Amendment #2
To the Plan Document and Summary Plan Description for
MSD of North Posey County

This Amendment to the MSD of North Posey County Employee Benefit Plan ("Plan") is made effective on and after the date stated herein.

WHEREAS, applicable provision of the Plan grant the Employer the right to amend the Plan; and,

WHEREAS, the Employer desires to make such amendment;

NOW, THEREFORE, the Plan is hereby amended as follows, with such amendment to be effective on and after the date listed herein.

1. **Effective July 1, 2022, all references to the Plan Appointed Claim Evaluator (PACE) Program are removed.**

2. **Effective January 1, 2022**, the following changes are made for the addition of **The No Surprises Act**:

- **No Surprises Act – Emergency Services and Surprise Bills**

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider [AS1] and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

All other sections of the Plan remain unchanged.

- **Continuity of Care**

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,

4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

- **"Certified IDR Entity"**

"Certified IDR Entity" shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

- **"Maximum Allowable Charge"**

The "Maximum Allowable Charge" shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

- ***External Review Process***

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

3. **Effective January 15, 2022,** the following is added for coverage of Over-the-Counter Tests for SARS-CoV-2 or the virus that causes COVID-19:

- *Over-the-Counter Tests (OTC Tests).* The Plan will cover OTC Tests for the detection of SARS-CoV-2 or the virus that causes COVID-19, which satisfy any **one** of the following conditions:
    - that are approved, cleared, or authorized by the FDA (including an emergency authorization);
    - for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
    - that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
    - that are deemed appropriate by the Secretary of Health and Human Services.
- OTC Tests neither require Pre-Certification nor involve an individualized clinical assessment from a Provider. The Plan will cover up to 8 OTC Tests, per Participant per 30 days. This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a Provider. OTC Tests purchased In-Network are covered by the Plan at the point of sale at 100%, deductible waived. When the Plan is billed for an Out-of-Network OTC Test, the Plan will pay the cash price publicly posted on the Provider's website, or such other amount as may be negotiated by the Provider and Plan. If the Participant pays for an Out-of-Network OTC Test, the Participant will be limited to reimbursement for the actual out-of-pocket cost of the OTC Test, up to a maximum of $12 per OTC Test. If the OTC Test is acquired with the involvement of or prescription by a Provider or if the Plan has not arranged for adequate In-Network access, the Plan will reimburse the Participant at full cost.
- The following limitations also apply:
    - Coverage will be denied if reasonable evidence exists that the purchase was solely for employment purposes; and
    - Coverage will be denied if reasonable evidence exists of fraud, abuse, or that the purchase was made for use by someone other than the Participant or their Dependents. **NOTE:** The Plan may require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC Test, including the UPC code for the OTC Test to verify that the item is one for which coverage is required under FFCRA, and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC Test. Further, the Plan may require a written attestation from the Participant describing the OTC Test, the price paid by the Participant, and the intended use (including for whom the OTC Test will be used).

All other provisions of this document remain as stated. The above is effective on and after the dates stated herein.

Signed this 28th day of September, 2022.

Michael Halvi, Superintendent

Authorized Representative MSD of North Posey County Employee Benefit Plan and Title