

AMENDMENT TO
AND
SUMMARY OF MATERIAL MODIFICATIONS
FOR THE
Barton County Community College Employee Health Care Plan

To: All Plan Participants and Beneficiaries of Barton County Community College Employee Health Care Plan:

This notice, called a "Summary of Material Modifications," advises you of changes to your coverage under the Plan listed above. Please read this notice carefully, and if you have any questions, contact the Plan Administrator.

Keep this notice with your Summary Plan Description/Benefit Description and make a note in your Benefit Description as to what sections have been changed so that when you go to look up information you will be reminded that certain information has changed.

Effective November 1st, 2022

Amendment Three
To

Barton County Community College Employee Health Care Plan:

1. In the **Definitions** section, the following definition is added:

"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.

2. In the **Definitions** section, the definition of the term "Emergency Services" is removed and replaced with the following:

"Emergency Services"

"Emergency Services" shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

3. In the **Definitions** section, the following definition is added:

“Independent Freestanding Emergency Department”

“Independent Freestanding Emergency Department” means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

4. In the **Definitions** section, the definition of the term “Maximum Allowable Charge” is removed and replaced with the following:

“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 services received from providers who are not participating in the network, the Plan will either limit the amount it allows for Covered Charges to the lesser of (1) the provider’s billed charges or (ii) an amount equal to 120% of the current Medicare allowable fee for the appropriate area, as such information is made publicly available. The Plan Administrator may, in its discretion, elect to issue an additional payment, in an amount not to exceed the Usual and Customary and Reasonable and Appropriate amount, if doing so is found to be in the best interest of the Covered Person. If there is no corresponding Medicare reimbursement rate for a charge from a non-network provider, the Maximum Allowable Charge will be an amount which is Usual and Customary, and Reasonable and Appropriate. The Covered Person is responsible for payment of Deductibles, Co-Payment/Co-Insurance amounts and non-covered services.

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 the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of these 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.

5. In the **Definitions** section, the following definitions are added:

"Participating Health Care Facility"

"Participating Health Care Facility" shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

"Qualifying Payment Amount"

"Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

"Recognized Amount"

"Recognized Amount" shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

6. In the **Claims Procedures; Payment of Claims** section, the following language is removed:

In PART VII – EXTERNAL REVIEW PROCESS Section 6.59 Determination Whether the Claim is Eligible for External Review, the following language is removed:

Within 5 days after Receiving a Claimant's request for External Review, the Plan Administrator shall determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

- (a) The Claimant is or was covered under the Plan at the time the Claim was made or incurred;
- (b) The denial relates to the Claimant's failure to meet the Plan's eligibility requirements. (If the Claim involves an eligibility issue, External Review is not available);

- (c) The Claimant has exhausted the Plan's internal Claims and Appeal procedures; and
- (d) The Claimant has provided all the information required to process an External Review.

And the following language is added:

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).
7. In the **Network and Non-Network Provider Arrangement** provision within the **Summary of Benefits** section, the following language is added:

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

8. In the **Medical Prescription Drug Benefit Description** section, the following provisions are added:

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 after termination that the Provider's contractual relationship with the Plan has terminated, 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, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

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 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.

9. In **Part II – Medical Benefits** section, the language in **I. Preventive Care Services** is removed and replaced with the language below:

To comply with the ACA, and in accordance with the recommendations and guidelines, the plan provides In-Network coverage without any cost-sharing for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).

4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:

<https://www.healthcare.gov/coverage/preventive-care-benefits/>;
<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>;
<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
<https://www.hrsa.gov/womensguidelines/>.

Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

- a. If the mammogram is performed in connection with the diagnosis or treatment of a medical condition and the provider properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the Plan dealing with diagnostic x-rays.
- b. If the Covered Person is at high risk of developing breast cancer or has a family history of breast cancer and the provider properly files the claim with this information, the claim will be processed as a preventive procedure according to the benefit provisions of the Plan's Preventive Care Services.

In all other cases the claim will be subject to the provisions described for Preventive Care Services.

Colorectal Cancer Screenings

Benefits for colorectal cancer screenings vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

- a. If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition and the provider properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the Plan dealing with surgical procedures. If a polyp is removed during the course of a preventive colonoscopy, the colonoscopy procedure, removal of the polyp, and the charges for pathological examination of the specimen are considered under the Plan's Preventive Care Services.
- b. If the Covered Person has a family history of colon cancer and the provider properly files the claim with this information, the claim will be processed as a preventive procedure according to the benefit provisions of the Plan's Preventive Care Services.

In all other cases the claim will be subject to the provisions described for Preventive Care Services.

The Plan intends to comply with the Affordable Care Act. Preventive Care Services may be added without notification. Contact the Claims Administrator if you have questions about these benefits.

For more information, Participants may contact the Plan Administrator / Employer.

All other sections of the Plan remain unchanged.

IN WITNESS WHEREOF, this Amendment Three is executed for Barton County Community College Employee Health Care Plan on the date signed below, to be effective on November 1, 2022.

By: 
Barton County Community College

Title: VP of Administration

Date: 11-17-22

