AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: ELAP Adoption Agreement - ELAP Services, LLC

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: Gunnison County Colorado as Plan Sponsor & ELAP Services, LLC

Term Begins: 01/01/2020 **Term Ends:** **Grant Contract #:**

Summary:

This is the agreement that serves as an interim amendment to the Plan until the new plan document can be written. ELAP is written in as a co-fiduciary and gives them authority to audit claims.

Fiscal Impact:

Submitted by: Cheryl Seling **Submitter's Email Address:** cseling@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:
No concerns, ln

Reviewed by: Discharge Date: 10/31/2019

County Attorney Review: (●) Required ( ) Not Required

Comments:
ok db 10/30/19

Reveiwed by: Discharge Date: 10/31/2019 Certificate of Insurance Required Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 10/31/2019

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 11/5/2019

Revised April 2015

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ELAP Adoption Agreement

This is the agreement that serves as an interim amendment to the Plan until the new PD can be written. Write ELAP in as a co-fiduciary and gives them authority to audit claims.

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Gunnison County

Effective: January 1, 2020

The following provisions are hereby adopted by the Plan Sponsor for the purpose of incorporating the Claim Review and Audit Program and granting certain fiduciary authority to ELAP Services, LLC as the Designated Decision Maker (the "DDM").

The *Gunnison County Colorado Employee Medical Benefit Plan* (the "Plan") hereby adopts the following provisions:

1. <u>Add the following new Plan provision:</u>

Claim Review and Audit Program
The Plan has arranged with the "Designated Decision Maker" ("DDM") for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a usual, customary or reasonable fee determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination which are the same rights and privileges accorded to Plan Participants; and, in return, the provider must agree not to bill the Plan Participant for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the Plan Participant to file an appeal under the Plan. Please refer to the section, "Procedures for Claims and Appeals" for additional information regarding Participant and provider appeals.

Any Plan Participant who receives a balance-due billing from a medical care provider for these charges should contact the DDM or the Plan Administrator right away for assistance.

The Plan Administrator is identified in the General Information section of this Summary Plan Description. The DDM may be contacted at:

ELAP Services, LLC
1550 Liberty Ridge
Suite 330
Wayne, PA 19087
Phone: 610-321-1030; Fax 610-321-1031

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as Deductibles, Coinsurance and Copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount

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of Covered Medical Expense that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Plan Participant. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under applicable regulations, it will be necessary to deny the claim. Should such a denial be necessary, the Plan Participant and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Procedures for Claims and Appeals" in this Summary Plan Description.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean the "Designated Decision Maker" ("DDM"):

"Allowable Claim Limits" means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. Errors, Unbundled and/or Unsubstantiated Charges. Allowable Claim Limits will not include the following amounts:

a. Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
b. Charges for treating injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the provider;
c. Charges that cannot be identified or understood; and
d. Charges that cannot be verified from audits of medical records.

2. Guidelines. The following guidelines will be used when determining Allowable Claim Limits:

a. Facilities. The Allowable Claim Limit for claims by a facility, including but not limited to, hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care facility, shall be the greater of (I) 112% of the facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. If insufficient information is available to identify either the facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

b. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including ambulatory surgery centers, which are independent facilities shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%.

c. Professional Providers. The Allowable Claim Limits for professional providers shall be determined using the following:

i. For general medical and primary care claims, the Medicare allowed amount in the geographic area plus an additional 40%;
ii. For specialist medical and surgical care claims, the Medicare allowed amount in the geographic area plus an additional 55%;
iii. For anesthesiologist claims, the Medicare allowed amount in the geographic area plus an additional 100%; or

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iv. For other non-facility claims and supplies (such as Durable Medical Equipment, laboratory services and supplies, ambulance, air ambulance, etc.), the Medicare allowed amount in the geographic area plus an additional 25%.

For purposes of determining the proper Allowable Claim Limits for professional providers in categories (i), (ii), (iii) or (iv), above, the Plan Administrator shall determine the applicable category for each claim based on the taxonomy code used by the professional provider for that claim. The Plan Administrator determines in its sole discretion the type of provider for determining Allowable Claim Limits, as detailed above.

d. Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

e. Insufficient Information to Determine Allowable Claim Limit. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, the DDM may apply the following guidelines:

i. **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.

ii. **Pharmaceuticals.** The Allowable Claim Limit for pharmacy charges by a provider may be determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK at the rate of 112% of AWP.

iii. **Medical and Surgical Supplies, Implants, Devices.** The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

iv. **Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

Comparable Services or Supplies. In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

In the event that a determination of Allowable Claim Limit for a Claim exceeds the actual Charges billed for the services and/or supplies, the actual Charges billed for the Claim shall be the Allowable Claim Limit.

2. <u>Delete Plan provisions for claim procedures and replace with the following</u>:

PROCEDURES FOR CLAIMS AND APPEALS

The procedures outlined below must be followed by Claimants to obtain payment of benefits under this Plan.

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NOTICE AND PROOF OF CLAIM

Written notice and proof of an incurred Claim should always be filed with the Claims Administrator as soon as possible. **Claims must be filed within twelve (12) months from the date the charge for the service to be covered by the Plan is Incurred.** If an individual's coverage under the Plan ceases, all Claims Incurred prior to termination of coverage **must** be filed within twelve (12) months from the date the charge for the service is Incurred, or the Claims will not be covered by the Plan.

Claims **must** be filed sooner in certain circumstances:

- If the Plan is terminated, all Claims Incurred prior to the Plan termination **must** be received within ninety (90) days after the termination or the Claims will not be covered.

Any Claims Incurred after termination of Plan coverage for any reason are not covered under the Plan.

Under ERISA, there are four types of Claims: Pre-service (Urgent), Pre-service (Non-urgent), Concurrent Care, and Post-service.

- A "Pre-service Claim" is a Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Because the Plan does not require Claimants to obtain approval of a medical service prior to getting treatment on an urgent or non-urgent basis, there are no "Pre-service Claims." The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

- A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either: (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests an extension of the course of treatment beyond that which the Plan has approved. Because the Plan does not require Claimants to obtain approval of medical services prior to getting treatment, there is no need to contact the Utilization Review Company to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

- A "Post-service Claim" is a Claim for a benefit under the Plan after the services have been rendered.

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator with a Form CMS-1500 or Form UB92 or any successor forms:

1. The date of service;
2. The name, address, telephone number, and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges (including any PPO repricing information);
6. The name of the Plan;
7. The name of the Covered Employee; and
8. The name of the patient.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred, or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Claimant has not incurred a Covered Expense, or that the benefit is not covered under the Plan, or if the Claimant fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

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CLAIMS DETERMINATION

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following timeframes:

- If the Claimant has provided all of the information needed to process the Claim in a reasonable period of time, but not later than 30 days after receipt of the Claim. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator: (a) determines that such an extension is necessary due to matters beyond the control of the Plan, and (b) notifies the Claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time, and the date by which the Plan expects to render a decision. If an extension has been requested, then the Plan Administrator shall notify the Claimant of any Adverse Benefit Determination prior to the end of the 15-day extension period.

- If additional information is requested from the Claimant to process the Claim during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period. If additional information is requested from the Claimant during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

- Notice to the Claimant of a rescission of coverage will be provided at least 30 days in advance of the retroactive termination of coverage by the Plan.

A Benefit Determination is required to be made within the period of time beginning when a Claim is deemed to be filed in accordance with the procedures of the Plan.

For purposes of the Plan's provisions for internal Claims and appeals and external review processes, a "Claim" for benefits is defined as a request for a plan benefit made by a Claimant in accordance with a plan's reasonable procedure for filing benefit Claims. A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "Claim" since an actual Claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a Claim.

An "Adverse Benefit Determination" is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, rescission of coverage, termination, or failure to provide or make a payment for a Claim that is based on:

1. A determination of an individual's eligibility to participate in a plan or health insurance coverage;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a source-of-Injury exclusion, PPO Provider network exclusion, or other limitation on otherwise covered benefits; or
4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Although it is not a Claim for benefits, the definition of an Adverse Benefit Determination also includes a rescission of coverage under the Plan. A "rescission of coverage" is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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NOTICE OF ADVERSE BENEFIT DETERMINATION

If the initial Benefit Determination is an Adverse Benefit Determination, notification will be sent to the Claimant and will include the following information:

1. Information sufficient to identify the Claim involved, including the date of the service, the health care Provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

2. The reason or reasons for the Adverse Benefit Determination or final internal Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the Claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision;

3. References to the Plan specific provisions on which the Adverse Benefit Determination is based;

4. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;

6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim;

7. The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request);

8. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such information was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request; and

9. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether the treatment was Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

PHYSICAL EXAMINATION

The Plan Administrator or Claims Administrator has the right to have the Claimant examined as often as reasonably necessary while a Claim is pending. Benefits are payable under this Plan only if they are Medically Necessary for the Illness or Accidental Injury of the Covered Person. This Plan reserves the right to make a Utilization Review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

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CLAIMS AUDIT

Once a written Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but may not be limited to, identifying: (a) charges for items/services that may not be covered or may not have been delivered, (b) duplicate charges, and (c) charges beyond the reasonable, necessary, and U&C guidelines as determined by the Plan. In addition, please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

PAYMENT OF CLAIMS

Plan benefits are payable to the Covered Employee, unless the Claimant gives written direction, at the time of filing proof of such loss, to pay directly the health care provider rendering such services. Such payment to a health care provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the Covered Employee, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow-up and determine how such paid money was used.

APPEAL PROCESS

The Plan provides for two (2) levels of appeal following an Adverse Benefit Determination. The Claimant has one hundred eighty (180) days following an initial Adverse Benefit Determination to file an appeal of that determination, and sixty (60) days following a second Adverse Benefit Determination to file an appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

1. Receipt of written request by the Claims Administrator from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.

2. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.

3. The Claimant will have the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

4. The Claimant will be provided, free of charge and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

5. The Claimant will be provided, on request and free of charge: (a) reasonable access to, and copies of all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator, the Designated Decision Maker (DDM) or the Claims Administrator; (b) information regarding any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information regarding any voluntary appeals procedures

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offered by the Plan; (d) information regarding the Claimant's right to an external review process; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

6. The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

7. No deference will be afforded to the previous Adverse Benefit Determination.

8. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.

9. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, Drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Claims Administrator, the DDM or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

10. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.

11. The first level of appeal will be the responsibility of the Claims Administrator and will be decided within thirty (30) days of the Claims Administrator's receipt of the request. The second level of appeal will be the responsibility of the DDM and will be decided within thirty (30) days of the Plan's receipt of the request.

For questions about appeal rights or for assistance, Claimants can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Consumer assistance may be available in your State. Contact your State Department of Insurance to find out if consumer assistance for claim appeals is available. See Appendix I for additional information.

FIRST APPEAL LEVEL

Requirements for First Appeal

The Claimant must file the first appeal, in writing, within 180 days following receipt of the notice of an Adverse Benefit Determination. The Claimant's appeal must be addressed as follows:

Appeals Department
Group & Pension Administrators, Inc.
Park Central 8
12770 Merit Drive, 2nd Floor
Dallas, Texas 75251

It shall be the responsibility of the Claimant to submit proof that the Claim is covered and payable under the provisions of the Plan. An appeal must include:

1. The name of the Employee/Claimant;
2. The Employee's/Claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the Claim for benefits. **Failure to include any theories or facts in the appeal will result in such facts being inadmissible. In other words, the Claimant will lose the right**

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to raise such factual arguments and theories which support this Claim if the Claimant fails to include them in the appeal;

5. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

For questions about appeal rights or for assistance, Claimants can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Consumer assistance may be available in your state. Contact your state Department of Insurance to find out if consumer assistance for claim appeals is available. Please refer to Appendix I or contact your state Department of Insurance to find out if consumer assistance for claim appeals is available. Texas Department of Insurance can be contacted at 855-839-2427 (855-TEX-CHAP).

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Notice of Benefit Determination on First Appeal

The Claimant will be notified of the Benefit Determination on appeal. If there is an Adverse Benefit Determination on appeal, the notification will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;

2. References to the Plan provisions on which the Adverse Benefit Determination is based;

3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;

6. A description of voluntary appeal procedures offered by the Plan and, upon the Claimant's request, any additional information about the voluntary appeal procedures;

7. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request;

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8. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether or not treatment is experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request;

9. The identity of any medical or vocational experts consulted in connection with the Claim, even if the Plan did not rely upon their advice; and

10. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to Notice of Benefit Determination on First Appeal, as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Claimant has 60 days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. **All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three (3) years after the Plan's Claim review procedures have been exhausted. Any action with respect to a Fiduciary's Breach of any responsibility, duty or obligation hereunder must be brought within three (3) years after the date of service.**

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Appointment of Authorized Representative

A Claimant is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit claim or appeal of an Adverse Benefit Determination. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an Authorized Representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. In the event a Claimant designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

PROVIDER OF SERVICE APPEAL RIGHTS

A Claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a Claimant's appeal, and will respond to the provider and the Claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeal Process," above. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Requirements for First Appeal," above.**

For purposes of this section, the provider's waiver to pursue Covered Medical Expenses does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program."** The provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB92 or on a CMS – 1500 Form (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeals.

External Review of Adverse Benefit Determinations

When the internal appeals procedures have been exhausted, the claimant may elect to have an additional and final opportunity for a review of an eligible adverse benefit determination (including a final internal adverse benefit determination) by an independent review organization (IRO). The IRO will be accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review.

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The request for an external review must be filed by the claimant within four months following the claimant's receipt of the notice of adverse benefit determination or final internal adverse benefit determination. However, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the claimant will be deemed to have exhausted the internal claims and appeals process, and the claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

The Plan's external review process applies to any eligible adverse benefit determination or final internal adverse benefit determination on appeal, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

There are two types of external reviews; standard and expedited. An external review is a standard external review unless the timing required to perform a standard external review involves circumstances that would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not yet been discharged from the facility. In such cases, the Plan will consider the external review to be an expedited review.

Expedited External Review for Urgent or Emergency Care
This Plan does <u>not</u> require a claimant to obtain prior approval for pre-service urgent care claims or emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these claims. In an emergency or urgent care situation, the claimant should follow instructions from his or her health care provider, and file the claim as a post-service claim. If the post-service claim results in an adverse benefit determination, the claimant may file an appeal in accordance with the Plan's provisions for "Appeal Process", which are explained above.

Appeals of claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

Procedures for Initiation of an External Review

<u>Standard External Review</u>
A request for an external review must include the same information that is required for an internal appeal, listed above in the section, "Appeal Process".

Once the request for a standard external review is filed, the Plan will have five business days to do a preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided.

Within one business day following completion of the preliminary review, the Plan will notify the claimant in writing whether the request is eligible for external review.

- If the request is complete but is not eligible for external review, the notice will contain an explanation of the reason that the request is ineligible.

- If the request is incomplete, the notice will describe the information or materials needed to make the request complete. The claimant must submit the information or materials needed within 48 hours following receipt of the notice, or the expiration of the original four-month filing period, whichever is later.

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An eligible request which is complete and timely filed will be assigned to an independent review organization (IRO) by the Plan. The Plan will have arrangements to access at least three accredited IROs to which external reviews will be assigned on a random or rotated basis to ensure an independent and unbiased review.

The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit to the IRO, in writing and within 10 business days following receipt of the notice, any additional information that the IRO must consider when conducting the external review.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review, and the IRO may decide to reverse the adverse benefit determination or final internal adverse benefit determination. In this case, the IRO will notify the Plan and the claimant within one business day following the decision to reverse the determination.

The assigned IRO will forward any information which is submitted by the claimant to the Plan, and the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination; however, reconsideration by the Plan will not delay the external review. If the Plan decides to reverse its adverse benefit determination or final internal adverse benefit determination, it may terminate the external review and notify the IRO and the claimant within one business day of the decision.

The IRO will provide written notice to the claimant and the Plan of the final external review decision with 45 days following receipt of the request for review. The notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;

- The date the IRO received the request for external review and the date on which it made the decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and the evidence-based standards that were relied on in making the decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

- A statement that judicial review may be available to the claimant; and

- Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Expedited External Review

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A final internal adverse benefit determination concerning an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not yet been discharged from the facility will be considered for an expedited external review. These are considered to be pre-service **non-urgent** care claims and concurrent claims.

The procedures that apply to standard external reviews will apply to expedited external reviews, except that:

- The preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided must be conducted immediately, and the Plan must immediately notify the claimant regarding the eligibility determination;

- Upon a determination that a request is eligible for external review following the preliminary review, the Plan will immediately assign an IRO pursuant to the requirements set forth for standard external reviews;

- The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically, by phone, facsimile or any other available expeditious method; and

- The IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan within 48 hours following the notice.

Decision Following an External Review

Upon receipt of a notice from the IRO reversing the decision of an adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment for the claim. An external review decision is binding on the Plan as well as the claimant, except to the extent other remedies are available under State or Federal law.

3. Delete Plan provisions related to recovery of payments and replace with the following:

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person or Dependent on whose behalf such payment was made.

A Covered Person, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within

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thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any Claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit Claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on Claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) shall assign, or be deemed to have assigned, to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to Facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a Claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any Claim for benefits under this Plan by a Covered Person or by any of his covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person.

If the Plan seeks to recoup funds from a Provider due to a Claim being made in error, a Claim being fraudulent on the part of the Provider, and/or the Claim is the result of the Provider's misstatement, said

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Provider shall, as part of its Assignment of Benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

4. <u>Delete Plan provisions related to plan administration and replace with the following</u>:

Plan Administrator and Designated Decision Maker

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain fiduciary responsibility to ELAP, Inc. *(the "Designated Decision Maker" or "DDM")*. The fiduciary responsibility allocated to the DDM is limited to discretionary authority and ultimate decision-making authority with respect to any appeals of denied claims which are referred to the DDM by the Plan Administrator. The Plan Sponsor has allocated additional fiduciary responsibility to the DDM, limited to discretionary authority and ultimate decision-making authority with respect to the review and audit of certain claims in accordance with the applicable Plan provisions under the section, “Claim Review and Audit Program”. Such claims selected as eligible for review and audit shall be identified by the DDM under guidelines to which the Plan Sponsor has agreed, and shall be referred to the DDM by the Plan Administrator. The DDM shall have no authority, responsibility or liability other than with respect to the Referred Appeals and its duties under the Claim Review and Audit Program.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator and the Designated Decision Maker shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and the Designated Decision Maker shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a Plan participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or the Designated Decision Maker as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or the Designated Decision Maker decides, in its discretion, that the Plan participant is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Plan participant's rights;

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6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Duties of the Designated Decision Maker

The Designated Decision Maker shall have the following duties with respect to the Referred Appeals:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to benefits payable under the Plan and negotiating settlements, if appropriate;
6. To review Referred Appeals and to uphold or reverse any denials;
7. To keep and maintain records pertaining to the referred appeals;
8. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and
9. To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of the DDM shall be limited to those set forth above

5. <u>Add the following new statement to any Plan provisions related to claim audits</u>:

Please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

6. <u>Add the following new statement to any Plan provisions related to usual, customary or reasonable fees (by whatever term used)</u>:

For claim determinations made in accordance with the Claim Review and Audit Program, the covered expenses will be limited to the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program" for the definition of Allowable Claim Limits.

7. <u>Delete Plan provisions describing preferred provider organization networks and replace with the following</u>:

PREFERRED PROVIDER INFORMATION

The Preferred Provider Network (PPO) includes Physicians and other professional Providers who have contracted with the medical Provider Networks. For Physicians and all other professional

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providers of service, this Plan contains provisions under which a Plan Participant may receive more benefits by using certain providers. PPO providers are individuals and entities that have contracted with the Plan to provide services to Plan Participants at pre-negotiated rates. A list of these Preferred Providers will be periodically provided automatically and free of charge by the Plan Administrator. In addition, a Plan Participant may request a Preferred Provider list by contacting the Plan Administrator. The Preferred Provider list changes frequently; therefore, it is recommended that a Plan Participant verify with the provider that the provider is still a Preferred Provider before receiving services.

The Preferred Provider Network (PPO) does **not** include services and supplies provided by facilities such as Hospital facilities, Ambulatory Surgery Center facilities and by dialysis clinics or facilities. You may contact the Claims Administrator or the Plan Administrator with any questions regarding which facilities may be included under the Claim Review and Audit Program, and which may be included under the PPO network agreement.

For all facility providers and those physicians and professional providers not participating in the PPO, the Plan will identify the reasonable cost for the services and supplies through its Claim Review and Audit Program.

This plan may use Allowable Claim Limits to determine Covered Charges in lieu of a PPO discount.

8. Add the following statement to Plan provisions defining or describing covered medical expenses under the Plan:

Covered expenses may be subject to the Allowable Claim Limits under the Claim Review and Audit Program.

9. Add the following statement to Plan provisions defining or describing excluded medical expenses under the Plan:

Charges in excess of Allowable Claim Limits**.**

10. Add as new, or replace existing Plan definitions with the following terms:

Allowable Expense or Covered Expense: Any medically necessary item of expense, for which the charge is reasonable and necessary, within Allowable Claim Limits, or is based on the contracted fee schedule of an alternate care delivery system. The Allowable Expense will be determined by the Plan Administrator, in its sole discretion.

11. Add the following to the Plan definition for "Maximum Amount" and/or "Maximum Allowable Amount":

For claims under the Claim Review and Audit Program, the Maximum Allowable Amount is the Allowable Claim Limit.

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12. **Add as new the following defined terms:**

Allowable Claim Limits: The charges for services and supplies, listed and included as covered medical expenses under the Plan, which are medically necessary for the care and treatment of a covered illness or injury, but only to the extent that such fees are within the allowable claim limits. Please refer to the section, "Claim Review and Audit Program" for additional information regarding allowable claim limits.

Direct Agreement: A complete agreement between a Directly Contracted Provider and the DDM or the Plan Sponsor which contains the terms and conditions under which the Covered Person may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for claims submitted by a directly contracted providers.

Directly Contracted Provider: A medical provider which has entered into a Direct Agreement with the DDM or the Plan Sponsor to provide certain medical services to Covered Persons at agreed upon Allowable Claim Limits.

13. Replace the current terms and definition for "usual and customary fee" (by whatever term used) with the following:

Usual and Customary: Covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care Facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

For Claim determinations made in accordance with the Claim Review and Audit Program, the Usual and Customary fee will be the Allowable Claim Limits. Please refer to the section, "Claim Review and Audit Program," for the definition of Allowable Claim Limits.

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14. <u>Add as new, or replace any existing related Plan provision for compliance or conformity to applicable law, with the following</u>:

Conformity to Law
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this summary plan description. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

15. <u>Add the following section as new or revise the current section as follows:</u>

Assignments
Benefits for medical expenses covered under this Plan may be assigned by a covered person to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received before the proof of loss is submitted.

No covered person shall at any time, either during the time in which he or she is a covered person in the Plan, or following his or her termination as a covered person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

All other provisions of the Plan Documents shall remain unchanged.

ADOPTED BY THE PLAN SPONSOR:

By: _____

Title: _____

Date: _____

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