AMENDMENT #12
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

HEALTH BENEFIT PLAN FOR EMPLOYEES OF
CITY OF MISSOULA - Group #2000203

Effective July 1, 2018, the Health Benefit Plan for Employees of City of Missoula is amended as follows (red and *italics* means addition and ~~strikeout~~ means deletion):

Within the **"SCHEDULE OF MEDICAL BENEFITS"**, the **"MISSOULA WALK-IN MEDICAL CLINICS BENEFIT"** table, as amended, is replaced as follows:

MISSOULA WALK-IN MEDICAL CLINICS BENEFIT **This benefit is restricted to CostCare walk in medical clinics which are operating under the business name "CostCare"** ***and Community Medical Center (CMC) walk-in-clinics which are*** **located in** ***the surrounding areas of*** **Missoula, MT.**
Office Visits: Deductible Waived, Copayment per Office Visit . . . . *$20* The Copayment applies to all charges for services provided in the office by the provider, including charges for evaluation and management and any additional charges for lab, x-ray and other diagnostic miscellaneous testing, except as stated below. **Copayment does apply towards the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied the Office Visit Copayment will no longer apply for the remainder of the Benefit Period.** This benefit includes charges made by CostCare Walk-In Medical Clinic *and CMC walk-in-clinics* in Missoula, MT for the Office visit and certain basic and common laboratory services and medical supplies only when initially ordered by a CostCare *or CMC walk-in-clinics* provider. This benefit also includes specialized laboratory charges ordered as part of treatment by a CostCare *or CMC walk-in-clinics* provider. **However, this benefit does not include laboratory charges and/or services or testing ordered by other providers, even if obtained through CostCare,** *CMC walk-in-clinics* **specialized procedures such as PET Scans, CT Scans, MRIs, radiation therapy, nuclear scans, Durable Medical Equipment including, but not limited to, CPAPs, wheelchairs, crutches, or medical devices and supplies such as IUDs, Norplant, and any similar items. Such services will be subject to the regular benefit provisions including, but not limited to, the Annual Deductible and Benefit Percentage.**

The **"PHARMACY BENEFIT"** section, as amended, is replaced as follows:

PHARMACY BENEFIT

Prescription drug charges are payable only through the Plan's Pharmacy Benefit Manager (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. Pharmacy Copayments do not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments do apply toward the applicable Pharmacy Benefit Out-of-Pocket Maximum. **The Pharmacy Benefit Manager (PBM) will provide separate information for details regarding Network pharmacies, Preferred Brand prescriptions and Specialty Drugs upon enrollment for coverage under this Plan.** ***Additional information regarding the Prescription Drug Benefits is also available at: www.navitus.com or by calling (855) 673-6504.***

The Benefit Period is a twelve month period commencing on July 1st and ending on June 30th of each succeeding year.

COST SHARING PROVISIONS

Pharmacy Deductible per Benefit Period
Per Covered Person/Family $50

Pharmacy Out-of-Pocket Maximum per Benefit Period
Per Covered Person $3,400*
Per Family $6,800*

*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** ~~**34-day supply per Copayment**~~	**Mail Order** ~~**90-day supply per Copayment**~~	**Specialty Drug**
~~Generic~~ *Tier 1*	10% (min. $5) *(1-34 days)* *10% (min. $10) (35-90 days)*	*10% (min. $5) (1-34 days)* 10% (min. $10) *(35-90 days)*	10% (min. $5)
~~Preferred Brand~~ *Tier 2*	20% (min. $20) *(1-34 days)* *20% (min. $40) (35-90 days)*	*20% (min. $20) (1-34 days)* 20% (min. $40) *(35-90 days)*	20% (min. $20)
~~Non-Preferred Brand~~ *Tier 3*	50% (min. $35) *(1-34 days)* *50% (min. $70) (35-90 days)*	*50% (min. $35) (1-34 days)* 50% (min. $70) *(35-90 days)*	50% (min. $35)

~~Diabetic supplies: Generic Copayment applies~~

~~The Copayment is waived for generic prescriptions obtained for coronary artery disease, diabetes, hypertension, osteoporosis, respiratory disorders, stroke and women's health. A complete list of generic Preventive Therapy Drug list can be obtained from the Pharmacy Benefit Manager.~~

*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/coverage/preventive-care-benefits/
4. *Vaccines includes coverage of: Influenza, Pneumonia, Tetanus, Hepatitis, Shingles, Measles, Mumps, Human Papillomavirus (HPV), Pertussis, Varicella and Meningitis.*

~~**Mandatory Mail Order Program:** Except for the first three fills for each maintenance drug that are obtained from a retail pharmacy, maintenance drugs must be obtained from a Mail Order Pharmacy. Maintenance drugs that have been filled more than three times from any retail pharmacy will not be covered under this Plan and the Covered Person will be responsible for the full cost of the maintenance drug.~~

Maintenance Therapy Drugs: *The Deductible and Copayment are waived if prescriptions are obtained for Maintenance Therapy Drugs. A complete list of generic Maintenance Therapy Drugs may be obtained from the Pharmacy Benefit Manager. The Maintenance Therapy Drug list may also be referred to as "Preventive Therapy Drug List" by the Pharmacy Benefit Manager.*

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. The Pharmacy Benefit Manager will coordinate benefits subject to the ~~following~~ *applicable* Copayments.

~~Generic~~ . . . . ~~10% (min. $5)~~
~~Brand Name~~ . . . . ~~20% (min. $20)~~

For coordination, the drug receipt must be submitted to the Pharmacy Benefit Manager (PBM).

COVERAGE

Coverage for prescription drugs will include only those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. ~~Self-administered~~ Contraceptives and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider.

   Female **contraceptives** ***and Contraceptive*** **Management~~, injectable contraceptives and contraceptive devices~~ are** ***also*** **covered under the Medical Benefits of this Plan.**

2. Legend vitamins (oral only): Prenatal agents used in Pregnancy and hemopoetic agents used to treat anemia.

3. Diabetic supplies, including *alcohol swabs,* syringes, *pen* needles, *pump cartridge (V-Go),* blood *glucose and ketone* test strips, blood glucose calibration solutions, urine tests, lancets and lancet devices.

4. Smoking deterrents prescribed by a Physician or Licensed Health Care Provider *up to two (2) ninety (90) day supply quit attempts per Calendar Year. Attempts in excess of two (2) ninety (90) day supply per Calendar Year are excluded*.

5. 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/coverage/preventive-care-benefits/.

6. Blood monitors and kits. Blood monitors and kits are also eligible under the Medical Benefits, subject to all provisions and limitations of this Plan.

7. *Vaccines if not covered under the Medical Benefits including: Influenza, Pneumonia, Tetanus, Hepatitis, Shingles, Measles, Mumps, Human Papillomavirus (HPV), Pertussis, Varicella and Meningitis*

8. *Medications related to a diagnosis of gender identity disorder.*

9. *Compounds subject to Prior Authorization.*

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:

PBM Network Prescriptions: Available only through a retail pharmacy that is part of the PBM Network. The pharmacy will bill the Plan directly for that part of the prescription cost that exceeds the Copayment (Copayment amount must be paid to pharmacy at time of purchase). **The prescription identification card is required for this option.**

Member Submit Prescriptions: Available only if the prescription identification card cannot be used because a pharmacy is not part of the PBM Network, or the prescription identification card is not used at a PBM pharmacy. **Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the Pharmacy Benefit Manager (PBM), along with a reimbursement form (Direct Reimbursement). 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.**

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. **The pharmacy will bill the Plan directly for prescription costs that exceed the Copayment.**

Specialty Drug(s): These medications are generic or non-generic drugs classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty drugs must be obtained from a preferred specialty pharmacy. **Only your first prescription can be obtained at a network retail pharmacy. All subsequent refills must be obtained through a preferred specialty pharmacy. A list of specialty drugs and preferred specialty pharmacies may be obtained from the PBM or Plan Supervisor.**

DRUG OPTIONS

The drug options available are:

~~**Generic:** Those drugs and supplies listed in the most current edition of the Physicians Desk Reference or by the PBM Program as generic drugs.~~

~~**Preferred Brand:** Non-generic drugs and supplies listed as "Preferred Brand" by the PBM Program as stated in a written list provided to Covered Persons and updated from time to time.~~

~~**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.~~

Tier 1: *Preferred generics and some lower cost brand products.*

Tier 2: *Preferred brand products and some high cost non-preferred generics.*

Tier 3: *Non-preferred brand products (may include some high cost non-preferred generics).*

COPAYMENT

"Copayment" means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of service. Copayments are specifically stated in this section. Copayments are not payable by the Plan and do not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments do apply towards the applicable Pharmacy Out-of-Pocket Maximum and after satisfaction of the Out-of-Pocket Maximum, Copayments will no longer apply for the remainder of the Benefit Period.

SUPPLY LIMITS

Supply is limited to ~~34~~ 90 days for *Retail Pharmacy prescriptions, 34 days for* Member Submit *prescriptions*, ~~PBM Network Prescriptions or a 90-day supply for Mail Order Prescriptions~~ *and 30 days for Specialty drugs*.

Prescription drug refills are not allowed until 75% *for Retail prescriptions and 70% for Mail Order* of the prescribed day supply is used.

The amount of certain medications are limited to promote safe, clinically appropriate drug usage. If you have exceeded a limit and your Physician believes you need an additional supply of a medication, it will be reviewed for Medical Necessity. A current list of applicable quantity limits can be obtained by contacting the PBM at the number listed on the Participant's identification card.

STEP THERAPY PROGRAM

~~Certain medications may require prior authorization before you will be able to obtain a second fill. If you purchase one of these medications, a letter will be sent to both you and your Physician explaining the steps necessary to obtain your refill.~~

~~**Failure to use the step therapy program will result in the Covered Person being responsible for the entire cost of the drug.**~~

A protocol that requires the member to try a preferred formulary medication before approving a more expensive preferred product or non-formulary product. A current list of drugs that require Step Therapy can be obtained by contacting the PBM at the number listed on the Participant's identification card.

PRIOR AUTHORIZATION

Certain drugs require approval before the drug can be dispensed. A current list of drugs that require prior authorization can be obtained by contacting the PBM at the number listed on the Participant's identification card.

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 *or hair removal* agents (Propecia, Vaniqa); and Injectable cosmetics (Botox cosmetic).

2. Dermatology: Agents used in the treatment of acne and/or for cosmetic purposes for Covered Persons ~~twenty-six (26)~~ *thirty-five (35)* years or older or depigmentation products used for skin conditions requiring a bleaching agent*, unless Prior Authorization has been obtained*.

3. Fertility agents, oral, vaginal and injectable.

4. Erectile dysfunction.

5. Weight management.

6. Allergens.

7. Serums *and* toxoids ~~and vaccines~~.

8. Legend vitamins, except as specifically covered.

9. Smoking Cessation products, except as specifically covered.

10. Over-the-counter equivalents and non-legend medications (OTC), except as specifically covered.

11. Durable Medical Equipment.*

12. Legend homeopathic drugs.

13. Experimental or Investigational drugs.

14. Abortifacient drugs.

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

Within the **"MEDICAL BENEFITS"** section, item #16 (drugs), as amended, is replaced as follows:

16. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptives ~~drugs not available through the Pharmacy Benefit~~ regardless of Medical Necessity and FDA approved over-the-counter female contraceptives prescribed by a Physician or Licensed Health Care Provider.

    Conditions of coverage for Outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Schedule of Benefits and Pharmacy Benefit sections of the Plan. ***Female contraceptives and Contraceptive Management are eligible for coverage under the Medical Benefits and Pharmacy Benefit.***

Within the **"MEDICAL BENEFITS"** section, item #24 (diabetic supplies), as amended, is replaced as follows:

24. Charges for diabetic supplies~~, except for those that are eligible for coverage under the Pharmacy Benefit of this Plan~~ including; *alcohol swabs,* syringes, *pen* needles, *pump cartridge (V-Go), blood glucose and ketone* test strips*, blood glucose calibration solutions, urine tests, lancets and lancet devices.*

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

Within the **"MEDICAL BENEFITS"** section, under the "PREVENTIVE CARE BENEFIT" subsection, item 6(E), as amended, is replaced as follows:

E. All Food and Drug Administration approved prescription contraceptives and female over-the-counter contraceptives when prescribed by a Physician or Licensed Health Care Provider, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. ~~Self-administered~~ Contraceptives *and devices* are available only through the Pharmacy Benefit as outlined in the Pharmacy Benefit section of this Plan.

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

CITY OF MISSOULA

BY: ______________________________

TITLE: ______________________________