PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

CITY OF BILLINGS
EMPLOYEE BENEFIT PLAN

STANDARD HEALTH PLAN
HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

EFFECTIVE: JANUARY 1, 2006

RESTATED: JANUARY 1, 2026

This plan document covers Medical, Rx & Dental

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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.

Medical Benefits Schedule. 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.

A covered Dependent child(ren) of a covered Retiree who reaches age 65, may remain on the Plan if there is a covered Spouse of the Retiree, until the covered Spouse 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.

All references to Employee will also be applicable to elected official coverage, *unless otherwise specified.*

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 includes common law marriage but ***does not*** include domestic partners. **The Plan Administrator *will require* documentation proving a legal marital relationship, *such as a notarized Declaration of Marriage or a notarized Affidavit of Common Law Marriage*.**

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 an eligible Employee 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 must be enrolled under the Plan on a timely basis as defined in the section "Timely Enrollments" following this section for there to be coverage for the newborn from the date of birth.

Charges for Well Newborn/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 Annual Open Enrollment period (see "Annual Open Enrollment" section below).

(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 annual open enrollment period.

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

(i) Annual Open 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 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.

(3) Medicaid or 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 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 CHIP.

If eligible, the Employee and/or Dependent may enroll under this Plan. If the Employee is not enrolled at the time of the event, he or she must enroll under this Special Enrollment Period in order for their eligible Dependent to enroll.

This Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. 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 be 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; or

(7) 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.

If the Employee's leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run *concurrent* with FMLA.

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 was enrolled at the time of termination, 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.

The Civilian Reservist Emergency Workforce Act of 2021 ("The CREW Act"). The CREW Act provides eligible Employees who are called to service by the Federal Emergency Management Agency (FEMA), continuation of coverage rights under USERRA.

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 Retiree's Plan ceases to be an active Plan;

(3) The date the covered Retiree'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) The first day of the month in which the Retiree reaches age 65. *This provision does not apply to Retired Employees who were grandfathered on to the plan prior to the **January 1, 2001,** Plan change.*

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 the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.);

(3) For a Dependent child, the date the Retired Employee's coverage under the Plan terminates; if the Spouse of the Retired Employee is still covered, the Dependent child may remain on the Plan until the date the covered Spouse of the Retired Employee loses coverage.

(4) The first day of the calendar month in which the Spouse of a Retiree reaches age 65. *This provision does not apply to the Spouse of a Retired Employee who was grandfathered on to the plan prior to the **January 1, 2001,** Plan change.*

(5) 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.);

(6) 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.);

(7) 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

(8) 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 until he or she reach age 65 and/or becomes eligible for Medicare, as long as the spouse is eligible for retirement benefits accrued by the deceased Employee or Retiree.

STANDARD HEALTH PLAN

SCHEDULE OF BENEFITS SECTION

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 Internal and External Claims Review Procedures.*

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 (TIER 1):

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

NETWORK PROVIDERS (TIER 2):

- 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 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 a Preferred Network Provider, services received from a Network Provider or a Non-Network Provider will be subject to the Preferred Network Provider benefit level.

- Remember, **the Plan Participant may still be balance billed** by the Non-Network Provider for the unpaid difference between the Allowable Charge and the Non-Network Provider's billed charge.

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

  - Remember, **the Plan Participant may still be balance billed** by the Non-Network Provider for the unpaid difference between the Allowable Charge and the Non-Network Provider's billed charge.

- For Plan Participants who reside outside Yellowstone County and who utilize a Network Provider or a Non-Network Provider in their community, **Network Provider or Non-Network Provider services will be subject to the Preferred Network Provider benefit level.**

  (This Provider exception 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.)

  - Remember, **the Plan Participant may still be balance billed** by the Non-Network Provider for the unpaid difference between the Allowable Charge and the Non-Network Provider's billed charge.

Covered Charges for Plan Participants who reside outside of the Network Provider service area, and for Non-Network Provider services considered under the above exceptions, reimbursement will be based on the Allowable Charge and payable subject to the Preferred Network Provider benefit amount as shown in the Medical Benefits Schedule. *Covered Charges processed under the above exceptions will accrue toward the Preferred Network Provider maximum out-of-pocket amount.*

Remember however, that Non-Network Providers are not contracted with the Plan, consequently:

- **Plan Participants will still be responsible for any applicable deductible and/or coinsurance/copay amounts as shown under the applicable Preferred Network Provider benefit; and**

- **Plan Participants may still be balance billed by the Non-Network Provider for the unpaid difference between the Allowable Charge and the Non-Network Provider's billed 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

(Applicable only to the Standard Health Plan)

Deductibles are dollar amounts that the Plan Participant must pay before the Plan pays. Medical benefit deductibles will accrue toward the medical maximum out-of-pocket amount. Prescription Drug benefits apply a separate deductible amount that accrues toward the separate Prescription Drug maximum out-of-pocket amount. Each **January 1,** a new medical deductible (and separate Prescription Drug deductible) amount is required.

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 deductible provision will not apply to the Prescription Drug deductible.

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 do not apply toward the deductible. Copayments, not including Prescription Drug copayments applied under the Standard Health Plan option, will accrue toward the medical maximum out-of-pocket amount.

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Medical Benefits Schedule and is payable by the Plan Participant until the maximum out-of-pocket amount, as shown in the Medical Benefits Schedule 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. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable by the Plan at the percentages shown each Calendar Year until the medical maximum out-of-pocket amount shown in the Medical Benefits Schedule 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.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit 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.

Prescription Drug benefits under the Standard Health Plan apply a separate maximum out-of-pocket amount as shown in the Prescription Drug Benefit - Standard Health Plan benefit schedule. Once this amount has been reached, eligible Prescription Drug expenses incurred by a Plan Participant will be payable at 100% for the rest of the Calendar Year.

STANDARD HEALTH PLAN

MEDICAL BENEFITS SCHEDULE

STANDARD HEALTH PLAN	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 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. 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	$1,250		
Per Family Unit	$2,400		
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	$2,500	$6,250	$6,250
Per Family Unit	$6,150	$17,400	$17,400
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%: • Prescription drug deductibles, copayments, out of pocket charges and coinsurance amounts. • 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. • Amounts over the Allowable Charge.			

STANDARD HEALTH PLAN	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	First Choice Health	
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 Room and Board	80% after deductible and Inpatient Hospital Copayment*	60% after deductible and Inpatient Hospital Copayment*	60% after deductible and Inpatient Hospital Copayment*
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		
Note: Under the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), Emergency Room Services will include any item or service provided during and after the Emergency Room visit, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation. See "Emergency Services" in the Definitions section of this Plan Document for reference.			
Skilled Nursing Facility	80% after deductible		
Rehabilitation Services 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 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.			

STANDARD HEALTH PLAN	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	**First Choice Health**	
Physician Services Inpatient Services	80% after deductible	60% after deductible	60% after deductible
Outpatient Services	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.			
Telehealth Services (Virtual Care)	Payable per normal Plan provisions	Payable per normal Plan provisions	Payable per normal Plan provisions
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		
Home Infusion Therapy	80% after deductible	60% after deductible	60% after deductible
Hospice Care	80% after deductible		
Infertility - In Vitro Fertilization	80% after deductible In Vitro Fertilization Lifetime maximum of two implantation attempts	60% after deductible In Vitro Fertilization Lifetime maximum of two implantation attempts	60% after deductible In Vitro Fertilization Lifetime maximum of two implantation attempts
Infusion Therapy	80% after deductible	60% after deductible	60% after deductible
Jaw Joint/TMJ	80% after deductible	60% after deductible	60% after deductible

STANDARD HEALTH PLAN	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	**First Choice Health**	
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 (must be performed by a Transplant Facility Partner)	80% after deductible		Not Covered
Note: Refer to the Organ Transplant benefit in the Covered Charges section for more information.			
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.			

STANDARD HEALTH PLAN	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	**First Choice Health**	
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. **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).** **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 Medical Benefits Schedule,* and which can be located using the following website:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; and
https://www.healthcare.gov/coverage/preventive-care-benefits

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 Medical Benefits Schedule,* and which can be located using the following websites:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; 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), counseling and screening for 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.

STANDARD HEALTH PLAN	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	**First Choice Health**	
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:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; and
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf (Bright Futures)

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 Medical Benefits Schedule,* and which can be located using the following website:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; and
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf (Bright Futures)

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.

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

STANDARD HEALTH PLAN	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	**First Choice Health**	
Obesity Interventions	100%, deductible and copayment waived	60% after deductible	60% after deductible
Plan Participants age 18 and older with a body mass index (BMI) ≥ 30 kg/m2	26 visits maximum per Calendar Year	26 visits maximum per Calendar Year	26 visits maximum per Calendar Year
Plan Participants age 6 through 17 with a BMI ≥ *the 95th percentile (for age & sex)*	26 visits maximum per Calendar Year	26 visits maximum per Calendar Year	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
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

STANDARD HEALTH PLAN

PRESCRIPTION DRUG BENEFIT

Prescription Drug expenses under the Standard Health Plan are subject to the Prescription Drug Deductible and Maximum Out-of-Pocket Amount as follows.

Copayment amounts shown represent Plan Participant responsibility.

PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE			
Applies to 30-day Retail Pharmacy Drugs and Specialty Pharmacy Drugs *(does not apply to maintenance medications obtained through the specified Pharmacy list or the Mail Order Pharmacy benefit.*			
Per Plan Participant	$350 per Calendar Year		
Per Family Unit	$600 per Calendar Year		
PRESCRIPTION DRUG CALENDAR YEAR MAXIMUM OUT-OF-POCKET AMOUNT (includes the Prescription Drug Calendar Year Deductible)			
Per Plan Participant	$2,500 per Calendar Year		
Per Family Unit	$7,150 per Calendar Year		
30-DAY RETAIL PHARMACY DRUGS			
Prescription Drug deductible applies	***30-day supply per prescription***		
Generic drugs	$5 copayment per prescription		
Preferred Brand drugs	20% copayment per prescription ($30 minimum/$60 maximum)		
Non-Preferred Brand drugs	40% copayment per prescription ($50 minimum/$100 maximum)		
MAINTENANCE MEDICATIONS and MAIL ORDER DRUGS			
Available through the following local Pharmacies: Costco Pharmacy, Walmart Pharmacy, Sam's Club Pharmacy, RiverStone Health Pharmacy, Downtown Family Pharmacy, Pharm406, Billings Pharmacy One (1), and Intermountain Pharmacy - St. Vincent.	**Available through:** *a SmithRx Mail Order partner such as Amazon Pharmacy and Walmart Mail Order Pharmacy.* **See www.mysmithrx.com for details.**		
Prescription Drug deductible does not apply	***30-day supply***	***60-day supply***	***90-day supply***
Generic drugs	$5 copayment per prescription	Not available	$10 copayment per prescription
Preferred Brand drugs	$30 copayment per prescription	$60 copayment per prescription	$90 copayment per prescription
Non-Preferred Brand drugs	$45 copayment per prescription	$90 copayment per prescription	$135 copayment per prescription
SPECIALTY DRUGS			
Mandatory purchase through the SmithRx Specialty Pharmacy Program; prior authorization through SmithRx is required.			
Prescription Drug deductible applies	***30-day supply per prescription***		
Generic drugs	$75 copayment per prescription		
Preferred Brand drugs	$125 copayment per prescription		
Non-Preferred Brand drugs	$125 copayment per prescription		

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.*

Expenses related to Prescription Drug Dispense As Written (DAW) penalties, Prescription Drug discounts and coupons (provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies), and Prescription Drugs obtained outside the United States, are not an eligible expense under this Plan and 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.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

SCHEDULE OF BENEFITS SECTION

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 Internal and External Claims Review Procedures.*

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 (TIER 1):

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

NETWORK PROVIDERS (TIER 2):

- 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 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 a Preferred Network Provider, services received from a Network Provider or a Non-Network Provider will be subject to the Preferred Network Provider benefit level.

    - Remember, **the Plan Participant may still be balance billed** by the Non-Network Provider for the unpaid difference between the Allowable Charge and the Non-Network Provider's billed charge.

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

    - Remember, **the Plan Participant may still be balance billed** by the Non-Network Provider for the unpaid difference between the Allowable Charge and the Non-Network Provider's billed charge.

- For Plan Participants who reside outside Yellowstone County and who utilize a Network Provider or a Non-Network Provider in their community, **Network Provider or Non-Network Provider services will be subject to the Preferred Network Provider benefit level.**

  (This Provider exception 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.)

    - Remember, **the Plan Participant may still be balance billed** by the Non-Network Provider for the unpaid difference between the Allowable Charge and the Non-Network Provider's billed charge.

Covered Charges for Plan Participants who reside outside of the Network Provider service area, and for Non-Network Provider services considered under the above exceptions, reimbursement will be based on the Allowable Charge and payable subject to the Preferred Network Provider benefit amount as shown in the Medical Benefits Schedule. *Covered Charges processed under the above exceptions will accrue toward the Preferred Network Provider maximum out-of-pocket amount.*

Remember however, that Non-Network Providers are not contracted with the Plan, consequently:

- **Plan Participants will still be responsible for any applicable deductible and/or coinsurance/copay amounts as shown under the applicable Preferred Network Provider benefit; and**

- **Plan Participants may still be balance billed by the Non-Network Provider for the unpaid difference between the Allowable Charge and the Non-Network Provider's billed 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
(Applicable only to the High Deductible Health Plan (HDHP))

Deductibles 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 Medical Benefits Schedule.

Family Coverage: Covered Employees **with covered Dependents** must meet the Family Coverage deductible amount, as shown in the Medical Benefits Schedule, 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 medical maximum out-of-pocket amount.*

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Medical Benefits Schedule and is payable by the Plan Participant until the maximum out-of-pocket amount, as shown in the Medical Benefits Schedule 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. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

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 Medical Benefits Schedule 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 Medical Benefits Schedule. For covered Employees with covered Dependents, the *Family Coverage* maximum out-of-pocket amount must be met before benefits will be paid. However, when 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.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

MEDICAL BENEFITS SCHEDULE

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 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. 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	$1,750		
Family Coverage	$3,400		
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 above. **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	$4,000	$6,750	$6,750
Family Coverage per Plan Participant *	$7,900 $4,000	$13,400 $6,750	$13,400 $6,750
* *Note: The maximum out-of-pocket amount for any one individual with Family Coverage will not exceed $3,900 per Calendar Year for Allowable Charges when utilizing a Preferred Network Provider, or $6,650 per Calendar Year for Allowable Charges when utilizing a Network Provider or a 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 has an "**embedded maximum out-of-pocket amount"** which means: **Single Coverage:** Covered Employees **with Employee only coverage** must meet the Single Coverage maximum out-of-pocket amount as shown above. **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. *However no one Plan Participant will have to satisfy more than the per Plan Participant amount.*			
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%: • Amounts over the Allowable Charge.			

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	**First Choice Health**	
• 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.			
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 Room & Board	80% after deductible and Inpatient Hospital Copayment*	60% after deductible and Inpatient Hospital Copayment*	60% after deductible and Inpatient Hospital Copayment*
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		
Note: Under the No Surprises Act (NSA) (part of the Consolidated Appropriations Act of 2021), Emergency Room Services will include any item or service provided during and after the Emergency Room visit, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation. See "Emergency Services" in the Definitions section of this Plan Document for reference.			
Skilled Nursing Facility	80% after deductible		
Rehabilitation Services 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 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 Inpatient Services	80% after deductible	60% after deductible	60% after deductible
Outpatient Services	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

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level) Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	TIER 2 NETWORK PROVIDERS First Choice Health	TIER 3 NON-NETWORK PROVIDERS
Note: The copayment will be applied to the office visit only. Any associated charges will be paid per normal Plan provisions.			
Telehealth Services (Virtual Care)	Payable per normal Plan provisions	Payable per normal Plan provisions	Payable per normal Plan provisions
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		
Home Infusion Therapy	80% after deductible	60% after deductible	60% after deductible
Hospice Care	80% after deductible		
Infertility - In Vitro Fertilization	80% after deductible In Vitro Fertilization Lifetime maximum of two implantation attempts	60% after deductible In Vitro Fertilization Lifetime maximum of two implantation attempts	60% after deductible In Vitro Fertilization Lifetime maximum of two implantation attempts
Infusion Therapy	80% after deductible	60% after deductible	60% after deductible
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 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. **Note:** The Office visit copayment will be applied to the office visit only. Any associated charges will be paid per normal Plan provisions.			

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	**First Choice Health**	
Organ Transplants (must be performed by a Transplant Facility Partner)	80% after deductible		Not Covered
Note: Refer to the Organ Transplant benefit in the Covered Charges section for more information.			
Pregnancy 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. **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. **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).** **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

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	**First Choice Health**	

[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 Medical Benefits Schedule,* and which can be located using the following website:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; and
https://www.healthcare.gov/coverage/preventive-care-benefits

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 Medical Benefits Schedule,* and which can be located using the following websites:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; 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), counseling and screening for 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:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; and
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf (Bright Futures)

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:

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	TIER 1 PREFERRED NETWORK PROVIDERS (highest reimbursement level)	TIER 2 NETWORK PROVIDERS	TIER 3 NON-NETWORK PROVIDERS
	Rocky Mountain Health Network (www.rmhn.org), & Riverstone Health	**First Choice Health**	
	https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results; and https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf (Bright Futures)		
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.			
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	100%, deductible and copayment waived	60% after deductible	60% after deductible
Plan Participants age 18 and older with a body mass index (BMI) ≥ 30 kg/m2	26 visits maximum per Calendar Year	26 visits maximum per Calendar Year	26 visits maximum per Calendar Year
Plan Participants age 6 through 17 with a BMI ≥ *the 95th percentile (for age & sex)*	26 visits maximum per Calendar Year	26 visits maximum per Calendar Year	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
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

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

PRESCRIPTION DRUG BENEFIT

Prescription Drug expenses under the HDHP *(except Preventive prescriptions)* are subject to the HDHP medical benefits deductible amount and apply to the HDHP medical maximum out-of-pocket amount, as shown in the HDHP Medical Benefits Schedule.

Added this statement for clarification purposes only.

30-DAY RETAIL PHARMACY DRUGS			
Medical Benefits deductible applies *(except Preventive Medications)*	***30-day supply per prescription***		
Generic drugs	$5 copayment per prescription		
Preferred Brand drugs	20% copayment per prescription ($30 minimum/$60 maximum)		
Non-Preferred Brand drugs	40% copayment per prescription ($50 minimum/$100 maximum)		
MAINTENANCE MEDICATIONS and MAIL ORDER DRUGS			
Available through the following local Pharmacies: *Costco Pharmacy, Walmart Pharmacy, Sam's Club Pharmacy, RiverStone Health Pharmacy, Downtown Family Pharmacy, Pharm406, Billings Pharmacy One (1), and Intermountain Pharmacy - St. Vincent.*	**Available through:** *a SmithRx Mail Order partner such as Amazon Pharmacy and Walmart Mail Order Pharmacy.* **See www.mysmithrx.com for details.**		
Medical Benefits deductible applies *(*except Preventive Medications)*	***30-day supply***	***60-day supply***	***90-day supply***
Generic drugs	$5 copayment per prescription	Not available	$10 copayment per prescription
Preferred Brand drugs	$30 copayment per prescription	$60 copayment per prescription	$90 copayment per prescription
Non-Preferred Brand drugs	$45 copayment per prescription	$90 copayment per prescription	$135 copayment per prescription
*H.S.A. Expanded List of Preventive Medications	Subject to the above copayment amounts; *deductible does not apply.*		
SPECIALTY DRUGS			
Mandatory purchase through the SmithRx Specialty Pharmacy Program; prior authorization through SmithRx is required.			
Medical Benefits deductible applies	***30-day supply per prescription***		
Generic drugs	$75 copayment per prescription		
Preferred Brand drugs	$125 copayment per prescription		
Non-Preferred Brand drugs	$125 copayment per prescription		

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.*

Expenses related to Prescription Drug Dispense As Written (DAW) penalties, Prescription Drug discounts and coupons (provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies), and Prescription Drugs obtained outside the United States, are not an eligible expense under this Plan and 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.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Illness 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.

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 Medical Benefits Schedule. After 23 observation hours, a confinement will be considered an inpatient confinement.

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

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

Note: Routine prenatal office visits will be payable as stated under the Pregnancy benefit as shown in the Medical Benefits Schedule 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 Illness 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 Services.** Local Medically Necessary professional land or air ambulance service which means local transportation to the closest facility that can provide Covered Services appropriate for the Plan Participant's condition. A charge for this service will be a Covered Charge only for transporting the sick and injured:

(i) To the nearest Hospital equipped to treat the condition when Medically Necessary due to a life-threatening emergency.

(ii) For transfer from one Hospital to another only when the initial Hospital is not equipped to provide the care required.

(iii) Round trip to another Hospital for tests not available where the Plan Participant is hospitalized.

(iv) From a Hospital to a Skilled Nursing Facility located within a reasonable distance.

(v) Air ambulance service related to (i) and (ii) when ground ambulance would not be safe or practical, but only to the nearest Hospital equipped to treat the condition.

(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 Medical Benefits Schedule 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 Medical Benefits Schedule 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) **Cataract surgery.** Covered Charges for Medically Necessary cataract or other covered eye surgery, including the initial **contact lenses** or glasses required following a covered eye surgery.

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

Pre-notification of services 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 seven days prior to the initiation of treatment.

For pre-notification of services, call CareLink at the following number:
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 Internal and External Claims Review Procedures.

(h) **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.

(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 Medical Benefits Schedule.

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 Medical Benefits Schedule.

(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) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies 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.

(m) **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 Medical Benefits Schedule. *See the Prescription Drug Benefits section for coverage of related Prescription Drugs.*

(n) **Infusion Therapy.** Medically Necessary Physician-prescribed administration of fluids, nutrition, or medication by intravenous or gastrointestinal (enteral) infusion or by intravenous injection. Covered Charges under this benefit include Prescription Drugs, nursing and administrative services.

(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 the 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 Medical Benefits Schedule.

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

(t) **Morbid Obesity.** Covered Charges for Morbid Obesity must be considered Medically Necessary under the guidelines of this Plan and will include Physician's office visits, related laboratory testing, surgical treatment, non-surgical treatment, and nutritional or dietary counseling.

Eligible expenses related to Medically Necessary surgical treatment of Morbid Obesity will include complications (whether direct or indirect), repeat surgical procedures, and revisions to previous surgical procedures.

A written Plan of Care by the attending Physician will be required in advance of any surgical treatment.

Prior approval of Morbid Obesity surgery is highly recommended to ensure services will be considered eligible.

Prescription or non-prescription weight loss medications or appetite suppressants, special foods or supplements, health club memberships, exercise equipment, weight loss/health centers, and treatment of obesity, will not be a Covered Charge under this Plan.

Morbid Obesity is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. A qualified Plan Participant must be at least 18 years of age and meet the current clinical standard measure for Morbid Obesity which 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). The measurement of Body Mass Index (BMI) as defined under this Plan or a BMI of 35 or greater with any co-morbid conditions that are expected to improve, reverse or be limited by this surgical treatment, and which must be documented in a record or letter of Medical Necessity which must demonstrate the diagnosis of Morbid Obesity.

Co-morbid conditions will include but are not limited to:

- Hypertension
- Sleep Apnea
- Diabetes
- Cardiopulmonary Condition
- Joint Disease
- High Cholesterol

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

(v) **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 Medical Benefits Schedule.

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

(w) **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act Preventive Care Services requirement. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Plan Participants age 6 through 17, and 18 and older as specified in the Medical Benefits Schedule.

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 (see Morbid Obesity).*

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

(x) **Occupational therapy** by a health care provider acting within the scope of his or her license, *subject to Medical Necessity*. Therapy must be ordered by a Physician, result from an Injury, Illness or autism spectrum disorder, and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

The Plan may require a documented Plan of Care 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.

(y) **Organ transplant.** 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 transplant benefit period begins the day the preparatory regimen (marrow ablation therapy) begins, or the date the marrow/stem cells is/are infused, whichever occurs first.
- **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.

Covered Charges must be provided by a "Transplant Facility Partner". Transplant Facility Partners are Facilities (i) that have entered into a contract with a national transplant network being utilized by the Plan and (ii) are designated by that transplant network as one of their highest tiered Facilities for the specific transplant based on performance guidelines and cost criteria. Highest tiered Facilities are sometimes referred to as Centers of Excellence (COE) or Designated Facilities by the national transplant network.

Organ Transplants that are not performed at a Transplant Facility Partner will not be a covered Medical Service under this Plan.

Coverage for the following procedures (sometimes referred to as a transplant procedure), 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 under this Plan:

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

(z) **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 Illness that occurred while covered under the Plan.

(aa) **Physical therapy** by a health care provider acting within the scope of his or her license, *subject to Medical Necessity*. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration for conditions which are subject to significant improvement through short-term therapy. Covered Charges include treatment of autism spectrum disorders.

The Plan may require a documented Plan of Care 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.

(bb) **Preventive Care/Routine Well Care.** Covered Charges under Medical Benefits are payable for Preventive Care/Routine Well Care as described in the Medical Benefits Schedule.
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) **Sleep disorders.** Medically Necessary care and treatment for sleep disorders.

(ff) **Speech therapy** by a health care provider acting within the scope of his or her license, *subject to Medical Necessity*. 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) (ii) an Injury; (iii) an Illness, or (iv) treatment of an autism spectrum disorder.

The Plan may require a documented Plan of Care 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.

(gg) **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 Medical Benefits Schedule.

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

The following charges will be payable per normal Plan provisions:

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

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

(jj) **Telehealth.** Telehealth services (virtual care) will be a Covered Charge subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.

(kk) **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 Medical Benefits Schedule. *Tobacco/nicotine cessation products are covered under the Prescription Drug Benefits of this Plan.*

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

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 and enrolled 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).

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.

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

(nn) **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 Internal and External Claims Review Procedures.*

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

- Inpatient admissions; to a Hospital, Rehabilitation Facility, Skilled Nursing Facility, free-standing Mental Disorder/Substance Abuse Facility;
    - Pre-notification is recommended for a **routine maternity admission** that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery;
    - Pre-notification is recommended within 48 hours or on the first business day following a holiday or weekend admission from the **emergency room;**
- Cancer Treatment;
- Hysterectomy;
- Spinal surgery;
- Bariatric surgery;
- Renal Dialysis;
- Genetic testing;
- Injectables (administered under the medical benefits Plan, not those received through the Prescription Drug Benefits of this Plan);
- Home Health Care;
- Hospice Care;
- 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, Ohio 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.

Facility means a healthcare institution which meets all applicable state or local licensure requirements.

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 not 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 Necessary (Medical Necessity) 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 condition of Morbid Obesity is determined by Body Mass Index (BMI) in accordance with the current clinical standard measure as identified through Utilization Management. 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 Facility 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 Facility 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.

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.

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 Illness. 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 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, Custodial or educational care.

(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 Benefits are shown in the Dental Plan (see Appendix A).

The following exclusions and/or limitations apply to expenses incurred by Plan Participants:

(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, *or when the life of a multiple fetus is endangered and has no chance of survival*.

(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 the expense for care and treatment of an Injury or Illness 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) **Foreign travel.** Charges for care, treatment or supplies incurred outside of the United States if travel is for the sole purpose of obtaining medical services. Charges for Prescription Drugs or other medications administered as "take home", and/or obtained outside the United States, regardless of the reason for travel.

(12) **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.

(13) **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.

(14) **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.

(15) **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.

(16) **Illegal Acts.** Charges for services received as a result of an Injury, Illness and/or Illness 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 Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

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

(18) **Learning disabilities**, behavioral modifications, or developmental delay services or treatment, except when provided as treatment for an autism spectrum disorder.

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

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

(21) **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.

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

(23) **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 Illness.

(24) **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 Illness, 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. *See Morbid Obesity in the Covered Charges section for more information.*

(25) **Occupational Injury.** Care and treatment of an Injury or Illness 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.

(26) **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, non-Prescription Drugs and medicines *(except as otherwise specified)*, and first-aid supplies and nonhospital adjustable beds.

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

(28) **Prescription Drugs.** Charges for Prescription Drugs submitted for reimbursement under the medical benefits of this Plan that:

- are administered as "take home" drugs from a Hospital, Emergency Room, Urgent Care, or Physician's Office;
- are available (or commonly available) through a Retail Pharmacy, Mail Order Pharmacy, Specialty Pharmacy or Program, other pharmaceutical vendor or dispensary, or specified as covered in the Prescription Drug Benefits of this Plan;
- are obtained (by any source) outside the United States;
- represent a discount or coupon offered through Prescription Drug assistance programs or drug manufacturers.

(29) **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.

(30) **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.

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

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

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

(34) **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.

Prescription Drug coverage is administered by **SmithRx,** known as the Pharmacy Benefits Manager (PBM). SmithRx provides a nationwide network of participating Pharmacies and a drug formulary. The presence of a drug on this formulary does not guarantee coverage and the drugs listed on the formulary are subject to change.

For more information on Prescription Drug Benefits, claim questions, or to confirm if a prescribed medication is covered under the Plan, Plan Participants should contact SmithRx

Toll-free: (844) 454-5201, or
Visit: https://portal.mysmithrx.com/login

Prescription Drug expenses under the **Standard Health Plan** apply to the separate Prescription Drug deductible and maximum out-of-pocket amount as shown in the Standard Health Plan Prescription Drug Benefit schedule.

Prescription Drug expenses under the **HDHP option** *(except Preventive prescriptions)* are subject to the medical benefits HDHP deductible amount and apply to the HDHP medical maximum out-of-pocket amount, as shown in the HDHP Medical Benefits Schedule.

30-DAY RETAIL PHARMACY DRUGS

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

Retail Pharmacy drugs are limited to a 30-day supply per prescription.

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 **SmithRx,** the Pharmacy Benefit Manager, for reimbursement (minus any applicable deductible or copayments as shown in the Prescription Drug Benefit Schedule).

MAINTENANCE MEDICATIONS and MAIL ORDER DRUGS

Maintenance medications and mail order drugs are available up to a 90-day supply per prescription.

Maintenance medications must be obtained through one of the following local Pharmacies to be eligible for reimbursement:

- Costco Pharmacy
- RiverStone Health Pharmacy
- Billings Pharmacy One (1)
- Walmart Pharmacy
- Downtown Family Pharmacy
- Intermountain Pharmacy – St. Vincent
- Sam's Club Pharmacy
- Pharm406

Mail order medications are available through a SmithRx Mail Order partner such as: *Amazon Pharmacy and Walmart Mail Order Pharmacy*.

SPECIALTY DRUGS

Specialty drugs are limited to a 30-day supply per prescription and must be obtained through the SmithRx Specialty Pharmacy Program. ***Prior authorization through SmithRx is required for all specialty medications.***

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 SmithRx 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.

> ***This Plan utilizes a specialty drug copayment assistance program administered through SmithRx.*** As part of this process, certain specialty drugs are considered non-essential health benefits under the Plan, consequently the cost of such drugs will not be applied toward satisfying the Plan Participant's maximum out-of-pocket amount.

For additional information regarding the SmithRx Specialty Pharmacy Program, including a list of medications included in the SmithRx specialty drug copayment assistance program, contact SmithRx as shown above.

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

H.S.A. EXPANDED LIST OF PREVENTIVE MEDICATIONS

The H.S.A. Expanded List of Preventive Medications are those approved by the Internal Revenue Service (IRS) for treatment of a wide range of chronic conditions for which benefits may be offered under a Qualified High Deductible Health Plan (HDHP) prior to satisfaction of the medical deductible. The H.S.A. Expanded List of Preventive Medications may be obtained through the Maintenance Medication or Mail Order Drugs options subject to the copayment amounts shown in the HDHP Prescription Drug Benefit schedule and are available in a 30, 60, or 90-day supply per prescription.

To see a current list of SmithRx Preventive Medications available under this benefit, select the following link:
Preventive Medications list

Or enter the following web address on the internet:
https://smithrx.adaptiverx.com/web/pdf?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B682CE186079272EAD1

*This Expanded List of Preventive Medications **does not include** the drugs and products that are required coverage through the Affordable Care Act Preventive Services mandate which are payable at 100%, no deductible or copayments apply.*

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.*

COVERED PRESCRIPTION DRUGS

Note: prior authorization and/or quantity limitations may apply.

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

(2) Compound prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin, diabetic supplies and syringes, blood glucose monitoring machines, insulin pumps and pump supplies, when prescribed by a Physician.

(4) Drugs to treat Attention Deficit Disorder.

(5) Fertility drugs.

(6) Acne medications, prior authorization is required age 25 and older.

(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.

Following are commonly used Preventive Care drugs and products required by the Affordable Care Act to be covered at 100%, no copayment or deductible 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 Drug copayment as shown in the Prescription Drug Benefit Schedule.* ***Contact SmithRx toll-free at (844) 454-5201 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.

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 ***SmithRx*** *toll-free at (844) 454-5201 for more information regarding which medications are available. Note: Age and/or quantity limitations may apply*:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results

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, 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.** Prescription drugs or medications for treatment of 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) **Prescription drugs** purchased outside the United States, by the Plan Participant or by any other entity on their behalf.

(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 and submit a manual claim for reimbursement.

For prescription claims questions or to obtain a claim form contact:

SmithRx
P.O. Box 994
Lehi, Utah 84043
Toll free: (844) 454-5201
Or visit www.mysmithrx.com, or https://portal.mysmithrx.com/login

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

Claims for expenses should be submitted to:

Employee Benefit Management Services, LLC
1550 Liberty Ridge Drive, Suite 330
Wayne, Pennsylvania 19087

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.

<u>Internal Appeal Procedure</u>

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)
Attn: Claims Appeals
1550 Liberty Ridge Drive, Suite 330
Wayne, Pennsylvania 19087

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)
Attn: Claims Appeals
1550 Liberty Ridge Drive, Suite 330
Wayne, Pennsylvania 19087

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 the 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:

(1) Group or nongroup insurance contracts and subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group and nongroup coverage through closed panel plans;

(4) Group-type contracts;

(5) The medical components of long-term care contracts, such as skilled nursing care;

(6) 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;

(7) 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:

- 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;

- 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 and the Plan Participant is enrolled under Part A, Part B, or both, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B. 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 Medical Benefits Schedule. 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, Montana 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, Montana 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, Montana 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, Montana 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, Montana 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, Montana 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, Montana 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
HR Generalist
Payroll/HR Analyst
HR Administrative Support
City Attorney
Assistant City Attorney
Information Technology Director
Information Technology Manager
Finance Director
City Clerk

(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
1550 Liberty Ridge Drive, Suite 330
Wayne, Pennsylvania 19087
(800) 777-3575

Plan Name: City of Billings Employee Benefit Plan

Plan Options: Standard Health Plan, High Deductible Health Plan

Effective: January 1, 2006

Restated: January 1, 2026

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 Appendix A, Dental Benefits.

Family Unit Limit. When the dollar amount shown in the Appendix A, Dental 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 Appendix A, Dental 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 Appendix A, Dental 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

Claims for expenses should be submitted to:

Employee Benefit Management Services, LLC
1550 Liberty Ridge Drive, Suite 330
Wayne, Pennsylvania 19087

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:

(6) 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).

(7) 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.

(8) 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)
Attn: Claims Appeals
1550 Liberty Ridge Drive, Suite 330
Wayne, Pennsylvania 19087

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)
Attn: Claims Appeals
1550 Liberty Ridge Drive, Suite 330
Wayne, Pennsylvania 19087

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 City of Billings does provide an EAP program to their permanent positioned employees; however, the program does not run through the medical benefits Plan. Please see the HR Resources and Voluntary Benefits Guide located on the public website (www.billingsmt.gov) under Human Resource Forms & Resources page for details.

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.

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 the *City of Billings* Human Resources Department for full details. Gift cards are subject to IRS tax fringe.

Please see the Human Resources, Resources and Voluntary Benefits Guide located on the *City of Billings* public website: https://billingsmt.gov/417/Forms-and-Resources, under the Human Resources, Forms & Resources page for more details on the Annual Wellness Exam Incentive and the Healthy Is Wellness programs.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personal 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?	$1,750 per single coverage; $3,400 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. Preventive well adult & well child 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 (Tier 1): $4,000 per single coverage; $7,900 per family coverage (not to exceed $4,000 per plan participant); network (Tier 2) & non-network (Tier 3) providers: $6,750 per single coverage; $13,400 per family coverage (not to exceed $6,750 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 (Tier 1) network providers, see Rocky Mountain Health Network at www.rmhn.com; for network (Tier 2) 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*
		Tier 1 - Preferred Network Provider (You will pay the least)	Tier 2 - Network Provider (You will pay more)	Tier 3 - 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 (844) 454-5201 (SmithRx)	Generic drugs	$5 copayment/prescription (30-day retail pharmacy) $10 copayment/prescription (90-day mail order pharmacy)			The medical deductible applies to all prescription drugs except preventive prescription drugs. The Pharmacy Benefit Manager (PBM) is SmithRx. This Plan will accept maintenance medications obtained through Costco Pharmacy, Walmart Pharmacy, Sam's Club Pharmacy, RiverStone Health Pharmacy, Downtown Family Pharmacy, Pharm406, Billings Pharmacy One (1), Intermountain Pharmacy-St. Vincent, or a SmithRx mail order option, for example, Amazon Pharmacy and Walmart Mail Order Pharmacy. Specialty drugs require prior authorization through SmithRx and must be purchased through the SmithRx Specialty Pharmacy program.
	Preferred brand drugs	20% copayment/prescription ($30 minimum and a $60 maximum) (30-day retail); $90 copayment/prescription (90-day mail order)			
	Non-preferred brand drugs	40% copayment/prescription ($50 minimum and a $100 maximum) (30-day retail); $135 copayment/prescription (90-day mail order)			
	Specialty drugs	30-day supply only Generic drugs: $75 copayment/prescription Preferred brand drugs: $125 copayment/prescription Non-preferred brand drugs: $125 copayment/prescription			
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

* 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*
		Tier 1 - Preferred Network Provider (You will pay the least)	Tier 2 - Network Provider (You will pay more)	Tier 3 - Non-Network Provider (You will pay the most)	
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.
	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 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*
		Tier 1 - Preferred Network Provider (You will pay the least)	Tier 2 - Network Provider (You will pay more)	Tier 3 - 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 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. Outpatient physical, speech, & occupational therapy visit limits are based on Medical Necessity.
	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			None
	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 combined with massage therapy)
- 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	$1,750
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	$1,750
Copayments	$210
Coinsurance	$2,050
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,070**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,750
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs*
Medical supplies *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$210
Coinsurance	$620
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,750
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	$1,750
Copayments	$80
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,970**

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(s), please see the HR Resources & Voluntary Benefits Guide at: https://billingsmt.gov/417/Forms-and-Resources.

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?	$1,250 per plan participant; $2,400 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, and preventive well adult & well child 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): $350 per plan participant; $600 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 (Tier 1):** $2,500 per plan participant; $6,150 per family unit; **Network (Tier 2) & non-network providers (Tier 3):** $6,250 per plan participant; $17,400 per family unit. **Prescription drugs:** $2,500 per plan participant; $7,150 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 (Tier 1) providers, see Rocky Mountain Health Network at www.rmhn.com; for network (Tier 2) 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*
		Tier 1 - Preferred Network Provider (You will pay the least)	Tier 2 - Network Provider (You will pay more)	Tier 3 - 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 (844) 454-5201 (SmithRx).	Generic drugs	$5 copayment/prescription (30-day retail); $10 copayment/prescription, deductible does not apply (90-day mail order)			A prescription drug deductible applies to retail pharmacy & specialty pharmacy drugs, but not maintenance or mail order drugs. A prescription drug out-of-pocket limit applies to all prescription drugs. The Pharmacy Benefit Manager (PBM) is SmithRx. This Plan will accept maintenance medications obtained through Costco Pharmacy, Walmart Pharmacy, Sam's Club Pharmacy, RiverStone Health Pharmacy, Downtown Family Pharmacy, Pharm406, Billings Pharmacy One (1), Intermountain Pharmacy-St. Vincent, or a SmithRx mail order option, for example, Amazon Pharmacy and Walmart Mail Order Pharmacy. Specialty drugs require prior authorization through SmithRx and must be purchased through the SmithRx Specialty Pharmacy program.
	Preferred brand drugs	20% copayment/prescription ($30 minimum and a $60 maximum) (30-day retail); $90 copayment/prescription, deductible does not apply (90-day mail order)			
	Non-preferred brand drugs	40% copayment/prescription ($50 minimum and a $100 maximum) (30-day retail); $135 copayment/prescription, deductible does not apply (90-day mail order pharmacy)			
	Specialty drugs	30-day supply only Generic drugs: $75 copayment/prescription Preferred brand drugs: $125 copayment/prescription 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*
		Tier 1 - Preferred Network Provider (You will pay the least)	Tier 2 - Network Provider (You will pay more)	Tier 3 - 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.
	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/	40% coinsurance and $200 inpatient hospital copayment/	40% coinsurance and $200 inpatient hospital copayment/	The inpatient hospital copayment per confinement will apply until the out-of-pocket limit has been met for the calendar year.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information*
		Tier 1 - Preferred Network Provider (You will pay the least)	Tier 2 - Network Provider (You will pay more)	Tier 3 - Non-Network Provider (You will pay the most)	
		confinement	confinement	confinement	
If you need help recovering or have other special health needs	Home health care	20% coinsurance			None
	Rehabilitation services 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. Outpatient physical, speech, & occupational therapy visit limits are based on Medical Necessity.
	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			None
	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, combined with massage therapy)
- 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.

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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	$1,250
Primary care copayment	$25
Hospital (facility) copay/coins	$200/20%
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*	$1,260
Copayments	$200
Coinsurance	$1,050
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,570**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,250
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*
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$120
Copayments	$2,270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,410**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,250
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*	$1,250
Copayments	$80
Coinsurance	$240
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,570**

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(s), please see the HR Resources & Voluntary Benefits Guide at: https://billingsmt.gov/417/Forms-and-Resources.
Note: These calculations may include other benefit deductibles or maximum out-of-pocket limits for specific services. See page one for more information.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.