liable for a wrongful act or omission that caused the Injury necessitating benefit payments.

If a Plan Participant intends to institute an action for damages against a Third Party, the Plan Participant shall give the Plan reasonable notice of the Plan Participant's intention to institute the action.

The Plan Participant may request that the Plan pay a proportionate share of the reasonable costs of the Third-Party action, including attorney fees.

The Plan may elect not to participate in the cost of the action. If such an election is made, the Plan waives 50% of any subrogation rights granted to it by this provision.

The Plan Participant shall take no action through settlement or otherwise which prejudices the rights and interests of the Plan.

## COBRA CONTINUATION COVERAGE

### Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA. ***A domestic partner is not a Qualified Beneficiary.***

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

**Note**: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**When is COBRA Continuation Coverage available?**

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

**Plan Administrator:**
City of Billings
P.O. Box 1178
Billings, MT 59103
(406) 657-8265

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

**How is COBRA Continuation Coverage provided?**

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

**How long does COBRA Continuation Coverage last?**

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

**Medicare extension of COBRA Continuation Coverage**

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18 month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18 month period.

**Disability extension of 18-month period of COBRA Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

**Plan Administrator:**
City of Billings
P.O. Box 1178
Billings, MT 59103
(406) 657-8265

**Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage**

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;

- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

**Plan Administrator:**
City of Billings
P.O. Box 1178
Billings, MT 59103
(406) 657-8265

**Does COBRA Continuation Coverage ever end earlier than the maximum periods above?**

COBRA Continuation Coverage also will end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;

- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;

- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;

- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or

- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

**How Do I Pay for COBRA Continuation Coverage?**

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

**Are There Other Coverage Options Besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.HealthCare.gov.

## Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator:

**Plan Administrator:**
City of Billings
P.O. Box 1178
Billings, MT 59103
(406) 657-8265

For more information about your rights under the Public Health Services Act, COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

## Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## COBRA CONTINUATION COVERAGE FOR A RETIREES' DEPENDENTS

**COBRA Continuation Coverage will not be available to those Retired Employees that elected, at the time of retirement, to continue coverage under the terms of the Plan as a Retiree. However, the following COBRA Continuation Coverage may apply to a Retired Employee's Qualified Beneficiaries.**

### Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to certain Plan Participants when group health coverage would otherwise end.

The Retired Employee's family members may have other options available when they lose group health coverage. For example, they may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, an individual may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which the individual is eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

### What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." Certain covered family members could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA. ***A domestic partner is not a Qualified Beneficiary.***

If you are the Spouse of a covered Retired Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- You become divorced or legally separated from your Spouse.

Dependent children of the covered Retired Employee will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-covered Retired Employee dies;
- The parent-covered Retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a "Dependent child."

**Note**: Medicare entitlement means that the Retired Employee is eligible for and enrolled in Medicare.

Filing a proceeding in bankruptcy with respect to the Employer under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is death of the covered Retiree, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other Qualifying Events (divorce or legal separation of the Retired Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

**Plan Administrator:**
City of Billings
P.O. Box 1178
Billings, MT 59103
(406) 657-8265

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

**How is COBRA Continuation Coverage provided?**

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Retirees may elect COBRA Continuation Coverage on behalf of their Spouse and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

**How long does COBRA Continuation Coverage last?**

COBRA Continuation Coverage is a temporary continuation of coverage that generally lasts for 18 months. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

If the Qualifying Event is the death of the covered Retiree (or former Retiree), divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

**Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage**

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Retiree dies, gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

**Plan Administrator:**
City of Billings
P.O. Box 1178
Billings, MT 59103
(406) 657-8265

**Does COBRA Continuation Coverage ever end earlier than the maximum periods above?**

COBRA Continuation Coverage also will end before the end of the maximum period on the earliest of the following dates:

- The date your former Employer ceases to provide a group health plan to any Retired Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

**How Do I Pay for COBRA Continuation Coverage?**

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

**Are There Other Coverage Options Besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.HealthCare.gov.

**Additional Information**

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator:

**Plan Administrator:**
City of Billings
P.O. Box 1178
Billings, MT 59103
(406) 657-8265

For more information about your rights under the Public Health Services Act, COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

**Current Addresses**

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## RESPONSIBILITIES FOR PLAN ADMINISTRATION

**PLAN ADMINISTRATOR.** City of Billings Employee Benefit Plan is the benefit plan of City of Billings, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by City of Billings to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, City of Billings shall appoint a new Plan Administrator as soon as reasonably possible.

> **Note:** The Plan Administrator has the authority to, and does so allocate limited fiduciary duties to American Health Holdings, Inc. Those duties are limited to a review of and determination on a Plan Participant's request (or a request by the Plan Participant's treating provider) for a pre-determination of benefits prior to the occurrence of treatment or services. As part of those limited duties, American Health Holdings shall have the discretionary authority and ultimate decision-making authority to review the request and any submitted documentation, make a decision, respond to an appeal if the decision is to deny the request, and to maintain records related to its activities related to this decision. See the Care Management Services section for additional information.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

### DUTIES OF THE PLAN ADMINISTRATOR

**(1)** To administer the Plan in accordance with its terms.

**(2)** To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

**(3)** To decide disputes which may arise relative to a Plan Participant's rights.

**(4)** To prescribe procedures for filing a claim for benefits and to review claim denials.

**(5)** To keep and maintain the Plan documents and all other records pertaining to the Plan.

**(6)** To appoint a Claims Administrator to pay claims.

**(7)** To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

**PLAN ADMINISTRATOR COMPENSATION.** The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.** A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

## FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

**For Employee and Dependent Coverage:** Funding is derived from the funds of the Employer and contributions made by the covered Employees. Benefits are paid directly from the Plan through the Claims Administrator.

## PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

## CLERICAL ERROR

*Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.*

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant the amount of overpayment may be deducted from future benefits payable.

## STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

**Disclosure of Summary Health Information to the Plan Sponsor**
In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

**Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes**
"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

**(1)** Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

**(2)** Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

**(3)** Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

**(4)** Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

**(5)** Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

**(6)** Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

**(7)** Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

**(8)** Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

**(9)** If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

**(10)** Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

**(a)** The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

**City Administrator**
**Assistant City Administrator**
**Executive Secretary**
**Human Resources Director**
**Human Resources Associate**
**Payroll/HR Generalist**
**Payroll/HR Analyst**
**HR Administrative Support**
**City Attorney**
**Assistant City Attorney**
**Information Technology Director**
**Information Technology Manager**
**Finance Director**

**(b)** The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

**(c)** In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

**Disclosure of Certain Enrollment Information to the Plan Sponsor**
Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

**Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage**
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

**Other Disclosures and Uses of PHI**
With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

## STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "SECURITY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

**Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions**

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

- Report to the Plan any security incident of which it becomes aware.

## GENERAL PLAN INFORMATION

### TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

### PLAN NAME

City of Billings Employee Benefit Plan

**PLAN EFFECTIVE DATE:** January 1, 2006

**PLAN YEAR ENDS:** December 31

### EMPLOYER INFORMATION

City of Billings
P.O. Box 1178
Billings, Montana 59103
(406) 657-8265

### PLAN ADMINISTRATOR

City Administrator
City of Billings
P.O. Box 1178
Billings, Montana 59103
(406) 657-8265

### CLAIMS ADMINISTRATOR

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

**APPENDIX A**
**DENTAL BENEFITS**

***Note***: When an Active Employee retires, he or she may elect to continue dental coverage as long as he or she was actively enrolled in the Dental Plan immediately prior to retirement.

**Note: The use of a specific dental provider network is not required for coverage under the dental benefits section under this Plan.**

When an Active Employee retires, he or she may elect to continue dental coverage as long as he or she was actively enrolled in the Dental Plan at the time of retirement. Retirees can remain on the Dental Plan as long as they are eligible under plan requirements. If the Retiree cancels Dental coverage, as a Retiree they will not have the option to re-elect coverage.

****Participation in the Plan's Dental Benefits is optional and requires a separate election and separate premium amount. Once elected, Active Employees are required to stay on the Dental Plan for two consecutive years.***

Calendar Year deductible –

| | |
|---|---|
| Per Plan Participant | $50 |
| Per Family Unit | $100 |

The deductible applies to these Classes of Service:

Class B Services – Basic
Class C Services – Major

**Dental Percentage Payable**

| | |
|---|---|
| Class A Services – Preventive and Diagnostic Dental Procedures | 100% |
| Class B Services – Basic Dental Procedures | 70% |
| Class C Services – Major Dental Procedures | 50% |
| Class D Services – Orthodontic Treatment and Appliances | 50% |

**Maximum Benefit Amount**

| | |
|---|---|
| For Class A Services | The Maximum Benefit Amount doesn't apply |

For Class B and Class C Services:

| | |
|---|---|
| Per Plan Participant per Calendar Year | $1,000 |

For Class D Services –Orthodontia:

| | |
|---|---|
| Lifetime maximum per Plan Participant | $1,500 |

## DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

## DEDUCTIBLE

**Deductible Amount.** This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Plan Participant must meet the deductible shown in the Schedule of Benefits.

**Family Unit Limit**. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

## BENEFIT PAYMENT

Each Calendar Year benefits will be payable for a Plan Participant for the dental charges in excess of the deductible. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

## MAXIMUM BENEFIT AMOUNT

The Maximum Dental Benefit Amount is shown in the Schedule of Benefits.

## DENTAL CHARGES

Dental charges are the Allowable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

## COVERED DENTAL SERVICES

### Class A Services:
### Preventive and Diagnostic Dental Procedures

The limits on Class A Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

**(1)** Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two exams per Plan Participant each Calendar Year.

**(2)** Bitewing x-ray series limited to two per Plan Participant each Calendar Years.

**(3)** One full mouth x-ray every thirty-six months.

**(4)** Fluoride treatment for covered Dependent children.

**(5)** Space maintainers for covered Dependent children to replace primary teeth.

**(6)** Emergency palliative treatment for pain.

**(7)** All other dental x-rays.

**(8)** Laboratory examinations.

**(9)** Sealants for permanent teeth.

**Class B Services:**
**Basic Dental Procedures**

**(1)** Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.

**(2)** Periodontics (gum treatments).

**(3)** Endodontics (root canals).

**(4)** Extractions. This service includes local anesthesia and routine post-operative care.

**(5)** Recementing bridges, crowns or inlays.

**(6)** Fillings, other than gold.

**(7)** General anesthetics, upon demonstration of Medical Necessity.

**(8)** Antibiotic drugs.

**(9)** Repair of crowns, bridgework and removable dentures.

**(10)** Rebasing or relining of removable dentures.

**(11)** Occlusal guard for bruxism; limited to one every five Calendar Years.

**Class C Services:**
**Major Dental Procedures**

**(1)** Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

**(2)** Installation of crowns.

**(3)** Installing precision attachments for removable dentures.

**(4)** Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during a six-month period following the installation.

**(5)** Addition of clasp or rest to existing partial removable dentures.

**(6)** Initial installation of fixed bridgework to replace one or more natural teeth which were extracted while the person was covered for these benefits.

**(7)** All services that apply to implants.

**(8)** Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

**(a)** The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits.

**(b)** The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

**(c)** The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

## Class D Services:
## Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

***These services are available for covered Dependent children under age 19*** and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

**EXCLUSIONS**

A charge for the following is not covered:

**(1)** **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

**(2)** **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

**(3)** **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

**(4)** **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

**(5)** **No listing.** Services which are not included in the list of covered dental services.

**(6)** **Orthognathic surgery**. Orthognathic surgery.

**(7)** **Personalization.** Personalization of dentures.

**(8)** **Replacement.** Replacement of lost or stolen appliances.

**(9)** **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

## HOW TO SUBMIT A DENTAL CLAIM

When services are received from a dental provider, a Plan Participant should show his or her EBMS/**City of Billings Employee Benefit Plan** identification card to the provider. Providers may submit claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill which includes procedure (CDT) codes from his or her dental provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

**Note:** A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at http://www.ebms.com.

## WHERE TO SUBMIT CLAIMS

Employee Benefit Management Services, LLC is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Employee Benefit Management Services, LLC
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

## DENTAL CLAIMS PROCEDURE

A **Claim** means a request for a Plan benefit, made by a Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims. A Claim for benefits is not a Claim that has been previously submitted, denied, appealed, and re-denied upon appeal.

A "Claim" is a Post-Service Claim under the terms of the Plan. A **Post-Service Claim** means a Claim for covered dental services that have already been received by the Plan Participant.

All questions regarding Claims should be directed to the Claims Administrator. All claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. 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 involving specialized medical knowledge or judgment. The Plan Administrator shall have full responsibility to adjudicate all claims and to provide a full and fair review of the initial claim determination in accordance with the following Claims review procedure.

**A Claim will not be deemed submitted until it is received by the Claims Administrator.**

For the purposes of this section, **Claimant** means the Plan Participant or the Plan Participant's authorized representative. A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives. A Claimant does not include a healthcare provider simply by virtue of an assignment of benefits.

An Adverse Benefit Determination shall mean a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. An inquiry regarding eligibility or benefits without a Claim for benefits is not a Claim and, therefore, cannot be appealed.

**Initial Benefit Determination**

The Initial Benefit Determination on a Post-Service Claim will be made within 30 days of the Claim Administrator's receipt of the Claim. If the Claims Administrator requires an extension due to circumstances beyond the Plan's control, the Claims Administrator will notify the Claimant of the reason for the delay within the initial 30-day period. A benefit determination on the Claim will be made within 15 days of the date the notice of the delay was provided to the Claimant. If additional information is necessary to process the Claim, the Claims Administrator will request the additional information from the Claimant within the initial 30-day period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits**. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

**Notice of Adverse Benefit Determination**

The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant. If a Claim is denied in whole or in part, notice will include the following:

**(1)** Specific reason(s) for the denial.

**(2)** Reference to the specific Plan provisions on which the denial was based.

**(3)** Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

**(4)** Description of the Plan's Claims review procedures and the time limits applicable to such procedures.

**(5)** Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

- Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and that a copy will be provided free of charge to the Claimant upon request).

- If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim, or a statement that such explanation will be provided free of charge, upon request.

**(6)** Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant does not understand the reason for the Adverse Benefit Determination, the Claimant should contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

**Claims Review Procedure - General**

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by either an appropriate Plan representative or the Claims Administrator on the Plan's behalf, who is neither the individual who made the Initial Benefit Determination, nor a subordinate of that individual. The review will take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in the Initial Benefit Determination.

If the Adverse Benefit Determination was based in whole or in part upon medical judgment, including determinations on whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary, the Plan Administrator or its designee will consult with a health care professional who has the appropriate training and experience in the applicable field of medicine; was not consulted in the Initial Benefit Determination; and is not the subordinate of the initial decision-maker. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

The Plan Administrator will provide free of charge upon request by the Claimant, reasonable access to and copies of, documents, records, and other information as described in Items 5 through 8 under "Notice of Adverse Benefit Determination".

**First Level of Claims Review**

The written request for review must be submitted within 180 days of the Claimant's receipt of notice of an Adverse Benefit Determination. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
℅ Employee Benefit Management Services, LLC (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

**An appeal will not be deemed submitted until it is received by the Claims Administrator. Failure to appeal the initial Adverse Benefit Determination within the 180 day period will render that determination final.**

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal.

**Second Level of Claims Review**

If the Claimant does not agree with the Claims Administrator's determination from the first level review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the first level of review, along with any additional supporting information to:

Plan Administrator
℅ Employee Benefit Management Services, LLC (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

**An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the determination from the first level of review within the 60 day period will render that determination final.**

The second level of review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal. The determination by the Plan Administrator upon review will be final, binding, and conclusive and will be afforded the maximum deference permitted by law.

If upon review, the Adverse Benefit Determination remains the same and the Claimant still does not agree with the determination, the Claimant has the right to bring an action for benefits. **Before filing a lawsuit, the Claimant must exhaust both levels of review as described in this section**. **A legal action to obtain benefits must be commenced within one year of the date of the notice of the Plan Administrator's determination on the second level of review.**

**APPENDIX B**
**EMPLOYEE ASSISTANCE PROGRAM (EAP)**

## EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employer offers an Employee Assistance Program (EAP) which provides confidential, professional referrals, and short-term counseling services for a wide-array of personal and work-related concerns at no cost for an Employee and his/her immediate family members, who are covered under the City of Billings Employee Benefit Plan.

This document describes the services available for Employees eligible for the Employer's EAP (also referred to as the "Plan") and serves as the Plan Document for the Plan. This document is also intended to give Employees an easily understood explanation for the EAP, so it also serves as the Summary Plan Description or "SPD".

We all have problems at some point in our lives. Usually we are able to handle those problems ourselves, but sometimes those problems can interfere with relationships, job performance, and physical health. That is why this Employer chooses to offer this EAP.

## ELIGIBILITY

The EAP benefit is only available to Employees and their eligible Dependents (Spouse and/or child(ren)) who are enrolled in the Medical Benefits under the City of Billings Employee Benefit Plan.

The EAP benefit is not available for Retired Employees, including Retired Elected Officials, or their Dependents (Spouse and/or child(ren)).

## ENROLLMENT

Eligible Employees (and their eligible Dependents) are automatically enrolled in the EAP benefit as of the date the Employee's coverage is effective under the Medical Benefits under this Plan.

## LEAVES OF ABSENCE

Coverage under the Plan will continue during an Employer-certified leave of absence, an FMLA leave or other such similar state leave. Coverage does not continue during a layoff or strike and will end the last day of the month in which the layoff or strike began.

## TERMINATION OF COVERAGE

Coverage for the Employee and his/her covered Dependents will terminate on the earlier of:

- The last day of the calendar month in which the Employee terminates his/her employment with the Employer;
- The date the Employee retires;
- The date the Employee dies;
- The date a covered Spouse loses coverage due to loss of dependency status;
- The last day of the calendar month in which a Dependent child ceases to be a Dependent (as defined under this Plan); or
- The date the EAP is terminated by the Employer.

## BENEFIT COVERAGE

The EAP is a company-sponsored resource which provides confidential, short-term counseling services coordinated with the individual's medical doctor by licensed mental health professionals. This benefit is administered by St. Vincent Behavioral Health.

Benefits will be limited to eight free counseling sessions per Calendar Year.

The EAP's multi-disciplinary team treats the following:

- Depression
- Posttraumatic Stress
- Addictive Illness
- Attention Deficit
- Marital and Relationship Issues
- Issues of Aging
- Anxiety
- Workplace Stress
- Grief and Loss
- Parent/Child Issues
- Adjustment to Illness and Injury

The following therapeutic services will also be provided through the EAP:

- Marital and Relationship Counseling
- Neuropsychological and Psychological Assessments
- Stress Management
- Individual Counseling
- Crisis Intervention
- Neuropsychological Assessment

## LIMITATIONS

Other than the benefits described in this Plan, the EAP offers no other medical benefits. Specifically, no benefits are payable for preventive screening tests, physical exams, or any other expense that would be covered by another group health plan or health insurance policy for which the Employer sponsors.

The EAP benefit is limited to eight free counseling sessions per Calendar Year. If the EAP counseling session maximum is exhausted for that Calendar Year, a Plan Participant may continue to see their EAP vendor with the additional EAP counseling sessions payable subject to the reimbursement level as stated under the applicable benefit Plan (i.e., Standard Plan or HDHP plan) under the City of Billings Employee Benefit Plan.

## CLAIMS REVIEW PROCEDURE

Since there is no cost to a participant for EAP services, there are no claims to file for benefits. However, if you believe you or a family member was denied benefits, you have specific rights and responsibilities for appealing the denial. This section describes the process to appeal.

If you believe you or your family member were denied benefits, you should submit in writing the benefits you believe were denied and why to:

**City Administrator**
City of Billings
P.O. Box 1178
Billings, Montana 59103
(406) 657-8265

You have up to 180 days after the denial to submit your appeal, but are encouraged to submit the request as soon as reasonably possible. You can also include any other documents or records that you would like to have reviewed with your appeal. You may also request, free of charge, copies of all relevant documents that we may have used or considered in administering your EAP benefit.

The EAP Administrator's review will take into account all comments, documents, records and other information related to your EAP benefit. The EAP Administrator's decision on the appeal will be independent from any previous decision and determined by an individual or individuals who were not involved with that previous decision. The decision on appeal will be made within 60 days after receipt of the request for review.

A written notice of the decision after review by the EAP Administrator will be provided and will include:

- The reason for the decision;
- A statement that you may request copies of all relevant documents, free of charge; and
- A statement that you have the right to bring a civil action under applicable law, once you have exhausted all rights of appeal.

**COBRA**

If you terminate employment with the Employer, the EAP will be provided at your cost to each qualified beneficiary who elects to continue coverage on the EAP, on the same terms as outlined in your Employer's medical plan document. The cost will be a monthly fee for each qualified beneficiary and will be due on the first of each month. Contact the Employer for more information regarding COBRA Continuation Coverage.

**GENERAL PROVISIONS**

AMENDMENT AND TERMINATION

Your Employer, as the Plan Sponsor, reserves the sole discretionary right to modify, amend, or terminate the EAP at any time and from time to time. You will be notified of any modification to, amendment of, or the termination of the EAP.

FUNDING

The Employer pays all costs of the EAP. There is no cost to the employee.

EAP IS PART OF THE EXCEPTED BENEFITS PLAN

The EAP is offered as a benefit under the Employer's Excepted Benefit Plan. Contact the Employer for a list of the Plan Administrator, Plan Sponsor, and other important information. Contact information for the Employer and EAP Administrator is:

**Employer** (also referred to as the Plan Administrator and Plan Sponsor)**:**

City Administrator
City of Billings
P.O. Box 1178
Billings, Montana 59103
(406) 657-8265

**EAP Administrator:**

St. Vincent Healthcare – Behavioral Health
Yellowstone Medical Building
2900 12th Avenue North, Suite 280W
Billings, Montana 59101

Office Hours: Monday through Thursday, 7 a.m. through 6 p.m. (MST)

For questions or appointments call:

In Billings, Montana (406) 237-3585
Outside of Billings, Montana toll free at 1 (888) 662-5461
24-Hour Crisis Hotline toll free at 1 (888) 662-5461

**HIPAA PRIVACY AND SECURITY STANDARDS**

Contact the Employer for a copy of the Notice of Privacy Practices for the EAP.

**APPENDIX C**
**WELLNESS PROGRAMS**
**NOTICE REGARDING WELLNESS PROGRAMS**

The City of Billings offers a voluntary wellness program available to Active Employees and their Spouse if they are on the city medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the annual wellness exam incentive program, your selected Primary Care Physician and you will discuss what exams, test and/or vaccinations are appropriate and recommended based on your age, gender and medical history. Claims for these services will process according to the city medical plan.

You are responsible for bringing the appropriate form – Annual Wellness Exam Incentive to your appointment for your Physician to sign. After completion, you are responsible for emailing the form to the Human Resources department. Email instructions are included on the form. The form is available on the *City of Billings* website under Human Resources, Forms and Documents.

If you complete the above, you will receive an incentive of a monetary gift card for participating in the voluntary wellness program. Gift cards are issued during specific times annually to the city employee and are included in their fringe benefits.

There is an additional opportunity to earn an incentive with participation in Healthy IS Wellness and completing at least six monthly or four quarterly InBody scans and coaching sessions per Calendar Year. Check with City HR for full details. Gift cards are subject to IRS tax fringe.

**Protections from Disclosure of Medical Information**
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the *City of Billings* may use aggregate information it collects to design a program based on identified health risks in the workplace, the *City of Billings* will never disclose any of your personal information except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through your provider, will be maintained and, stored electronically and encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact *City of Billings – Human Resources* at *(406) 657-8265.*

*The city reserves the right to modify this program at any time.*

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call **1-866-660-8935** or visit www.ebms.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-487-2365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,000 per plan participant; $2,000 per family unit. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Office visits, urgent care office visits, initial office visit related to pregnancy, mail order prescription drugs, and preferred network provider preventive care, are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. **Prescription drugs** (applies to retail pharmacy and specialty pharmacy only): $100 per plan participant; $200 per family unit. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | **Medical benefits: Preferred network providers:** $2,250 per plan participant; $5,750 per family unit; **Network/non-network providers:** $6,000 per plan participant; $17,000 per family unit. **Prescription drugs:** $2,250 per plan participant; $6,750 per family unit. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Prescription drug expenses; pharmacy discount programs & DAW penalties; premiums; balance-billing charges (unless balanced billing is prohibited); and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of preferred network providers, see Rocky Mountain Health Network at www.rmhn.com; for network providers see www.fchn.com; or for all contracted providers see www.ebms.com or call (866) 275-7646, (866) 660-8935 or (406) 238-6066. | This plan uses a preferred provider network. You will pay less if you use a provider in the plan's preferred provider network. You will pay more if you use a (non-preferred) network provider, and you will pay the most if you use a non-network provider, and you might receive a bill from the provider for the difference between their charge and what your plan pays (balance billing). Be aware, your preferred network provider might use a non-preferred/network provider or non-network provider for some services (such as lab work). Check with your provider before you get services. |

| | | |
|---|---|---|
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Network Provider (You will pay more) | Non-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | The office visit copayment applies to the office visit charge only. Any associated charges will be paid per normal plan provisions. |
| | Specialist visit | $25 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | |
| | Preventive care/screening/ immunization | No charge | 40% coinsurance; *(deductible applies to some Preventive care services)* | 40% coinsurance; *(deductible applies to some Preventive care services)* | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.ebms.com or Magellan Rx toll-free at 1 (800) 424-7908. | Generic drugs | $5 copayment/prescription (retail); $10 copayment/prescription, deductible does not apply (mail order) | | | A prescription drug deductible applies to retail pharmacy and to specialty pharmacy drugs. A prescription drug out-of-pocket limit applies to all prescription drugs. Retail drugs are limited to a 30-day supply per prescription; mail order drugs are available up to a 90-day supply per prescription. The *mi*Rx mail order pharmacy is **mandatory** for all prescription drugs considered maintenance medications. Specialty drugs are limited to a 30-day supply and must be purchased through the Specialty Pharmacy program. Only the first fill will be allowed through the retail pharmacy. Contact miRx Pharmacy at (406) 869-6551 or toll-free at (866) 894-1496 or visit www.ebms.com for more information regarding specialty drugs. |
| | Preferred brand drugs | 20% copayment/prescription ($30 minimum and a $60 maximum) (retail); $90 copayment/prescription, deductible does not apply (mail order) | | | |
| | Non-preferred brand drugs | 40% copayment/prescription ($50 minimum and a $100 maximum) (retail); $135 copayment/prescription, deductible does not apply (mail order pharmacy) | | | |
| | Specialty drugs | Generic drugs: $75 copayment/prescription<br>Preferred brand drugs: $125 copayment/prescription<br>Non-preferred brand drugs: $125 copayment/prescription | | | |

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Network Provider (You will pay more) | Non-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | | | None |
| | Emergency medical transportation | 20% coinsurance | | | None |
| | Urgent care Facility | 20% coinsurance | 40% coinsurance | 40% coinsurance | The copayment applies to the urgent care office visit only. Any associated charges will be paid per normal plan provisions. |
| | Urgent care Office visit | $25 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | The inpatient hospital copayment per confinement will apply until the out-of-pocket limit has been met for the calendar year. Facility charges are limited to the semiprivate room rate. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient (facility/physician) Office visits | 20% coinsurance | 40% coinsurance | 40% coinsurance | The office visit copayment applies to the office visit charge only. Any associated charges will be paid per normal plan provisions. |
| | | $25 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | |
| | Inpatient services Facility | 20% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | The inpatient hospital copayment per confinement will apply until the out-of-pocket limit has been met for the calendar year. |
| | Physician | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Office visits | $25 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | $50 copayment/visit; deductible does not apply | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | The inpatient hospital copayment per confinement will apply until the out-of-pocket limit has been met for the calendar year. |

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Network Provider (You will pay more) | Non-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | | | None |
| | Rehabilitation services<br>Inpatient facility | 20% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | The inpatient hospital copayment per confinement will apply until the out-of-pocket limit has been met for the calendar year. |
| | Inpatient physician | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| | Outpatient facility/ Outpatient physician | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| | Habilitation services | Payable the same as Rehabilitation services | | | |
| | Skilled nursing care | 20% coinsurance | | | Coverage is limited to the semiprivate room rate. |
| | Durable medical equipment | 20% coinsurance | | | None |
| | Hospice services | 20% coinsurance | | | None |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | | | Vision benefits may be available through a separate plan election. |
| | Children's glasses | Not covered | | | |
| | Children's dental check-up | Not covered | | | Dental benefits may be available through a separate plan election. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except through Home Health Care)
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care (limited to 24 visits/calendar year)
- Infertility treatment (limited to 2 implantation attempts/lifetime)

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: EBMS at 1-800-777-3575. Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance -Grants/.

**Does this plan provide Minimum Essential Coverage?** **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Languge Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al **1-866-660-8935.**
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-660-8935.**
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码1-866-660-8935**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-660-8935.**

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Primary care copayment | $25 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Primary care office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,010 |
| Copayments | $200 |
| Coinsurance | $1,050 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,320** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist physician copayment | $25 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Specialist physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs*
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $220 |
| Copayments | $360 |
| Coinsurance | $760 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,360** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist physician copayment | $25 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,000 |
| Copayments | $75 |
| Coinsurance | $290 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,365** |

**Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the City Administrator at: (406) 657-8265.**
***Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call **1-866-660-8935** or visit www.ebms.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-487-2365 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,500 per single coverage; $3,000 per family unit. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preferred network provider preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Preferred network providers: $3,750 per single coverage; $7,500 per family coverage (not to exceed $3,750 per plan participant); network/non-network providers: $6,500 per single coverage; $13,000 per family coverage (not to exceed $6,500 per plan participant). | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Pharmacy discount programs & DAW penalties, premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of preferred network providers, see Rocky Mountain Health Network at www.rmhn.com; for network providers see www.fchn.com; or for all contracted providers see www.ebms.com or call (866) 275-7646, (866) 660-8935 or (406) 238-6066. | This plan uses a preferred provider network. You will pay less if you use a provider in the plan's preferred provider network. You will pay more if you use a (non-preferred) network provider, and you will pay the most if you use a non-network provider, and you might receive a bill from the provider for the difference between their charge and what your plan pays (balance billing). Be aware, your preferred network provider might use a non-preferred/network provider or non-network provider for some services (such as lab work). Check with your provider before you get services. |

| | | |
|---|---|---|
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral**.** |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Network Provider (You will pay more) | Non-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copayment/visit | $50 copayment/visit | $50 copayment/visit | The office visit copayment applies to the office visit charge only. Any associated charges will be paid per normal plan provisions. |
| | Specialist visit | $25 copayment/visit | $50 copayment/visit | $50 copayment/visit | |
| | Preventive care/screening/ immunization | No charge | 40% coinsurance; *(deductible applies to some Preventive care services)* | 40% coinsurance; *(deductible applies to some Preventive care services)* | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.ebms.com or Magellan Rx toll-free at 1 (800) 424-7908. | Generic drugs | $5 copayment/prescription (retail pharmacy)<br>$10 copayment/prescription (mail order pharmacy) | | | The medical deductible applies to all prescription drugs except preventive prescription drugs. Contact *mi*Rx Pharmacy at (406) 869-6551 or toll-free at 1 (866) 894-1496 for a list of these preventive medications. Retail drugs are limited to a 30-day supply per prescription; mail order drugs are available up to a 90-day supply per prescription. The *mi*Rx mail order pharmacy is **mandatory** for all prescription drugs considered maintenance medications.<br>Specialty drugs are limited to a 30-day supply and must be purchased through the Specialty Pharmacy program. Only the first fill will be allowed through the retail pharmacy. Contact miRx Pharmacy at (406) 869-6551 or toll-free at (866) 894-1496 or visit www.ebms.com for more information regarding specialty drugs. |
| | Preferred brand drugs | 20% copayment/prescription ($30 minimum and a $60 maximum) (retail);<br>$90 copayment/prescription (mail order) | | | |
| | Non-preferred brand drugs | 40% copayment/prescription ($50 minimum and a $100 maximum) (retail);<br>$135 copayment/prescription (mail order) | | | |
| | Specialty drugs | Generic drugs: $75 copayment/prescription<br>Preferred brand drugs: $125 copayment/prescription<br>Non-preferred brand drugs: $125 copayment/prescription | | | |

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Network Provider (You will pay more) | Non-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | | | None |
| | Emergency medical transportation | 20% coinsurance | | | None |
| | Urgent care Facility | 20% coinsurance | 40% coinsurance | 40% coinsurance | The copayment applies to the urgent care office visit only. Any associated charges will be paid per normal plan provisions. |
| | Urgent care Office visit | $25 copayment/visit | $50 copayment/visit | $50 copayment/visit | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | The inpatient hospital copayment per confinement will apply until the out-of-pocket limit has been met for the calendar year. Facility charges are limited to the semiprivate room rate. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient (facility/physician) | 20% coinsurance | 40% coinsurance | 40% coinsurance | The office visit copayment applies to the office visit charge only. Any associated charges will be paid per normal plan provisions. |
| | Office visits | $25 copayment/visit | $50 copayment/visit | $50 copayment/visit | |
| | Inpatient services<br>Facility | 20% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | The inpatient hospital copayment per confinement will apply until the out-of-pocket limit has been met for the calendar year. |
| | Physician | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Office visits | $25 copayment/visit | $50 copayment/visit | $50 copayment/visit | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | The inpatient hospital copayment per confinement will apply until the out-of-pocket limit has been met for the calendar year. |

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information* |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You will pay the least) | Network Provider (You will pay more) | Non-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | | | None |
| | Rehabilitation services<br>Inpatient facility | 20% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | 40% coinsurance and $200 inpatient hospital copayment/ confinement | The inpatient hospital copayment per confinement will apply until the out-of-pocket limit has been met for the calendar year. |
| | Inpatient physician | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| | Outpatient facility/ Outpatient physician | 20% coinsurance | 40% coinsurance | 40% coinsurance | |
| | Habilitation services | Payable the same as Rehabilitation services | | | |
| | Skilled nursing care | 20% coinsurance | | | Coverage is limited to the semiprivate room rate. |
| | Durable medical equipment | 20% coinsurance | | | None |
| | Hospice services | 20% coinsurance | | | None |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | | | Vision benefits may be available through a separate plan election. |
| | Children's glasses | Not covered | | | |
| | Children's dental check-up | Not covered | | | Dental benefits may be available through a separate plan election. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except through Home Health Care)
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care(limited to 24 visits/calendar year)
- Infertility treatment (limited to 2 implantation attempts/lifetime)

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: EBMS at 1-800-777-3575. Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance -Grants/.

**Does this plan provide Minimum Essential Coverage?** **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Languge Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al **1-866-660-8935.**
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-660-8935.**
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码1-866-660-8935**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-660-8935.**

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist copayment | $25 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $210 |
| Coinsurance | $2,040 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,810** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Primary care physician copayment | $25 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs*
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $380 |
| Coinsurance | $670 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,570** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist copayment | $25 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $5 |
| Coinsurance | $260 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,765** |

**Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the City Administrator at: (406) 657-8265.**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

**AMENDMENT #2-2022**
**TO THE**
**PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION**
**FOR**
**CITY OF BILLINGS EMPLOYEE BENEFIT PLAN**

**Effective: August 1, 2022**

1. **AMEND** the **"PRESCRIPTION DRUG BENEFIT STANDARD HEALTH PLAN"** subsection of the **SCHEDULE OF BENEFITS STANDARD HEALTH PLAN** section, as follows:

**PRESCRIPTION DRUG BENEFIT STANDARD HEALTH PLAN**

**RETIREES AGE 65 AND/OR ELIGIBLE FOR MEDICARE ARE NOT ELIGIBLE FOR THIS PRESCRIPTION DRUG BENEFIT**

***The Coordination of Benefits provision will not apply to the Prescription Drug Benefits.***

**PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET AMOUNT**

| | |
|---|---|
| Per Calendar Year, per Plan Participant | $2,250 |
| Per Calendar Year, per Family Unit | $6,750 |

**PRESCRIPTION DRUG DEDUCTIBLES** - ***Applies to Specialty Pharmacy Program and Retail Pharmacy Program;*** *does not apply to the miRx Mail Order Pharmacy Program or to maintenance medications.*

| | |
|---|---|
| Deductible per Calendar Year, per Plan Participant | $100 |
| Deductible per Calendar Year, per Family Unit | $200 |

***mi*Rx MAIL ORDER PHARMACY PROGRAM** (deductible does not apply)

***Mail Order medications are available in a 30, 60, or 90-day supply per prescription***

| | |
|---|---|
| Generic drugs | $5/30 days, $10/90 days |
| Preferred Brand Name drugs | $30/30 days, $60/60 days, $90/90 days |
| Non-Preferred Brand Name drugs | $45/30 days, $90/60 days, $135/90 days |

Prescriptions requiring compounding will need to be utilized under the Retail Pharmacy Program, at specific compounding Pharmacies.

**MAINTENANCE MEDICATION OPTIONS** (deductible does not apply) - ***Limited to purchase through the miRx Pharmacy, Pharmacy 1-SCL, Pharm406, Downtown Family Pharmacy, Riverstone Health Pharmacy, or any Costco, Wal-Mart, or Sam's Club Pharmacy.***

***Maintenance medications are available in a 30, 60, or 90-day supply per prescription***

| | |
|---|---|
| Generic drugs | $5/30 days, $10/90 days |
| Preferred Brand Name drugs | $30/30 days, $60/60 days, $90/90 days |
| Non-Preferred Brand Name drugs | $45/30 days, $90/60 days, $135/90 days |

**SPECIALTY MEDICATIONS** – ***mandatory purchase through the miRx or Magellan Specialty Pharmacy Program***

***Specialty Pharmacy medications are limited to a 30-day supply per prescription***

| | |
|---|---|
| Generic | $75 after prescription drug deductible |
| Preferred Brand Name | $125 after prescription drug deductible |
| Non-Preferred Brand Name | $125 after prescription drug deductible |

**RETAIL PHARMACY PROGRAM**

***Retail Pharmacy medications are limited to a 30-day supply per prescription***

| | |
|---|---|
| Generic | $5 after prescription drug deductible |
| Preferred Brand Name | 20% after prescription drug deductible ($30 minimum and $60 maximum) |

| | |
|---|---|
| Non-preferred Brand Name ..... | 40% after prescription drug deductible ($50 minimum and $100 maximum) |

**Please Note:** Plan Participants are encouraged to utilize the *mi*Rx Pharmacy, as a community Pharmacy, for retail medications that are prescribed for short-term acute conditions; but it is not mandatory. However, for convenience, if the Plan Participant utilizes the *mi*Rx community Pharmacy for retail medications, they will process based on the copayment and deductibles for retail Pharmacy.

**All medications will be dispensed as a Generic Drug, if available, instead of its brand name product.** *If a Brand Name Drug is dispensed when a Generic Drug equivalent is available, the Plan Participant will be responsible for the Brand Name Drug copayment plus the difference in cost between the Brand Name Drug and the Generic Drug. If there is no Generic Drug available or the Physician prescribes a Brand Name Drug over the Generic Drug* ***due to medical necessity****, the applicable Brand Name Drug copayment will apply. Prescription drug DAW (Dispense As Written) penalties do not apply toward the maximum out-of-pocket amount.*

**Prescription Drug Dispense As Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies will not apply toward the maximum out-of-pocket amount.**

**For more information regarding the Prescription Drug benefits, refer to the separate Prescription Drug Benefit section under this Plan.**

2. **AMEND** the **"PRESCRIPTION DRUG BENEFIT HIGH DEDUCTIBLE HEALTH PLAN (HDHP)"** subsection of the **SCHEDULE OF BENEFITS STANDARD HEALTH PLAN** section, as follows:

**PRESCRIPTION DRUG BENEFIT HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**

**RETIREES AGE 65 AND/OR ELIGIBLE FOR MEDICARE ARE NOT ELIGIBLE FOR THIS PRESCRIPTION DRUG BENEFIT**

***The Coordination of Benefits provision will not apply to the Prescription Drug Benefits.***

**Prescription Drug expenses under the HDHP Plan are subject to the HDHP Plan medical deductible amount** ***(except Preventive prescriptions),*** **and apply to the medical maximum out-of-pocket amount.**

***mi*Rx MAIL ORDER PHARMACY PROGRAM**

***miRx Mail Order medications are available in a 30, 60, or 90-day supply per prescription***

| | |
|---|---|
| Generic drugs..... | $5/30 days, after medical deductible<br>$10/90 days, after medical deductible |
| Preferred Brand Name drugs ..... | $30/30 days, after medical deductible<br>$60/60 days, after medical deductible<br>$90/90 days, after medical deductible |
| Non-Preferred Brand Name drugs ..... | $45/30 days, after medical deductible<br>$90/60 days, after medical deductible<br>$135/90 days, after medical deductible |
| Preventive medications..... | Subject to the above copayments;<br>*medical deductible does not apply* |

Prescriptions requiring compounding will need to be utilized under the Retail Pharmacy Program, at specific compounding Pharmacies.

**MAINTENANCE MEDICATION OPTIONS** (deductible does not apply) - ***Limited to purchase through the miRx Pharmacy, Pharmacy 1-SCL, Pharm406, Downtown Family Pharmacy, Riverstone Health Pharmacy, or any Costco, Wal-Mart, or Sam's Club Pharmacy.***

***Maintenance medications are available in a 30, 60, or 90-day supply per prescription***

| | |
|---|---|
| Generic drugs..... | $5/30 days, after medical deductible<br>$10/90 days, after medical deductible |

| | |
|---|---|
| Preferred Brand Name drugs | $30/30 days, after medical deductible<br>$60/60 days, after medical deductible<br>$90/90 days, after medical deductible |
| Non-Preferred Brand Name drugs | $45/30 days, after medical deductible<br>$90/60 days, after medical deductible<br>$135/90 days, after medical deductible |
| Preventive medications | Subject to the above copayments;<br>*medical deductible does not apply* |

**SPECIALTY MEDICATIONS** – ***mandatory purchase through the miRx or Magellan Specialty Pharmacy Program***

***Specialty Pharmacy medications are– limited to a 30-day supply per prescription***

| | |
|---|---|
| Generic | $75 after medical deductible |
| Preferred Brand Name | $125 after medical deductible |
| Non-Preferred Brand Name | $125 after medical deductible |

**RETAIL PHARMACY PROGRAM**

***Retail Pharmacy medications are limited to a 30-day supply per prescription***

| | |
|---|---|
| Generic | $5 after medical deductible |
| Preferred Brand Name | 20% after medical deductible<br>($30 minimum and $60 maximum) |
| Non-preferred Brand Name | 40% after medical deductible<br>($50 minimum and $100 maximum) |

**Please Note:** Plan Participants are encouraged to utilize the *mi*Rx Pharmacy, as a community Pharmacy, for retail medications that are prescribed for short-term acute conditions; but it is not mandatory. However, for convenience, if the Plan Participant utilizes the *mi*Rx community Pharmacy for retail medications, they will process based on the copayment and deductibles for retail Pharmacy.

**All medications will be dispensed as a Generic Drug, if available, instead of its brand name product.** *If a Brand Name Drug is dispensed when a Generic Drug equivalent is available, the Plan Participant will be responsible for the Brand Name Drug copayment plus the difference in cost between the Brand Name Drug and the Generic Drug. If there is no Generic Drug available or the Physician prescribes a Brand Name Drug over the Generic Drug* ***due to medical necessity****, the applicable Brand Name Drug copayment will apply. Prescription drug DAW (Dispense As Written) penalties do not apply toward the maximum out-of-pocket amount.*

**Prescription Drug Dispense As Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies will not apply toward the maximum out-of-pocket amount.**

**For more information regarding the Prescription Drug benefits, refer to the separate Prescription Drug Benefit section under this Plan.**

3. **AMEND** the **"PRESCRIPTION DRUG BENEFITS"** section, as follows:

**PRESCRIPTION DRUG BENEFITS**

**The Coordination of Benefits provision will not apply to Prescription Drug Benefits.**

**RETIREES AGE 65 AND/OR ELIGIBLE FOR MEDICARE ARE NOT ELIGIBLE FOR THIS PRESCRIPTION DRUG BENEFIT**

**Mail order medications** are available through the *mi*Rx Mail Order Pharmacy Program.

**Maintenance medications** are limited to purchase only through the *mi*Rx Pharmacy, Pharmacy 1-SCL, Pharm406, Downtown Family Pharmacy, Riverstone Health Pharmacy, or any Costco, Wal-Mart, or Sam's Club Pharmacy.

**Specialty medications** are mandatory to be filled through the *mi*Rx Specialty Pharmacy Program or the Magellan Rx Specialty Pharmacy Program. These are medications for certain chronic Illnesses or complex diseases.

**Please note:** Plan Participants are encouraged to utilize the *mi*Rx Pharmacy, as a community Pharmacy, for retail medications that are prescribed for short-term acute conditions; but it is not mandatory. However, for convenience, if the Plan Participant utilizes the *mi*Rx community Pharmacy for retail medications, they will process based on the copayment and deductibles for retail Pharmacy.

All Prescription Drugs will be payable subject to the applicable dispensing limits, copayment amounts, deductible amounts, and maximum out-of-pocket amounts as shown in the applicable Schedule of Benefits sections for either the Standard Plan or HDHP option.

**All medications will be dispensed as a Generic Drug, if available, instead of its brand name product.** *If a Brand Name Drug is dispensed when a Generic Drug equivalent is available, the Plan Participant will be responsible for the Brand Name Drug copayment plus the difference in cost between the Brand Name Drug and the Generic Drug. If there is no Generic Drug available or the Physician prescribes a Brand Name Drug over the Generic Drug* ***due to medical necessity****, the applicable Brand Name Drug copayment will apply.*

Prescriptions requiring compounding will need to be utilized under the Retail Pharmacy Program, at specific compounding pharmacies.

## *mi*Rx MAIL ORDER PHARMACY PROGRAM

The *mi*Rx Mail Order Pharmacy is available for purchase of Prescription Drugs considered to be a maintenance medication. Maintenance medications are those medications taken for long periods such as high blood pressure, heart disease, cholesterol, asthma, etc. Because of volume buying, the mail order Pharmacy is able to offer Plan Participants significant savings on their prescriptions.

In addition to the *mi*Rx Mail Order Pharmacy, maintenance medications may also be purchased through Pharmacy 1-SCL, Pharm406, Downtown Family Pharmacy, Riverstone Health Pharmacy, or any Costco, Wal-Mart, or Sam's Club Pharmacy.

*Mail Order medications and maintenance medications are available up to a 90-day supply per prescription.*

Note: The *mi*Rx Mail Order Pharmacy Option is only available in certain states. Please contact Magellan Rx for more information regarding this benefit.

*Preventive* medications – to determine if your medication is considered *preventive*, please see the preventive formulary on your *mi*Benefits website.

## COMMUNITY PHARMACY PRESCRIPTION DRUG PROGRAM – Administered by *mi*Rx Pharmacy

You *may* also utilize *mi*Rx Pharmacy as a **community Pharmacy** for medications that are prescribed on an acute, short-term, or as needed (e.g. antibiotics, pain medication, anti-inflammatories, etc.) basis as well.

Please contact the *mi*Rx Pharmacy at (406) 869-6551 or toll-free at 1 (866) 894-1496 for more information concerning the *mi*Rx Pharmacy. **Note:** The Plan Participant will have the option of having these Prescription Drugs mailed directly to their home or to pick up directly from the *mi*Rx Pharmacy.

*Community Pharmacy medications through the mi*Rx *Pharmacy are limited to a 30-day supply per prescription.*

**SPECIALTY MEDICATIONS** – ***mandatory purchase through the miRx or Magellan Specialty Pharmacy Program***

Specialty medications must be purchased through the *mi*Rx Specialty Pharmacy Program or the Magellan Rx Specialty Pharmacy Program. Examples of specialty medications are injectable biopharmaceuticals and other medication therapies for conditions such as cystic fibrosis, growth hormone deficiency, hepatitis, Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS), multiple sclerosis, Respiratory Syncytial Virus (RSV), rheumatoid arthritis and solid organ transplants.

In the event the *mi*Rx Specialty Pharmacy or Magellan Rx Specialty Pharmacy is not able to fill a prescription, the Plan Participant will be re-directed to a retail or other specialty Pharmacy that can fill the Prescription Drug request.

**To enroll in the *mi*Rx Specialty Pharmacy Program or for more information, Plan Participants can contact the *mi*Rx Specialty Pharmacy at (406) 869-6551 or toll-free (866) 894-1496, or visit the following website at www.ebms.com.**

**For additional information regarding the Magellan Rx Specialty Pharmacy Program, contact Magellan Rx toll-free at (800) 424-7908.**

Specialty medications are limited to a 30-day supply unless the Federal Drug Administration recommended guidelines or the drug manufacturer's packaging limits the supply in another manner. Any requests for quantities above the recommended FDA or manufacturer packaging guidelines will require a letter from the prescribing Physician demonstrating medical necessity and will be subject to medical review. An additional copayment will be charged for any amount over the 30-day dispensing limit.

**RETAIL PHARMACY PROGRAM - Administered by Magellan Rx**

Retail Pharmacy medications are medications that *are not* considered maintenance medications (those that are taken for long periods of time) and are prescribed for acute conditions (a condition with a rapid onset and/or of short duration and generally urgent in nature, such as antibiotics). Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. **Magellan Rx** is the administrator of the Retail Pharmacy Program.

*Retail Pharmacy medications are limited to a 30-day supply per prescription.*

**For Retail Pharmacy Program Prescription Drug claims questions or to obtain a claim form please call:**
Magellan Rx toll-free (800) 424-7908 or visit www.ebms.com.

**Note:** If a Prescription Drug is purchased from a Non-Participating Pharmacy or a Participating Pharmacy when the Plan Participant's ID card is not used, the Plan Participant will be required to pay 100% of the total cost at the point of sale, no discount will be given, and the Plan Participant will be required to submit the prescription receipt to **Magellan Rx,** the Pharmacy benefit manager, for reimbursement (minus any applicable deductible or copayments as shown in the Schedule of Benefits).

**COVERED PRESCRIPTION DRUGS**

Note: Some prior authorizations and/or quantity limitations may apply.

**(1)** All drugs prescribed by a Physician that require a prescription either by federal or state law, except any drugs not covered under this Plan.

**(2)** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. Compounded prescriptions are not available through the mail order Pharmacy. Compound prescriptions can be purchased through the Retail Pharmacy Program and will be payable subject to the non-preferred Brand Name drug benefit as shown in the Schedule of Benefits.

**(3)** Insulin and diabetic supplies and syringes (not including glucometer) when prescribed by a Physician.

**(4)** Drugs to treat Attention Deficit Disorder.

**(5)** Fertility drugs.

**(6)** Retin-A up to age 25; thereafter, prior authorization is required.

**(7)** Migraine products. Chronic condition migraine products will process as maintenance medications under this Plan.

**(8)** Potassium supplements.

**(9)** Dermatologicals.

**(10)** Anti-viral medications.

**(11)** Injectable drugs and delivery devices.

**(12)** Impotence / sexual dysfunction medications. Prior authorization and quantity limits will apply.

**The following will be covered at 100%, no copayment required for formulary drugs.**
*Benefits may be subject to prescription formulary and/or quantity limitations. Non-formulary prescriptions may be payable subject to the applicable prescription copayment as shown in the Schedule of Benefits.* ***Contact Magellan Rx toll-free (800) 424-7908 to request coverage of the medication as a non-formulary medical exception.***

**(1)** Tobacco/nicotine cessation agents, including over-the-counter when prescribed by a Physician.

**(2)** Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Plan Participants with reproductive capacity.

*Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.*

**(3)** Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance or deductible will be required, and will only be available when utilizing a Participating Pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact *Magellan Rx toll-free (800) 424-7908 for more information regarding which medications are available. Note: Age and/or quantity limitations may apply*:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

**LIMITS TO THIS BENEFIT**

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

**(1)** Refills only up to the number of times specified by a Physician.
**(2)** Refills up to one year from the date of order by a Physician.

## EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements, vitamin supplements, fluoride supplements, and prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, blood glucose monitoring machines, insulin pumps and pump supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*

(5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)

(6) **FDA.** Any drug not approved by the Food and Drug Administration.

(7) **Hair loss.** Rogaine and Propecia for hair loss.

(8) **Inpatient medication.** A drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(9) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(10) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(11) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(12) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin and syringes or to over-the-counter drugs that are prescribed by a Physician and as specifically stated as a Covered Charge under this Plan.

(13) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

## HOW TO SUBMIT PHARMACY CLAIMS

When obtaining a prescription, a Plan Participant should show his or her **City of Billings Employee Benefit Plan** identification card to the pharmacist. Participating Pharmacies may submit claims on a Plan Participant's behalf. If the Pharmacy provider is unable to submit the claim, the Plan Participant should request a receipt.

**For prescription claims questions or to obtain a claim form contact:**

Magellan Health Services
Attention: Claims Department
11013 W. Broad Street, Suite 500
Glen Allen, Virginia 23060

Toll free: (800) 424-7908
Fax: (888) 656-3607
Or visit www.ebms.com.

I, Kevin Iffland (Name), certify that I am the Assistant City Administrator (Title) of the Plan Administrator for the above named Plan, and further certify that I am authorized to sign this Amendment. I have read and agree with the above change to the Plan and hereby authorize its implementation as of the effective date stated above.

Signature: _____

Printed Name: Kevin Iffland

Date: 7-25-2022