



2021

Employee Health Insurance Announcements And Benefits Guide



October 2020



2021 Health Insurance ANNOUNCEMENTS

Health Insurance **2021** open enrollment will be **the first 2 weeks of November**.

Specific dates & instructions will roll out at the end of October.

Only during this period, do you have the option to make any allowed changes for **2021**.

Open enrollment information will be sent out by November 1st as follows - a *change from last year*.

- **Teamster Union Employees** -hardcopy via interoffice mail & city email
- **Non-Bargaining, Police Union & Fire Union Employees** - electronically via city email only

The open enrollment process contains three options:

1. If you do not have **any changes** from your current elections and you **do not have flex** - then you *don't have to do anything! Everything will stay the same. Do not go online to miBenefits.*
2. If you do not have **any changes** from your current elections, but you **do have flex** - then you will need to complete the form provided in the Open Enrollment packet at the end of October. Per the IRS, you are required to re-elect Flex (not HSA) annually. *Do not go online to miBenefits.* You will need to submit the Flex form provided, during the open enrollment period. If you do not return the Flex form, then *your FLEX contributions will default to \$0.00 (medical & daycare).*
3. If you have **ANY allowed changes** (medical/rxplan, dental, flex, HSA & vision) from your current elections then you will need to complete Open Enrollment online through your EBMS miBenefits login and re-elect **ALL** of your health insurance elections for the New Year. Therefore, options 1 & 2 do not apply to you.

Bottom line, submissions through the EBMS miBenefits Open Enrollment portal should only be needed for employees with health insurance election changes for 2021.

City Retirees:

Please note, this document is written mainly for active employees. There are items that will not apply to you.

This document is intended as a brief description of coverages.

Please refer to the Plan Document for specific information.

Plan documents are available on the City website under "Forms and Resources" and in your EBMS miBenefits account.



Leta Lintern

HR Associate/Benefits Coordinator

Email: LinternL@billingsmt.gov

Phone: 657-8265



Vision Plan

www.vsp.com

Make sure you have registered to access your EBMS miBenefits Portal; your username must be your personal email, not your city email. You will need your EBMS ID card # to set up your access. This website is managed by EBMS, not the city.

Employee Benefit Management Services is our Third Party Administrator (TPA) for:

- Medical/Rx
- Dental
- Flex (medical & daycare)
- HSA - Health Savings Account thru Avidia Bank

EBMS miBenefits also will show VSP-Vision covered persons; however, they do not administer claims for VSP.

Employees will use their SSN as the proof of coverage and claims processing at their VSP provider.

No ID cards are issued for VSP.

Your EBMS miBenefits portal will show if VSP coverage is elected; however, EBMS does not administer claims for VSP.



City of Billings In-Network providers for Medical coverage are Rocky Mountain Health Network.

These are providers that we have negotiated discounts with and our coverage is 80/20.

Visit www.RMHN.org and select "Find a Provider/Facility" and then select Insurance Accepted "EBMS-City of Billings".

Please note the out of network medical providers can balance bill you.

First Choice Health

First Choice Health is an EBMS secondary network, and is not the medical In-Network provider for the City of Billings.



SCL Health St. Vincent

www.sclhealth.org

SCL Health liaisons are available to City employees. Neither liaison will be able to answer questions regarding the City's health plans.

→Anne Schafer: billing & payment questions

- Email: anne.schafer@sclhealth.org
- Phone: 237-3304

→Teresa Litter: other general St. Vincent questions

- Email: teresa.litter@sclhealth.org
- Phone: 237-3317

Summary of Material Modifications to the Plan for 2021

We have very limited changes for the new year! The restated plan document will be available online at miBenefits and on the city website during Open Enrollment. Below is a list of the modifications and premium information for 2021.

We appreciate your continued efforts to make your health plan sustainable and the hard work of the Health Insurance Committee! The Committee will continue to closely monitor the plan's financial performance, seeking to balance the premiums paid by employees with the long-term health of the plan.

City Contribution to the Medical fund for Employees:

The City's contribution into the medical fund will remain the same. The City's annual contribution is \$10,152 per employee, which is \$846 per month. *That is more than \$10,000 of added value you are realizing, beyond your pay!*

Medical Plan Premiums:

Rocky Mountain Health Network is the City of Billings in-network medical providers. These providers can be found at www.RMHN.org Our negotiated agreement has allowed our medical *premiums to remain the same for next year.*

Employee Medical Premiums Per 26 pay periods		
Tier	2018-2021 Standard	2018-2021 HDHP
Employee Only	\$26.88	(\$9.79)
Employee + Spouse	\$96.47	\$24.69
Employee + Children	\$87.07	\$22.27
Employee + Family	\$136.48	\$34.92

Medical Premiums for Pre-Medicare* & grandfathered Medicare Retirees			
Tier	2018-2021 - monthly Pre-Medicare Retiree Standard Plan	2018-2021 - monthly Pre-Medicare Retiree HDHP	2018-2021 - monthly Grandfathered Medicare Retiree Standard Plan
Retiree Only	\$534.66	\$478.69	\$438.09
Retiree + Spouse	\$1,090.63	\$981.33	\$898.06
Retiree+ Children	\$989.15	\$885.60	n/a
Retiree + Family	\$1,550.56	\$1,388.21	n/a

*As a reminder, Pre-Medicare retirees are only able to continue City retiree coverages until they are Medicare eligible at age 65 or through SS Disability.

Dental Plan Premiums:

In 2019, preventive dental services were enhanced to not tally towards the annual maximum. Participants understand the importance of preventive dental care and have utilized these services which has resulted in increased expenses for the plan. Therefore, to offset the dental fund deficit, the Health Insurance Committee has voted to increase dental premiums for 2021.

Dental Premiums for Employees & Pre-Medicare Retirees*		
Tier	2021 Employees Per Pay Period (26 ct.)	2021 Retirees (monthly)
Employee/Retiree Only	\$17.89	\$38.76
Employee/Retiree + Spouse	\$35.75	\$77.46
Employee/Retiree + Children	\$44.60	\$96.63
Employee/Retiree + Family	\$62.56	\$135.55
NonBargaining Employee only	\$8.95	n/a
NonBargaining Employee +Dependents	\$32.01	n/a

Vision Plan Premiums:

There are no premium changes for vision! In fact, the current premiums will continue through 2023, and VSP even upgraded the benefit allowance for contacts and frames to \$130.

Vision Premiums for Employees & Pre-Medicare Retirees*		
Tier	2016-2023 Employees Per 26 Pay Periods	2016-2023 Retirees (monthly)
Employee/Retiree Only	\$3.90	\$8.45
Employee/Retiree + Spouse	\$7.79	\$16.88
Employee/Retiree + Children	\$8.34	\$18.07
Employee/Retiree + Family	\$13.32	\$28.86

Flexible Spending Accounts (FSA) - debit card provided:

	2020 Plan Year	2021 Plan Year – IRS limits allowed
Medical FSA/Medical Flex	\$2,750 IRS limit	IRS to determine at the end of October
Dependent/Daycare FSA	\$5,000 per household per IRS	

Health Savings Account (HSA) – Avidia Bank debit card provided: (option for HDHP employees only)

Contribution Limits for Health Savings Account (HSA) per the IRS		
	2020	2021
HSA Contribution limits (employee + employer contributions)	Single: \$3,550 Family: \$7,100	Single: \$3,600 Family: \$7,200
HSA Catch-Up Contribution limits (age 55 or older)*	\$1,000	\$1,000

*catch-up contributions can be made any time during the year in which the HSA participant turns 55.

Annual Wellness Exam Incentive Program - 2021:

Employees and spouses on our medical plan should have an appointment with their treating physician annually regarding the appropriate preventive services for your age and gender. Please see your plan document for preventive care details.

The City will continue to provide \$100 gift card incentives, for active employees and the employee's spouse on our medical plan to have an annual visit with their treating physician. Claims for that annual visit will process according to the medical plan; the incentive applies to the annual physician visit. *A new 2021 Annual Wellness Exam Incentive form will be available on the City website at the beginning of 2021.* The incentive gift cards are processed quarterly; distributed with payroll and are subject to IRS fringe benefit taxes.

Healthy Is Wellness (HIW) incentive – 2021:

Led by a PhD researcher who studies Health and Human Performance, with the belief that *healthy* is not something you are; *healthy* is something you do! Your health *is* your behavior.

This wellness initiative aims to not only save money on health care costs, but also to help create a culture of health and catalyze a proactive approach to health in our Billings community. With Healthy IS, they go beyond just biometric results and create a proactive, action-centered wellness program that engages employees every month and unifies them in unique monthly health challenges. What is so unique about their program is that they take away the greatest barrier and they bring their mobile lab and their InBody 770 composition machine to city building locations monthly. The InBody measures body fat percentage, lean body mass, visceral fat, total skeletal muscle, basal metabolism, segmental breakdowns, intra- vs. extra-cellular water and more...all in 1 minute! These objective measures combined with personalized, engaging monthly challenges are what help employees have major positive health changes.

This program will continue into 2021; however, to qualify for the incentive, *six (6) monthly visits will be required annually* for the \$100 gift card incentive for active employees and the employees' spouses on our medical plan. Healthy IS will provide the list of who qualifies through November and we will issue gift cards in December. If any additional participants qualify with their December visit, those gift cards will process in the New Year. Gift cards will be distributed with payroll and are subject to IRS fringe benefit taxes.

Other 2021 Plan Document updates and clarifications:

- Spring 2020 amendments added for COVID coverage & SCL Health RightCare Video telehealth.
- Doc on Demand telehealth will be removed since the City added SCL Health RightCare.
- Gender Dysphoria, subject to medical necessity coverage is added; plan exclusion for "Sex changes" is removed.
- Revise non-emergency terminology for consistency and to align with the standard definition of "Medical Non-Emergency", plus Non-Network Non-Emergency Services copay will be \$100
- Inpatient Hospital Copayment to have consistent verbiage within both Schedules of Benefits
- Added coverage of wigs to each schedule as wigs applies to benefit limit & change to Lifetime maximum of \$500, instead of "one wig" per lifetime.
- Updated Rehabilitation Services to clarify how inpatient rehab services pay.
- Updated the Outpatient Mental Health/Substance Abuse benefits to clarify how Outpatient Facility pays and how Outpatient Physician pays.
- Removed information with the Prescription Drug Coverage under the HDHP option as it stated a Prescription Drug Maximum Out-of-Pocket (OOP) applied, but the separate Rx OOP only applies to the Standard Plan prescription drug benefits.
- Updated the definition of Allowable charges.
- Updated the miRx Pharmacy mail order benefit in the prescription Drug Benefit section to indicate "only the first fill will be eligible through the retail Pharmacy option"

REMINDERS & ITEMS TO CONSIDER:

Dependent Coverage on Health Insurance:

If you are adding dependents to your health insurance, during our annual Open Enrollment or mid-year, due to an IRS Qualifying Life Event (QLE), you will be required to provide documentation proving they are an eligible dependent. To add a dependent spouse, a legal marriage certificate or Legal Declaration of Marriage is required. This does not include common law marriage. To add a child, under the age of 26, a birth certificate is required. If you are adding your dependent during Open Enrollment in your EBMS miBenefits portal, you will have the ability to upload this documentation.

Pharmacy/Rx:

Maintenance Rx and Specialty Rx are **required** to be obtained through miRx Pharmacy. MagellanRx is our Pharmacy Benefit Manager (PBM) and manages pharmacy claims.

Flexible Spending Accounts (FSA) & Flex debit cards:

Flex expenses must be incurred between January 1 and December 31. However, our plan has a two-month run out grace period; through February 28 to complete processing of the previous year's flex. It is your responsibility to make sure you receive the billing information from your provider's office in time to process end-of-year expenses.

Please note, you **cannot** use your debit card to pay for last year's flex expenses in the New Year. The debit card cannot tell what date of service the member is paying for, so it will assume it is for the current service year. Therefore, if members wish to access a prior plan year's funds during the run out grace period, they must submit a manual claim either through the online miBenefits portal or by personally submitting the completed Request for Flex Reimbursement form with the appropriate documentation to EBMS. That is the only way to ensure that funds are taken from the appropriate plan year during the run out period. If you miss processing expenses to exhaust your plan year funds by the end of the run out grace period, you will forfeit that year's flex funds.

If you separate service from the City midyear, your eligibility for flex, and to incur expenses, is your last day of employment. You have 60 days from your last day of employment to request reimbursement or you forfeit your funds.

Preventive Services:

Mammograms and Prostrate screenings are the only preventive exams that are based on a year timeframe. For example, if you have a mammogram July 1 of the current year, you will have to wait until after July 1 of the following year to have another as a preventive screening. EBMS will review these services and if they are within a month of the year timeframe, they will process the claim as a preventive service.

EBMS processes claims based on the diagnosis codes submitted by your treating physician. Please understand that you could schedule a preventive service, and based on the diagnosis it may become medical in nature. This service then becomes subject to your deductible and copayments. This often happens with mammograms and colonoscopies.

Married spouses that both work for the City:

There are numerous married City employees who have the option during each Open Enrollment to elect separate insurances, or they can combine coverage under one plan with one person as the main employee and the other as a dependent. Please contact Leta via email if you plan to change yours, so she can determine the best route to make your changes. Please note that in this situation, you are not allowed to be double covered on City insurances.

Human Resources: Forms, Resources & Personal Emails

Forms and Resources utilized by HR are available on the city website: <https://ci.billings.mt.us/417/Forms-and-Resources>.

Also due to the pandemic, HR is emailing, not mailing forms/letters, etc. to employees. Soon we will roll a project to each department to collect a personal email for each employee to have on file for this purpose. In addition, as time allows, HR will be working to convert forms to electronic fillable forms to be emailed to HR, instead of hardcopy.

Health Insurance Committee

The City of Billings established a benefit committee to maintain a group health insurance plan for employees/retirees of the City of Billings and their dependents. The committee consists of 15 members appointed as follows:

- 1. Three members of each employee union appointed by each union.*
- 2. Six members appointed by the City Administrator. One member shall be a retired city employee currently covered by the city health insurance plan.*

The Committee will manage the City Health Insurance Plan and report directly to the City Administrator.

The committee shall meet at least quarterly to:

- Review the existing city group health insurance plan;*
- Review the claims experience, projections and plan problems;*
- Maintain the plan on a sound actuarial basis;*
- Establish plan premium rates and cost sharing by both the City and the employees;*
- Advise the City Administrator on all other group insurance matters.*

Decisions will be made by a simple majority vote where all members have one vote and can vote by absentee ballot.

Name	Representing	Dept./Division
Banfield, Jason	Fire	Fire
Gordan, Josh	Teamsters	PRPL
Dahl, Gina	Non-Bargaining	Legal
Iffland, Kevin*	Non-Bargaining	Administration
Kaiser, Kodi	Police	Police
Kindness, Anne	Retiree	Retiree
Lapham, Brett	Police	Police
Lintern, Leta	Non-Bargaining	Human Resources
Shearer, David	Teamster	Library
Spaulding, Wanda	Police	Police
Stanton, Karla	Non-Bargaining	Human Resources
Tatum, Bill	Fire	Fire
Williams, Heather	Teamster	Public Works
Willkins, Jacob	Fire	Fire
Zoeller, Andy	Non-Bargaining	Finance
<i>*Also the HIC facilitator</i>		

Benefits Overview

City of Billings is proud to offer a comprehensive benefits package to eligible, permanent 20+ hour employees after a month of employment and the 1st of the month following that. All 20+ hour permanent employees are REQUIRED to participate in the medical plan; however, the rest of the health insurance options are voluntary elections.

The City of Billings is self-funded for medical and dental. The City also contributes money per employee, per month in the health insurance fund. Premiums are set up on a pre-tax basis, over 26 pay periods. Mayor/City Council premiums are processed monthly. You share the costs of some benefits (medical, dental and vision), and City of Billings provides other benefits at no cost to you, for example, our Employee Assistance Program (EAP). In addition, there are voluntary benefits that you can purchase through City of Billings pay-roll deductions. Please see the Voluntary Benefits document for details.

Benefit Plans Offered

- ◆ Medical
- ◆ Dental
- ◆ Vision
- ◆ Life Insurance
- ◆ Flexible Spending Account - Medical Flex & Dependent Care (daycare) Flex
- ◆ Health Savings Account - HSA
- ◆ Employee Assistance Program - EAP (separate from health insurance)
- ◆ Freedom from Smoking (SVH)

Eligibility

You and your dependents are eligible for City of Billings benefits on the first of the month following one (1) month of employment. Eligible dependents are your legally married spouse, children under age 26 or disabled dependents of any age. Proof of qualifying dependent is required. Marriage certificate for spouse and/or birth certification for dependent child(ren). Elections made now will remain until the next annual open enrollment, unless you or your family members experience a qualifying life event (QLE).

QLE—Qualifying Life Event

The only way you can add/delete dependents mid-year is per the IRS regulations of Qualifying Life Events (QLE). A QLE Form will need to be filled out with the required documentation when adding or deleting dependents within the 31 day timeframe. Proof of dependency is required on all spouses and/or children added to the plan. When you add a dependent through QLE, for medical or dental, it is based on the QLE date. For vision, it rolls to the 1st of the following month the QLE date.

Retirees

Eligible retirees on the plan, at the time of retirement, can elect their health insurance options into retirement for medical/RX, dental and/or vision. If they did not elect it at that time, they are not able to elect it later or if they drop that coverage, they are not able to re-elect it. Eligible retirees on the plan are defined as the following: Effective January 1, 2006, a covered retiree or his or her Spouse who reaches age 65 and/or becomes eligible for Medicare on or after January 1, 2006, will no longer be eligible for coverage under this plan. If the retiree becomes Medicare eligible, but the retiree's spouse on the plan is not, the spouse will become the mail city retiree at that time. City HR will notify you in writing of your retiree insurance ending due to Medicare eligibility. You are eligible for Medicare the 1st of the month in which you turn 65, so we would turn your insurance off or make that appropriate changes with that same effective date.

As a Retiree on the City insurance, if you become Medicare insurance eligible due to Social Security Disability, you are no longer eligible for the city retiree health insurance. It is your responsibility to notify City HR ASAP.

As a retiree, if you decide to cancel your retiree insurance, we will need this in writing prior to the date of when you want the coverage to end. Once you cancel, you are not eligible to re-elect as a retiree.

When both Spouses are working for the City

The City's plan has allowed married City employees to either elect their own plan or have one employee as the primary participant and the other employee as a dependent under the Plan. However, employees are not able to have double coverage of city insurances. Annually you have the option to switch this election. *If you are choosing to change this, please consult your HR Benefits Coordinator—Leta, regarding this process.*



This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Leta Lintern

City of Billings
HR Associate/Benefit Coordinator

Email: LinternL@BillingsMT.gov

Phone: 657-8265



Mid-Year Qualified Life Event (QLE) Form

To add/remove dependent(s) to health insurance elections

→ If you experience a life event mid-year, any change to your coverage must be consistent with the qualifying life event, and be requested within 31 days of the life event date. Otherwise, effective 1/1/14 there is an annual open enrollment to add qualifying dependents to your health insurance without a QLE. Proof of dependency is required when adding qualifying dependents- Marriage Certificate for spouse, Birth Certificate for children.

What is a Qualifying Life Event (QLE)?

The City's insurance enrollment is conducted annually because certain benefits allow you to make changes only once per year. Generally, these are benefit plans governed under the Internal Revenue Code (IRC) Section 125 where your employee contributions are set up to be deducted pre-tax. The City has set up your health, dental, vision, health savings account (HSA) and flexible spending accounts (medical & dependent care) under IRC Section 125. So a Qualifying Life Event is an event defined by the Internal Revenue Service (IRS) in Section 125 that allows you to change your medical elections mid-year.

EXAMPLES OF VALID SUPPORTING DOCUMENTATION

LIFE EVENT	To ADD a dependent(s)*	To REMOVE a dependent(s)	Effective Date of change, if within 31 day timeframe
Marriage* * Effective 1/1/14, includes same-sex, Legal marriages	Copy of Legal Marriage Certificate or copy of Legal Declaration of Marriage. <i>This does not include common law.</i>	n/a	
Birth/Adoption/Legal Custody of a Child	Birth Certificate, Hospital certificate or discharge paperwork (must provide newborn's name and date of birth), or Court Documents (must include the effective date of the custody of child)	No employee action required for supporting documents	Benefit changes are effective as of the date of the event, so if that payroll has been missed, the change in charges will need to be back billed on the next available payroll.
Death of Dependent	n/a	Copy of Death Certificate	
Change in employment status, that causes a change in insurance coverage.	COBRA Paperwork and/or Certificate of Credible Coverage. Documentation of dependency - birth certificate (for child) or marriage certificate (for spouse).	No employee action required for supporting documents	Benefit changes are effective as of the date of the event, so if that payroll has been missed, the change in charges will need to be back billed on the next available payroll. Removal is typically the 1 st of the month following.
Divorce	n/a	Court Documents (must include the effective date of the divorce)	For Divorce, benefits end as of the 1 st of the month following the date of the divorce. It is critical to notify Human Resources immediately of the divorce being finalized. Please provide an address of the spouse for COBRA purposes.
<p><i>In order to ADD dependents to your existing plan coverage mid-year, the employee must already have the existing coverage elected and a QLE. However, if you can provide proof that you, as the employee lost that coverage as part of the QLE, you may be able to add that election mid-year.</i></p> <p>IMPORTANT: Any dependents added must meet eligibility requirements per the plan.</p>			



Employee: If you have a mid-year Qualifying Life Event (QLE) that affects ANY of your City health insurance benefits, it is your responsibility to complete this form and delivery to Human Resources within 31 days of the qualifying event date in order to make the mid-year change. Please Note: if you miss the 31-day timeframe, you will be able to enroll that dependent during the next annual open enrollment period with an effective date of the 1st of the year of coverage. Documentation of QLE is typically required, as previously described. If you have any questions, please call HR/Benefits Coordinator Ph: 657-8265 or Email: LintemL@billingsmt.gov

Employee Name: _____		(City) Effective Date of change: _____				
Qualifying Life Event (QLE) is: _____ QLE Date: _____						
Did you provide proof of QLE? <input type="checkbox"/> No <input type="checkbox"/> Yes If adding dependent, provided marriage or birth/hospital cert? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Dependent full Name, including middle initial	SS number*	Date of Birth	Relationship to employee	Medical Plan (EBMS) <input type="checkbox"/> Standard <input type="checkbox"/> HDHP	Dental Plan (EBMS)	Vision Plan (VSP)
			<input type="checkbox"/> Spouse <input type="checkbox"/> Male Child <input type="checkbox"/> Female Child	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
			<input type="checkbox"/> Spouse <input type="checkbox"/> Male Child <input type="checkbox"/> Female Child	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE
			<input type="checkbox"/> Spouse <input type="checkbox"/> Male Child <input type="checkbox"/> Female Child	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE	<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE

*For a birth, you will not have the SSN within the 31 days from the birth. Please submit form in ASAP and when the SSN is received, get the number to me for our system and EBMS.

If you are changing MEDICAL or DAYCARE FLEX contributions, you will need to request another form to change due those due to the QLE.

If REMOVING dependent(s), do they have other insurance? No Yes *if you mark Yes, they have other insurance, a COBRA notice will not be mailed, except for divorce QLE, we are required to mail the notice.

If you are Removing dependent(s), please provide mailing address for COBRA health insurance notice:

Employees address or Other Address: _____

By signing below, I understand that if I have a change in premium based on the QLE date; Payroll will catchup premiums at the next available payday for payrolls missed. If I was receiving the Employee only, HDHP premium kickback, the City will need to process a "miscellaneous health insurance" deduction to take those monies back; however, the actual funds you received will stay in your HSA or Flex account. EBMS changes to add dependent(s) are based on the QLE date; however, to remove dependent(s) it is based on the 1st of the following month.

Employee Signature: _____ **Date:** _____ **Phone #:** _____ **Personal Email:** _____

HR PAYROLL: _____

Medical Benefits

Administered by Employee Benefit Management Services (EBMS)

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost. Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through City of Billings.

City of Billings annually offers you a choice of the Standard Plan or the HDHP—High Deductible Health Plan. You may select where you receive your medical services; however, our in-network provider group for medical services is through Rocky Mountain Health Network. If you select in-network providers, your costs will be less. You can be balance billed by going out-of-network. See your cost sharing below. Go to www.RMHN.org, select Find a Provider and Insurance Accepted as EBMS - City of Billings. When services are received at RiverStone Health, benefits will be paid at in-network level. See your plan document for full details.

	Standard Plan		HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	\$1,000 / \$2,000	\$1,000 / \$2,000	\$1,500 / \$3,000	\$1,500 / \$3,000
Annual Out-of-Pocket Maximum (Individual/Family) (includes Deductible)	\$2,250 / \$5,750	\$6,000 / \$17,000	\$3,750 / person (\$7,500 max/family)	\$6,500 / person (\$13,000 max/family)
Coinsurance	20%	40%	20%	40%
DOCTOR'S OFFICE				
Office Visits	\$25	\$50	\$25 copay & deductible	\$50 copay & deductible
Wellness/Preventive Care (routine exams, x-rays/tests, immunizations, well baby care and mammograms)	No Charge	40% (deductible does not apply)	No Charge	40% (deductible does not apply)
PRESCRIPTION DRUGS <i>MiRX Pharmacy is REQUIRED for maintenance & specialty RX. Acute/Short-term RX can be purchased there, but is not required.</i>				
Annual Deductible (Individual/Family)	\$100 / \$200		Medical Deductible Applies	
Annual Out-of-Pocket Maximum (Individual/Family)	\$2,250 / \$6,750		Medical Out of Pocket Applies	
Acute/Short-term retail Rx - Generic Drug (30-day supply)	\$5	\$5	\$5	\$5
Acute/Short-term retail Rx - Formulary Drug (30-day supply)	20% (\$30 minimum and \$60 maximum)	20% (\$30 minimum and \$60 maximum)	20% (\$30 minimum and \$60 maximum)	20% (\$30 minimum and \$60 maximum)
Acute/Short-term retail Rx - Non-Formulary Drug (30-day supply)	40% (\$50 minimum and \$100 maximum)	40% (\$50 minimum and \$100 maximum)	40% (\$50 minimum and \$100 maximum)	40% (\$50 minimum and \$100 maximum)
Maintenance miRx Mail Order Rx - Generic Drug (31-90-day supply)	\$10 (deductible waived)	Not Covered	\$10	Not Covered
Maintenance miRx Mail Order Rx - Formulary Drug (31-90-day supply)	\$90 (deductible waived)	Not Covered	\$90	Not Covered
Maintenance miRx Mail Order Rx - Non-Formulary Drug (31-90-day supply)	\$135 (deductible waived)	Not Covered	\$135	Not Covered
Specialty Drug –miRx (30 Day Supply)	Generic \$75 Preferred Brand \$125 Non-Preferred Brand \$125	Not Covered	Generic \$75 Preferred Brand \$125 Non-Preferred Brand \$125	Not Covered



What is miRx ?

Since 01/01/2012, any maintenance medications are *Required* to be purchased through EBMS’s miRx mail order service pharmacy – miRx. Since then, any specialty medical, which can be maintenance or short-term, is *Required* to be purchased through the miRx pharmacy also.

miRx pharmacy is located in Billings:

- 993 S 24th Street West STE A
- miRx Hours: M-F, 8:00am to 6:00pm & Sat, 8:00am to Noon
- miRx Phone #'s: (406) 869-6551
- Email: miRx@ebms.com

Is miRx – MANDATORY for maintenance and specialty rx for the City of Billings participants:

Yes. If you complete the miRx Patient Profile and Prescription Order form, this will help miRx set up your account. This form is available www.EBMS.com. You will also need to provide them the original Rx script, unless your treating physician is sending it to them directly.

miRx – NEW maintenance medication

If you are issued a NEW maintenance medication and don’t feel that you can wait to have miRx fill it, you can get an override to have the first 30 days filled at a retail pharmacy. When the retail pharmacy runs the script it will be alerted that this is a maintenance medication and they will need to call EBMS for an override approval. The 30 days will process in accordance with the Retail Rx plan structure. In this case you will need to have your treating physician issue a 30-day script for the retail Rx plus a 90-day script for miRx. If you don’t do this, and only have the 90-day script and take it to the retail pharmacy, you will be responsible for transferring the remaining 60 days to miRx. miRx is also able to issue controlled maintenance which are typically a 30-day issue.

Can I drop off & pick up in the same day at miRx?

miRx is technically a mail-order pharmacy. If you are electing to pick up your script, instead of having it mailed, you will need to communicate that to miRx.

Acute/short-term “retail” rx at miRx pharmacy?

Yes, you can purchase these at miRx; however, you are not required to. Please note, that even if it is purchased at miRx, it will still process according to the acute/short term “retail” rx copay structure.

Does the City of Billings Rx plan coordinate benefits with other Rx plans?

No, there is no coordination of benefits. If you want your maintenance script to be processed by miRx, miRx has to be the primary.

Rx EOB’s

Reminder that the EOB’s – Explanation of Benefits forms, only show what the plan paid, not what you have paid since this is a separate claims Rx system, managed by our PBM (Pharmacy Benefit Manager) – MagellanRx.

	Standard Plan		HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
HOSPITAL SERVICES				
Emergency Room	20% after deductible (Non Emergency Penalty of \$50 may apply)	20% after deductible (Non Emergency Penalty of \$50 may apply)	20% after deductible (Non Emergency Penalty of \$50 may apply)	20% after deductible (Non Emergency Penalty of \$50 may apply)
Inpatient	20% after deductible and \$200 copay per confinement	40% after deductible and \$200 copay per confinement	20% after deductible and \$200 copay per confinement	40% after deductible and \$200 copay per confinement
Outpatient Surgery	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Ambulance Service	20% after deductible	20% after deductible	20% after deductible	20% after deductible
MENTAL HEALTH SERVICES <i>For Mental Health treatment at RMHN & Billings Clinic, benefit paid at In-Network level</i>				
Inpatient Services	Facility: 20% after deductible + \$200 copay Physician: 20% after deductible	Facility: 40% after deductible + \$200 copay Physician: 40% after deductible	Facility: 20% after deductible + \$200 copay Physician: 20% after deductible	Facility: 40% after deductible + \$200 copay Physician: 40% after deductible
Outpatient Services	Office Visit: \$25 (deductible does not apply) Services: 20% after deductible	Office Visit: \$50 (deductible does not apply) Services: 40% after deductible	Office Visit: \$25 after deductible Services: 20% after deductible	Office Visit: \$50 after deductible Services: 40% after deductible
SUBSTANCE ABUSE SERVICES <i>For Substance Abuse treatment at RMHN & Billings Clinic, benefits paid at In-Network level</i>				
Inpatient Services	Facility: 20% after deductible + \$200 copay Physician: 20% after deductible	Facility: 40% after deductible + \$200 copay Physician: 40% after deductible	Facility: 20% after deductible + \$200 copay Physician: 20% after deductible	Facility: 40% after deductible + \$200 copay Physician: 40% after deductible
Outpatient Services	Office Visit: \$25 (deductible does not apply) Services: 20% after deductible	Office Visit: \$50 (deductible does not apply) Services: 40% after deductible	Office Visit: \$25 after deductible Services: 20% after deductible	Office Visit: \$50 after deductible Services: 40% after deductible
OTHER SERVICES				
Freedom from Smoking (SVH)	Free—see plan doc	n/a	Free-see plan doc	n/a
Maternity Services—Delivery/ Facility	Delivery Services: 20% after deductible Facility: 20% after deductible + \$200 copay	Delivery Services: 40% after deductible Facility: 40% after deductible + \$200 copay	Delivery Services: 20% after deductible Facility: 20% after deductible + \$200 copay	Delivery Services: 40% after deductible Facility: 40% after deductible + \$200 copay
Spinal Manipulation/ Chiropractic/ Massage Therapy Services 24 annual maximum benefit	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Physical, Occupational & Speech Therapy Services	20% after deductible	40% after deductible	20% after deductible	40% after deductible

Voluntary Dental Benefits

Administered by Employee Benefit Management Services (EBMS)

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with City of Billings dental benefit plan.

Dental has an open enrollment process annually, once you enroll, you agree to remain as a paying subscriber for a period not less than two (2) years or during employment with the City, whichever period is shorter. There is no required network with dental.

<i>See plan document for full details</i>	Dental
Annual Deductible (Individual/Family)	\$50 / \$100
Annual Benefit Maximum	\$1,000/ person
Preventive Dental Services (cleanings, exams, x-rays)	100%
Basic Dental Services (fillings, root canal therapy, oral surgery)	70%
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%
Orthodontic Services Dependent children under age 19	50% (\$1,500 lifetime max)



Flexible Spending Account (FSA)

Administered by Employee Benefit Management Services (EBMS)

You can save money on your healthcare (medical flex) and/or daycare (dependent flex) expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

Flexible Spending has to be re-elected annually and you may choose to enroll in one or both. Each account under the Flexible Benefits Plan has separate rules governing benefits and plan administration. It is important not to overestimate your eligible expenses because tax laws require that any unused amounts be forfeited at the end of each Plan Year. FSA through the EBMS platform offers debit cards for flex participants.

Health Flexible Spending Accounts (FSA) – “Medical Flex” at the City of Billings

At the time of printing, the IRS limit is \$2750 for medical flex. However, the IRS typically will announce the new year IRS limit at the end of October. When you do open enrollment in November, if the max has changed, it will be updated in the open enrollment process. The City always defaults to what the per pay period is, since that is what we have to put in payroll.

If you are on the HDHP—Employee only and are putting the kickback credit premium into flex plus your own contribution, in total you still can not exceed the annual max allowed.

Flexible Spending Accounts – Other Facts to Consider

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on this benefit:

1. Compensation redirection authorized for both medical and dependent care expense reimbursement is in effect for the entire year unless you have a change according to the IRS regulation on qualifying life events.
2. You must use all of the funds in your spending accounts by the end of the Plan Year or you will lose them; the balances cannot be combined, carried over into the next year, or converted to cash. Therefore, plan your annual elections carefully. City of Billings – Flex Plan Year: January 1 through December 31
3. Review your account on miBenefits periodically to see how much flex you have left. This money must be used for expenses incurred before the end of the Plan Year or **FORFEITED**. You may continue to submit claims up to sixty (60) days after the Plan Year ends for prior year's expenses. Debit card swipe machines assume that the day you swipe your card is the date of service you're paying for, they don't understand that today's payment is to pay for an office visit you had three weeks ago. So if you are trying to use up your previous year Flex balance and paying a bill in the 60 day runout grace period – don't use your debit card! If you swipe your flex debit card, it's going to pull money from your current year Flex plan; even if you're really trying to pay for a date of service in the prior year Flex balance. After December 31, you will need to manually submit your Flex claim to EBMS to collect the prior year's balance. You can manually submit Flex claims to EBMS in multiple ways, via e-mail (EBMS_receipts@alegeus.com), using the mobile app (EBMS CDH), through the miBenefits website (www.ebms.com), mail (PO Box 21367 in Billings, MT 59104) or faxing to 1-844-791-8315.
4. If your employment with the City terminates during the calendar year and you are participating in Flexible benefits, then your eligibility for participation ends on your final day of employment and you **FORFEIT** any monies left. However, you will be given sixty days (60) days from your last day to submit expenses incurred prior to your termination.



Dependent Care Reimbursement Flex Account – Daycare

Dependent care refers to the care of a dependent under the age of 13, or a family member of any age at your home who is mentally or physically unable to care for themselves, who rely upon your financial support and are eligible to be claimed as an exemption on your federal tax return. This may include spouses, children, parents, etc.

Eligible expenses also include payment for summer day camps, after-school care and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19), or a non relative, as long as such a person is reporting payments as income, is also eligible.

The dependent care spending account enables you to pay for eligible dependent care expenses on a pretax basis. This means you save money on the amount of income taxes you pay because your taxable income is reduced.

Eligibility requirements for dependent care flexible spending include the following:

- Dependent care that is necessary for you to work.
- Both employee and spouse must work (unless a spouse is a full-time student).
- Contribution election between the employee and spouse cannot exceed the following:
 - * \$5,000
 - * \$2,500 – if married, filing separate tax returns
- Daycare facilities must be licensed.
- Babysitting services must be provided by someone other than a child of yours who will be under the age of 19 at the end of the year in which the expenses are incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

The maximum limit allowed by the IRS is \$5,000 annually by the family. For an annual calendar year city enrollment over 26 pay periods, the max allowed is: \$4,999.80 (\$192.30 x 26 pay periods)

Dependent Care flex accounts are different than Health FSA accounts. You must have accumulated a sufficient credit balance in your Dependent Care Reimbursement Account in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent weeks as more dollars are contributed from your pay to your account.

For questions, please contact EBMS.



Employee FAQ:

Flexible Spending Accounts

What is an FSA?

A healthcare flexible spending account (FSA) is an employer-sponsored benefit that allows you to set aside pre-tax dollars into an account to be used for eligible medical expenses.

Why should I participate in an FSA?

Contributions to the FSA are deducted from your paycheck on a pre-tax basis, reducing your taxable income. You can increase your spendable income by an average of 30% of your annual contribution with the tax savings.

How do I contribute money to my FSA?

Your annual election will be divided by the number of pay periods in your plan year. This amount will be deducted from your paycheck before taxes are assessed.

Who is eligible under an FSA?

An FSA covers eligible expenses for you and all of your dependents, even if they are not covered under your primary health plan.

What expenses are eligible for reimbursement?

Health plan co-pays, deductibles, co-insurance, eyeglasses, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).

How do I determine the date my expenses were incurred?

Expenses are incurred at the time the medical care was provided, not when you are invoiced or pay the bill.

How do I get the funds out of my FSA?

If you have a benefits debit card, simply swipe it at the register. Otherwise, just file a claim including the receipt documenting the type, amount and date. Once approved, your reimbursement check will be mailed or deposited into your bank account.

What happens if I don't spend all of my FSA by the end of the plan year?

Be sure to only allocate dollars for predictable medical expenses. Any unused funds at the end of the plan year are forfeited, also called the use-it-or-lose-it rule.

How soon can I start spending my FSA funds?

With a healthcare FSA, your entire annual election amount is available on the first day of the plan year even though you have not yet contributed that amount.

Can I change my election amount mid-year?

Elections can only be altered if you experience a change in status as defined by IRS regulations, such as marriage, divorce, birth, or death in your immediate family.

What happens to my FSA if my employment is terminated?

Participation in your FSA is also terminated. This means that only expenses that were incurred prior to your termination date are eligible for reimbursement.

What is the deadline for submitting claims?

You can submit claims for reimbursement at any time during the same plan year that you incur the expense. You may also have a grace period at the end of the plan year. Check the summary plan document your employer provided.

Can I still deduct healthcare expenses on my tax return?

Yes, but not the same expenses for which you have already been reimbursed from your FSA.

Are over-the-counter (OTC) medications eligible for reimbursement?

Yes. OTC medications are eligible. *Please refer to the eligible expenses list provided by the IRS.*

What is a Letter of Medical Necessity?

The IRS mandates that eligible expenses be primarily for the diagnosis, treatment or prevention of disease or for treatment of conditions affecting any functional part of the body. For example, vitamins are not typically covered because they are used for general wellness, but your doctor may prescribe a vitamin to treat your medical condition. The vitamin would then be eligible if your doctor verified the necessity in treatment.



Contact us at **866-857-8182** or **flex@ebms.com**.



2075 Overland Ave. • Billings, MT 59102 • www.ebms.com

Debit Card Substantiation FAQs



Do All FSA Debit Card Purchases Have to be Substantiated?

Because your accounts use pre-tax money, the IRS requires all FSA and HRA transactions – even those made using a debit card – to be substantiated. Substantiation means the transaction is verified by documentation that proves the purchase is a qualified medical expense.

Unless your transaction can be automatically substantiated by an IRS approved method, you are required to submit documentation.

How Are Debit Card Transactions Substantiated?

There are several ways purchases made with your debit card are substantiated that comply with the IRS requirements:

Automatic Substantiation – Certain debit card transactions may be substantiated automatically (verified electronically). Examples include:

- **Recurring Charge Matching** – a charge at the same provider for the same dollar amount as a transaction that was previously approved and substantiated. An example may be monthly orthodontia payments.
- **Co-pay Matching** – a charge that matches your health plan's co-pay amounts are eligible for automatic substantiation. An example might be your \$20 co-payment for a prescription drug.
- **Point-of-Sale Substantiation (IIAS)** – IIAS is a voluntary standard that merchants use to comply with IRS substantiation requirements. For example, if you use your card to buy FSA eligible items at a grocery, discount store, or pharmacy, your purchase will be automatically substantiated if that store uses an IIAS system. EBMS will not ask for receipts for items you purchased at a retailer with IIAS. You will be asked to use a different form of payment for the non-eligible items as they will not be accepted with your debit card. Most merchants have already implemented this system, but for a complete list of participating locations, please visit www.sig-is.org
- **Data File Feeds** – If EBMS administers your medical, dental or vision plan, the debit card system will attempt to match your card transaction data to medical, dental and vision

claims within our system. Data matching requires the debit card transaction amount to match the patient responsibility amount on your EOB exactly.

Manual Substantiation – If EBMS can't substantiate the expense through any of the IRS-endorsed automated processes, we must send you a letter requesting this information. There are several reasons why we may ask you for documentation:

- Doctor, dentist, eye doctor and other provider visits where the amount paid does not equal a co-pay amount or does not equal information on your EOB. In these cases, you will be requested to provide documentation for these transactions.
- If your health care provider requires payment at the time of service, the provider will estimate your financial responsibility for the service. That amount is then "swiped" on your card. When the claim is processed through your EBMS medical plan, the amount you actually owe may be different from that estimate. Because the amounts differ, the debit card system cannot match your card transaction to the medical data received on the file for substantiation. EBMS must then send you a letter requesting this information. This happens often, especially with dental and vision providers.
- When you use your card to pay for a medical service, EBMS' automated system will keep looking back for 90 days to try to match the card transaction. If your provider did not file the claim with EBMS in a timely manner, the system may not be able to find a match on the medical data file.
- If you use your card to pay for a medical expense incurred outside of the current plan year, EBMS will require documentation. These expenses are not eligible to be paid with current year money and an overpayment will be placed on your account.
- If you choose to have insurance coverage under your spouse's health plan and opt out of your employer's plan, your card transactions will likely not auto-substantiate because there are no medical claims to match.
- If you use the card to pay for services for someone who is not covered under your insurance, the transaction cannot auto-substantiate.
- Since not all products and services purchased from a medical provider or at a pharmacy are qualified medical expenses, receipts are required to verify the qualified status of the expense. For example, a dentist may perform teeth whitening, a cosmetic procedure, which is not eligible for reimbursement.

What are Acceptable Forms of Substantiation Documentation?

All documentation submitted to substantiate a transaction must include all of the following information:

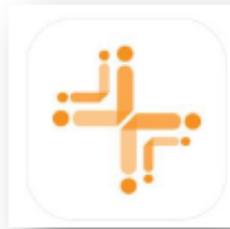
1. Name of the person who incurred the service or expense.
2. Name and address of the provider or merchant.
3. Date service or expense was incurred.
4. Detailed description of the service or expense.
5. The charged amount for the service or expense.

EBMS makes it easy to submit documentation and provides several alternatives:

- Upload a copy or image of the documentation by logging in to your miBenefits account. When you are in the FSA portal, select the claim requiring the documentation and drop and drag the image to the receipt box.



- Use your smartphone to take a picture of the receipt and upload it through our mobile app. Select the claim requiring the documentation and attach the photo.



- Email your information to EBMS_Receipts@alegeus.com



- Fax to EBMS toll free at 844-791-8315.



- Mail your information to us at:

EBMS
PO Box 21367
Billings, MT 59104-1367



What Happens If Documentation is Not Submitted to Verify a Transaction?

EBMS will send you request letters three times. If we don't hear back from you after the third and final request for documentation, the transaction will be marked ineligible and your card will be temporarily deactivated. You'll receive a notice telling you that your card has been suspended.

Once your card has been suspended, you won't be able to use it for purchases. However, if you need to purchase items during this suspension period, you can still submit a paper reimbursement request form or request reimbursement through your miBenefits account or through the mobile app. Unsubstantiated debit card purchase amounts may be deducted from future paper reimbursement requests in order to reactivate the debit card.

You'll also receive a letter asking you to send us a check in the amount of the transaction in question to reimburse your account for the ineligible amount. You have the option of providing the requested documentation or submitting other claims to offset the ineligible amount. Once the ineligible amount has been offset your card will be reactivated and ready for use.

- ☎ Questions? Call our friendly and knowledgeable client service representatives at the toll free number on the back of your debit card or 1-866-857-8182.





The Benefit of Balance

Eligible Expense Table

Reference List for Health Flexible Spending Accounts

Expenses Eligible for Reimbursement Under Health FSAs

- Abortions (legal)
- Acupuncture
- Alcoholism treatment
- Ambulance Fees
- Baby Electrolytes (e.g. Pedialyte)
- Bandages
- Birth Control
- Blood Pressure Monitors
- Body Scans
- Chem. Dep. Services
- Chiropractic Services
- Contact Lens
- Contact Lens Solution
- Co-Payments/Co-Insurance
- CPAP Machine/Supplies
- Crowns (dental)
- Crutches
- Deductibles
- Denture Adhesive
- Diabetic Supplies
- Diagnostic Services
- Doctor Office Visits
- Eye Drops
- Eye Exams/Eye Glasses
- Fertility Treatments
- First Aid Supplies
- Flu Shots
- Hearing Aids/Supplies
- Home Medical Equipment
- Hospital Costs
- Immunizations
- Insulin
- In Vitro Fertilization
- Lab Charges
- Lasik/Laser Eye Surgery
- Massage Therapy (Medical)
- Medic Alert Bracelet
- Naturopath Charges
- Orthodontia
- Orthopedic Inserts
- Orthotics
- Osteopath Fees
- Physical Exam
- Physical Therapy
- Physician Fees
- Pregnancy Tests
- Prescription Medications
- Psychiatrist Charges
- Psychologist Charges
- Reading Glasses
- Rental Fees-Medical Equipment
- Routine Exams
- Smoking Cessation
- Sterilization
- Surgical Fees
- Thermometer
- Vaccinations
- Walker/Wheelchair
- X-Ray

Potentially Eligible Items - Letter of Medical Necessity from you doctor is required

- Blood Storage
- Books, health related
- Breast Pumps
- Counseling
- Exercise Equipment
- Fiber Supplements
- Foot insoles
- Health Club fees
- Humidifier
- Massage Therapy
- Orthopedic Shoes
- Personal trainer fee
- Sunscreen
- Vitamins
- Weight loss program

Please Note: The IRS will not allow the above services to be reimbursed by a Health Care FSA, HRA or HSA funds unless accompanied by a Letter of Medical Necessity that includes the existing medical condition that is being treated.



Over the Counter Medications

- Acid Controllers
 - Allergy and Sinus
 - Antibiotic Products
 - Anti-Diarrheal
 - Anti-Gas Products
 - Anti-Itch and Insect Bite
 - Anti-Parasitic Treatments
 - Baby Rash Ointment and Creams
 - Cough, Cold and Flu Products
 - Digestive Aids
 - Feminine Anti-Fungal/Anti-Itch
 - Hemorrhoidal Medications
 - Laxatives
 - Motion Sickness
 - Pain Relievers
 - Respiratory Treatments
 - Sleep Aids and Sedatives
 - Stomach Remedies
-

Ineligible Expenses

- Chapstick
- Charges for No-Shows
- Charges for Missed/Canceled Appointments
- Contact Lens Insurance
- Cosmetic Procedures/Products
- Dental Floss
- Deodorant
- Diapers for Newborns
- Diet Foods
- Electrolysis
- Feminine hygiene products
- Finance Charges
- Funeral Expenses
- Gender Reassignment
- Hand lotion
- Insurance Premiums
- Late Fees (e.g. for late payments of bills for medical services)
- Marijuana
- Marriage Counseling
- Massage Therapy (non-medical)
- Rogaine
- Teeth Bleaching
- Toiletries
- Veneers

Eligible medical expenses are defined by Section 213(d) of the Internal Revenue Code. This list is provided merely as a guide, and is not intended to serve as legal or tax advice. Your employer's Flex Plan may be more restrictive than the IRS allows. For further information on what expenses may be eligible for reimbursement under your particular Flex Plan, call EBMS at 866-857-8182, or flex@ebms.com.

Health Savings Account (HSA)

Health Savings Accounts are only available to active employees on a High Deductible Health Plan (HDHP) per IRS regulations.

An HSA is a tax-advantaged account established to pay for qualified medical expenses for those who are covered under a high deductible health plan. An HSA has maximum allowable contributions annually on a pretax basis depending on if you have individual coverage or family unit coverage. Your HSA can pay for medical expenses that the HDHP does not cover and for other qualified medical expenses, which include most medical care such as dental and vision. Funds are placed in your account and they are portable, meaning you keep your account even after you leave your job. You will use a debit card for payments.

Who can elect a health savings account?

An eligible individual is anyone who is under age 65 and:

- Is covered under a high deductible health plan (HDHP)
- Is not covered by any other health plan that is not a HDHP
- Is not currently enrolled in Medicare or TRICARE
- Has not received medical benefits through the VA during the preceding three months
- May not be claimed as a dependent on another person's tax return

Who qualifies as a dependent? Who & what can you use the HSA monies for?

A person generally qualifies as your dependent for HSA purposes if you claim them as an exemption on your federal tax return.

HSA monies may be used by the employee to reimburse qualified expenses for themselves or for any tax – eligible dependent even if that dependent is not covered by the HDHP. The penalty on taxable, nonmedical distributions is 20%, if you use any of the money for nonmedical expenses before age 65.

Coverage of Adult Child's medical bills through HSA on HDHP

While the Affordable Care Act allows parents to add their adult children (up to age 26) to their health plans, the IRS has not changed its definition of a dependent for health savings accounts. This means that an employee whose 24-year-old child is covered on his HSA-qualified high deductible health plan is not eligible to use HSA funds to pay that child's medical bills.

If account holders can't claim a child as a dependent on their tax returns, then they can't spend HSA dollars on services provided to that child. According to the IRS definition, a dependent is a qualifying child (daughter, son, stepchild, sibling or stepsibling, or any descendant of these) who:

- Has the same principal place of abode as the covered employee for more than one-half of the taxable year.
- Has not provided more than one-half of his or her own support during the taxable year.
- Is not yet 19 (or, if a student, not yet 24) at the end of the tax year or is permanently and totally disabled.

What happens after reaching age 65 with an HSA?

You cannot continue to contribute towards your HSA. You can use the HSA funds for nonmedical expenses and you will not incur the 20% penalty; however, you would need to pay income taxes on withdrawn money. Keep in mind you may continue to withdraw funds from your HSA for qualified medical expenses without creating a personal taxable event after attaining age 65. If you turn 65 mid-year and have an HSA account, it is your responsibility to notify HR.

Combining HSA and Medical Flex Accounts

If you elect HDHP and choose to participate in a HSA and the Flexible Spending Account, you will have a Limited Scope Flex Account. You will not be able to use the medical flex account for the reimbursement of qualified medical expenses – it may only be used for the reimbursement of vision and/or dental expenses not covered by insurance.

HDHP – Credit Premium into HSA

Employee Only participants on the HDHP (no dependents on the plan) with a credit premium kickback can apply it to their HSA. The total of this premium credit kickback and any personal contributions to the HSA cannot exceed the annual IRS maximum.

Fees related to HSA account

The City will pay the general administration fee to have your HSA account as long as you are on the City HDHP—High Deductible Health Plan and an actively working employee.

The maximum IRS limit for Health Savings Accounts typically change annually. Please see enrollment form for details.

Employee FAQ: Health Savings Accounts

What is a health savings account (HSA)?

An HSA is a tax-advantaged personal savings account that can be used to pay for medical, dental, vision and other qualified expenses now or later in life. To contribute to an HSA you must be enrolled in a qualified high-deductible health plan (HDHP) and your contributions are limited annually. The funds can even be invested, making it a great addition to your retirement portfolio.

Why should I participate in an HSA?

Funds contributed to an HSA are triple-tax-advantaged.

- 1. Money goes in tax-free.** Most employers offer a payroll deduction through a Section 125 Cafeteria Plan, allowing you to make contributions to your HSA on a pre-tax basis. The contribution is deposited into your HSA prior to taxes being applied to your paycheck, making your savings immediate. You can also contribute to your HSA post-tax and recognize the same tax savings by claiming the deduction when filing your annual taxes.
- 2. Money comes out tax-free.** Eligible healthcare purchases can be made tax-free when you use your HSA. Purchases can be made directly from your HSA account, either by using your benefits debit card, ACH, online bill-pay, or check – or, you can pay out-of-pocket and then reimburse yourself from your HSA.
- 3. Earn interest, tax-free.** The interest on HSA funds grows on a tax-free basis. And, unlike most savings accounts, interest earned on an HSA is not considered taxable income when the funds are used for eligible medical expenses.

What expenses are eligible for reimbursement?

Health plan co-pays, deductibles, co-insurance, vision, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).

Am I eligible to participate?

In order to contribute, you must be enrolled in a qualified HDHP, not covered under a secondary health insurance plan, not enrolled in Medicare, and not another person's dependent. There are no eligibility requirements to spend previously-contributed HSA funds.

What is a high-deductible health plan?

A HDHP is a health insurance plan with deductible amounts that are greater than \$1,400 for individual or \$2,800 for family coverage and have an out-of-pocket maximum that does not exceed \$7000 for individual or \$14,000 for family coverage.

How do I contribute money to my HSA?

Payroll deduction is most likely offered by your employer. Your annual contribution will be divided into equal amounts and deducted from your payroll before taxes. Direct contributions can also be made from your personal checking account and can be deducted on your personal income tax return.

Can I change my contributions to my HSA during the year?

Yes. You will not be subject to the change-in-status rules applicable to other benefit accounts. You will be able to make changes in your contributions by providing the applicable notice of change provided by your employer.

How much can I contribute to my HSA?

Contributions can be made by the eligible employee, their employer, or any other individual. Annual contributions from all sources may not exceed \$3,600 for singles or \$7,200 for families in 2021. Individuals aged 55 and over may make an additional \$1,000 catch-up contributions.

Do I have to spend all my contributions by the end of the plan year?

No. HSA money is yours to keep. Unlike a flexible spending account (FSA), unused money in your HSA isn't forfeited at the end of the year; it continues to grow, tax-deferred.

What happens if my employment is terminated?

HSAs are portable and move with you if you change employment. Your HSA belongs to you, not your employer, just like your personal checking account.

How do I access the funds in my HSA?

Your HSA is similar to a checking account. You are responsible for ensuring the money is spent on qualified purchases only and maintaining records to withstand IRS scrutiny. Payments can be made via check, ACH, online bill-pay, or debit card, depending on what is available to you.

When must contributions be made to an HSA for a taxable year?

Contributions for the taxable year can be made in one or more payments at any time after the year has begun and prior to the individual's deadline (without extensions) for filing the eligible individual's federal income tax return for that year. For most taxpayers, the deadline is April 15 of the year following the year for which contributions are made.

What happens to the money in my HSA if I no longer have HDHP coverage?

Once you discontinue coverage under an HDHP and/or get secondary health insurance coverage that disqualifies you from an HSA, you can no longer make contributions to your HSA. However, since you own the HSA, you can continue to use the remaining funds for future healthcare expenses.

Is tax reporting required for an HSA?

Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize to complete this form.

Can I still deduct healthcare expenses on my tax return?

Yes, but not the same expenses for which you have already been reimbursed from your HSA.

Can I withdraw the money for non-healthcare purchases?

Yes. If you withdraw the money for an unqualified expense prior to age 65, you'll be subject to your ordinary income tax, in addition to 20% tax penalty. You can withdraw the money for any reason without penalty after age 65, but are subject to applicable income taxes.

Can I roll over or transfer funds from my HSA or Medical Savings Account (or Archer MSA) into an HSA?

Yes. Pre-existing HSA funds or MSA monies may be rolled into an HSA and will continue their tax-free status.

Can I control how the funds are invested?

Yes. Once your HSA cash account balance reaches the minimum amount required by the custodian, you can transfer funds to an HSA investment account. You can choose from a selection of mutual funds and setup and allocation model for future transfers like you would for a 401k plan.

Can I transfer funds between the cash and investment accounts?

Yes. You can transfer money between your HSA cash and HSA investment account at any time.



For more information, call 866-857-8182 or flex@ebms.com.



P.O. Box 21367 • Billings, MT 59104 • www.ebms.com



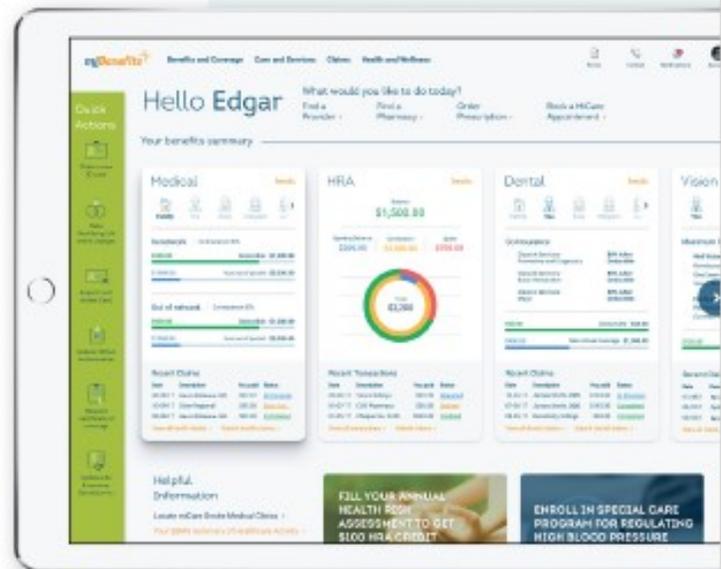
EBMS technology that improves benefits for everyone

The miBenefits portal

Members

Isn't It About Time Something in Your Life Got Easier?

We have important information about your EBMS benefit plan.



Members

Manage your benefits online, right from your browser, with our miBenefits portal.

Our latest technology allows you easier access to your healthcare information.

To register* for miBenefits, please visit miBenefits.ebms.com

Fast, simple, and frustration-free!

Like a digital helping hand, our next-generation portal makes your life easier. The days of struggling to make sense of a confusing benefit statement are gone. With our miBenefits portal, you'll login to a dynamic dashboard that puts everything you need right at your fingertips. We think you'll find it's even easier than calling our customer service center.

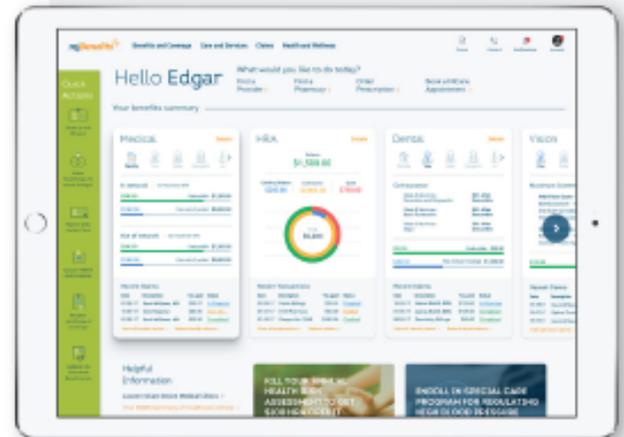
What you'll find in the miBenefits portal:

- ✔ One login for everything - medical, dental, vision, prescription, and HSA/FSA
- ✔ Quick-links to find a physician, order an ID card, and perform other common tasks
- ✔ Simplified navigation - get 80% of what you need right from the home page

Other features to check out:

- Claims status in real time
- Separate tabs for each family member on your plan
- At-a-glance tracking of where you are in terms of deductibles and out-of-pocket maximums

You can find more information about the miBenefits portal by calling the number on the back of your card



Be an empowered healthcare consumer

Comparison shopping has always been nearly impossible in healthcare. We're changing the game with our consumer-oriented transparency tools, available through the miBenefits portal.

You can compare hospitals and doctors based on quality measures and typical costs. You can easily identify the providers that have the best outcomes and the fewest complications. And you can make better choices with your healthcare dollars.



Voluntary Vision Insurance

Administered by VSP - Voluntary Vision Plan (not part of EBMS)

The City works directly with VSP for our voluntary vision plan. If you elect this coverage, you will NOT be issued an insurance card. When you go to the VSP network provider, they will pull up your information using the main participant's SS#. Vision has an open enrollment process annually; however, once you enroll, you agree to remain as a paying subscriber for a period not less than one (1) year or during your employment with the City, whichever period is shorter.

Vision Services Plan (VSP) network, consisting of over 29,000 individually contracted providers (optometrists and ophthalmologists) nationwide, is available to help reduce your out-of-pocket costs for eye exams, eyeglasses, and contact lenses. You are able to access your member benefits on the VSP website: <https://www.vsp.com/>

Visit SeeMuchMore.com to get information about VSP or contact www.vsp.com | 800.877.7195

See VSP plan document for full details.

City of Billings—group #30016484	In-Network (VSP provider)	Out-of-Network (any qualified non-network provider of your choice)
Eye Exam — once every 12 months		
Office Visit	\$15 then 100% (up to allowance)	Up to \$46
Lenses — once every 12 months		
Single Vision Lenses	\$25 then 100% (up to allowance)	Up to \$55
Lined Bifocal Lenses	\$25 then 100% (up to allowance)	Up to \$75
Lined Trifocal Lenses	\$25 then 100% (up to allowance)	Up to \$95
Frames — once every 12 months		
Materials	\$25 then 100% (up to allowance)	Up to \$50
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames		
Elective	Up to \$60 (Evaluation/Fitting) Up to \$105 (Materials)	Up to \$105
Necessary	\$25 then 100% (up to allowance)	Up to \$210

How to process claims for reimbursement for a Non-VSP provider?

Members will have to pay the Non VSP provider directly and submit a request for reimbursement:

- Pay the provider the full amount and request an itemized copy of the bill. The bill should separately detail the charges for the eye exam and materials, including lens type.
- Include the following information with the bill:
 - * The name, address, and phone number of the open access provider
 - * The covered member's ID number
 - * The covered member's name, address, and phone number
 - * The name of the group
 - * The patient's name, date of birth, address, and phone number
 - * The patient's relationship to the covered member (self, spouse, child, student, etc.).
- Claims must be filed within 12 months of the date of service

Members can write the information on the bill or use the printable form available when members sign on to view benefits information at vsp.com. Send a copy of the itemized bill(s) with the above information to VSP at: VSP Attn: Claims PO Box 385018 Birmingham, AL 35238-5018

Want to get reimbursed faster and track your claim status? Here's how:

- Complete the vsp.com online claim form.
- Attach your receipts to get reimbursed faster.
- Track the status of your claim so you know when your reimbursement is on its way. For added convenience, mobile users can simply snap a photo and attach their receipts.

VSP Doctor Directory

October 09, 2020
Search Criteria: Yellowstone County, MT

For: CITY OF BILLINGS
By: Leta Lintern

MONTANA

YELLOWSTONE COUNTY

BILLINGS

Bauer and Clausen Optometry

David E. Bauer, OD
NPI: 1407807068 License: OPT-OPT-LIC-755

Last Credentialed Date: 06/26/2019

Gender: Male
100 Brookshire Blvd # 2 Ste 2
Billings, MT 59102
(406) 656-8888

Robyn N. Clausen, OD
NPI: 1427046713 License: OPT-OPT-LIC-769

Last Credentialed Date: 01/15/2020

Gender: Female
100 Brookshire Blvd # 2 Ste 2
Billings, MT 59102
(406) 656-8888

Matthew Dooper, OD
NPI: 1801456686 License: 3577

Last Credentialed Date: 07/29/2019

Gender: Male
100 Brookshire Blvd # 2 Ste 2
Billings, MT 59102
(406) 656-8888

Jessica Forsch, OD
NPI: 1073058731 License: OPT-OPT-LIC-2806

Last Credentialed Date: 10/28/2019

Gender: Female
100 Brookshire Blvd # 2 Ste 2
Billings, MT 59102
(406) 656-8888

Handicap Accessible

Beartooth Vision Center PC*

Robert P. Currence, OD
NPI: 1275516742 License: OPT-OPT-LIC-622

Last Credentialed Date: 09/14/2020

Gender: Male
2499 Gabel Rd Ste 3
Billings, MT 59102
(406) 652-9339

Mikel L. Mettler, OD
NPI: 1841604683 License: OPT-OPT-LIC-2136

Last Credentialed Date: 06/22/2020

Gender: Female
2499 Gabel Rd Ste 3
Billings, MT 59102
(406) 652-9339

Stephanie Shoults, OD
NPI: 1811551500 License: OPT-OPT-LIC-3611

Last Credentialed Date: 08/05/2019

Gender: Female
2499 Gabel Rd Ste 3
Billings, MT 59102
(406) 652-9339

Handicap Accessible

Billings Eyecare Associates*

Languages spoken: Spanish

Kerry T. Sanchez, OD
NPI: 1932169984 License: OPT-OPT-LIC-745

Last Credentialed Date: 08/22/2018

Gender: Male
1445 Ave B
Billings, MT 59102
(406) 259-2567

Ruben C. Sanchez, OD
NPI: 1750342119 License: OPT-OPT-LIC-382

Last Credentialed Date: 08/22/2018

Gender: Male
1445 Ave B
Billings, MT 59102
(406) 259-2567

Handicap Accessible

Billings Family Optical PLLC*

Languages spoken: Spanish
Crystal M. Carringtonhellier, OD
NPI: 1689666968 License: OPT-OPT-LIC-3079

Last Credentialed Date: 11/25/2019

Gender: Female
1540 Lake Elmo Dr Ste 1
Billings, MT 59105
(406) 245-2299

Devin B. Despain, OD
NPI: 1730344698 License: OPT-OPT-LIC-800

Last Credentialed Date: 05/18/2020

Gender: Male
1540 Lake Elmo Dr Ste 1
Billings, MT 59105
(406) 245-2299

Handicap Accessible

Billings Vision Center

Thomas R. Felstet, OD
NPI: 1992727903 License: OPT-OPT-LIC-726

Last Credentialed Date: 10/22/2018

Gender: Male
1331 24th St W
Billings, MT 59102
(406) 534-8848

Kyle Hibbert, OD
NPI: 1093092629 License: OPT-829

Last Credentialed Date: 08/14/2020

Gender: Male
1331 24th St W
Billings, MT 59102
(406) 534-8848

Handicap Accessible

Billings Visn and Contact Len

Languages spoken: Spanish
Kevin B. Biegel, OD
NPI: 1427108836 License: OPT-OPT-LIC-556

Last Credentialed Date: 01/16/2019

Gender: Male
111 S 24th St W Ste 18
Billings, MT 59102
(406) 652-4141

Handicap Accessible

Eye Physicians*

Jennifer J. Cross, OD
NPI: 1568566784 License: OPT-OPT-LIC-756

Last Credentialed Date: 07/29/2019

Gender: Female
1221 N 26th St
Billings, MT 59101
(406) 252-5881

George F. Hatch Jr, MD
NPI: 1801857651 License: MED-PHYS-LIC-4288

Last Credentialed Date: 02/14/2020

Gender: Male
1221 N 26th St
Billings, MT 59101
(406) 252-5881

Handicap Accessible

Heights Eyecare*

Jennifer H. Dull, OD
NPI: 1124165618 License: OPT-OPT-LIC-747

Last Credentialed Date: 02/28/2018

Gender: Female
430 Lake Elmo Dr Ste 1
Billings, MT 59105
(406) 252-9927

* This office has extended hours.

VSP Doctor Directory

October 09, 2020

Search Criteria: Yellowstone County, MT

For: CITY OF BILLINGS

By: Leta Lintern

Amanda L. Haber, OD
NPI: 1750349049 License: OPT-OPT-
LIC-767

Last Credentialed Date: 09/30/2019

Gender: Female
430 Lake Elmo Dr Ste 1
Billings, MT 59105
(406) 252-9927

Sarah E. Hill, OD
NPI: 1952475790 License: OPT-OPT-
LIC-781

Last Credentialed Date: 10/23/2019

Gender: Female
430 Lake Elmo Dr Ste 1
Billings, MT 59105
(406) 252-9927

Brad A. Kimball, OD
NPI: 1174691109 License: OPT-OPT-
LIC-665

Last Credentialed Date: 09/30/2019

Gender: Male
430 Lake Elmo Dr Ste 1
Billings, MT 59105
(406) 252-9927

Brian E. Linde, OD
NPI: 1508934142 License: OPT-OPT-
LIC-532

Last Credentialed Date: 02/14/2020

Gender: Male
430 Lake Elmo Dr Ste 1
Billings, MT 59105
(406) 252-9927

Kelci K. Rolfstad, OD
NPI: 1730498817 License: OPT-OPT-
LIC-1845

Last Credentialed Date: 05/06/2019

Gender: Female
430 Lake Elmo Dr Ste 1
Billings, MT 59105
(406) 252-9927

Handicap Accessible

Kautz Optometry

Robert W. Kautz, OD
NPI: 1568432334 License: OPT-OPT-
LIC-596

Last Credentialed Date: 08/07/2020

Gender: Male
805 24th St W Ste 9
Billings, MT 59102
(406) 248-1676

Handicap Accessible

Kristi D Schied OD PC*

Kristi D. Schied, OD
NPI: 1649360785 License: OPT-OPT-
LIC-612

Last Credentialed Date: 08/30/2019

Gender: Female
2203 Broadwater Ave
Billings, MT 59102
(406) 652-4455

Handicap Accessible

Mcbride and Mcbride*

Languages spoken: Spanish

Shawn N. Lebsack, OD

NPI: 1124427257 License: OPT-OPT-
LIC-2220

Last Credentialed Date: 10/28/2019

Gender: Male
2120 Grand Ave
Billings, MT 59102
(406) 656-7605

Kevin W. Mcbride, OD
NPI: 1922161538 License: OPT-OPT-
LIC-505

Last Credentialed Date: 12/29/2017

Gender: Male
2120 Grand Ave
Billings, MT 59102
(406) 656-7605

Joseph S. Steiner, OD
NPI: 1205157161 License: OPT-OPT-
LIC-828

Last Credentialed Date: 01/31/2020

Gender: Male
2120 Grand Ave
Billings, MT 59102
(406) 656-7605

Handicap Accessible

Wardell Vision Center PC

Michael B Wardell, OD
NPI: 1477695856 License: OPT-OPT-
LIC-528

Last Credentialed Date: 03/30/2018

Gender: Male
1005 24th St W Ste 8
Billings, MT 59102
(406) 281-8480

Michael Craig Wardell, OD
NPI: 1043757057 License: OPT-OPT-
LIC-2937

Last Credentialed Date: 09/23/2020

Gender: Male
1005 24th St W Ste 8
Billings, MT 59102
(406) 281-8480

Handicap Accessible

LAUREL

Southern Montana Optometric Center OD PC*

Ron L. Benner, OD
NPI: 1710037437 License: OPT-OPT-
LIC-523

Last Credentialed Date: 12/13/2017

Gender: Male
210 1st Ave
Laurel, MT 59044
(406) 628-8668

Handicap Accessible

Note: By using this VSP doctor list, you agree that the information it contains is protected and proprietary. Publication or sharing of the information for any purpose other than implementing the VSP vision care plan is prohibited.

All VSP doctors accept new patients. The VSP doctors and affiliate providers on this list were VSP doctors or affiliate providers at the time the list was created. However, this list is subject to change without notice. Please check with the VSP doctor or affiliate provider of your choice when making your appointment to ensure he or she provides the services you require.

Accessibility indicator based on doctor/practice reporting.

Timely Access to Care. Enrollees have the right to receive care and services in a timely manner: access to a routine eye exam within 30 calendar days; access to non-urgent medical needs within seven days; access to urgent care if the call is received during office hours, and the doctor determines the need of the member to be urgent, member should be seen within 24 hours; access to a telephone screening when evaluated to determine the severity of the condition and disposition of the patient; and access to specialty care within 14 calendar days from the time the primary care provider requests the referral.

Enrollees are entitled to language interpreter services, at no cost. For more information, please contact VSP at (800) 877.7195. For interpreter services at the time of an appointment, enrollees should tell the provider's office that they need an interpreter when scheduling their appointment.

* This office has extended hours.

VSP Doctor Directory

October 09, 2020

Search Criteria: Yellowstone County, MT

For: CITY OF BILLINGS

By: Leta Lintern

VSP contracted providers allow full and equal access to covered services, including insureds with disabilities as required under the Federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

VSP continually assesses the doctor network to ensure adequate access for members. VSP's access standard is one doctor in a 10-mile radius urban/suburban and one doctor in a 25-mile radius for rural. VSP utilizes reports to analyze and determine the percentage of members that will have access to a doctor within a specified distance. VSP runs specific reports to determine if standards are being met and whether to apply appropriate interventions when gaps are identified.

VSP Network Providers are offered ongoing Cultural Competency education and training.

VSP recredentials doctors within thirty-six (36) months of the prior credentialing date^[1] in accordance with state and federal requirements and NCQA guidelines.

[1] Virginia state regulations require recredentialing within 3 years of the day (date) of the prior credential.

Important Notice:

Any physician included in this directory is listed for outpatient office visits. In addition, the directory includes information regarding whether the provider is currently accepting new patients.

Directory Last Updated on 10/04/2020

SAVINGS NEVER LOOKED SO GOOD

Get access to over \$3,000 in savings with Exclusive Member Extras from VSP and industry-leading brands.

DISCOVER YOUR SAVINGS

- Extra \$20 on featured frame brands¹
- Instant savings and satisfaction guarantees on popular lenses and enhancements²
- Savings on LASIK
- Mail-in rebates and free trials on popular contact lens brands
- Discounts on medical care, prescription drugs, lab work, as well as entertainment and theme park passes⁴
- Savings on digital hearing aids and replacement batteries⁵



QUALITY SELECTION OF BENEFITS

Spend lightly on the best that VSP® and other industry-leading brands has to offer.

BONUS OFFERS

Maximize your savings with bonus offers only available at Premier Program locations.

LENSES AND FRAMES

EXTRA \$20 TO SPEND



CONTACTS

LASIK



FINANCING AND HEARING AIDS

HEALTH AND ENTERTAINMENT



View Bonus Offers at vsp.com/offers

Offers subject to change without notice. Some members may not be eligible for all offers. Visit [VSP.COM/OFFERS](https://vsp.com/offers) for terms and conditions on specific offers.

1. Brands and promotions are subject to change. 2. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. 3. Available to VSP members with applicable plan benefits. 4. Some members may not be eligible for this program. Visit [VSP.COM/SIMPLEVALUES](https://vsp.com/simplevalues) for terms and conditions. 5. VSP is providing information to its members, but does not offer or provide any discount hearing program. The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representation or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly. TruHearing offers individuals the opportunity to purchase hearing aids at discounted prices, including individuals covered by self-funded health plans not subject to state insurance or health plan regulations. TruHearing is not insurance and not subject to state insurance regulations. TruHearing provides discounts to certain healthcare groups for hearing aid sales and services; TruHearing provides fitting, programming, and three adjustment visits at no cost; the member is obligated to pay for testing, and all post-fitting hearing care services, but will receive a discount from those healthcare providers who have contracted with TruHearing. Not available directly from VSP in the states of Washington and California.

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TruHearing[®] Hearing Aid Discount Program

VSP[®] Vision Care members can save up to 60% on the latest brand-name hearing aids. Dependents and even extended family members are eligible for exclusive savings, too.



Hearing loss is growing in the workplace.

Like vision loss, hearing loss can have a huge impact on productivity and overall quality of life. Unfortunately, of the over 38 million people who need hearing aids, only one in five has them. And the high cost of hearing aids is a major factor keeping people from addressing their hearing loss.

*96% of customers surveyed would recommend TruHearing to their friends and family.**

More Than Just Great Pricing

TruHearing also provides members with:

- Three provider visits for fitting and adjustments
- A 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Plus, members get:

- Access to a national network of more than 3,800 hearing healthcare providers
- Straight-forward, nationally-fixed pricing on a wide selection of the latest brand-name hearing aids
- Deep discounts on batteries shipped directly to their door

Best of all, if your organization already offers a hearing aid benefit, members can combine it with TruHearing prices to reduce their out-of-pocket expense even more!

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call 877.396.7194 with questions.

Here's how it works:

- 1. Members call TruHearing.**
Members and their family call **877.396.7194** and mention VSP.
- 2. Schedule exam.**
TruHearing will answer questions and schedule a hearing exam with a local provider.
- 3. Attend appointment.**
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for the member.

*Based on a 2013 satisfaction study of VSP members.

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VSP is a registered trademark of Vision Service Plan. All other brands or marks are the property of their respective owners.

VSP is providing information to its members, but does not offer or provide any discount hearing program. The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.

TruHearing offers individuals the opportunity to purchase hearing aids at discounted prices, including individuals covered by self-funded health plans not subject to state insurance or health plan regulations. TruHearing is not insurance and not subject to state insurance regulations. TruHearing provides discounts to certain health care groups for hearing aid sales and services; TruHearing provides fitting, programming and three adjustment visits at no cost; the member is obligated to pay for testing, and all post-fitting hearing care services, but will receive a discount from those health care providers who have contracted with TruHearing. Not available directly from VSP in the states of Washington and California. 13793 VCCM

Employee Assistance Program (EAP)

Insured by St. Vincent Healthcare (SCL Health):

For Questions or Appointments:

St. Vincent Healthcare – Behavioral Health
Yellowstone Medical Building
2900 12th Avenue North, Suite 280W
Office Hours: Monday-Thursday, 7 a.m. – 6 p.m.
In Billings – 237.3585
Outside Billings – 888.662.5461
24-Hour Crisis Hotline – 888.662.5461

City of Billings EAP Benefit details

- Eight (8) **FREE** counseling sessions annually, January 1 through December 31.
- This benefit is available to employees in permanent city positions. This benefit also applies to any of your dependents on the City of Billings health insurance.
- When you call (237.3585) St. Vincent Behavioral Health/EAP to set up your appointment, please inform them this is your City of Billings EAP benefit.
- Please arrive early for your appointment to allow time for registration. You will need your insurance card information at your first appointment so that it is on file if you exceed your annual free EAP visits so it can be processed through your health insurance.

St. Vincent Physicians – Behavioral Health

What is St. Vincent Healthcare EAP?

The St. Vincent Healthcare Employee Assistance Program (EAP) is a benefit to employees that offers confidential, short-term counseling services for you and your family. This City of Billings sponsored benefit is provided at no cost to you as described in this flier.

Why use EAP?

We all face personal challenges throughout our lives. Sometimes, we need help working through a problem in order to gain perspective and regain a sense of control. If you feel the need to take some time for yourself, to talk freely about the problems and challenges that concern you or your family, EAP can help. Our professional caring staff is available to provide counseling and if needed, referrals to other resources that may be helpful to you.

Outpatient Mental Health Services St. Vincent Physicians

Behavioral Health offers a comprehensive array of mental health services for all ages. Our licensed mental health professionals provide caring, personalized outpatient services. We coordinate your care with your medical doctor.

Our multi-disciplinary team treats:

- Depression
- Posttraumatic Stress
- Addictive Illness
- Attention Deficit
- Marital and Relationship Issues
- Issues of Aging
- Anxiety
- Workplace Stress
- Grief and Loss
- Parent/Child Issues
- Adjustment to Illness and Injury
- Parent/Child Issues

Our therapeutic services include:

- Marital and Relationship Counseling
- Neuropsychological and Psychological Assessments
- Stress Management
- Individual Counseling
- Crisis Intervention
- Neuropsychological Assessment

Please Note: The City of Billings—EAP benefit is only available at SVH Behavioral Health

- If you exhaust your annual EAP benefit at SVH Behavioral Health, it will then run through your health insurance for any remaining visits in the calendar year.
- If you do not want to utilize SVH Behavioral Health for counseling, you can go to a provider of your choice, however it will run through your health insurance plan.
- If specialized counseling is required, EAP will refer patient and the services then would run through their medical insurance.

Create Your Account

- Visit mychart.sclhealth.org
- Select **SIGN UP NOW**, then select **SIGN UP ONLINE**. Follow the instructions to securely verify your identity online.

For technical questions:

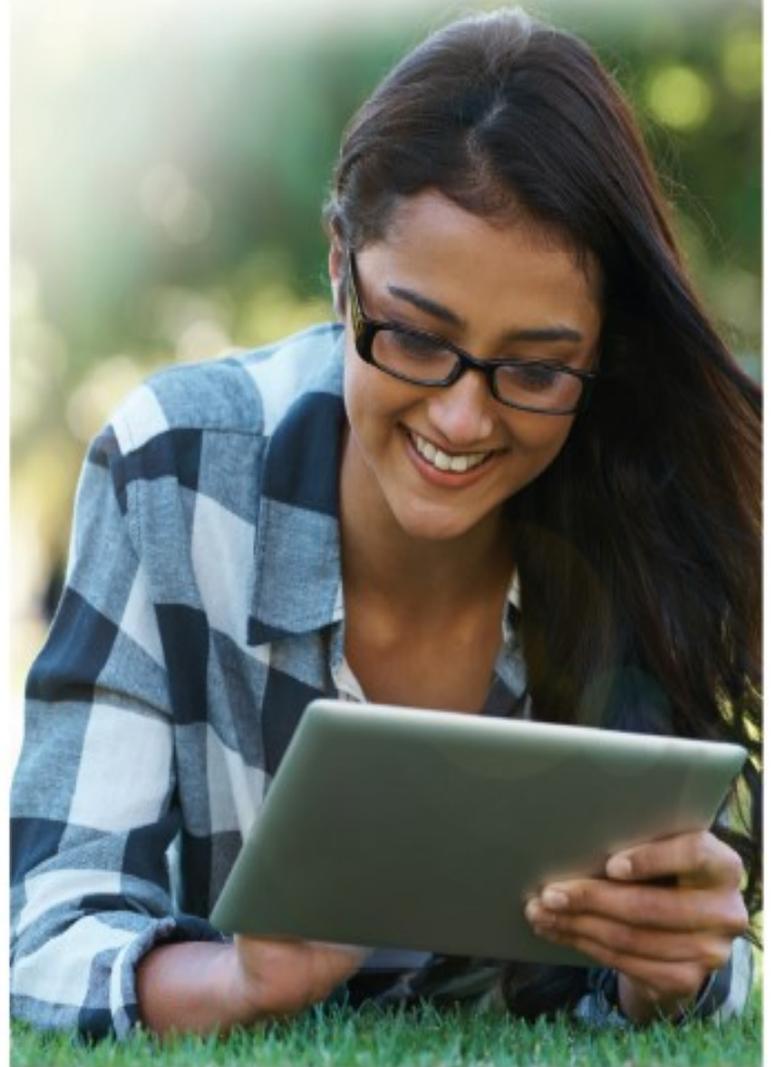
- Click the **Let's Chat** icon on the SCL Health MyChart login screen to chat online.
- Call toll-free **855-274-2517** and select the SCL Health MyChart option.



Download the SCL Health MyChart mobile app from the Apple or Android app stores.

SCL Health MyChart

The secure connection to your health information and online care.



500 Eldorado Blvd., Suite 4300
Broomfield, CO 80021

sclhealth.org



Create your SCL Health MyChart account today.

If you already have an account, sign in at mychart.sclhealth.org. Creating a new account is easy – just follow the instructions online.

You are the only person who can access your SCL Health MyChart account (unless you grant proxy access to a caregiver).



With **SCL Health MyChart**, you can:



View your electronic medical records

- View portions online, and request your full electronic medical records.
- Request an update to your medications, allergies and health issues.
- View test and lab results.
-  Happy Together lets you view your health information from other participating organizations where you have records in SCL Health MyChart. Connect your accounts to see medications, health issues, test results and more.



Communicate with your healthcare team

- Send secure, non-emergency messages to your healthcare team.
- Request prescription renewals.
- Enable email and text notifications.
-  Upload images and documents for your healthcare team.



Manage appointments

- Schedule appointments.
- Sign up for waitlist notifications.
- Download appointments to your calendar.
- Check in before upcoming appointments.



Manage your accounts and payments

- View billing statements.
- Pay online.
- Contact billing customer service.



Access your family's records

- Request proxy access to view the account of someone for whom you are legally responsible.



Start a video or e-visit for many common health conditions

Contact Information

If you have specific questions about any of the benefit plans, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website
Medical	Employee Benefit Management Services (EBMS)	408.869.5505 866.660.8935	www.ebms.com
Dental	Employee Benefit Management Services (EBMS)	408.869.5505 866.660.8935	www.ebms.com
Vision	Vision Service Plan (VSP)	800.877.7195	www.vsp.com www.ebms.com (eligibility only)
Flexible Spending Accounts/ Health Spending Accounts	Employee Benefit Management Services (EBMS)	866.857.8182	www.ebms.com
Employee Assistance Program (EAP)	St. Vincent Healthcare—Behavioral Health	In-Billings: 237.3585 Outside Billings: 888.662.5461	www.sclhealthsystem.org
City of Billings, Human Resources	Leta Lintern, HR Associate/Benefits Coordinator LinternL@billingsmt.gov	406.657.8265	www.ci.billings.mt.us www.cityofbillings.org



Annual Notices

The City is required by law annually to provide certain notices to all plan participants- the following are those notices:

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment & Annual Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits, under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymph edemas.

These benefits will be provided subject to the plan's annual deductible, copayments, and coinsurance applicable to other medical and surgical benefits provided under the plan. These provisions

MODEL NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment"

opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
Medicaid Eligibility: The AK Health Insurance Premium Payment Program http://myakhipp.com/ 866.251.4861 CustomerService@MyAKHIPPI.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/mediciad/default.aspx
ARKANSAS—Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
COLORADO – Medicaid
Health First Colorado (Colorado's Medicaid Program) http://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 State Relay 711 Child Health Plan Plus (CHP+) http://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 State Relay 711
FLORIDA – Medicaid
https://www.flmedicaidprecovery.com/hipp/ 877.357.3268
GEORGIA – Medicaid
http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678-664-1162 ext 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip 877.438.4479 All other Medicaid http://www.indianamedicaid.com 800.403.0864
IOWA – Medicaid
http://dhs.iowa.gov/Hawki 800.257.8563
KANSAS – Medicaid
http://www.kaheks.gov/hcfl/ 785.296.3512
KENTUCKY – Medicaid
http://chfs.ky.gov/ 800.635.2570
LOUISIANA – Medicaid
http://www.dhh.louisiana.gov/index.cfm/subhome/1/n/331 888.695.2447

MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth 800.862.4840
MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov 855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov/ 800.992.0900
NEW HAMPSHIRE – Medicaid
http://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 Toll free for HIPP program: 800.852.3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
http://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
http://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid/ 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm 800.692.7462
RHODE ISLAND – Medicaid
www.eohhs.ri.gov 855.697.4347 401.462.0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.gethipptexas.com/ 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: http://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org/ 800.250.8427
VIRGINIA – Medicaid and CHIP
Medicaid: http://www.coverva.org/programs_premium_assistance.cfm 800.432.5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm 855.242.8282
WASHINGTON – Medicaid
http://www.hca.wa.gov/ 800.562.3022 ext. 15473
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
http://wyequalitycare.acs-inc.com 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

PRESCRIPTION DRUG COVERAGE AND MEDICARE ANNUAL NOTICES

Disclosure notices advise plan participants of the “creditable” or “not creditable” coverage status of the prescription drug plan. Medicare eligible participants need this information to make a decision regarding purchasing Medicare Part D qualified prescription drug coverage. Coverage is “creditable” if it is expected to pay out at least as much as a standard Medicare Part D Plan would pay. A plan that is not “creditable” is not expected to pay out as much as a standard Medicare Part D Plan. Medicare eligible participants are penalized if they do not maintain creditable coverage and apply for Part D later. The annual Medicare Part D notices are now required to be communicated no later than October 14th.

Creditable coverage applies to: employees, Pre-Medicare Retirees & COBRA participants.

Important Notice from City of Billings About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Billings and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Billings has determined that the prescription drug coverage offered by the Standard and HDHP plans, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Billings coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current City of Billings coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Billings and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the department listed below for further information.

NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Billings changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 12, 2020
Name of Entity/Sender: City of Billings
Contact Office: Human Resources
Address: 210 North 27th Street,
Billings, MT 59101
Ph. #: 406.657.8265

**Non-Creditable coverage applies to: Medicare Retiree participants.
There is NO Prescription coverage available for Medicare participants on the City of Billings plan.**

NON-CREDITABLE COVERAGE DISCLOSURE NOTICE

Important Notice From City of Billings About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Billings and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Billings has determined that the prescription drug coverage offered by the City of Billings Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the City of Billings. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from City of Billings. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to

December 7th.

However, if you decide to drop your current coverage with City of Billings since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under *City of Billings*.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under City of Billings is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Billings coverage will be affected. See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current City of Billings coverage, be aware that you and your dependents will not be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information at 406.657.8265. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through City of Billings changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Date: October 12, 2020
Name of Entity: City of Billings
Contact office: Human Resources Division
Address: 210 North 27th Street, Billings, MT 59101
Ph. #: 406.657.8265

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Effective: 01/01/2020

This Notice of Privacy Practices applies to the City of Billings and the vendors they work with:

- EBMS- Employee Benefit Management Services
- Gallagher Benefit Services
- St. Vincent Healthcare
- Rocky Mountain Health Network
- Health Is
- VSP
- Avidia Bank
- Standard Life Insurance
- Any medical providers Human Resources works with regarding FMLA certifications, workers compensation, etc.

City of Billings P.O. Box 1178 Billings, MT 59103-1178
HR@billingsmt.gov
Ph: 406.657.8265
Fx: 406.657.8390

This benefit summary prepared by



Gallagher

Insurance | Risk Management | Consulting