AMENDMENT #1
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION
FOR THE
HEALTH BENEFIT PLAN FOR EMPLOYEES OF CITY OF MISSOULA - GROUP 2000203

Effective July 1, 2020, the Health Benefit Plan for Employees of City of Missoula is amended as follows:

Within "**PROCEDURES FOR CLAIMING BENEFITS**", item 2 within "APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM" is replaced as follows:

2. **Second Level of Benefit Determination Review**

   The Committee of City Administrators to include the Plan Administrator will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Committee members who are neither the original decisionmaker nor the decisionmaker's subordinate. The Committee cannot give deference to the initial benefit determination. The Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

   After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

Within "**PROCEDURES FOR CLAIMING BENEFITS**", item 2 within "APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM" is replaced as follows:

2. **Second Level of Benefit Determination Review**

   The Committee of City Administrators to include the Plan Administrator will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Committee members who are neither the original decisionmaker nor the decisionmaker's subordinate. The Committee cannot give deference to the initial benefit determination. The Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

   After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan at each level of review.

All claim payments are based upon the terms contained in the Plan Document, on file with the Plan Administrator and the Plan Supervisor. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

Within "**ELIGIBILITY PROVISIONS**", "EMPLOYEE ELIGIBILITY", "WAITING PERIOD" and "DEPENDENT ELIGIBILITY" are replaced as follows:

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

EMPLOYEE ELIGIBILITY

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

1. Class I: is classified as a Regular Full-time Status Employee who normally works at least forty (40) hours per week in a position which is budgeted for at least ten (10) consecutive months in any twelve (12) month period.

2. Class II: is classified as a Regular Part-time Status Employee who normally works at least twenty (20) hours per week in a position which is budgeted for at least ten (10) consecutive months in any twelve (12) month period.

3. Class III: is classified as a Seasonal Full-time Status Employee who normally works at least forty (40) hours per week in a position which is budgeted for less than (10) consecutive months in any twelve (12) month period and which is generally determined by seasonal or weather conditions.

4. Class IV: is classified as a Seasonal Part-time Status Employee who normally works at least twenty (20) hours but less than forty (40) hours per week in a position which is budgeted for less than (10) consecutive months in any twelve (12) month period and which is generally limited by specific seasonal or weather conditions.

5. Class V: is classified as a Temporary Full-time Status Employee who normally works at least forty (40) hours per week in a position created and budgeted for a definite period of time not to exceed nine (9) months or two hundred seventy (270) calendar days. Temporary status positions are not renewable.

6. Class VI: is classified as a Temporary Part-time Status Employee who normally works at least twenty (20) hours but less than forty (40) hours per week in a position created and budgeted for a definite period of time not to exceed nine (9) months or two hundred and seventy (270) calendar days. Temporary status positions are not renewable.

7. Class VII: is classified as an Intermittent Status Employee who normally works less than one thousand four hundred (1,400) hours per fiscal year; and

   A. Is scheduled for work on a call-in basis, normally less than twenty (20) hours per week; or

   B. Is an Employee schedule variable hours per week based solely on department needs.

   No time limit is placed on the number of months an Intermittent Status Employee may work, and a variable hour Employee does not have an expectation or promise of working any minimum number of hours in any given time period. **Intermittent Status Employees are not eligible for coverage under this Plan.**

8. Class VIII: is classified as an Intern Status Employee who is hired according to terms and conditions prescribed by a specific funding source (such as grant, work study or budgetary line item) for a definite period of time not to exceed nine (9) months in any twelve (12) month period.

9. Class IX: is an Elected Official. An eligible Elected Official includes a person whose service with the City of Missoula is as a result of election to an official governmental office as required by Montana law, or as a result of appointment to such an official governmental office to serve out the remainder of an unexpired term of an elected official who has resigned or been removed from an official governmental office, as allowed by Montana law. A person will be considered an Elected Official only during the legal term of office for any such official governmental office.

WAITING PERIOD

With respect to an eligible Employee or Elected Official, coverage under the Plan will not start until the Employee or Elected Official completes a Waiting Period. For Medical and Dental Benefits, if applicable, the Waiting Period commences with the date the Employee meets the eligibility requirements stated above (Enrollment Date) and ends for each classification of Employee as follows:

1. Class I: for Regular Full-time Status Employees, the first pay period immediately following thirty (30) days from the Enrollment Date.

2. Class II: for Regular Part-time Status Employees, the first pay period immediately following thirty (30) days from the Enrollment Date.

3. Class III: for Seasonal Full-time Status Employees, the first pay period immediately following thirty (30) days from the Enrollment Date.

4. Class IV: for Seasonal Part-time Status Employees, the first pay period immediately following thirty (30) days from the Enrollment Date.

5. Class V: for Temporary Full-time Status Employees, the first pay period immediately following thirty (30) days from the Enrollment Date.

6. Class VI: for Temporary Part-time Status Employees, the first pay period immediately following thirty (30) days from the Enrollment Date.

7. Class VII: Intermittent Status Employees are not eligible for coverage under this Plan.

8. Class VIII: for Intern Status Employees, no Waiting Period applies. **Intern Status Employees are not eligible for coverage under this Plan.**

9. Class IIX: for Elected Officials, the first pay period immediately following thirty (30) days from the Enrollment Date.

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant has been assigned by the Employer, and who is either:

1. The Participant's or Retiree's legal spouse, according to the marriage laws of the state where the marriage was first solemnized or established. **Proof of common-law marriage must be furnished to the Plan Administrator at the beginning of each Benefit Period, including a copy of the Participant's or Retiree's most recent Federal tax return.**

   An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant or Retiree and has a court order or decree stating such from a court of competent jurisdiction.

2. The Participant's or Retiree's Domestic Partner, provided all of the following "Required Eligibility Conditions" are met:

   A. The Participant and Domestic Partner are both eighteen (18) years of age or older and each has the capacity to enter into a contract: and

   B. The Participant or Retiree and Domestic Partner share and have shared a common residence for at least the last twelve (12) consecutive months; and

   C. Neither the Participant or Retiree nor the Domestic Partner is married to or legally separated from another person; and

   D. The Participant or Retiree has no other Domestic Partner under this Plan; and

   E. The Participant or Retiree and Domestic Partner are not legally related to each other as siblings, parents, first cousins, aunts, uncles, grandparents or grandchildren.

   F. A signed Declaration of Domestic Partnership must be furnished to the Plan Administrator upon enrollment.

3. The Participant's Dependent child who meets all of the following "Required Eligibility Conditions":

   A. Is a natural child; step-child; legally adopted child; a child of the Participant's Domestic Partner; a child who has been Placed for Adoption with the Participant and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

   B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time; and

   An eligible Dependent does not include a spouse of the Dependent child or a child of the Dependent child.

Within "**EFFECTIVE DATE OF COVERAGE**", "PARTICIPANT COVERAGE" and "OPEN ENROLLMENT PERIOD" are 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 Participant coverage under the Plan during the Initial Enrollment Period will be able to become covered later in only two situations, Open Enrollment Period and Special Enrollment Period.

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

If an eligible Employee chooses not to enroll or fails to enroll for coverage under the Plan during the Initial 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.

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will be a two (2) week period generally during the month of May as determined by the Plan Administrator of each year during which an Employee and the Employee's eligible Dependents who are not covered under this Plan may request Participant or Dependent coverage. Coverage must be requested on the Plan's enrollment form.

Coverage requested during any Open Enrollment Period will begin on July 1st immediately following the Open Enrollment Period.

Within "**TERMINATION OF COVERAGE**", "PARTICIPANT TERMINATION", "REINSTATEMENT OF COVERAGE" and "DEPENDENT TERMINATION" are replaced as follows:

PARTICIPANT TERMINATION

Participant coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Participant's employment terminates; or
2. On the last day of the month in which the Participant ceases to be eligible for coverage; or
3. The date the Participant fails to make any required contribution for coverage; or
4. The date the Plan is terminated; or
5. The date the City terminates the Participant's coverage; or
6. The date the Participant dies; or
7. The date the Participant enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days; or
8. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Participant.

A Participant whose Active Service ceases because of Illness or Injury or as a result of any other approved leave of absence may remain covered as an Employee in Active Service for a period of twelve (12) weeks pursuant to the Family and Medical Leave Act, or such other length of time that is consistent with and stated in the City's current Employee Personnel Policy Manual. Coverage under this provision will be subject to all the provisions of FMLA if the leave is classified as FMLA leave.

A Participant whose Active Service ceases due to temporary layoff will be considered employed by the City for the purposes of his/her coverage under this Plan, and such coverage may continue until the end of the month in which the layoff began.

If a Participant's coverage is to be continued during disability, approved leave of absence or temporary layoff, the amount of his or her coverage will be the same as the Plan benefits in force for an active Employee, subject to the Plan's right to amend coverage and benefits.

REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of termination of employment or reduction in hours and who again becomes eligible for coverage under the Plan within a thirteen (13) week period immediately following the date of such termination of employment or reduction in hours 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 date of renewed eligibility, if covered on the date of termination, 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 sub-section, 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.

DEPENDENT TERMINATION

Each Participant, covered Dependent Spouse or covered Dependent Child, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage After Termination. Covered Domestic Partners are not eligible for COBRA Continuation Coverage.

Coverage for a Dependent will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Dependent ceases to be an eligible Dependent; or
2. On the last day of the month in which the Participant's coverage terminates under the Plan; or
3. On the last day of the month in which the Participant ceases to be eligible for Dependent Coverage; or
4. The date the Participant fails to make any required contribution for Dependent Coverage; or
5. The date the Plan is terminated; or
6. The date the City terminates the Dependent's coverage; or
7. On the last day of the month in which the Participant dies; or
8. The date that the Participant and Domestic Partner terminate their Domestic Partnership as evidenced by a signed Declaration of Termination of Domestic Partnership; or
9. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Dependent whose coverage is to be terminated.

Within "**CONTINUATION COVERAGE AFTER TERMINATION**", the second paragraph is replaced as follows:

The Plan Administrator is the City of Missoula (by and through the City Council), 435 Ryman St - City Hall, Missoula, MT 59802; (406) 258-4703. COBRA Continuation Coverage for the Plan is administered by Allegiance COBRA Services, Inc., P.O. Box 2097, Missoula, MT 59806, (406)721-2222; facsimile (406)523-3131; email: COBRAinquire@askallegiance.com.

Within "**GENERAL DEFINITIONS**", "PLAN ADMINISTRATOR" is replaced as follows:

PLAN ADMINISTRATOR

"Plan Administrator" means the City of Missoula (by and through the City Council) (City), and/or its designee which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purposes of the Employee Retirement Income Security Act of 1974, as amended, and any applicable state legislation of a similar nature, the City will be deemed to be the Plan Administrator of the Plan unless by action of the Board of Directors, the City designates an individual or committee to act as Plan Administrator of the Plan.

Within "**PLAN ADMINISTRATION**", "NAMED FIDUCIARY AND PLAN ADMINISTRATOR" and "CONTRIBUTIONS TO THE PLAN" are replaced as follows:

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is the City of Missoula, a political subdivision of the State of Montana, by and through the City Council who shall act as Plan advisor to the Plan Administrator and who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

CONTRIBUTIONS TO THE PLAN

The City will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the City, if any, and the amount to be contributed, if any, by each Participant.

If the City terminates the Plan, the City and Participants will have no obligation to contribute to the Plan after the date of termination.

Within "**PLAN SUMMARY**", item 5 is deleted, item 6 is replaced and remaining items renumbered accordingly:

~~5. PLAN ADMINISTRATOR~~

~~The Plan Administrator is the Plan Sponsor.~~

6. NAMED FIDUCIARY AND PLAN ADMINISTRATOR

Name:	City of Missoula
Phone:	(406) 552-6109
Address:	435 Ryman Street Missoula, MT 59802

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: Mayor