AMENDMENT #45
TO THE
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR

BILLINGS PUBLIC SCHOOLS EMPLOYEE HEALTH PLAN

Effective Date: September 1, 2021

1. **ADD the following PROVIDER INFORMATION subsection prior to the "Deductibles/ Copayments/Coinsurance payable by Plan Participants" language in the SCHEDULE OF BENEFITS section as follows:**

   PROVIDER INFORMATION

   This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

   Therefore, when a Plan Participant uses a Network Provider, that Plan Participant will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Plan Participant's choice as to which provider to use.

   To access a list of Network Providers, please refer to the Network Provider website and/or toll free number listed on the **Billings Public Schools Employee Health Plan identification card.** Prior to receiving medical care services, the Plan Participant should confirm with the provider that the provider is a participant in this network.

2. **ADD the following language between the last two paragraphs in the MEDICAL BENEFITS subsection in the SCHEDULE OF BENEFITS section as follows:**

   Sutter Health System network providers will be given additional consideration if this Plan is secondary. In this case, the Claims Administrator will also consider a claim received from a Sutter Health System network provider within one year from the date of issuance of the primary Explanation of Benefits. Claims received later than that date will be denied.

3. **ADD the following language as the third paragraph in the MEDICAL BENEFITS section as follows:**

   Sutter Health System network providers will be given additional consideration if this Plan is secondary. In this case, the Claims Administrator will also consider a claim received from a Sutter Health System network provider within one year from the date of issuance of the primary Explanation of Benefits. Claims received later than that date will be denied.

4. **ADD the following language between the last two paragraphs in the PLAN EXCLUSIONS section as follows:**

   Sutter Health System network providers will be given additional consideration if this Plan is secondary. In this case, the Claims Administrator will also consider a claim received from a Sutter Health System network provider within one year from the date of issuance of the primary Explanation of Benefits. Claims received later than that date will be denied.

5. **ADD the following language as the second paragraph in the WHEN CLAIMS SHOULD BE FILED section as follows:**

Sutter Health System network providers will be given additional consideration if this Plan is secondary. In this case, the Claims Administrator will also consider a claim received from a Sutter Health System network provider within one year from the date of issuance of the primary Explanation of Benefits. Claims received later than that date will be denied.

6. **AMEND the first paragraph under the "First Level of Internal Review" in the "Internal Appeal Procedure" subsection in the INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES section as follows:**

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). For Sutter Health System network provider claims, the written request must be submitted within 24 months of the date of the Initial Benefit Dertermination on a Post Service Claim. 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
c/o Employee Benefit Management Services, LLC (EBMS)
Attn: Claims Appeals
P.O. Box 21367
Billings, Montana 59104

7. **AMEND the second paragraph in the COORDINATION OF BENEFITS section as follows:**

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. However, this Plan does not adopt the definition for "Allowable Expenses" set forth in the NAIC Model COB Regulations, as amended. If there is a difference between the contracted rates of the primary plan and this Plan, this Plan will base its payment on the lower of the two contracted rates.

I, Katie Nordstrom (Name), certify that I am the Exec. Director HR (Title) of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Amendment. I have read and agree with the above change to the Plan and am hereby authorizing its implementation as of the effective date stated above.

Signature: Katie Nordstrom

Print Name: Katie Nordstrom

Date: 1-31-22

AMENDMENT #46
TO THE
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR

BILLINGS PUBLIC SCHOOLS EMPLOYEE HEALTH PLAN

Effective Date: July 1, 2021

1. **AMEND the "When Employee Coverage Terminates" language in the TERMINATION OF COVERAGE subsection in the ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS section as follows:**

   When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

   (1) The date the Plan is terminated or, with respect to any benefit under this Plan, the date of termination of such benefit;

   (2) The last day of the calendar month in which the covered Employee's employment terminates, except Certified Long-Term Assignment Participants who leave employment prior to the end of the school year coverage will end on the last contracted day of work;

   (3) The last day of the calendar month in which the covered Employee ceases to be in a classification (if any) as shown in the Eligible Classes provision under the Eligibility section under this Plan or, if 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 a collectively bargained agreement specifically provides for continuation during these periods;

   (4) The last day of the calendar month in which the covered Employee fails to make any required contribution for coverage;

   (5) For Billings Education Association bargaining unit members, as well as Certified Long-Term Assignment Participants, who leave employment as of the end of the school year, coverage will end as of August 31st of that year;

   (6) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and 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; or

   (7) As otherwise stated in the Eligibility section.

   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.

I, Kate Nordstrom, certify that I am the Exec Director HR
Name Title

of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Amendment. I have read and agree with the above change to the Plan and am hereby authorizing its implementation as of the effective date stated above.

Signature: Kate Nords

Print Name: Kate Nordstrom

Date: 2-1-22