Benefit Program Application ("ASO BPA")

Application to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, hereinafter referred to as the "Claim Administrator" or "BCBSMT"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 252390 Group Number(s): 252391, 252392

Section Number(s): 0001-0018, 9901-9909

Legal Employer Name: Yellowstone County

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED.)

ERISA Regulated Group Health* Plan: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Effective Date of Coverage specified below? ☐ Yes
If not, specify your ERISA Plan Year*: Beginning Date / / End Date / / (month/day/year)

ERISA Plan Administrator*:

Plan Administrator's Address:

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Non-Federal - County; if applicable, specify other:

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒ Yes
If not, please specify your Non-ERISA Plan Year*: Beginning Date / / End Date / / (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/day/Year) 07 / 01 / 2025

Anniversary Date: (Month/Day/Year) 07 / 01 / 2026

Retiree-Only Plan(s) Identification:
For more information regarding Retiree-only plans, contact your Legal Advisor.

Do you have one or more Retiree-only plan(s)? ☐ Yes ☒ No

If yes, please provide Benefit Agreement number, or group and section numbers of the Retiree-only plan(s):

Account Information	☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS	
Standard Industry Code (SIC): 9920	Employer Identification Number (EIN): 81-6001449	
Address: 217 North 27th Street Room 106		
City: Billings	State: MT	ZIP: 59101
Administrative Contact: LynnDee Schmidt	Title: Benefits and Safety Manager	
Email Address: lschmidt@yellowstonecountymt.gov	Phone Number: 406-256-2737	Fax Number: 406-254-7908
☑ Mailing address is different from primary address		
Mailing Address: PO BOX 35041		
City: Billings	State: MT	ZIP: 59107-5041
Mailing Contact: LynnDee Schmidt	Title: Benefits and Safety Manager	
Email Address: lschmidt@yellowstonecountymt.gov	Phone Number: 406-256-2737	Fax Number: 406-254-7908
☐ Billing address is different from primary address		
Billing Address:		
City:	State:	ZIP:
Billing Contact: LynnDee Schmidt	Title: Benefits and Safety Manager	

Email Address: lschmidt@yellowstonecountymt.gov Phone Number: 406-256-2737 Fax Number: 406-254-7908

Wholly Owned Subsidiaries to be covered:

Affiliated Companies to be covered: Employer Identification Number (EIN):

(Affiliated Companies must be required or permitted to be aggregated per IRS Guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m) or (o), or under applicable law.)

Blue Access for Employers℠ ("BAE℠") Contact: LynnDee Schmidt Title: Benefits & Safety Mgr

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: lschmidt@yellowstonecountymt.gov Phone Number: 406-256-2737 Fax Number: 406-254-7908

☑ The Employer or other company listed in this BPA is a public entity or governmental agency/contractor

Producer of Record Information ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Effective: 01/01/2020

If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as a representative in negotiations with and to receive commissions from BCBSMT, or Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for Employer's employee benefit program(s). This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

Producer/Consultant Compensation:
The Employer acknowledges that if its POR acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's POR a commission and/or other compensation in connection with such services under the Administrative Services Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid to the POR by the Claim Administrator in connection with services under the Administrative Services Agreement, the Employer should contact its POR.

Producer or Agency to whom commissions are to be paid*: Alliant Insurance Services, Inc.

Montana Producer #: 010017891

Address: 1420 5th Ave STE 1500 City: Seattle State: WA ZIP: 98101

Phone: 206-962-2000 Fax: Email: MaryKay.Puckett@alliant.com

Is Producer/Agency appointed with BCBSMT in Montana? ☐ Yes ☐ No

Secondary Producer or Agency to whom commissions are to be paid*: Mary Kay Puckett, 0%

Montana Producer #: 107829564

Address: 1420 5th Ave STE 1500 City: Seattle State: WA ZIP: 98101

Phone: 406-438-5615 Fax: Email: MaryKay.Puckett@alliant.com

Is Producer/Agency appointed with BCBSMT of Montana? ☒ Yes ☐ No

Commissions:

☐ PCPM $ Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)

☐ Flat $ Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)

☐ Percentage of Stop Loss: %

ADDITIONAL COMMISSIONS: Producer 1 = 100%, Producer 2 = 0%

*The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

Schedule of Eligibility ☒ NO CHANGES ☒ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions:

1. **Eligible Person means**:
   ☒ A full-time employee of the Employer.

☐ A full-time employee of the Employer who is a member of: (*name of union*)
☒ A part-time employee of the Employer.
☒ A retiree of the Employer. Define criteria:
☒ Other: COBRA

All Elected Officials

The following Participants are eligible for participation in the Plan:

1. Employees who have completed the Eligibility Waiting Period and who are actively working at least 40 hours per week for full-time Employees and 20-39 hours per week for part-time. Employees in the employ of entities eligible to participate in this health plan, or

2. Employees retiring from entities eligible to participate in this health plan and are under age of 65, and within 31 days of retirement have:

   a. Elected coverage, are at least age 50 (hired prior to July 1, 2011) or at least age 55 (hired July 1, 2011 or after), or on disability retirement and are receiving a monthly pension benefit from Montana Public Employee Retirement Board, (Defined Benefit Plan or Defined Contribution Plan); and

   b. Completed and filed with Yellowstone County, the Authorization for Deduction for Health Insurance Premium form. Add 2 "C" - language in separate document

3. Officials, who have been elected to office and completed at least one term of office, who are terminating employment, under age 65, and within 31 days of leaving office have:

   a. Elected coverage; and

   b. Are at least age 50 (elected prior to July 1, 2011) or at least age 55 (elected July 1, 2011 or after).

Retirees satisfying the above criteria, but receiving a Defined Benefit pension payment less the amount of the health insurance premium,

may continue coverage by submitting full payment by personal check to Yellowstone County. Premiums are requested by the 20th of each month for the following month's coverage. According to the terms of this contract, if a payment is not received by the due date (the first of the month) a 15-day grace period is allowed, but if full payment is not received within the grace period, the policy will be canceled. Check should be made payable to Yellowstone County. Mail payments to:

Yellowstone County

Human Resources

P.O. Box 35041
Billings, MT 59107

Are any classes of employees to be excluded from coverage? ☐ Yes ☒ No
If yes, please identify the classes and describe the exclusion:

2. Employee definition:
Full-Time Employee means:
☒ A person who is regularly scheduled to work a minimum of 40 hours per week and who is on the permanent payroll of the Employer.
☒ Other: See Comments under Question 1
Part-Time Employee means:
☒ A person who is regularly scheduled to work a minimum of 20 hours per week and who is on the permanent payroll of the Employer.
☒ Other: See Comments under Question 1

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:
☐ The date such person ceases to meet the definition of Eligible Person.
☐ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
☒ Other:

An individual's insurance will end automatically on the earliest of the following dates:

*Note: "Period" is defined as the following:

1st of the month through the 14th of the month;

15th of the month through the last day of the month:

1. The date this Plan ends;

2. The end of the last period for which any required contribution agreed to in writing has been made (1st – 14th; or 15th – last day of month);

3. The last day of the period in which he or she is no longer eligible for insurance;

4. The last day of the period in which Employee's employment with the Employer ends. Except that: The Employer may, at its option, continue insurance as shown below for individuals whose employment has ended, if it does so without individual selection between Employees and if it continues making premium payments for those individuals.

Insurance may be continued for all Benefits for:

• An Employee on an approved leave of absence; or

• An Employee temporarily laid off; or

• An Employee unable to work because of disability.

Employee should refer to the Employee Handbook and/or Collective Bargaining Agreement for more specific information.

The Employer may, at its option, continue Employee's insurance for up to 12 months if the Employee's insurance would otherwise end due to his or her work schedule reducing to less than the minimum time required to qualify for coverage, provided the Employer does so without individual selection among Employees and provided that premium payments are continued for those individuals.

No Benefits are payable for charges incurred after an individual's insurance ends.

4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (the effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).

☐ The date of employment.
☐ The day of employment.
☐ The day of the month following month(s) of employment.
☐ The day of the month following days of employment.
☐ The day of the month following the date of employment.
☒ Other: 1. Employees

If Employee coverage is noncontributory, an Employee's coverage will be effective on the day he or she becomes eligible.

If Employee coverage is contributory, each Employee who both applies for coverage on a form approved by BCBSMT and agrees in writing to pay the required contributions, will become covered as follows:

If the Employee applies within 31 days of the date he or she first becomes eligible, he or she will be covered on the later of:

a. The date he or she applies; or
b. The date he or she becomes eligible.

2. Dependents

If dependent coverage is noncontributory, a dependent's coverage will be effective on the date he or she becomes eligible. The Employee must be covered in order for his or her dependents to be covered.

If the dependent coverage is contributory, the Employee who both applies for dependent coverage on a form approved by BCBSMT and agrees in writing to pay the required contributions for dependents will become covered for his or her dependents as follows:

If the Employee applies within 31 days after the date he or she became eligible for dependents' coverage, his or her dependents will be covered on the later of:

a. The date the Employee applies for dependents' coverage; or
b. The date the Employee becomes covered.
3. Employees and Dependents
a. If an Employee and spouse are both Employees of the group, any children shall be considered dependents of only one of the Employees, not both.
b. If an individual is not eligible because:
1) The Employee is not actively working for the Employer; and/or
2) The dependent is confined in a Hospital or Skilled Nursing Facility;
The Employee will not become covered until the day he or she returns to full - time or qualified
part - time active work and the dependent will not become covered if the Employee is not covered or if the dependent is confined in a Hospital or Skilled Nursing Facility.
Special Enrollment Period
A Special Enrollment Period is allowed with substantiating documentation for eligible Employees and/or
dependents who are not currently enrolled and who originally declined coverage because they had other coverage, and:
•Whose other coverage was as a COBRA covered person and that coverage was exhausted, or
•Who lost eligibility for the prior coverage, or
•Who were covered on a group plan whose employer terminated contributions to that plan, and
•Who apply for coverage and submit required documentation under the current employer's plan within 31 days of the termination of such coverage.
•Who lost eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the Employee or Family Participant becomes eligible for financial assistance for group health coverage, under either the Children's Health Insurance Program or the Medicaid Program.
A Special Enrollment Period also occurs when there is a change in family status: a birth, adoption, marriage, divorce, death or loss of eligible coverage.
*Note: "Period" is defined as the following:
1st of the month through the 14th of the month;
15th of the month through the last day of the month:

•In the event of birth or adoption, the Employee and the Employee's dependents may enroll within 31 days of the birth or adoption. The effective date of the child will be the date of birth or adoption providing the new dependent wasproperly enrolled. The effective date of the dependents will be the first day of the period following birth or adoption.
•In the event of a marriage, an Employee previously eligible, but not enrolled, may enroll within 31 days after the marriage. The Employee's new spouse and/or children under the age of 26 may enroll within 31 days after the marriage. The effective date will be no later than the first day of the period beginning after the date the completed request for enrollment is received by the Plan.
•In the event of losing eligibility under either the Children's Health Insurance Program or the Medicaid Program, or the Employee must request enrollment for the Employee or Family Participant not later than 60 days after the date of termination of coverage. The effective date will be no later than the first day of the period beginning after the date the completed request for enrollment is received by the Plan.
Note: Required documentation may be, but not limited to, one or more of the following:
a. Certified marriage certificate;
b. Declaration of marriage without solemnization certificate;
c. Court adoption papers;
d. Certified birth certificate;
e. Employment paperwork showing separation of employment (i.e., reduction in force, termination letter, etc.);
f. Certificate of Eligible Coverage.

Is the waiting period requirement to be waived on initial group enrollment? ☐ Yes ☒ No
Are there multiple new hire waiting periods? ☐ Yes ☒ No
If yes, please attach eligibility and contribution details for each section.

5. Domestic partners covered: ☐ Yes ☒ No
***If yes**, a domestic partner is eligible to enroll for coverage.*

If yes, are domestic partners eligible for continuation of coverage? ☐ Yes ☐ No
If yes, are dependents of domestic partners eligible to enroll for coverage? ☐ Yes ☐ No
If yes, *are* dependents of domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for domestic partners and/or dependents of domestic partners.

6. **Limiting Age for covered children**: Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

7. **Termination of coverage upon reaching the Limiting Age**:
   ☐ The last day of coverage is the day prior to the birthday.
   ☒ The last day of coverage is the last day of the month in which the limiting age is reached.
   ☐ The last day of coverage is the last day of the billing month.
   ☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
   ☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

   Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the Limiting Age even if the child continues to be both disabled and dependent on the employee? ☐ Yes ☒ No
   However, such coverage shall be extended in accordance with any applicable federal or state law and the Disabled Dependent provisions of this BPA. The Employer will notify BCBSMT *of any instance where the continuation of disabled dependent coverage is required.*

8. **Disabled dependent:** A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse. A child is a disabled child when the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, per Internal Revenue Code Section 22(e)(3).

   To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. BCBSMT will administer its standard process for administration of disabled dependent coverage if (a) below is selected by Employer, or at the Employer's direction memorialized below, BCBSMT will follow a customized process if Employer selects (b). If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

(a) ☒ Disabled dependent administration will follow **Standard Rules.**

A disabled dependent is eligible to ***continue*** coverage beyond the limiting age, provided the disability began before the child attained the age of 26. A disabled dependent is eligible to ***add*** coverage beyond the limiting age, provided the disability began before the child attained the age of 26, and proof of coverage as a disabled dependent is provided. Administration of certification review is administered by BCBSMT; a disabled dependent certification form must be submitted to BCBSMT.

(b) ☐ Disabled dependent Administration will follow **Custom Rules**. Please make the following sections:

Age: *Please select one option regarding age of when the disability began.*
☐ The disability must have begun before the child attained the age of 26.
☐ All disabled dependents are covered regardless of when the disability began.

Proof of prior coverage: *Please select required or not required below:*
When ***adding*** coverage, proof of prior coverage as a disabled dependent is ☐ required ☐ not required.

Certification review: *Please select one option regarding the administration of certification review.*
☐ Certification review is administered by BCBSMT; a disabled dependent certification form must be submitted to BCBSMT.
☐ Certification review is administered by the Employer; there are no disabled dependent certification form requirements.

If certification review is administered by BCBSMT, *please select one option regarding forms:*

☐ Utilize BCBSMT disabled dependent certification forms.
☐ Utilize custom/other disabled dependent certification forms.

If Certification Review administered by BCBSMT, *please select allowed or not allowed below:*
A disabled dependent approved certification from a prior insurance carrier is ☐ allowed ☐ not allowed.
A disabled dependent approved certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

9. Will extension of benefits due to temporary layoff, disability or leave of absence apply?
☒ Yes (specify number of days below) ☐ No
Temporary Layoff: TBD by Yellowstone County days Disability: TBD by Yellowstone County days
Leave of Absence: TBD by Yellowstone County days
However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. The Employer will notify BCBSMT *of such requirements.*

10. Enrollment:
Special Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for group coverage assistance under a state Medicaid or CHIP premium assistance program.

Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so, during the Employer's annual Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period. Specify Open Enrollment Period: TBD Changed "Open Enrollment" language...I'll send separate.

Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.
Select one of the provisions below:
☒ Open Enrollment – Late applicants may only apply during Open Enrollment.
☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and the rules governing off-cycle enrollments.

11. * Does COBRA Auto Cancel apply? ☒ Yes ☐ No
Member's COBRA/Continuation of coverage will be automatically cancelled at the end of the member's eligibility period.
**Not recommended for accounts with automated eligibility*

CURRENT EMPLOYEE ELIGIBILITY INFORMATION

☒ **NO CHANGES** **Current number of Employees enrolled** ☐ **SEE ADDITIONAL PROVISIONS**

Current Employee Eligibility Information only applies to new accounts. If your account is renewing, please just indicate the current number of enrolled employees (above).

Total number of Employees:
1. on payroll :
2. presently eligible for coverage:
3. serving new hire probationary period:

4. with other coverage (i.e., other group coverage, Medicare, Medicaid, TRICARE/Champus):
5. total number of individuals currently covered under COBRA:
6. with retiree coverage (if applicable) :

Lines of Business (Check all applicable services)	☐ NO CHANGES ☐ See Additional Provisions

Medical Plan Services:

☒ PPO
☐ POS
☐ Traditional

Consumer Driven Health Plan:

☒ Blue Edge℠ HSA (PPO) (Preferred Vendor: HealthEquity, Inc.)* If HealthEquity, Inc. is selected, BCBSMT to send HSA enrollment to HealthEquity, Inc
☒ Yes ☐ No

Non-Preferred Vendor:
☐ Blue Edge℠ (HCA) Administrative Services *(if purchased, complete separate HCA BPA)*
☒ FSA (Preferred Vendor: HealthEquity, Inc.)*
Non-Preferred Vendor:
☐ HRA (Preferred Vendor: Select Vendor)*
Non-Preferred Vendor:

Additional Services:

☒ Wellbeing Management
☐ Wellness Incentives
☐ Health Advocacy Solutions
☐ Mercer Health Advantage
☐ Custom Care Management Unit
☐ Employee Assistance Program (EAP)
☐ Blue Directions℠ (Private Exchange) *(If selected, the Blue Directions Addendum is attached and made a part of the parties' Administrative Services Agreement.)*

☐ Limited Fiduciary Services for Claims and Appeals

☐ Other Select Product
☐ Other Select Product
☐ Other
☐ Other

Ancillary Services:

☒ Dental Plan Services
☐ Vision Insurance (if selected, complete a separate application)
☐ Stop Loss *(if selected, complete separate Application and Policy Schedule for Stop Loss Coverage)*
☐ Life, Disability, Critical Illness, Accident or Hospital Indemnity Insurance *(if selected, complete a separate application for those coverages)*
☒ COBRA Administrative Services *(if selected, complete separate HCSC COBRA Administrative Services Addendum)*

Benefit Period

☐ Plan Year
☒ Contract Period 01/01 to 12/31

Prescription Drugs:

☒ Covered under a pharmacy benefit *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)*
☐ Covered under the medical benefit

Pharmacy Network (Select one):

☒ Traditional Select Network
☐ Advantage Network
☐ Value Network
☐ Elite Network
☐ Network on PBM Fee Schedule Addendum
DRUG LIST: Balanced Drug List
Other (please specify): Biosimiliar Exclusive Balanced Drug Lis

PPO/HSA Preventive Drug List:

Please specify: HSA

Other Rx programs:

Please specify: Select Program

*An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy with respect to HSAs, FSAs, HRAs, or other benefit arrangements does not conflict with current IRS requirements.

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of Montana.
Custom Care Management Unit is offered by Willis Towers Watson, an independent company, and is administered by Blue Cross and Blue Shield of Montana.
Medical and Dental benefits and services are administered by Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this Fee Schedule.

Payment Specifications ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer Payment Method: ☐ Online Bill Pay ☒ Electronic ☐ Auto Debit ☐ Check

Employer Payment Period: ☒ **Weekly** (cannot be selected if Check is selected as payment method above)
☐ **Semi Monthly** (cannot be selected if Check is selected as payment method above)
☐ **Monthly**

Claim Settlement Period: ☐ **Weekly** ☒ **Monthly**

Run-Off Period: Employer payments are to be made for 12 months following end of Fee Schedule Period. *Standard is twelve (12) months.*

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: months.

Administrative Per Employee Per Month (PEPM) Charges ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

	2025	2026	2027	
Administrative Fee	$28.36	$29.21	$30.09	$_____
Dental	$3.74	$TBD	$TBD	$_____
Claims Fiduciary	$_____	$_____	$_____	$_____
Advanced Payment Review	_____% $_____	_____% $_____	_____% $_____	_____% $_____
*Medical Drug Rebate Credit	$(2.50)	$(TBD)	$(TBD)	$(_____)
*Rebate Credit for the Prescription Drug Program	$(97.15)	$(102.20)	$(110.80)	$(_____)
Telehealth (Virtual Visits)	$_____	$_____	$_____	$_____
Wellbeing Management	$Included in admin fee	$Included in admin fee	$included in admin fee	$_____
Health Advocacy Solutions	$_____	$_____	$_____	$_____
Commissions: _____	$_____	$_____	$_____	$_____
Commissions: _____	$_____	$_____	$_____	$_____
Commissions: _____	$_____	$_____	$_____	$_____
Other: Stop Loss Accommodation Fee List Service: _____	$2.00	$TBD	$TBD	$_____
Other: Other Services List Service: Prescription Drug Administrative Fee	$4.65	$4.70	$4.75	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Other: Select Service Category	$_____	$_____	$_____	$_____

List Service: _____				
Miscellaneous: _____	$_____	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Total	$(55.05)	$_____	$_____	$_____

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges ☒ **SEE ADDITIONAL PROVISIONS**	**Frequency**	**Amount**
Other: Data Exchange List Service: Claims Extract	Annual If applicable, describe other: _____	$400
Other: Data Exchange List Service: Reverse Eligibility	Annual If applicable, describe other: _____	$2,000
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	_____%
	Total:	$_____

Other Service and/or Program Fee(s) ☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

NSA Fees

In connection with the claims, items, and services that are subject to the No Surprises Act ("NSA") and disputed by a Provider, Employer agrees to pay Claim Administrator the following fees:

- Fifty dollars ($50) for each claim that is the subject of informal negotiation with a Provider (this fee will be charged in the event the Provider, in its sole discretion, determines that it will not accept the initial payment amount); and
- An additional seventy-five dollars ($75) per claim for each independent dispute resolution process ("IDR") where Claim Administrator represents Plan (this fee will be charged in the event the Provider, in its sole discretion, determines that it will initiate IDR after the informal negotiation period); and

All costs imposed by the IDR entity or any state, federal or local government entity in connection with an IDR.

Not applicable to Grandfathered Plans

External Review Coordination: ☒ Yes ☐ No

If yes, coordination fee: $700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan. Employer elects for external reviews to be performed under the Affordable Care Act external review process.

Advanced Payment Review (APR): ☐ Yes ☒ No

APR is a suite of payment integrity offerings. Refer to the Matrix. If Employer elects APR, indicate APR Savings Program or PEPM below:

☐ APR Savings Program

☐ PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program, Claim Administrator will invoice the percentage indicated in the Fee Schedule of any savings amounts identified by Claim Administrator or third-party.

Reimbursement Services: ☒ Yes ☐ No If yes, Claim Administrator will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

FlexAccess™: ☒ Yes ☐ No

As part of its plan design, Employer has directed Claim Administrator to administer claims, copay and coinsurance requirements for Covered Persons enrolled in the FlexAccess program, including (i) adjusting Covered Persons' copayment amounts to the amount of the manufacturer copay assistance, (ii) applying such manufacturer assistance to reduce Covered Persons' out of pocket costs, and (3) not applying the manufacturer assistance to Covered Persons' deductibles and out of pocket maximum accumulators. Employer agrees that FlexAccess is a plan design decision of Employer and is consistent with Employer's plan design and supported by plan documents. Employer further agrees it is solely responsible for, and will hold Claim Administrator harmless for, the legal and regulatory compliance of the Plan and its plan design.

Claim Administrator will assess a program fee equal to 20% of the total shared savings. Total shared savings is calculated as follows:
The difference between Employer responsibility without the FlexAccess Program and Employer responsibility with the FlexAccess Program. The Employer responsibility with the FlexAccess Program is cost of the drug minus: (1) the manufacturer copay assistance dollars that are allocated to the cost of the drug and (2) the member's cost share for the member enrolled in the program. The Employer responsibility without the FlexAccess Program is the cost of the drug minus the member cost share if the member was not enrolled in the program.

FLEXACCESS™ QUALIFIED HDHP: ☒ Yes ☐ No

Claim Administrator will assess a fee equal to 20% of program savings for administrative fees. Program savings (shared savings) will be calculated based on the manufacturer copay assistance dollars that are allocated to the cost of the drug minus the member's estimated cost share (copay or coinsurance) that would have been paid if they were not enrolled in the program.

The difference between Employer Responsibility for claims utilizing FlexAccess Qualified HDHP and not utilizing FlexAccess Qualified HDHP includes as follows:

WITH FLEXACCESS QUALIFIED HDHP: Cost of drug – amount manufacturer copay assistance used – Member out-of-pocket cost (if any) up to Deductible... Copay assistance reversed from deductible. Plan pays no portion.

WITHOUT FLEXACCESS QUALIFIED HDHP: Cost of drug – member out-of-pocket cost - Non-FlexAccess Qualified HDHP coupon... Copay assistance applied to Deductible. Plan may pay portion of claim after deductible met

Third-Party Law Firms Provisions (other than Reimbursement Services):
Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for Covered Services under such Arrangements is described in the Administrative Services Agreement between the Claim Administrator and the Employer.

Virtual Visits Program: ☐ Yes ☒ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Virtual Visits powered by MDLIVE.

Termination Administrative Charges

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category *(per Covered Employee per individual or family composite)* during the three (3) months immediately preceding the date of termination by the appropriate factors shown below. In the event of a partial termination, the Termination Administrative Charge shall be the sum of the amount obtained by multiplying three (3) times the total number of terminated Covered Employees by the appropriate factors shown below.

Service	Composite			
Medical Run-off Administration Charge	$20.32	$_____	$_____	$_____
Dental Run-off Administration Charge	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Total:	$20.32	$_____	$_____	$_____

Other Provisions ☒ NO CHANGES ☐ SEE ADDITIONALPROVISIONS

1. **Summary of Benefits & Coverage**:

   a. Will Claim Administrator create Summary of Benefits and Coverage (SBC)?

   ☒ Yes. (Please answer question b. The SBC Addendum is attached.)

   ☐ No. (If No, then skip question b and refer to the Administrative Services Agreement for further information.)

   b. Will Claim Administrator distribute the (SBC) to Covered Persons?

   ☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (or hire a third party to distribute) as required by law.

   ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and distribute SBC to Covered Persons via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is one dollar and fifty cents ($1.50) per package.

2. **Massachusetts Health Care Reform Act**:

   Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☒ Yes ☐ No

   If no: The Employer acknowledges (1) it will provide written statements and electronic reporting to the Massachusetts Department of Revenue if required by the Massachusetts Health Care Reform Act or (2) that it does not believe it is subject to the notification and reporting requirements of the Massachusetts Health Care Reform Act.

3. **Prior Authorization** (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which Prior Authorization (also called pre-notification or preauthorization) is required.

4. **Essential Health Benefits ("EHB") Election**:

   Employer elects EHBs based on the following:

   1. ☒ EHBs based on a Claim Administrator state benchmark:
      ☐ Illinois ☒ Montana ☐ New Mexico ☐ Oklahoma ☐ Texas
   2. ☐ EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

If so, indicate the state's benchmark that Employer elects: ___

3. ☐ Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Montana benchmark plan.

5. **Alternative Care Management Program** (applicable to the purchased medical management program):

☒ Yes ☐ No

The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

6. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement between the parties with both such documents to be referred to collectively as the "Administrative Services Agreement" unless specified otherwise.

7. **Independent Dispute Resolution Process**:
Employer authorizes and directs Claim Administrator to offer an amount not to exceed the greater of the Qualifying Payment Amount (QPA) or the amount allowed on the initial notice of payment or denial of a claim on behalf of the Employer during negotiations under the federal IDR process.

Additional Provisions:

Benefit Changes 7/1/2025:

- Group has elected the Balanced Biosimilar Exclusive Formulary
- No other changes

BCBSMT will provide a one-time wellness credit of $30,000 for the twelve-month period beginning on the 07/01/2025, to be used to cover costs and expenses associated with implementation and/or operation of a wellness program. If Employer cancels coverage before expiration of the policy period, Employer will be required to refund BCBSMT the full amount of the wellness credit.

Group is a 7-1 Plan Year. Plan Document should list the plan as a 7-1 Plan year
- Spouse is defined as, The opposite sex or the same sex person to whom the Employee cohabitates and is legally married, based upon the law in effect at the time of and in the state or other appropriate jurisdiction in which the marriage was performed, recognized, or declared.

Each Employee must fill out and sign an enrollment card.

For the purposes of the SPD, special enrollment period should be noted as: 1st through the 14th and then 15th through the last day of the month. The paperwork says 1st through the 15th and then 16th through the last day of the month for our system requirement, but the book need to say through the 14th and then 15th until the last day of the month. This clarification in our SPD is needed so it matches the county's other handbooks and documentation.

-Yellowstone County Human Resources is the Plan Administrator, Plan Sponsor, and Plan Fudiciary
-LynnDee Schmidt, Benefits and Safety Manager, is a Plan Contact, Appeals/Exception Contact, Claims and Admin Fee Billing Contact, Privacy Contact, and has Access to PHI through the portal
-Yellowstone County Civil Attorney, Attn: Plan Sponsor, is the Agent for Service of Legal process

BCBSMT creates the plan documents and these include the Plan Logo. BCBSMT will provide Yellowstone County electronic copies for distribution. - BCBSMT will provide 25 hard copies of each SPD to Yellowstone County

- ID Cards include the Plan Logo and is a combined medical/rx/dental card

- All eligibility is provided by Yellowstone County

- BCBSMT can accept address and demographic changes directly from participants

- Group does not offer free coverage for 31 day babies/grand children. Permanent addition only via Plan notification. Grandchildren are only allowed via legal adoption and notification is from Plan only

Appeals Determinations and Extra Contractual Benefits

The Plan Administrator or Plan Contact identified above is authorized to render a final determination as to whether to uphold Claim Administrator's determination on appeal to deny benefits to a Covered Person. The individual(s), if any, identified on Claim Administrator's Letter of Acknowledgment and Indemnification for Extra-Contractual Payments is(are) authorized to request extra-contractual benefits on behalf of Covered Persons. A Letter of Acknowledgment need only be executed annually.

7/1/2025 is year 1 of a three year rate guarantee.

Employer has directed Claim Administrator to administer claims, copay and co-insurance requirements for members enrolled in FlexAccess™ Qualified HDHP with dates of services on or after 07/01/2024. Additionally, pursuant to Employer's direction, Claim Administrator will process any manufacturer copay assistance for which member is eligible and receives and will not apply the value of the manufacturer copay assistance for covered drugs to the members' deductibles and Out of Pocket Maximum accumulators. The member's Out of Pocket costs would apply to the deductibles and Out of Pocket Maximum. For avoid-ance of doubt, Employer agrees that the FlexAccess™ Qualified HDHP program is a plan design decision of Employer in its role as plan sponsor and Employer hereby acknowledges that this benefit is consistent with their plan design and supported by the Employer's plan documents. Employer is solely responsible for the design and operation of any Plan it offers to Covered Persons, including the legal and regulatory compliance of those benefit plan designs. Employer hereby acknowledges and agrees to be solely responsible for its plan design and the directions provided here, including compliance with ERISA, the Affordable Care Act, Internal Revenue Code and related IRS regulations, and any other applica-ble State or Federal laws, and agrees to indemnify and hold harmless Claim Administrator for any costs, losses, lawsuit or other liabilities related to this plan de-sign and these directions regarding FlexAccess™ Qualified HDHP."

Renalogic for outpatient dialysis. Claims denied by BCBSMT for facility and independent lab claims. Dialysis services are carved out to Renalogic for outpatient services only. For any section in the SPD that refers to the Outpatient Dialysis benefit state: "Please see the separate dialysis booklet."

FOR COMMISSIONS - Please use the below address.
Lockbox # & Address
AIS DB EB Op Account
PO Box 745977
Los Angeles CA 90074-5977

Fedex Delivery Address only
Bank of America Lockbox Services
Lockbox 745977
2706 Media Center Drive
Los Angeles CA 90065-1733

The employer health plan has opted OUT to participating in in-state and out-of-state Value-Based Programs for the 2025 year

Signature

Erin Huffman Erin Huffman
Sales Representative

600 406-437-6336
District Phone & FAX Numbers

Mary Kay Puckett
Producer Representative

Alliant Insurance Services, Inc.
Producer Firm

1420 5th Ave Ste 1500, Seattle WA 98101
Producer Address

406-438-5615
Producer Phone & FAX Numbers

MaryKay.Puckett@aliant.com
Producer Email Address

107829564
Tax I.D. No.

Kevin Gillen
Signature of Authorized Purchaser

Kevin Gillen
Print Name

Interim Human Resource Direct
Title

7-30-25
Date

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until either revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

☐ Intentionally left blank by the Employer

Group No.: 252390 By: Kevin Gillan
Print Signer's Name Here

➡ Kevin Gillan INTERIM HUMAN RESOURCE DIRECTOR
Signature and Title

Group Name: Yellowstone County

Address: PO Box 35041

City: Billings State: MT ZIP: 59107

Dated this 30th day of July 2025
Month Year