

AMENDMENT #5
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION
for the
HEALTH BENEFIT PLAN FOR EMPLOYEES OF CITY OF MISSOULA - GROUP #2000203

The Health Benefit Plan for Employees of City of Missoula is amended as follows (**red** and *italics* mean change/addition; ~~strikeout~~ means deletion):

Effective November 1, 2021: Within “**PPO BENEFIT**”, item 2 within “NON-PPO BENEFIT EXCEPTION” is replaced as follows:

2. Charges eligible for coverage under the Mental Illness, Alcoholism and/or Chemical Dependency, Dental *Services (Accidental Injury)*, Voluntary Second and Third Surgical Opinion, Routine Wellness Care or Alternative Treatment.

Effective November 1, 2021 through December 31, 2021: Within “**SCHEDULE OF MEDICAL BENEFITS - JULY 1, 2021 THROUGH DECEMBER 31, 2021**”, as amended, “**TYPE OF SERVICE / LIMITATIONS**” table is replaced as follows:

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE	
	PPO	NON-PPO
ALTERNATIVE TREATMENT Alternative treatment includes Chiropractic Care, Naturopathy treatment, Acupuncture and Massage Therapy. Benefit Limits: Maximum number of Treatments for all types combined per Benefit Period / 18 . “Treatment” includes all services provided during a calendar day, including x-rays. Benefit limits are for services received from PPO and Non-PPO Providers.	70% after <i>PPO</i> Deductible	
BARIATRIC SURGERY Benefit Limits: Maximum Lifetime Benefit / \$40,000 . Benefit limits are for services received from PPO and Non-PPO Providers.	70% after Deductible	50% after Deductible
COLONOSCOPY BENEFIT - ROUTINE OR DIAGNOSTIC	100%, Deductible Waived	50% after Deductible
COVID-19 VACCINE The Non-PPO benefit is effective 15 days after a COVID-19 vaccine receives emergency approval by the FDA through the duration of the Declared National Emergency.	100%, Deductible Waived	100%, Deductible Waived
<i>DENTAL SERVICES (ACCIDENTAL INJURY)</i>	<i>70% after PPO Deductible</i>	
DIABETES PREVENTION PROGRAM THROUGH MISSOULA CITY-COUNTY HEALTH DEPARTMENT* Benefit Limits: Maximum Lifetime Benefit / \$350 . *Requires a Physician referral.	100%, Deductible Waived	
EYE EXAMINATION FOR REFRACTORY CONDITIONS AND RETINAL SCREENING (Not otherwise covered under the Preventive Care Benefit)	100%, Deductible Waived	100%, Deductible Waived
Benefit Limits: Maximum Benefit per Benefit Period / \$60 . This benefit can be waived, though waiver will not change the required contribution. Benefit limits are for services received from Network and Non-Network Providers. This benefit can be waived, though waiver does not change the required contribution.		

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE	
	PPO	NON-PPO
HEARING AID BENEFIT (Includes exam and fitting)	70% after <i>PPO</i> Deductible	
Benefit Limits: Maximum Benefit / \$2,500 once every 3 Benefit Periods. Benefit limits are for services received from PPO and Non-PPO Providers.		
HEARING EXAMINATION (Not otherwise covered under the Preventive Care Benefit)	100%, Deductible Waived	100%, Deductible Waived
Benefit Limits: Maximum Benefit per Benefit Period / \$60 . This benefit can be waived, though waiver will not change the required contribution. Benefit limits are for services received from Network and Non-Network Providers. This benefit can be waived, though waiver does not change the required contribution.		
HOME HEALTH CARE	70% after Deductible	50% after Deductible
HOSPITAL ROOM AND BOARD	70% after Deductible	50% after Deductible
MENTAL ILLNESS, ALCOHOLISM AND/OR CHEMICAL DEPENDENCY	<i>70% after PPO Deductible</i>	
NON-AMBULANCE TRAVEL BENEFIT	70% after <i>PPO</i> Deductible	
Benefit Limits: Maximum Lifetime Benefit of \$10,000, limited to the following: Coach airfare Mileage if driving reimbursed at IRS standard mileage rate Meals limited to \$71 per day per person Lodging, not to exceed \$139 per day For the patient and one companion, limited to travel to a contracted Center of Excellence if treatment at a contracted Center of Excellence is more cost effective than the same treatment if received from other providers.		
OFFICE VISITS - PHYSICIAN/LICENSED HEALTH CARE PROVIDER (Excluding Alternative Treatment)	70% after Deductible	50% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE	
	PPO	NON-PPO
ORGAN AND TISSUE TRANSPLANT SERVICES	70% after Deductible	50% after Deductible
Benefit Limits: Maximum Benefit per Procedure:		
Allogenic Stem Cell (related)		\$250,000
Allogenic Stem Cell (unrelated)		\$340,000
Autologous Stem Cell		\$140,000
Stem Cell Other		\$230,000
Heart		\$275,000
Heart Lung		\$345,000
Intestine		\$485,000
Kidney		\$95,000
Kidney Pancreas		\$160,000
Liver		\$220,000
Lung		\$275,000
Pancreas		\$140,000
Solid Other		\$440,000
Other Eligible Transplant or Replacement Procedure		\$75,000
Benefit limits are for services received from Non-PPO Providers. For PPO Providers, payment will be made pursuant to the provider contract.		
Maximums apply to all expenses in connection with any eligible organ or tissue transplant procedure as stated in Medical Benefits under Organ and Tissue Transplant Services.		
Services subject to the maximums include, but are not limited to evaluation; pre-transplant, transplant and post-transplant care (not including Outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. Charges incurred after such 12-month period are eligible under the Medical Benefits of the Plan and <u>do not</u> accrue toward the Transplant benefit limits.		
Amounts exceeding the maximum case rate at contracted Centers of Excellence (also known as outliers) will be eligible for reimbursement under Medical benefits. Excess charges at non-contracted facilities will not be eligible for reimbursement.		
PHYSICAL THERAPY	70% after Deductible	50% after Deductible

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE									
	PPO	NON-PPO								
PREVENTIVE CARE BENEFIT	100%, Deductible Waived	50%, Deductible Waived								
PREVENTIVE CARE BENEFIT (ROUTINE WELLNESS CARE)	100% Deductible Waived*									
<p>Routine Wellness Care (*All ages, except Colonoscopy - Routine or Diagnostic. See Colonoscopy Benefit - Routine or Diagnostic for specific cost sharing information).</p> <p>Covered Services:</p> <ul style="list-style-type: none"> ◆ Well-Child Care ◆ Physical examinations ◆ Pelvic examination and pap smear ◆ Laboratory and testing ◆ Hearing and vision screening ◆ Mammogram ◆ Prostate cancer screening Prostate-Specific Antigen (PSA) or Digital Rectal Examination (DRE) ◆ Cardiovascular screening blood tests ◆ Colorectal cancer screening tests ◆ Vaccinations and Immunizations recommended by Physician ◆ BRCA1 and BRCA2 when medically indicated ◆ Nutritional counseling ◆ Well Women Preventive Care, subject to Plan limitations on sterilization procedures <p>Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.</p> <p>If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.</p>										
RENAL DIALYSIS - OUTPATIENT	70% after Deductible	50% after Deductible								
<p>Benefit Limits: Maximum Benefit per dialysis session* / \$550</p> <p>*Dialysis session includes charges for the dialysis, use of facility, professional fees and any and all drugs provided during the administration of a single course of dialysis.</p>										
ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE	80%, Deductible Waived	50% after Deductible								
<p>Routine Newborn Inpatient Nursery/Physician Care applies until the earlier of the Newborn's discharge from hospital or 48 hours for vaginal delivery or 96 hours for cesarean section.</p>										
SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES	70% after Deductible	50% after Deductible								
<p>Benefit Limits: Maximum Benefit per Implant for the following:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding-left: 20px;">Orthopedic Implants</td> <td style="text-align: right;">\$40,000</td> </tr> <tr> <td style="padding-left: 20px;">Cardiac Implants (except for LVAD and RVAD)</td> <td style="text-align: right;">\$60,000</td> </tr> <tr> <td style="padding-left: 20px;">Cochlear Implants.</td> <td style="text-align: right;">\$85,000</td> </tr> <tr> <td style="padding-left: 20px;">LVAD / RVAD Implants</td> <td style="text-align: right;">\$200,000</td> </tr> </table> <p>Maximums apply to any implantable device and all supplies associated with that implantable device. Benefit limits are for services received from Non-PPO Providers. For PPO Providers, payment will be made pursuant to the provider contract.</p>			Orthopedic Implants	\$40,000	Cardiac Implants (except for LVAD and RVAD)	\$60,000	Cochlear Implants.	\$85,000	LVAD / RVAD Implants	\$200,000
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	PPO	NON-PPO
VOLUNTARY SECOND AND THIRD SURGICAL OPINION	100%, Deductible Waived	
Benefit Limits: Maximum Benefit per eligible surgical opinion / \$100		
WIG	70% after <i>PPO</i> Deductible	
Benefit Limits: Maximum Benefit per Benefit Period / \$300 . Benefit limited to loss of hair as a result of alopecia or medical treatment.		

Effective January 1, 2022: Within “**SCHEDULE OF MEDICAL BENEFITS**”, as amended, “**TYPE OF SERVICE / LIMITATIONS**” table is replaced as follows:

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RENAL DIALYSIS - OUTPATIENT	70% after Deductible	50% after Deductible								
<p>Benefit Limits: Maximum Benefit per dialysis session* / \$550</p> <p>*Dialysis session includes charges for the dialysis, use of facility, professional fees and any and all drugs provided during the administration of a single course of dialysis.</p>										
ROUTINE NEWBORN INPATIENT NURSERY/PHYSICIAN CARE	80%, Deductible Waived	50% after Deductible								
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SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES	70% after Deductible	50% after Deductible								
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Benefit Limits: Maximum Benefit per eligible surgical opinion / \$100		
WIG	70% after <i>PPO</i> Deductible	
Benefit Limits: Maximum Benefit per Benefit Period / \$300 . Benefit limited to loss of hair as a result of alopecia or medical treatment.		

Effective November 1, 2021: Within **MEDICAL BENEFITS**, “DENTAL SERVICES - ACCIDENTAL INJURY” is added following “COLONOSCOPY BENEFIT - ROUTINE OR DIAGNOSTIC”:

DENTAL SERVICES - ACCIDENTAL INJURY


*Coverage includes charges for dental treatment required because of Accidental Injury to natural teeth. Such expenses must be Incurred within six (6) months of the date of accident **except in the event that it is medically impossible for service to be completed within that time frame because of the age of the Covered Person or because of the healing process of the Injury.** Coverage will not in any event include charges for treatment for the repair or replacement of a denture.*


Effective November 1, 2021: Within “**MEDICAL BENEFIT EXCLUSIONS**”, item 10 (dental treatment), as amended, is replaced as follows:


- Charges for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; ~~however, benefits will be payable for treatment required because of Accidental Injury to natural teeth. Such expenses must be Incurred within six (6) months of the date of accident. This exception will not in any event be deemed to include charges for treatment for the repair or replacement of a denture,~~ *except as specifically listed as a covered service.*

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

CITY OF MISSOULA

BY: 
 John Engen (Oct 1, 2021 08:30 PDT)
 MAYOR

ATTEST: 
 Marty Reinlein (Oct 5, 2021 14:40 MDT)
 CITY CLERK

ACCORD: 
 JIM NUGENT (Sep 30, 2021 15:10 MDT)
 CITY ATTORNEY












Health Benefit Plan Amendment #5

Final Audit Report

2021-10-05

Created:	2021-09-30
By:	Alicia Vanderheiden (vanderheidena@ci.missoula.mt.us)
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"Health Benefit Plan Amendment #5" History

-  Document created by Alicia Vanderheiden (vanderheidena@ci.missoula.mt.us)
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