

AMENDMENT #11
TO THE
PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION
FOR THE
MONTANA ASSOCIATION OF COUNTIES HEALTH CARE TRUST (MACOHCT)

Effective July 1, 2009, Montana Association of Counties Health Care Trust (the Plan) is amended as follows:

CHANGE #1: Add Bariatric Surgery Benefit.

REVISION #1:

Within the “**MEDICAL BENEFITS**”, under “Morbid Obesity Exclusions”, item 3 is replaced as follows:

3. Charges incurred for gastric bypass, stomach stapling, gastroplasty and similar surgical procedures regardless of the diagnosis, *except as specifically covered under the “Bariatric Surgery Benefit”*.

Within the “**MEDICAL BENEFITS**”, “BARIATRIC SURGERY BENEFIT” is added following “Morbid Obesity Exclusions” as follows:

BARIATRIC SURGERY BENEFIT

Charges are payable as specifically stated in the Schedule of Medical Benefits. Coverage is limited to the following bariatric surgeries for the treatment of Morbid Obesity as defined by this section:

- Laparoscopic Gastric Banding (Lap Banding Procedure)
- Gastric Bypass (Roux-en-Y)

The definition of “Morbid Obesity” for surgical intervention means a condition of persistent and uncontrollable weight gain and is defined as a body mass index (BMI) of 35 to 39 with at least two co-morbid conditions (conditions listed under Selection Criteria) or a BMI of 40 with or without accompanying co-morbid conditions. BMI is calculated by dividing a person’s weight (in kilograms) by his/her height squared (in meters).

Treatment must be Prior Authorized as Medically Necessary by APS HealthCare. If Prior Authorization is not obtained or charges are found not to be Medically Necessary, charges in connection with or related to bariatric surgery will not be covered. Specialized case management by a registered nurse will be mandatory for Covered Person’s who are considering bariatric surgery to assist them with prior-authorization of services. For Covered Person’s who meet medical necessity for bariatric surgery, the case manager will continue to collaborate with the participant and their provider(s) in the pre-operative and post-operative phase.

Adjustment to the Lap Band is considered medically necessary. The adjustment is usually performed in the physician’s office. Performance of the procedure in an outpatient surgery setting requires documentation of medical necessity as well as X-rays, including a before and after barium swallow.

Upon prior approval of a gastric bypass or lap banding procedure, covered services for bariatric surgery for Morbid Obesity as well as any complications that might result from approved bariatric surgery are considered medically necessary only when **all** of the selection criteria are met.

Selection criteria:

1. Presence of morbid obesity that has persisted for at least 3 years is defined as a body mass index (BMI) of 35 to 39 with at least two co-morbid conditions as listed or a BMI of 40 with or without accompanying co-morbid conditions which must be documented by a Physician. Co-morbid conditions include:
 - a. Clinically significant obstructive sleep apnea
 - b. Obesity Hypoventilation Syndrome
 - c. Obesity related Cardiomyopathy
 - d. Insulin dependent or oral medication dependent diabetes
 - e. Mechanical Arthropathy
 - f. Gastroesophageal reflux disorder (GERD)
 - g. Hypertension
 - h. Medically refractory hypertension (blood pressure greater than 140 mmHg. Systolic and/or 90 mmHg diastolic despite optimal medical management)
 - i. Coronary artery disease
 - j. Dyslipidemia
2. Covered Person has completed growth (18 years of age or documentation of completion of bone growth);
3. Covered Person attempted weight loss in the past without successful long-term weight reduction, which must be documented;
4. Covered Person must meet *either* the physician-supervised nutrition and exercise program *or* the multidisciplinary surgical preparatory regimen described below:
 - a. *Physician-supervised nutrition and exercise program:* Documentation* that the Covered Person has participated in a physician-supervised nutrition and exercise program including dietician/nutritionist consultation, low calorie diet, increased physical activity, behavioral modification and this is documented in the medical record. A physician supervised multidisciplinary program for the purpose of meeting this standard must meet **all** of the following criteria:
 - i. The program must be supervised and monitored by the physician;
 - ii. The nutrition and exercise program(s) must be for a cumulative total of 6 months or longer in duration and occur within 1 year prior to surgery, with participation in one program for at least 6 consecutive months. (Prior authorization may be made prior to completion of nutrition and exercise program as long as a consecutive six months participation in a multidisciplinary program(s) will be completed prior to the date of surgery).
 - iii. Covered Person's participation in a physician-supervised nutrition and exercise program must be documented in the medical records by an attending physician who supervised the Covered Person's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. The Covered Person must lose 10% of their starting body weight prior to surgery.

**A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the physician's contemporaneous assessment of the patient's progress throughout the course of the nutrition and exercise program. For Covered Persons who participate in a medically supervised nutrition and exercise program (e.g., Medifast, Optifast), records documenting the Covered Person's participation and progress may substitute for physician medical records.*

- b. *Multidisciplinary surgical preparatory regimen:* Immediately prior to the time of surgery, the prescribing physician must document** that the Covered Person participated in an organized multidisciplinary surgical preparatory regimen of at least 3 consecutive months meeting **all** of the criteria below. The regimen is necessary in order to improve surgical outcomes, reduce the potential for surgical complications, and to establish the Covered Person's ability to comply with post-operative medical care and dietary restrictions. Multidisciplinary surgical preparatory regimen includes:
- i. Consultation with a licensed dietician or nutritionist.
 - ii. Participation in a reduced-calorie diet program supervised by a licensed dietician or nutritionist;
 - iii. Loss of 10% of their starting body weight prior to surgery
 - iv. A physical activity assessment prior to surgery, supervised by a licensed exercise therapist or other licensed qualified professional
 - v. Participation in a behavior modification program supervised by a licensed qualified professional
 - vi. Attendance at all of the pre-surgery and postoperative surgery appointments and support group meetings

***Documentation is required in the medical record of the Covered Person's attendance and participation in the multidisciplinary surgical preparatory regimen and post-operative support group meetings; and*

A physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation must include medical records of the physician's initial assessment of the Covered Person, and the physician's assessment of the Covered Person's progress at the completion of the multidisciplinary surgical preparatory regimen.

5. For both criterion a and b, the Covered Person must have a documented psychological evaluation by a licensed mental health professional that addresses the following:
- a. Absence of problems related to alcohol or substance abuse (other than nicotine/caffeine) for at least one year
 - b. Absence of major psychotic or severe psychiatric disturbances (schizophrenia, borderline personality disorder, suicidal ideation, severe depression)
 - c. Absence of compulsive or obsessive-compulsive disorder
 - d. Absence of an active binge eating disorder
 - e. Absence of severe mental retardation
 - f. Absence of unrealistic expectations for weight loss and lack of knowledge about surgery; *and*
 - g. An assessment of the patient's likelihood to comply with long-term post-operative requirements.

Note: The presence of depression due to obesity is not normally considered a contraindication to obesity surgery.

Exclusions:

The following charges incurred for weight reduction, weight loss, the treatment of obesity, and the treatment of Morbid Obesity are excluded:

1. Vitamins, food supplementation, commercial or franchise diet programs, exercise and educational programs (See Morbid Obesity Eligible Expenses Section for medical coverage guidelines for morbid obesity).
2. Any incurred expenses for which all of the conditions of the bariatric surgery benefit of this Plan have not been met.
3. Revision of bariatric surgery is not medically necessary for a stretched stomach pouch (formed by a previous gastric restrictive procedure) due to the patient overeating.
4. A second bariatric surgical procedure, whether or not the first procedure was performed while covered under this Plan.
5. Surgical procedures except for Roux-en-Y Gastric Bypass Surgery and the Lap-Banding surgical procedure.
6. Complications resulting from any type of bariatric surgery that was performed while the Covered Person was covered under another plan.

Prophylactic cholecystectomy is considered inclusive of the bariatric surgery.

CHANGE #2: Remove coverage for oral or injectable drugs obtained from a physician's office if not obtained through the Pharmacy Benefit (J Code Prescriptions).

REVISION #2:

Within the "**MEDICAL BENEFITS**" section, under "GENERAL MEDICAL BENEFITS", item 6, 14 and 16 are replaced as follows:

6. The services of a legally qualified Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care and surgical opinion consultations.

Charges are eligible for drugs intended for use in a physician's office or settings other than home use that are billed during the course of an evaluation or management encounter. **However, specifically identified oral or injectable drugs that can be self-administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit Manager's Specialty Pharmacy. These drugs are excluded for coverage under the Medical Benefits. The list of drugs can be obtained from the Plan Supervisor or can be found on the MACoHCT website.**

13. Charges for drugs requiring the written prescription of a licensed Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs not available through the Pharmacy Benefit regardless of Medical Necessity. **However, specifically identified oral or injectable drug that can be self-administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit Manager's Specialty Pharmacy. These drugs are excluded for coverage under the Medical Benefits. The list of drugs can be obtained from the Plan Supervisor or found on the MACoHCT website.**

Conditions of coverage for outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Schedule of Benefits and Pharmacy Benefit sections of the Plan.

Note: Coverage for drugs requiring the written prescription of a licensed Physician are not eligible under the Basic Medical Plan Option.

15. Charges for radiation therapy or treatment and chemotherapy. ***However, any oral or injectable drug that can be administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit, unless there is a documented medical reason for administration of the drug in an office or outpatient setting.***

Within the “**MEDICAL BENEFIT EXCLUSIONS**” section item 24 is added as follows:

23. *Charges for specially identified oral or injectable drug that can be self-administered in a non-facility or non-office setting must be obtained through the Pharmacy Benefit’s Specialty Pharmacy. These drugs are excluded for coverage under the Medical Benefits. The list of drugs can be obtained from the Plan Supervisor or can be found on the MACoHCT website.*

CHANGE #3: Add coverage for virtual colonoscopy.

REVISION #3:

Within the “**MEDICAL BENEFITS**” section, “PREVENTIVE CARE”, as amended, is replaced as follows:

PREVENTIVE CARE

Charges are payable as specifically stated and limited in the Schedule of Medical Benefits for “Preventive Care” for Covered Persons eight (8) years of age or older, except for immunizations.

“Preventive Care” means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, which is not provided as a result of any Injury or Illness.

Coverage under this benefit includes the following routine services, subject to the following limitations:

1. **Physician Charges and Diagnostic Screening Tests.** Physician charges for a physical examination and selected diagnostic screening tests, including, but not limited to: x-ray and laboratory charges for electrocardiogram, complete blood count, urinalysis, prostate examination up to the maximum benefit stated in the Schedule of Medical Benefits.
2. **Mammogram.** Limited to once per Benefit Period up to the maximum benefit stated in the Schedule of Medical Benefits.
3. **Pap Test.** Pathology charges only, limited to once per Benefit Period up to UCR.

4. **Immunizations.** For Covered Persons *eight (8)* years of age or older according to the schedule of immunizations which is recommended by the Immunization Practices Advisory Committee of the United States Department of Health and Human Services.

IMMUNIZATIONS OBTAINED THROUGH PROVIDERS OTHER THAN ANY COUNTY HEALTH DEPARTMENT APPLY TOWARD THE ROUTINE CARE LIMITATIONS AND MAXIMUMS.

IMMUNIZATIONS OBTAINED AT ANY COUNTY HEALTH DEPARTMENT DO NOT APPLY TOWARD THE WELL-CHILD OR PREVENTIVE CARE LIMITATIONS AND MAXIMUMS AND ARE PAYABLE AT 100%, DEDUCTIBLE WAIVED.

Expenses payable under this Preventive Care benefit will not be subject to the Medical Necessity provisions of this Plan.

Charges for treatment of an active illness or injury are subject to the Deductible and Benefit Percentage and other plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

Within the **“MEDICAL BENEFITS”** section, “COLON CANCER SCREENING” is added following “PREVENTIVE CARE” as follows:

COLON CANCER SCREENING

Charges are payable as specifically stated and limited in the Schedule of Medical Benefits for “Colon Cancer Screening”. Coverage under this benefit includes Colon Cancer Screening services, subject to the following limitations:

1. Fecal Occult Blood Test, limited to one per Benefit Period for 50 years or older;
2. Flexible Sigmoidoscopy, limited to one every 5 Benefit Periods for 50 years or older;
3. Colonoscopy *or computed Tomographic (CT) colonography i.e., virtual colonoscopy* (including facility and physician services), limited to one every 10 Benefit Periods for 50 years or older.

Colon Cancer testing performed more frequently or earlier than 50 years, regardless of diagnosis, is payable under the regular Medical Benefits of this Plan.

CHANGE #4: Waive premium for Newborn born to Participant for the first 31 days.

REVISION #4:

Within the “**EFFECTIVE DATE OF COVERAGE**” section, “AUTOMATIC NEWBORN ELIGIBILITY” is added following subsection “SPECIAL ENROLLMENT PERIOD”:

AUTOMATIC NEWBORN ELIGIBILITY

A child born to a Participant will be automatically enrolled for benefits for a period of thirty-one days whether the child is enrolled or not from the moment of birth.

The child must be enrolled in accordance with the terms of the applicable Special Enrollment provisions of the Plan for coverage to continue beyond thirty-one (31) days.

CHANGE #5: Remove restriction for Dental Care and Treatment benefit to allow coverage under Medical benefits.

REVISION #5:

Within the “**MEDICAL BENEFITS**” section, item 27 is replaced as follows:

26. Dental Care and treatment, including the services of an oral surgeon or licensed Dentist and eligible Hospital services, provided such services are rendered for the following conditions:
 - A. Excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination;
 - B. Surgical procedures required to correct accidental injuries to sound natural teeth and the jaw, including the initial repair or replacement of such damaged teeth. Such expenses must be incurred within six (6) months from the date of the accident;
 - C. Excision of exostoses of the jaws and hard palate;
 - D. Treatment of fractures of the facial bones;
 - E. Excision of accessory sinuses, salivary glands and ducts; or
 - F. Reductions, dislocations and excisions of the temporomandibular joint.

Hospital Eligible Expenses incurred in conjunction with covered oral surgery will be payable on the same basis as any other claim.

CHANGE #6: Allow first test for colonoscopy or mammography to be paid regardless of diagnosis.

REVISION #6:

Within the “**COMPREHENSIVE MEDICAL SCHEDULE OF BENEFITS**”, “PREVENTIVE CARE”, as amended, is deleted and replaced as follows:

COMPREHENSIVE MEDICAL PLAN LIMITED MEDICAL BENEFITS	Benefit Limits
<u>PREVENTIVE CARE (8 years of age or older)</u>	
Physician Charges and Diagnostic Screening Tests	
Deductible Waived, Benefit Percentage	100%
Maximum Benefit per Benefit Period	\$300
Mammogram, once per Benefit Period	
<i>First one performed during Benefit Period regardless of diagnosis. Subsequent tests are subject to Medical Necessity and payable under Medical Benefits.</i>	
Deductible Waived, Benefit Percentage	100%
Maximum Benefit per Benefit Period	\$250
Pap Test (pathology only, excluding office visit), once per Benefit Period	
Deductible Waived, Benefit Percentage	100%
Maximum Payable up to UCR	
Immunizations	
Deductible Waived, Benefit Percentage	Applies
IMMUNIZATIONS OBTAINED THROUGH PROVIDERS OTHER THAN ANY COUNTY HEALTH DEPARTMENT APPLY TOWARD THE ROUTINE CARE LIMITATIONS AND MAXIMUMS.	
IMMUNIZATIONS OBTAINED AT ANY COUNTY HEALTH DEPARTMENT DO NOT APPLY TOWARD THE WELL-CHILD OR PREVENTIVE CARE LIMITATIONS AND MAXIMUMS AND ARE PAYABLE AT 100%, DEDUCTIBLE WAIVED.	

Within the “**COMPREHENSIVE MEDICAL SCHEDULE OF BENEFITS**”, “COLON CANCER SCREENING” is deleted and replaced as follows:

COMPREHENSIVE MEDICAL PLAN LIMITED MEDICAL BENEFITS	
<u>COLON CANCER SCREENING</u>	
Fecal Occult Blood Test, limited to one per Benefit Period for 50 years or older Deductible Waived, Benefit Percentage	100%
Flexible Sigmoidoscopy, limited to one every 5 Benefit Periods for 50 years or older Deductible Waived, Benefit Percentage	100%
Colonoscopy or virtual colonoscopy (including facility and physician services), limited to one every 10 Benefit Periods for 50 years or older. <i>First one performed during Benefit Period regardless of diagnosis.</i> First \$1,500 of charges, Deductible Waived, Benefit Percentage	100%
Charges exceeding \$1,500, Deductible Applies, Benefit Percentage	Applies
Colon Cancer testing performed more frequently or earlier than 50 years, regardless of diagnosis Deductible Applies, Benefit Percentage	Applies

Within the “**REVISED MEDICAL SCHEDULE OF BENEFITS**”, “PREVENTIVE CARE”, as amended, is deleted and replaced as follows:

REVISED MEDICAL PLAN LIMITED MEDICAL BENEFITS	Benefit Limits
<u>PREVENTIVE CARE (8 years of age or older)</u>	
Physician Charges and Diagnostic Screening Tests	
Deductible Waived, Benefit Percentage	100%
Maximum Benefit per Benefit Period	\$300
Mammogram, once per Benefit Period	
<i>First one performed during Benefit Period regardless of diagnosis. Subsequent tests are subject to Medical Necessity and payable under Medical Benefits.</i>	
Deductible Waived, Benefit Percentage	100%
Maximum Benefit per Benefit Period	\$250
Pap Test (Pathology only, excluding office visit), once per Benefit Period	
Deductible Waived, Benefit Percentage	100%
Maximum Payable up to UCR	
Immunizations	
Deductible Waived, Benefit Percentage	Applies
IMMUNIZATIONS OBTAINED THROUGH PROVIDERS OTHER THAN ANY COUNTY HEALTH DEPARTMENT APPLY TOWARD THE ROUTINE CARE LIMITATIONS AND MAXIMUMS.	
IMMUNIZATIONS OBTAINED AT ANY COUNTY HEALTH DEPARTMENT DO NOT APPLY TOWARD THE WELL-CHILD OR PREVENTIVE CARE LIMITATIONS AND MAXIMUMS AND ARE PAYABLE AT 100%, DEDUCTIBLE WAIVED.	

Within the “**REVISED MEDICAL SCHEDULE OF BENEFITS**”, “COLON CANCER SCREENING” is deleted and replaced as follows:

REVISED MEDICAL PLAN LIMITED MEDICAL BENEFITS	
<u>COLON CANCER SCREENING</u>	
Fecal Occult Blood Test, limited to one per Benefit Period for 50 years or older Deductible Waived, Benefit Percentage	100%
Flexible Sigmoidoscopy, limited to one every 5 Benefit Periods for 50 years or older Deductible Waived, Benefit Percentage	100%
Colonoscopy or virtual colonoscopy (including facility and physician services), limited to one every 10 Benefit Periods for 50 years or older. <i>First one performed during Benefit Period regardless of diagnosis.</i> First \$1,500 of charges, Deductible Waived, Benefit Percentage	100%
Charges exceeding \$1,500, Deductible Applies, Benefit Percentage	Applies
Colon Cancer testing performed more frequently or earlier than 50 years, regardless of diagnosis Deductible Applies, Benefit Percentage	Applies

Within the “**BASIC MEDICAL SCHEDULE OF BENEFITS**”, “PREVENTIVE CARE”, as amended, is deleted and replaced as follows:

BASIC MEDICAL PLAN OPTION LIMITED MEDICAL BENEFITS	
<u>PREVENTIVE CARE (8 years of age or older)</u>	
Physician Charges and Diagnostic Screening Tests	
Deductible Waived, Benefit Percentage	100%
Maximum Benefit per Benefit Period	\$300
Mammogram, once per Benefit Period	
<i>First one performed during Benefit Period regardless of diagnosis. Subsequent tests are subject to Medical Necessity and payable under Medical Benefits.</i>	
Deductible Waived, Benefit Percentage	100%
Maximum Benefit per Benefit Period	\$250
Pap Test (pathology only, excluding office visit charges), once per Benefit Period	
Deductible Waived, Benefit Percentage	100%
Maximum Payable up to UCR	
Immunizations	
Deductible Waived, Benefit Percentage	Applies
IMMUNIZATIONS OBTAINED THROUGH PROVIDERS OTHER THAN ANY COUNTY HEALTH DEPARTMENT APPLY TOWARD THE ROUTINE CARE LIMITATIONS AND MAXIMUMS.	
IMMUNIZATIONS OBTAINED AT ANY COUNTY HEALTH DEPARTMENT DO NOT APPLY TOWARD THE WELL-CHILD OR PREVENTIVE CARE LIMITATIONS AND MAXIMUMS AND ARE PAYABLE AT 100%, DEDUCTIBLE WAIVED.	

Within the “**BASIC MEDICAL SCHEDULE OF BENEFITS**”, “COLON CANCER SCREENING” is deleted and replaced as follows:

BASIC MEDICAL PLAN OPTION LIMITED MEDICAL BENEFITS	
<u>COLON CANCER SCREENING</u>	
Fecal Occult Blood Test, limited to one per Benefit Period for 50 years or older Deductible Waived, Benefit Percentage	100%
Flexible Sigmoidoscopy, limited to one every 5 Benefit Periods for 50 years or older Deductible Waived, Benefit Percentage	100%
Colonoscopy or virtual colonoscopy (including facility and physician services), limited to one every 10 Benefit Periods for 50 years or older. <i>First one performed during Benefit Period regardless of diagnosis.</i> First \$1,500 of charges, Deductible Waived, Benefit Percentage	100%
Charges exceeding \$1,500, Deductible Applies, Benefit Percentage	Applies
Colon Cancer testing performed more frequently or earlier than 50 years, regardless of diagnosis Deductible Applies, Benefit Percentage	Applies

CHANGE #7: Add penalty for non-participation of case management.

REVISION #7:

Within the “**HOSPITAL ADMISSION CERTIFICATION**” section, the following subsection is added following “EMERGENCY NOTIFICATION/CERTIFICATION”:

CASE MANAGEMENT PROGRAM

This Program is administered through APS Healthcare and provides support to Covered Persons to ensure the best possible outcome of a condition which will help to reduce costs to the Plan. APS Healthcare will make several attempts to contact an individual identified as needing case management. While participation in case management is voluntary, declining to participate or declining to continue participating in case management services when requested by the Program will result in a penalty. Upon notification from APS Healthcare of an individual who has opted out of case management services, all claims will be processed according to the plan, subject to an additional \$2,500 in out-of-pocket Maximum.

Reviews regarding case management determinations must be submitted to the Plan Administrator at 2717D Skyway Drive; Helena MT 59602.

CHANGE #8: Add Medical Plan Options for CM1500-80%-3000; CM2000-80%-4000; CM5000-80%-7500; and HD2000-80%-4000.

REVISION #8:

Within the “**MEDICAL PLAN COVERAGE OPTIONS**”, “**COMPREHENSIVE MAJOR MEDICAL PLAN OPTIONS**” are replaced as follows:

COMPREHENSIVE MAJOR MEDICAL PLAN OPTIONS		
The Benefit Period is the period for each Member Group as defined in Appendix A – Member Groups Plan Year/Benefit Period/Open Enrollment Period.		
Deductible per Covered Person / Family per Benefit Period	Benefit Percentage	Out-of-Pocket Maximum per Benefit Period*
\$200 / \$400	80%	\$1200 / \$2400
\$200 / \$400	90%	\$1200 / \$2400
\$500 / \$1000	80%	\$1500 / \$3000
\$1000 / \$2000	80%	\$3000 / \$6000
\$2000 / \$4000	80%	\$4000 / \$8000
\$500 / \$1000	90%	\$1500 / \$3000
\$200 / \$400	70%	\$1200 / \$2400
\$500 / \$1000	70%	\$1500 / \$3000
\$1000 / \$2000	70%	\$3000 / \$6000
\$2000 / \$4000	70%	\$4000 / \$8000
\$1500 / \$3000	80%	\$3000 / \$6000
\$2000 / \$4000	80%	\$4000 / \$8000
\$5000 / \$10000	80%	\$7500 / \$15000

***Out-of-Pocket Maximum includes amounts applied toward the Deductible and charges for Eligible Expenses in excess of the Benefit Percentage.**

Within the “**MEDICAL PLAN COVERAGE OPTIONS**”, “**HSA COMPATIBLE OPTION COST SHARING**” is deleted and replaced as follows:

HSA COMPATIBLE OPTION COST SHARING				
The Benefit Period is a twelve-month period as follows:				
For July Renewals the Benefit Period commences on JULY 1 ST and ends on JUNE 30 TH of each year				
For September Renewals the Benefit Period commences on SEPTEMBER 1 ST and ends on AUGUST 31 ST of each year				
Single Coverage Deductible per Benefit Period	Family Coverage Deductible per Benefit Period	Benefit Percentage	Single Coverage Out-of-Pocket Maximum per Benefit Period*	Family Coverage Out-of-Pocket Maximum per Benefit Period*
\$1,200	\$2,400	80%	\$3,600	\$7,200
\$3,000	\$6,000	80%	\$5,000	\$10,000
\$2,000	\$4,000	80%	\$4,000	\$8,000

Single Coverage means only the Employee is covered under the Plan.
 Family Coverage means the Employee and Dependent(s) are covered under the Plan.

The Deductible applies to Eligible Expenses Incurred during each Benefit Period, unless specifically waived. After satisfaction of the Single Coverage Deductible, no further Deductible will apply during that Benefit Period.

The Family Coverage Deductible applies to Eligible Expenses Incurred by every covered family member (Employee and Dependents) during each Benefit Period, unless specifically waived. A single family member or a combination of family members can meet the family deductible. After satisfaction of the Family Coverage Deductible, no further Deductible will apply to any member of that Family during that Benefit Period. No benefits, except those specifically waived, will be payable until satisfaction of the Family Coverage Deductible.

***Out-of-Pocket Maximum includes amounts applied toward the Deductible and charges for Eligible Expenses in excess of the Benefit Percentage. The Out-of-Pocket Maximum can be met by an individual family member or a combination of family members. Family includes employee/spouse, employee/children, or family.**

CHANGE #9: Change Well-Child Care age limits in schedule to match Amendment #6 for consistency.

REVISION #9:

Within the “**COMPREHENSIVE MEDICAL SCHEDULE OF BENEFITS**”, “ROUTINE OUTPATIENT WELL-CHILD CARE”, as amended, is replaced as follows:

COMPREHENSIVE MEDICAL PLAN LIMITED MEDICAL BENEFITS	Benefit Limits
ROUTINE OUTPATIENT WELL-CHILD CARE (limited to 10 visits from birth through 36 months of age and one visit per Benefit Period between 3 and 7 years of age.) Deductible Waived, Benefit Percentage Applies	

Within the “**REVISED MEDICAL SCHEDULE OF BENEFITS**”, “ROUTINE OUTPATIENT WELL-CHILD CARE”, as amended, is replaced as follows:

REVISED MEDICAL PLAN LIMITED MEDICAL BENEFITS	Benefit Limits
ROUTINE OUTPATIENT WELL-CHILD CARE (limited to 10 visits from birth through 36 months of age and one visit per Benefit Period between 3 and 7 years of age.) Deductible Waived, Benefit Percentage Applies	

Within the “**BASIC MEDICAL SCHEDULE OF BENEFITS**”, “ROUTINE OUTPATIENT WELL-CHILD CARE”, as amended, is replaced as follows:

BASIC MEDICAL PLAN OPTION LIMITED MEDICAL BENEFITS	
ROUTINE OUTPATIENT WELL-CHILD CARE (limited to 10 visits from birth through 36 months of age and one visit per Benefit Period between 3 and 7 years of age.)	
Deductible Waived, Benefit Percentage	70%

Within the “**HSA COMPATIBLE (HDHP) SCHEDULE OF BENEFITS**”, “ROUTINE OUTPATIENT WELL-CHILD CARE”, as amended, is replaced as follows:

HSA COMPATIBLE MEDICAL PLAN LIMITED MEDICAL BENEFITS	
ROUTINE OUTPATIENT WELL-CHILD CARE (limited to 10 visits from birth through 36 months of age and one visit per Benefit Period between 3 and 7 years of age.)	
Deductible Waived, Benefit Percentage	Applies

CHANGE #10: Change Vision Benefit Maximum Payment.

REVISION #10:

Within the “**VISION BENEFITS**” section, the “SCHEDULE OF VISION BENEFITS”, as amended, is replaced as follows:

SCHEDULE OF VISION BENEFITS

**THE BENEFIT PERIOD IS THE PERIOD FOR EACH MEMBER GROUP AS DEFINED IN
 APPENDIX A – MEMBER GROUPS PLAN YEAR/ BENEFIT PERIOD/OPEN ENROLLMENT
 PERIOD**

PAYMENT PROVISIONS AND LIMITATIONS	MAXIMUM PAYMENT
ANNUAL DEDUCTIBLE	None
BENEFIT PERCENTAGE	100% of eligible charges, up to the schedule amount
EXAMINATION (spectacle lenses or contacts) Limited to one exam per Covered Person per Benefit Period	\$70
MATERIALS Limited to one pair of glasses (frames and lenses) or contact lenses, but not both, per Benefit Period, and then only as needed.	\$160

CHANGE #11: Change Quantity Limits for Migraine Medications.

REVISION #11:

Within the “**PHARMACY BENEFIT**” section, the “QUANTITY LIMITS” subsection, as amended, is replaced as follows:

QUANTITY LIMITS

Supply is limited to 30 or 90 days for Member Submit and PBM Network Prescriptions or a 90-day supply for Mail Order Prescriptions, except for the following:

Type of Medication	Quantity Limits
Cox-2 Inhibitors	Celebrex: 60 Tablets per 30-day supply; 180/90-day supply
Migraine Therapy <i>All Strengths</i>	Amerge: 9 tablets/30-day supply; 27/90-day supply Axert: 12 tablets/30-day supply; 36 tablets /90-day supply Frova: 9 tablets/30-day supply; 27/90-day supply Imitrex Injection: Syringes 8/30-day supply; 24/90-day supply Imitrex Nasal Spray 20mg: 12 units nasal sprays/30-day supply Imitrex Nasal Spray 5mg: 12 unit nasal sprays/30-day supply Imitrex tablets: 9 tablets/30-day supply; 27/90-day supply Imitrex Vials 10/30-day supply; 30/90-day supply Maxalt: 12 tablets/30-day supply; 36/90-day supply Replax: 12 tablets/30-day supply; 36/90-day supply Treximet: 9 tablets/30-day supply; 27/90-day supply Zomig/ZMT 2.5mg tablets: 12 tablets/30-day supply; 36/90-day supply Zomig/ZMT 5mg tablets: 12 tablets/30-day supply; 36/90-day supply Zomig Nasal Spray 5 mg: 6 unit nasal sprays (1 pkg of 6)
Influenza Agents	<i>Relenza, Tamiflu</i> : two (2) treatments per 12-month period

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

MONTANA ASSOCIATION OF COUNTIES HEALTH CARE TRUST

BY: _____

TITLE: _____