AMENDMENT #8
TO THE
PLAN DOCUMENT SUMMARY PLAN DESCRIPTION
for the
COLLIER COUNTY GOVERNMENT EMPLOYEE BENEFIT PLAN - GROUP 2003021

Effective January 1, 2022, the Collier County Government Employee Benefit Plan is amended as follows (red and *italics* means addition; ~~strikeout~~ means deletion):

Within "**IN-NETWORK BENEFIT**", "IN-NETWORK BENEFIT" is replaced and "CONTINUITY OF CARE" is added following "IN-NETWORK BENEFIT":

IN-NETWORK BENEFIT

This Plan provides benefits through a group of contracted providers (In-Network Providers). An In-Network Provider means using a provider who is part of the group of contracted providers. Using In-Network providers offers cost-savings advantages because a Covered Person pays only a percentage of the scheduled fee for services provided.

Out-of-Network Provider means a provider who is not an In-Network Provider. A Covered Person who uses an Out-of-Network Provider will pay more and his or her share of the cost may not apply to the Out-of-Pocket Maximum.

To determine if a Physician or Licensed Health Care Provider qualifies as an eligible In-Network Provider under this Plan, please consult Allegiance's website at www.askallegiance.com/ccg to access links for directories of participating providers.

The following benefit provisions apply when a covered service is rendered by a Out-of-Network provider:

1. Charges for an Emergency as defined by this Plan, limited to only those emergency medical procedures necessary to treat and stabilize an eligible Injury or Illness and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time to an In-Network Hospital, clinic or other facility, or discharged will be paid at the In-Network level of benefits.

2. Charges which are incurred as a result of and related to confinement in or use of an In-Network Hospital, clinic or other facility only for Out-of-Network services and providers over whom or which the Covered Person does not have any choice in or ability to select will be paid at the In-Network Provider level of benefits. **The Plan UCR limitations will not apply to this exception.**

3. If the provider rendering service is located in Collier County and is not part of the CHP Network but is part of the CIGNA Network, benefits will be paid at the Out-of-Network Provider level of benefits.

4. If the provider rendering service is located outside of Collier County and is not part of the CHP Network but is part of the CIGNA Network, benefits will be paid at the In-Network Provider level of benefits.

5. *Charges for Emergency use of an Air Ambulance.*

CONTINUITY OF CARE

In the event a provider that a Covered Person is currently receiving services, treatment or care of an Illness or Injury for any of the following terminates its Network affiliation, the Plan will pay the provider at the Network benefit level and allowable amount for a period of up to ninety (90) days after the date the provider terminates its Network affiliation:

1. *Pregnancy in the second or third trimester or postpartum care;*
2. *Continuation of treatment for a chronic or acute medical condition;*
3. *Active care at an Inpatient facility;*
4. *A disabling, degenerative, congenital or life threatening Illness;*
5. *Ongoing treatment of a terminal illness or serious medical condition; or*
6. *A Mental Illness or Alcohol and/or Chemical Dependency condition.*

To be eligible for this benefit, call the customer service number listed on the Participant's identification card.

The "**BARIATRIC PROGRAM**" section is replaced as follows:

BARIATRIC PROGRAM

A Covered Person must enroll in the Bariatric Program and actively participate for twelve (12) consecutive months in the Bariatric Program prior to consideration for pre-certification of any gastric by-pass surgery and six (6) consecutive months following the surgery. Surgery must be performed immediately after completing the twelve (12) month program. Recommendation regarding request for gastric procedures limited to: Bariatric Surgery, Gastric Stapling, Laparoscopic Gastric Bypass, Roux-en-Y Gastric Bypass (RYGB), ~~Vertical Banded Gastroplasty (VBG)~~ *or other medical policy standard technique*.

The following criteria will be used for pre-certifying benefits for the above procedures:

1. A clinical history of unsuccessful diet and other weight management programs.
2. Must receive a positive assessment of surgery risk-benefit from all evaluating staff members of the pre-surgery program.
3. Must be at least 18 years of age and less than 70 years of age.

The following is specifically excluded:

1. Surgical procedures except for *Bariatric Surgery, Gastric Stapling,* Roux-en-Y Divided Bypass Surgery ~~or laparoscopic adjustable gastric banding) surgery~~ *or other medical policy standard technique*.
2. Any Expenses Incurred for which all of the conditions of the Bariatric Program have not been met.
3. Any redo or revision of a prior bariatric surgical procedure*, unless the indication for surgery is to treat or manage a diagnosis or condition unrelated to further weight loss*.
4. A second bariatric surgical procedure, whether or not the first procedure was performed while covered under this Plan or not.

Please contact The MedCenter for further information at (239) 252-4257.

Within "**PROCEDURES FOR CLAIMING BENEFITS**", item 5 (Payment Disputes) is added numerically to "CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY" as follows:

5. ***Claims for Payment Disputes for Non-Network Emergency Air Ambulance, Emergency Use of an Emergency Room and Non-Network Physicians and Licensed Health Care Providers While Providing Services Over Which the Covered Person Has No Control -*** *For providers in this category, the Plan will pay an amount equal to the Median network fee for the same service in the same geographic area. Once payment is made by the Plan, the provider will have thirty (30) days from the date of payment to contact the Plan Supervisor and attempt to negotiate a different payment amount. Failure to contact the Plan Supervisor within such thirty (30) days will result in the amount paid by the Plan being considered payment in full for all purposes. If negotiations are attempted within thirty (30) days but cannot be resolved within that time, the provider may follow the applicable federal or state rules to seek mediation (Independent Dispute Resolution) of the fee amount. The mediators decision shall be binding on the Plan and the provider.*

Within "**GENERAL DEFINITIONS**", "USUAL, CUSTOMARY AND REASONABLE (UCR) is replaced as follows:

USUAL, CUSTOMARY AND REASONABLE (UCR)

"Usual, Customary and Reasonable" (UCR) means the maximum amount considered for payment by this Plan for any covered treatment, service, or supply, subject however, to all Plan annual and Maximum Lifetime Benefit limitations. The following will apply in the order below to determine the Usual, Customary and Reasonable amount:

1. A contracted amount as established by a preferred provider or other discounting contract; or

2. An amount established through a nationally recognized, published Usual, Customary and Reasonable (UCR) data base utilized by the Plan Supervisor and adopted by the Plan Administrator using the 90th percentile of said database; or

3. The billed charge if less than 2 above.

For non-contracted providers for Emergency service, Air Ambulance and non-contracted providers providing services in a contracted facility, the UCR is equal to and used as the Qualified Payment Amount for No Surprise Billing Act purposes.

Nothing in this amendment is deemed to change any other provision of the Plan Document Summary Plan Description of which it becomes a part.

COLLIER COUNTY GOVERNMENT

BY: _____

TITLE: Director, Risk Management