

**AMENDMENT #6  
TO THE  
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION**

**HEALTH BENEFIT PLAN  
FOR EMPLOYEES OF  
FLATHEAD COUNTY - Group #0010675**

Effective January 1, 2016, the Health Benefit Plan for Employees of Flathead County is amended as follows:

Within the "**SCHEDULE OF BENEFITS**" section, the "SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES" subsection is replaced as follows:

**SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES**

Deductible Applies, Benefit Percentage .....	75%
Maximum Benefit per Implant for the following:	
Orthopedic Implants .....	\$40,000
Cardiac Implants (except for LVAD and RVAD) .....	\$60,000
Cochlear Implants .....	\$85,000
LVAD / RVAD Implants .....	\$200,000

Maximums apply to any implantable device and all supplies associated with that implantable device.

**Pre-treatment Review by the Plan is strongly recommended for all surgical implant procedures. If you choose not to obtain a Pre-treatment Review, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary *or found to be otherwise excluded by the Plan* when the claim is submitted.**

Within the "**PHARMACY BENEFIT**" section, the "COST SHARING PROVISIONS" subsection, as amended, is replaced as follows:

**COST SHARING PROVISIONS**

**Active Employees Annual Deductible per Benefit Period:**

Maximum per Employee .....	\$300
Maximum per Employee + 1 Dependent .....	\$600
Maximum per Employee + 2 or more Dependents .....	\$900

**Retirees and COBRA Participants Annual Deductible per Benefit Period:**

Maximum per Covered Person .....	\$300
Maximum per 2 Covered Persons per Family .....	\$600
Maximum per 3 or more Covered Persons per Family .....	\$900

**Active Employees Annual Out-of-Pocket Maximum per Benefit Period:**

Per Employee .....	\$4,550*
Per Employee + 1 or more Dependents .....	\$9,100*

**Retirees and COBRA Participants Annual Out-of-Pocket Maximum per Benefit Period:**

Maximum per Covered Person .....	<b>\$4,550*</b>
Maximum per 2 Covered Persons per Family .....	\$9,100*
Maximum per 3 or more Covered Persons per Family .....	\$9,100*

\*Includes the Pharmacy Deductible and any applicable Pharmacy Copayments. Pharmacy Benefits are payable at 100% after satisfaction of the Pharmacy Out-of-Pocket Maximum for the remainder of the Benefit Period.

Copayment per Prescription				
Drug Type	Retail PBM Network	Member Submit*	Mail Order	Specialty Drug
Generic	10% (min. \$7)	10% (min. \$7)	10% (min. \$14)	10% (min. \$7)
Preferred Brand	20% (min. \$15)	20% (min. \$15)	20% (min. \$30)	20% (min. \$15)
Non-Preferred Brand	30% (min. \$35)	30% (min. \$35)	30% (min. \$70)	30% (min. \$35)

\*For Member Submit prescriptions, the PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription.

The following are payable at 100% and are not subject to any Deductible or Copayment:

1. Prescribed generic contraceptives or brand if generic is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and
3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: <https://www.healthcare.gov/preventive-care-benefits/>.

**When Primary Coverage exists Under Another Plan**

If primary coverage exists under another plan, including Medicare Part D, charges for prescription drugs must be submitted to the primary carrier first. Once this Plan receives a copy of the drug receipt or explanation of benefits showing the total charges and amounts paid for eligible prescription drugs from the primary carrier, if applicable, this Plan will reimburse the Participant for the remainder of Eligible Expenses, subject to the following Copayments:

Generic ..... 10% (min. \$7)  
 Brand Name ..... 20% (min. \$15)

**In order to receive reimbursement, the drug receipt must be submitted to Allegiance, or through the Pharmacy Benefit Manager (PBM) if primary coverage is Medicare Part D.**

Within the "PHARMACY BENEFIT" section, item #4 and #7 under the "COVERAGE" subsection, as amended, are replaced as follows:

4. Dermatology: agents used in the treatment of acne and/or for cosmetic purposes.
7. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: <https://www.healthcare.gov/preventive-care-benefits/>.

Within the "PHARMACY BENEFIT" section, the "Non-Preferred Brand" paragraph under the "DRUG OPTIONS" subsection is replaced as follows:

**Non-Preferred Brand:** Copyrighted or patented brand name drugs (Non-Generic) which are not recognized or listed as Preferred Brand drugs or supplies by the PBM Program. *On limited occasions a Generic may be included when specific regulatory or market places circumstances exist.*

Within the "PHARMACY BENEFIT" section, the "EXCLUSIONS" subsection, as amended, is replaced as follows:

#### EXCLUSIONS

Prescription drugs or supplies in the following categories are specifically excluded:

1. Cosmetic only indications including, but not limited to; photo-aged skin products (Renova), Hair Growth Agents (Propecia, Vaniqa), and Injectable cosmetics (botox cosmetic).
2. Dermatology: Depigmentation products used for skin conditions requiring a bleaching agent.
3. Legend homeopathic drugs.
4. Fertility agents: oral, vaginal and injectable.
5. Erectile dysfunction injectables.
6. Weight management.
7. Allergens.
8. Serums, toxoids and vaccines.
9. Legend vitamins and legend fluoride products.
10. Over-the-counter equivalents and non-legend medications (OTC).
11. Durable Medical Equipment.\*
12. Experimental or Investigational drugs.
13. Abortifacient drugs.
14. *Compounded pharmaceuticals containing bulk chemicals.*

\*Eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

#### NON-FORMULARY EXCLUSION

*Certain drugs may be excluded by the Plan's Pharmacy Benefit Manager (PBM). Those exclusions are based upon the PBM's clinical research regarding the efficacy of the drug as compared to other similar drugs, the availability of the drug, and clinical prescribing rules. Drugs excluded under this basis may be covered if a request for Prior Authorization is made, or if a denial of coverage for the drug is appealed under the claims and appeals procedures of this Plan.*

Within the "MEDICAL BENEFITS" section, item #22 (dressings, sutures, etc.) is replaced as follows:

22. Charges by a Physician or Licensed Health Care Provider for dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics or other Medically Necessary medical supplies, except for dental braces or corrective shoes, which are specifically excluded.

Diabetic supplies are only eligible for coverage under the Pharmacy Benefit of this Plan, including insulin, needles, syringes, test strips and lancets.

*Blood monitors and kits are eligible for coverage under the Medical Benefits and the Pharmacy Benefit, subject to all provisions and limitations of this Plan.*

Within the "**MEDICAL BENEFITS**" section, item #3 under the "PREVENTIVE CARE" subsection, as amended, is replaced as follows:

3. Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at: <https://www.healthcare.gov/preventive-care-benefits/>.

Within the "**MEDICAL BENEFIT**" section, the "SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES" subsection is replaced as follows:

#### SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES

Charges for surgical implants and/or devices and related supplies are payable as specifically outlined in the Schedule of Benefits, subject to all terms and conditions of this Plan. Coverage under this benefit includes charges for implants, devices and related supplies, including fastenings, screws and all other hardware related to the device or implant.

**Pre-treatment Review by the Plan is strongly recommended for all implantable procedures. If you choose not to obtain Pre-treatment Review, the charge could be denied if the service, treatment or supply is not found to be Medically Necessary *or found to be otherwise excluded by the Plan* when the claim is submitted.**

Within the "**ELIGIBILITY PROVISIONS**" section, the "EMPLOYEE ELIGIBILITY" subsection, as amended, is replaced as follows:

#### EMPLOYEE ELIGIBILITY

An Employee becomes eligible under this Plan for each classification of Employee as follows::

1. Class I - Is classified as an eligible Employee employed by the County on a continuing and regular basis for at least twenty (20) hours per week, including seasonal Employees as defined by Montana Code Annotated (MCA) who work on a continuing and regular basis for at least twenty (20) hours per week for more than six (6) consecutive months; or
2. Class II - Is classified as a Variable Hour Employee employed by the Company and completes a Measurement Period of twelve (12) consecutive months, during which the Variable Hour Employee averages thirty (30) hours per week of actual work and/or paid leave, *FMLA leave, or jury duty whether paid or not*, for twelve (12) consecutive months. Variable Hour Employees include part-time, temporary, and seasonal Employees who are not within the MCA statutory definition.

"Measurement Period" is the period of time adopted by the Plan for Variable Hour Employees during which such Employees' work hours and *applicable* leave are measured to determine whether such Employees are eligible for coverage.

An Employee is not eligible while on active military duty if that duty exceeds a period of thirty-one (31) consecutive days.

Within the "EFFECTIVE DATE OF COVERAGE" section, the "PARTICIPANT COVERAGE" subsection, as amended, is replaced as follows:

PARTICIPANT COVERAGE

Participant coverage under the Plan will become effective on the first day immediately after the Employee satisfies the applicable eligibility requirements and Waiting Period. If these requirements are met, the Employee must be offered coverage or an opportunity to waive coverage even if the offer is after the date coverage should become effective, regardless of the time that has elapsed, provided that the reason coverage was not offered before the end of the Waiting Period was as a result of an administrative error on the part of the Employer, Plan Administrator or Plan Supervisor.

An eligible Employee who declines coverage under the Plan or fails to enroll during the Initial Enrollment Period will be able to become covered later in only two situations, Open Enrollment and Special Enrollment Period.

A Variable Hour Employee will remain covered for a period of time not to exceed twelve (12) months from the effective date of coverage (the Coverage Period) regardless of the number of hours worked *and applicable leave*, as long as the individual remains employed by the Company. At the end of the Coverage Period, if the individual remains employed as a Variable Hour Employee and averages at least thirty (30) per week during the Coverage Period, the individual will remain covered for a period of time not to exceed an additional twelve (12) months.

"Coverage Period" is the maximum period of time Variable Hour Employees can be covered under the Plan as active Employees after completion of a Measurement Period as defined in the "Eligibility Provisions under the "Employee Eligibility" subsection.

If an eligible Employee chooses not to enroll or fails to enroll for coverage under the Plan during the Initial Enrollment Period or the Special Enrollment Period, coverage for the Employee and Dependents will be deemed waived.

If a Participant chooses not to re-enroll or fails to re-enroll during any Open Enrollment Period, coverage for the Participant and any Dependents covered at the time will remain the same as that elected prior to the Open Enrollment Period.

Within the "**TERMINATION OF COVERAGE**" section, the "REINSTATEMENT OF COVERAGE" subsection, as amended, is replaced as follows:

REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of termination of employment or temporary layoff and who again becomes eligible for coverage under the Plan within a *ninety (90)* day period immediately following the date coverage is terminated will become eligible for reinstatement of coverage on the date of renewed eligibility. Coverage will be reinstated for the Employee and eligible Dependents on the first of the month following the date of renewed eligibility, provided that application for such coverage is made on the Plan's enrollment form within thirty (30) days after the date of renewed eligibility. Reinstatement of Coverage is subject to the following:

1. Credit will be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.
2. All prior accumulations toward annual or lifetime benefit maximums will apply.

If renewed eligibility occurs under any circumstances other than as stated in this subsection, enrollment for coverage for the Employee and his/her Dependents will be treated as if initially hired for purposes of eligibility and coverage under this Plan.

The Reinstatement of Coverage provision is not applicable to a Variable Hour Employee except for any period of time that the Variable Employee is actually enrolled and covered during the Coverage Period.

Within the "**FRAUD AND ABUSE**" section, the "MISREPRESENTATION OF ELIGIBILITY" subsection is replaced as follows:

MISREPRESENTATION OF ELIGIBILITY

If a Participant misrepresents a Dependent's marital status, age, dependent child relationship or other eligibility criteria to get coverage for that Dependent, when he or she would not otherwise be eligible, coverage for that Dependent will terminate as though never effective.

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.



FLATHEAD COUNTY

BY:

*Carmelo J. Holmquist*

TITLE:

*Chairperson, Board  
of County Commissioners*