GRACE COTTAGE
EMPLOYEE GROUP MEDICAL PLAN
AMENDMENT #9 TO THE
JANUARY 1, 2016 PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2022

The Plan is amended in accordance with the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) to cover Emergency Care, Out-of-Network air ambulance services and certain non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility at the In-Network level of benefits, subject to the Qualifying Payment Amount; revise the definition of Allowed Amount and Emergency Care and add the definition of Qualifying Payment Amount; include continuity of care provisions for when a provider is no longer In-Network; and include final internal appeal denials related to compliance with the NSA as eligible for external review.

This Plan is also amended to include the following updates: update the URL for the HPI website; lower the age limit for routine colonorectal screenings; eliminate coverage for routine eye exam and routine eyewear benefits; update orthotics benefit to require precertification and include coverage for foot orthotics; refer Covered Persons to contact the Pharmacy vendor for assistance with formulary drug lists; and update the Plan's right of subrogation and reimbursement to ensure that the Plan is indemnified against attorney's fees, costs, or other expenses related to the recovery of funds. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Document and Summary Plan Description are hereby amended as follows:

SECTION I, ESTABLISHMENT OF PLAN; The Plan is hereby amended as follows:

The HPI website URL is updated to www.hpiTPA.com. All references to this website are updated throughout the document.

SECTION III, DEFINITIONS; The definitions of **Allowed Amount** and **Emergency Care** are hereby **deleted** and **replaced** in their entirety with the following:

Allowed Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services that are **not** subject to the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) (hereinafter referred to as "Non-NSA Covered Services"), minus any applicable Coinsurance, Co-payment or Deductible a Covered Person may be responsible for under the Plan. See the definition of "Qualifying Payment Amount" for the Covered Services that are subject to the NSA.

The Allowed Amount for Non-NSA Covered Services received from an Out-of-Network Provider depends upon where the services are provided.

> If Non-NSA Covered Services are received from an Out-of-Network Provider in New England, the Allowed Amount is an amount that is consistent with historically accepted reimbursements, commercial pricing benchmarks, accepted Medicare rates, preferred provider contractual reimbursements and geographic adjustments.
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> If Non-NSA Covered Services are received from an Out-of-Network Provider located outside of New England, the Allowed Amount is applied based on the following order of payment:
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> - Fee(s) that are negotiated with the Physician or facility;
> - 200% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic area; or

- 50% of the billed charges

The specific reimbursement formula used for services provided by an Out-of-Network Provider located outside of New England will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Covered Persons may be responsible for paying excess charges above the Allowed Amount for Non-NSA Covered Services after the Plan pays its portion.

Emergency Care – care administered in a Hospital, independent freestanding emergency department, clinic, urgent care center, or Physician's office for a Medical Emergency. Emergency Care includes: (1) an appropriate medical screening examination, including ancillary services routinely available to evaluate whether a Medical Emergency exists; and (2) such further medical examination and treatment as may be required to stabilize the Covered Person (regardless of the department of a Hospital or independent freestanding emergency department in which the further medical examination and treatment is furnished). Emergency Care does not include ambulance service to the facility where treatment is received.

SECTION III, DEFINITIONS; The definition of **Qualifying Payment Amount** is hereby **added** in its entirety:

Qualifying Payment Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services that are subject to the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) (hereinafter referred to as "NSA Covered Services"). Such NSA Covered Services are: emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the NSA. The NSA Covered Services will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

The Qualifying Payment Amount will be based on the median of the contracted rate for the same or 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. The Qualifying Payment Amount will be determined in accordance with the NSA, as amended. Any amendments to the foregoing methodology will be deemed to be included and in effect for the Plan as of the NSA amended date.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's In-Network level of benefits, subject to the Allowed Amount.

SECTION IV, SCHEDULE OF MEDICAL BENEFITS (Silver EPO, Gold EPO and Platinum EPO Plans),

- **PREVENTIVE CARE; USPSTF Recommendations** for **Colorectal Screenings** are **updated** as follows:

  Colorectal Screenings - decrease minimum age from 50 to 45

- **VISION CARE; Routine Eye Exam** and **Routine Eyewear** benefits are hereby deleted in their entirety.

- **OTHER SERVICES & SUPPLIES; Orthotics** is hereby **deleted** and **replaced** in its entirety with the following:

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Orthotics (*Precertification required;* includes coverage for foot orthotics; s*ee* Medical Benefits *section for other limitations*)	100%	NOT COVERED

SECTION V, MEDICAL BENEFITS, A. Benefit Levels;

- **In-Network Providers, Out-of-Network Providers** and **Traveling Benefit** are hereby **deleted** and **replaced** in its entirety with the following; and **No Surprises Billing** and **Continuity of Care** provisions are hereby **added** in their entirety with the following:

  In-Network Providers – If a Covered Person has incurred Covered Services rendered by an In-Network Provider, the Plan will pay the Coinsurance amount as shown in the Schedule of Medical Benefits subject to the Contracted Rate (after satisfaction of the applicable Calendar Year Deductible).

  Out-of-Network Providers – If a Covered Person has incurred Covered Services rendered by an Out-of-Network Provider, the Plan will pay the Coinsurance amount as shown in the Schedule of Medical Benefits subject to the Allowed Amount or Qualifying Payment Amount, as applicable (after satisfaction of the applicable Calendar Year Deductible).

  No Surprises Billing - Covered Services that are emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA), will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

  When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's In-Network level of benefits, subject to the Allowed Amount.

When services are rendered by an Out-of-Network Provider in any instance other than the reasons listed above, Covered Persons may be responsible for any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.

Traveling benefit – If a Covered Person is traveling out of country and requires medical treatment from an Out-of-Network Provider (excluding when a Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies), benefits shall be payable at In-Network Provider Co-payment and Coinsurance levels subject to the Allowed Amount or Qualifying Payment Amount, as applicable (after satisfaction of the applicable Calendar Year Deductible).

Continuity of Care - In the event a Covered Person is a continuing care patient receiving a course of treatment from an In-Network Physician Provider or from a provider that 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 Covered Person shall have the following rights to continuation of care, if so elected, for a period ending 90 days later or when the Covered Person 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 Covered Person for any amounts above the Plan's benefit amount.

SECTION V, MEDICAL BENEFITS, C. Covered Services:

- **(1)** Prescription Drugs; The following provision is hereby added in its entirety:

  The presence of a drug on the Prescription Benefit Manager's formulary list does not guarantee coverage. The drugs listed on the Prescription Benefit Manager's formulary are subject to change. To find out if a medication is covered under the Plan, Covered Persons should contact the Pharmacy vendor at the phone number list on the back of his/her ID card for the most current formulary information.

- **(3)** **Vision Care; Routine Vision Exam** and **Routine Eyewear** are hereby **deleted** in their entirety.

- **(4)** **Physician Services; (h) Surgery (Inpatient/Outpatient/Office)** is hereby **deleted** and **replaced** in its entirety with the following:

  (h) Surgery (Inpatient/Outpatient/Office)

  Physician or surgeon charges for a surgical operation and for the administration of anesthesia

  If two or more surgical procedures are performed at one time through the same incision in the same operative field, the maximum allowable amount for the surgery will be as follows:

  (i) For In-Network Providers: the Contracted Rate for the primary procedure and the greater of 50% of such Contracted Rate or the amount specified in the In-Network Provider's contract for the secondary or lesser procedure(s).

(ii) For Out-of-Network Providers (who are not in the network but otherwise covered, such as emergency medical care and urgent care received outside the service area): the Allowed Amount or Qualifying Payment Amount, as applicable, for the major procedure and 50% of the Allowed Amount or Qualifying Payment Amount, as applicable, for the secondary or lesser procedure(s).

No additional benefit will be paid under this Plan for incidental surgery done at the same time and under the same anesthetic as another surgery.

The Plan will also pay for a surgical assistant when the nature of the procedure is such that the services of an assistant Physician are Medically Necessary.

- **(10) Other Services and Supplies; Orthotics** is hereby **deleted** and **replaced** in its entirety with the following:

  Orthotics

  For the purpose of treating an Illness or Injury, services and equipment such as orthopedic braces, including leg braces with attached shoes; arm, back and neck braces; surgical supports; and head halters and specially molded orthopedic shoes and/or orthotic inserts

SECTION VI, MEDICAL LIMITATIONS AND EXCLUSIONS; The following exclusions are hereby **added** in their entirety, with all other items renumbered accordingly:

(25) Eyewear, routine (including lenses, frames and contact lenses, and their fitting)

(42) Vision exams for routine care

SECTION XII, THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT, C. Right of Reimbursement, paragraph (2) is hereby **deleted** and **replaced** in its entirety with the following:

C. Right of Reimbursement

(2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent

SECTION XV, CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS is hereby amended as follows:

Final internal appeal denials related to compliance with the No Surprises Act of the Consolidated Appropriations Act of 2021 are added as denials eligible for external review.

Accepted by:
Grace Cottage

	Director of Human Resources
Authorized Signature	**Title**
Jennifer Newman	5/9/2022
Print Name	**Date**