Mendocino County Schools (Staywell, JPA)
Active Plan
Amendment #1

Effective beginning on July 1, 2020

Mendocino County Schools (Staywell, JPA) Employee Benefit Plan (the "Plan") is hereby amended as follows:

NOTE: The Outpatient Dialysis Carveout Program shown in this amendment applies to California Participants only. It does not apply to Participants outside of California.

On pages 18 and 19, DEFINITIONS, the definition of "Maximum Allowable Charge" is hereby amended:

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

With respect to Non-Network Emergency Services, the Plan allowance is the greater of:

- If applicable, the negotiated amount for In-Network Providers (the median amount if more than one amount to In-Network Providers).
- The Plan's normal Non-Network payable amount after consideration of the criteria described below (reduced for cost-sharing).
- For outpatient dialysis (California Participants only), the Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based on the average payment actually made for reasonably comparable services and/or supplies to all Providers of the same services and/or supplies by all types of plans in the applicable market during the preceding Calendar Year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.
- The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

If and only if there is no negotiated rate for a given claim, 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.

On page 28, ELIGIBILITY FOR COVERAGE, the "Eligibility for Individual Coverage" section is hereby amended:

Eligibility for Individual Coverage

Each Non-Variable Hour Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following completion of a Service Waiting Period of 30 days, provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work.

> If an Employee changes schools within the district, such change will not be considered a break in service and a new Service Waiting Period will not be applied when such Employee changes schools.

Each Variable Hour Employee who has averaged the requisite Hours of Service, as defined herein, will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period, as defined herein.

Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

On page 80, SUMMARY OF BENEFITS, the following language is added to the Plan, before the Out-of-Area Services section:

Dialysis Treatment – Outpatient

Note: This program applies to California Participants only.

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:
    1. the concentration of dialysis providers in the market in which Plan reside may allow such providers to exercise control over prices for dialysis-related products and services,
    2. the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
    3. evidence of (i) significant inflation of the prices charged to Plan by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of non-governmental and non-commercial plans, such as the Plan, by dialysis providers as profit centers, and

4. the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the interests of Plan members, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

1. Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").
2. Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan for expenses incurred on or after July 1, 2020, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.
3. Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:
    a. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
    b. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.
4. In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services.

    Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the member, to the following payment limitations, under the following conditions:
    a. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
    b. Maximum Benefit. Except as provided in the preceding subsection or where an acceptable provider agreement is entered into, the maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.
    c. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

d. Additional Information related to Value of Dialysis-Related Services and Supplies. The member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

e. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.
6. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of this Section, to make determinations regarding issues which relate to eligibility for benefits under this Section, to decide disputes which may arise relative to a Plan's rights under this Section, and to decide questions of interpretation of this Section and those of fact relating to the application of this Section. The decisions of the Plan Administrator will be final and binding on all interested parties.
7. Provider Acceptance. A provider that accepts the payment from the Plan under this Section will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan member, and (ii) it shall not "balance bill" a Plan member for any amount billed but not paid by the Plan.

On page 83, MEDICAL BENEFITS, SUMMARY OF BENEFIT, the Pre-Authorization list is hereby amended.

Note: The following services must be Pre-Authorized or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain Pre-Authorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

- **Home Infusion/Home Injection Therapy**
- **Radiological and Nuclear Imaging Procedures (CT, MRI, MRA, PET, Diagnostic Cardiac procedures utilizing nuclear medicine)**
- **Inpatient Hospital Admissions**
- **Skilled Nursing Facility Admissions**
- **Transplant Services**
- **Bariatric Surgery**
- **Mental Health and Substance Use Disorder Hospital Admissions (Partial Hospitalization Programs, Intensive Outpatient Program, Electroconvulsive Therapy and Psychological Testing)**
- **Transcranial Magnetic Stimulation**
- **Home Health Services.**

- **California Participants Only: Outpatient Dialysis Services.**

Please see the Utilization Management section of this booklet for details.

On page 88, MEDICAL BENEFITS, SUMMARY OF BENFEITS, the "Dialysis Services" benefit is hereby amended:

	Participating Providers	Non-Participating Providers
Dialysis Services (Outpatient) – for California Participants only	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. **NOTE: Outpatient Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims. Please refer to the Dialysis Treatment Outpatient Description**	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. **NOTE: Outpatient Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims. Please refer to the Dialysis Treatment Outpatient Description**

On page 89, MEDICAL BENEFITS, SUMMARY OF BENEFITS, the "Routine Well Woman" section of the Preventive Care benefit is hereby amended. (The mammogram limits are new.)

	Participating Providers	Non-Participating Providers
Preventive Care		
Routine Well Adult Care	100%, deductible waived	50% after deductible
All preventive care services as recommended by the U.S. Preventive Services Task Force. For a complete listing go to: www.uspreventiveservicestaskforce.org/		
Rouinte Well Child Care – Includes all Immunizations	100%, deductible waived	50% after deductible
All preventive care services as recommended by the U.S. Preventive Services Task Force. For a complete listing go to: www.uspreventiveservicestaskforce.org/		
Routine Well Woman	100%, deductible waived	50% after deductible
All preventive care services as recommended by the U.S. Preventive Services Task Force. For a complete listing go to: www.uspreventiveservicestaskforce.org/. (**Mammograms**: one every other year for ages 50-74. If authorized by the Participant's Physician in writing, mammograms will be allowed as often as annually for ages 40-49 as preventive. Mammograms prior to age 40 will be considered diagnostic and will be subject to the deductible and coinsurance.)		

On page 89, MEDICAL BENEFITS, SUMMARY OF BENEFITS, the "Renal Dialysis" benefits under the Therapeutic Services are for the Non-California Participants only. (Outpatient dialysis benefits for the California Participants are part of a separate dialysis benefit, as shown on a previous page.)

On page 89, MEDICAL BENEFITS SUMMARY OF BENEFITS, the "Telemedicine (Health Tap)" benefit is deleted and replaced with the following benefits:

	Participating Providers	Non-Participating Providers
Telemedicine	Paid the same as any office visit	Paid the same as any office visit
Telemedicine (Health Tap)	100% (deductible waived)	Not Applicable

In the MEDICAL BENEFITS, SUMMARY OF BENEFITS section of the Plan, the following benefit for Independent Labs is added to the Summary of Benefits

	Participating Providers	Non-Participating Providers
Independent Lab (including blood draw)	100% (deductible waived)	50% after deductible

On page 100, Medical Exclusions, the "Obesity" exclusion is hereby amended:

Obesity. Charges related to the care and treatment of obesity, weight loss or dietary control through medication and/or nutritional counseling/diet programs are excluded. This exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit. This exclusion does not apply to the Bariatric Surgery Services benefit that is shown on the Schedule of Benefits.

On page 102, UTILIZATION MANAGEMENT, the "Services that Require Pre-Certification" list is hereby amended.

Services that Require Pre-Certification

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

The attending Physician does not have to obtain Pre-Authorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

- Home Infusion/Home Injection Therapy.
- Radiological and Nuclear Imaging Procedures:
    a. CT,
    b. MRI,
    c. MRA,
    d. PET,
    e. Diagnostic Cardiac Procedures utilizing nuclear medicine.
- Inpatient Hospital Admissions.
- Skilled Nursing Facility Admissions.

- Transplant Services.
- Bariatric Surgery.
- Mental Health and Substance Use Disorder Hospital Admissions:
    a. Partial Hospitalization Program,
    b. Intensive Outpatient Program,
    c. Electroconvulsive Therapy,
    d. Psychological Testing.
- Transcranial Magnetic Stimulation
- Home Health Services.
- **California Participants Only**: Outpatient Dialysis Services.

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:
Mendocino County Schools – Staywell (Active)
Amendment #1
Effective July 1, 2020

By: _____

Title: _____

Date: _____