Ops Forum Legal Update

SPD Updates

Overview of the No Surprises Act

Prepared by
Jayson Welter, J.D., M.A.
General Counsel and Corporate Secretary
949.593.0184
jwelter@unitedag.org

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Overview of Changes and Additions

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Part V General Definitions

- Section 9: *Assignment of Benefits* **20**

  Clarified payment of network provider, clarified AoB and legal action, added authorized representative section, added full rewrite of assignments section.

  (Please review this section in its entirety to fully familiarize yourselves with the new language and definition).

- Section 15: *Contracting Panel* **21**

  Expanded definition and added AoB language:

  "The UABT Contracting Panel or "Network Panel" is a Preferred Provider Organization ("PPO") through which UABT contracts for health, dental, and vision care services for covered beneficiaries. These providers have contracted with the PPO to accept a competitive rate structure for medical services performed. Benefits due to any Network Panel provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed.

  A list of the Contracting Panel providers is available at no cost to you from UABT on request or you can call the PPO at the telephone number listed on the back of your UABT Identification Card."

Part V General Definitions Cont.

- Section 16: *Contracting Providers and Hospitals* **22**

  Added AoB Language:

  "Contracting Hospitals agree to accept the negotiated fees instead of their billedfees. Benefits due to any Network Panel provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed."

- Section 20: *Covered Expense* **22**

  Expanded definition to include Maximum Allowable Charge. Added language on provisions designated in the schedule of benefits.

  "The term "Covered Expense" means the maximum allowable charge for a medically necessary service, treatment, or supply(ies). Expense incurred for a type of treatment, service, or supply which is allowed by the Plan,if all Plan Definitions have been satisfied; the services are not excluded by Plan Limitation, and; the charges do not exceed the applicable benefit maximum which will be determined based upon all other Plan provisions designated in the schedules of benefits.**"**

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Part V General Definitions Cont.

- Section 26: *Durable Medical Equipment* **(New Section) 23**

  "The term "durable medical equipment" means physician-prescribed wheelchairs (manual and electric), hospital beds, traction equipment, canes, crutches, walkers, kidney machines, ventilators, oxygen, monitors, pressure mattresses, lifts, nebulizers, bili blankets and bili lights. All durable medical equipment must be prescribed by a doctor or medical professional indicating that the equipment is medically necessary."

- Section 30: *Experimental and/or Investigational Procedure-Medication/Procedure* **23**

  Added "investigational procedure", added language on New to Market drugs, and devices, added approval of FDA Advisory Board, added language on Drugs prescribed for non-approved treatment, added Plan Administrator has discretionary authority to determine E&I. (Please review this section in its entirety to fully familiarize yourselves with the new language and definition).

- Section 48: *Medical Emergency* **26**

  Rewritten. Added language on prudent layperson and added NSA language.

  (See NSA Overview).

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Part V General Definitions Cont.

- Section 49: **Medical Record Review (New Section) 27**

  "The term "Medical Record Review" means measurement and review of medical records to compare documentation of care to measurable criteria. Service quality is measured by reviewing each clinic's process for assuring the timeliness and safety of appropriate patient care. This includes emergency, urgent and non-urgent care. The review also considers the medical necessity of the treatment and service."

- Section 56: **Obesity (New Section) 28**

  "Obesity screening and counseling is a Covered Expense when you are determined morbidly obese (100 or more pounds overweight or a BMI above 40) by a licensed physician. UABT pre-authorization must be obtained for any procedure, including but not limited to Roux-en-Y gastric bypass, gastric banding (adjustable or non-adjustable), sleeve gastrectomy, malabsorption procedures (biliopancreatic diversion, duodenal switch) and vertical banded gastroplasty."

- *Section 57: **Other Plan (New Section) 28***

  "The term "Other Plan**"** means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such other plan(s) include auto insurance, workers' compensation insurance, crime victims' restitution, etc. . "Other Plan" also include Medicare, Medicaid, or a state child health insurance program (CHIP). Other Plan does not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies."

Part V General Definitions Cont.

- Section 76: *Transparency and Surprise Medical Bills* **<u>(New Section)</u> 31**
  (See NSA Overiew).

- Section 80: *Transplant Procedure* **<u>(New Section)</u> 31**
  Defines what organs and tissues are considered transplants as well as the locations where they are available.

- Section 81: *Urgent Care* **<u>(New Section)</u> 32**
  "The term "Urgent Care" means medical care provided for illnesses or injuries which require prompt attention but are typically not of such seriousness as to require the services of an <u>emergency room</u>."

- Section 82: *Usual and Customary Fees* **32**
  <u>Added</u> term "Reasonable", <u>added</u> term "Maximum Allowable Charge"
  (Please review this section in its entirety to fully familiarize yourselves with the new language and definition).

Part VI General Provisions and Limitations

- Section 2: General Exclusions **33**
  - (b) Travel Expenses **added**
  - (c) Complications related to non-covered services/supplies
  - (d) Prescription medications not received at UABT pharmacy
  - (e) Medical not approved by FDA or FDA Advisory Board
  - (h) **Added** prescribed opioids or any other substance creating a state of intoxication
  - (l) Growth Hormones unless Medically Necessary
  - (m) Hazardous Activities/**Pursuit-Expanded** Definition
  - (n) Implantable Hearing Devices
  - (q) **Expanded** on negligence/malfeasance exclusion
  - (s) Services/Treatments not accepted as standard practice
  - (t) Reversal of Sterilization
  - (y) Services not actually performed
  - (aa) Weight loss medication
  - (bb) Wilderness Treatment Programs

Part VII Coordination of Benefits (C.O.B.)

Section 2 (m) Hazardous Activities (34):

"(m) An injury or illness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hob-by, or activity is hazardous if it involves, or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Participant's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger, or risk of bodily harm including but not limited to: hang gliding, skydiving, bungee jumping, parasailing, rock climbing, use of explosives, automobile racing, motorcycle racing, aircraft racing, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

Clarified Maximum Plan Payment (36):

"Coordinationmeans that no more than one hundred percent (100%) of the Plan's Maximum Allowable Charge will be reimbursed underthe combined benefits of all plans to which the patient is entitled."

– Section 3: Order of Benefits Determination **36**

Explanation of C.O.B. in opening paragraph:

"Coordination of Benefits (or COB, as it is usually called) operates so that one of the Plans (called the primary plan) will pay its benefits first. The secondary and subsequent plan(s) will pay the balance due to up to 100% of the total Allowable Expenses."

Part X Pharmacy Benefit Network *New Section* 44

Part X, Pharmacy Benefit Network

Section 1, Pharmacy Benefit Network

UABT contracts with a network of independent and chain-store pharmacies which agrees to furnish prescription medications for a set fee schedule. Your use of these pharmacies will limit your expense for prescription medications to a designated co-payment referenced in your Schedule of Prescription Medication Expense Benefits or your Schedule of Medical Expense Benefits. Refer to Part XI, Section 9 for Pharmacy Charges.

Section 2, Panel Pharmacy Services

When you or your eligible dependent chooses to fill a covered prescription for up to a thirty-four (34) day supply at a panel pharmacy, you will pay a designated co-payment and the balance of the cost of the medication will be paid in full by UABT after deductible, if applicable. UABT's Panel Pharmacy Services is designed to provide coverage for generic equivalents, formulary medications and brand medications. (Refer to your Pharmacy Benefit Schedule for details of your pharmacy benefits.

Section 3, Mail Order Pharmacy

When you or your eligible dependent chooses to fill a covered prescription for up to ninety (90) day supply, through UABT's mail order program, you will pay a co-payment to the mail order pharmacy and the balance of the cost of the medication will be paid in full by UABT after deductible, if applicable. The mail order option is designed for maintenance (long-term) prescriptions.

Part X Pharmacy Benefit Network *New Section* 44

Section 4, Specialty Medications

Certain medications used for treating complex health conditions must be obtained through the Specialty Pharmacy Programs. Prescriptions for these types of drugs require a prior authorization. (Call the UABT Member Services Department at 800.223.4590 for assistance).

Section 5, Appeals of Denied/Adverse Benefit Determinations

The PBM shall conduct the first level of internal appeals of denials and/or adverse benefit determinations consistent with your UABT Pharmacy Benefit Schedule of Benefits. The PBM will proved all applicable benefit of rights and appeal notifications to you or your eligible dependent relating to such first level of internal appeals in accordance with the UABT Plan and all applicable federal laws.

To appeal a pharmacy benefit denial or adverse determination, you must submit a written request (letter, emails, etc.) which are reviewed by the PBM Grievance and Appeals Coordinator. Within five (5) days of receipt of your letter, you will be notified that your letter has been received.

The PBM Grievance and Appeals Coordinator reviews the information submitted by you and contacts prescribing provider to obtain any additional documentation necessary for a clinical review. The clinical review is conducted by an independent pharmacist and will be completed within thirty (30) days of receiving the written appeal.

If the PBM Grievance and Appeals Coordinator upholds the denial or adverse benefit determination, you have the right to appeal to UABT pursuant to the Part XV, Section 9.

Part XV Claims for Benefits

Section 1: How to file a Claim for Medical, Prescription Medication, Dental or Vision Benefits **59**

Added language on Assignment of legal rights, added language that proof of incurred expenses may be required, added language that confirmation of eligibility is not a guarantee of benefits AND oral statements do not override Plan provisions, Deleted >$200 Dental X-Ray provision.

"4) The UABT Plan does not allow or recognize "assignment of benefits," which many providers require as a condition of payment. If you sign such an "assignment of benefits," UABT will treat that as your authorization to remit paymentdirectly to your health care provider. UABT will remit payment directly to your provider if you so authorize but the UABT Plan does not permit or recognize any assignment of claims or legal rights of any health care provider to pursue any legal action against UABT."

"6) You or the provider may need to furnish written proof that the expenses were incurred or that the benefit is covered under the Plan. If you or the provider do not provide us with the documentation provided, the claim may be denied."

"7) Confirmation of eligibility or benefit confirmation by a provider does not guarantee payment of benefits. All claims are subject to the provision, limitations and exclusions of the Plan. Oral statements and representations do not override the Plan provisions."

Section 5: Claim Filing Deadlines **60**

Changed filing limit to 12 months.

Section 7: Adverse Benefit Determination (New Section) **60**

An "adverse benefit determination" is any decision by UABT that involves the denial, reduction, or termination of a benefit. ... When UABT makes an adverse benefit determination, UABT will provide adequate notice of the decision."

Part XV Claims for Benefits Cont.

Section 8: Review and Appeal Procedures for Denied Prescription Medication **(New Section) 60**

"If a claim for prescription medication is denied in whole or in part, you have the right to appeal this decision to the UABT Pharmacy Benefit Network (PBN). This appeal process will consist of a full and thorough review and evaluation of the denial of the medication.
If you do not agree with the determination of the PBN, you have the right to request review and appeal through UABT."

Section 9: Review and Appeal Procedures for Denied Medical, Prescription, Dental or Vision **60**

Changed Benefit Administrator to Appeals Committee

Section 13: Appointment of Authorized Representative **61**

Added language that Provider cannot be an authorized representative and for legal proceedings against UABT

"An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative for legal proceedings and other similar matters. Assignment and its limitations under this Plan are described below."

Section 14: Payment of Benefits **62**

Added Assignment of Benefit language

"A medical provider which accepts the Assignment of Benefits does so as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document. (An assignment of benefits does not allow the provider to file legal action against the Trust – any legal action must be filed by the participant.)"

Overview of Regulations

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Overview of the Act

In December 2020, the Consolidated Appropriations Act, 2021 was passed into law and within the Act, the law included the No Surprises Act (NSA). The intent of the law was to protect patients from surprise balance bills in situations where the patient had little or no control over who provided their care.

No Surprises Act

Requirement	Description	Deadline
Mental Health Parity and Addiction Equity Act (MHPAEA) assessment required	Analysis of non-quantitative treatment limitations	2/10/2021
Disclosure of broker and consultant compensation	Amends ERISA Section 408 (B)(2) to require disclosure of compensation.	12/27/2021
No Surprises Act: emergency services	All ER at in-network cost sharing. Providers and facilities are banned from balance billing.	1/1/2022
No Surprises Act: independent dispute resolution	Plans must pay non-participating providers within 30 days or deny payment. Parties may request independent dispute resolution.	1/1/2022
ID card requirement	Plans must include plan deductibles, OOP maximums and consumer assistance contact information (phone number and website) in clear writing on any physical or electronic plan or insurance identification card.	1/1/2022
External review	External review applies to adverse determinations concerning emergency services or air ambulance services covered by the No Surprises Act.	1/1/2022
Notice of continuity of care	Plans must notify individuals who are "continuing care patients" of the right to continue to receive care for up to 90 days after termination of a provider/facility contract. The notice places rules on contract terms in plan rules.	1/1/2022
Provider directory requirements	Plans must create a process to verify the accuracy of their provider databases and update at least every 90 days. If the participant was informed the provider was a participating provider when in fact a non-participating provider, the plan cannot impose higher cost-sharing that would apply for participating provider, and must apply the participating deductible and OOP.	1/1/2022

No Surprises Act

Requirement	Description	Deadline
Group health plan transparency rule for public disclosure	Plans must make public the following information online using three machine-readable files: 1. In-network rates 2. Out-of-network allowed amounts and 3. Prescription drug negotiated rates (enforcement date TBD)	7/1/2022
Price comparison tool required	Plans must offer price comparison guidance by telephone and make available on the public website of the plan or issuer a price comparison tool that allows an enrolled individual to compare the amount of cost-sharing that the individual would be responsible for paying for items and services by a participating provider, by geographic region.	1/1/2023
Group health plan transparency rule for disclosures to participants and beneficiaries	Plans must provide cost-sharing information and rate information that is accurate at the time of the request to participants on a searchable, internet-based, self-service tool; and must provide a notice when the tool is used.	1/1/2023
Reporting on prescription drug costs- "Top 50s reports" and disclosure of rebates	Plans must submit prescription drug cost information to the federal government.	TBD/Maybe 12/27/2022
Provider fee disclosure	When a patient schedules a service, providers must provide a timely notification in clear and understandable language of the good-faith estimate of the expected charges for providing items and services to the plan or insurer (or if uninsured, the individual).	TBD
Advanced Explanation of Benefits disclosure	After receiving notice from a provider/facility of estimated charges, plans must provide the participant an Advanced EOB	TBD

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Beginning with plan years on or after January 1, 2022, the No Surprise Act applies to three service types provided by health care providers and facilities:

1. OON emergency services and supplies
2. OON services / supplies incurred while in an INN facility
3. Air ambulance services and supplies

Emergency Medical Condition Defined

Under the NSA, emergency medical condition has been defined as follows: ..a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that ***a prudent layperson who possesses an average knowledge of health and medicine***, could reasonably expect the absence of immediate medical attention to result in a condition described in EMTALA*, including

(1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(2) serious impairment to bodily functions, or

(3) serious dysfunction of any bodily organ or part. This definition includes mental health conditions and substance abuse disorders.

**EMTALA refers to the Emergency Medical Treatment & Labor Act, 1986*

Balance Bill & Surprise Balance Bill Defined

A balance bill occurs when a person who has health insurance receives treatment or services from a provider and the health insurer/ health plan reimburses this provider based on an allowed amount that is not contractually agreed upon by both parties. This amount is usually less than the total billed charges and the benefit level under the health plan is typically less than the benefit level applied had the member/ patient received care from a contracted provider. The provider can bill the difference between the total billed charges and the plan's reimbursement amount. This is often referred to as a "balance bill". ***When a member unexpectedly received a balance bill from a provider that they have no control over receiving care from, it can result in a "surprise balance bill".***

Note: A Surprise Balance Bill is a Balance Bill, but not all Balance Bills are Surprise Balance Bills. The law protects patients from Surprise Balance Bills under certain circumstances, such as when they unknowingly receive care from a provider that the member had no choice in who provided for their care.

OON Emergency Services and Supplies

Patients cannot be balance billed when seeking emergency services at an OON Emergency facility. Patients are only liable for deductibles and copayment/ coinsurance applicable at the in-network level, and all cost-sharing amounts paid by the patient must accumulate to the in-network deductible and out- of- pocket maximums.

Emergency Service Facilities includes a hospital emergency room, a free-standing emergency department, and urgent care centers, *provided the state licenses urgent care centers to perform emergency services*.

OON Emergency Services may include additional services and supplies provided to the patient as part of a post-stabilization period and are subject to the provisions in the NSA, including prohibiting balance billing the patient.

Post-Stabilization services that are not subject to the NSA include:

- If the attending provider determines that the patient can be moved by non-medical transportation to a participating provider or facility so long as it is located within a reasonable travel distance.
- If the patient receives notice in advance of services that the provider is out of network, along with an estimate of charges and,
- If the patient is in a condition to receive notice and provides consent to receive the services.

OON Services Provided at the InN Facility

Services and Supplies received at an In Network Facility will be covered at the in-network benefit level. Any cost-sharing payments made by the member will apply to the in-network deductibles and/ or out -of- pocket maximums.

Examples of Service Types Include:

- Emergency physician services provided at an INN facility
- Anesthesiology
- Radiology
- Pathology
- Laboratory
- Neonatology
- Assistant Surgeon
- Hospitalist
- Intensive Services

When a Provider Can Balance Bill a Patient

An OON provider at an INN facility may balance bill the patient for **non-ancillary charges** if the patient is given advance notice to the member that the service is OON and the patient is given an estimated cost for the service.

The member must sign an acknowledgement that they received the notice and understand that any cost-sharing will apply to their OON deductible and out of pocket maximums, with the member also being responsible for any balance bill.

NOTE: Ancillary Providers at INN facilities may not balance bill.

Medical Necessity

Any service or supply that are not medically necessary are excluded from the independent review process (IDR). If a service or supply is found not to be medically necessary, the appeal process needs to be followed as outlined in the SPD.

External Review

The Federal External Review has expanded to include any adverse benefit determination related to the NSA.

Air Ambulance Transportation

- Air ambulance transportation is included in the ban on patient balance billing. Providers are prohibited from balance billing patients the amounts over the in- network cost share amount paid by their insurer.
- Currently, the law does not have the same protection for ground ambulance services (it is expected though).
- Air ambulance must still meet medical necessity and appropriateness.
- All coinsurance and/ or deductibles must apply to the patient's in-network deductibles and out of pocket maximums.

Continuation of Care

- Requires that health plans to notify members when a provider leaves the network
- Plan must allow members to request to continue to have benefits provided under their current coverage under the same terms and conditions had the provider not terminated the network
- The timing starts on the date of notice of the right to elect and ends either 90 days later or the date on which the patient is no longer undergoing care

Continuation of Care Includes:

- Serious or Complex Conditions
- Course of institutional or inpatient care
- Scheduled non-elective surgery including post-operative care
- Course of treatment for pregnancy
- Terminally ill patients

Continuation of Care:

- Blue Shield will be notifying impacted members with a letter
- Member must complete a request to determine eligibility
- First Health will not be notifying members
- UnitedAg responsible for identifying and requesting repricing of claims

Open Negotiation Period Defined

For OON NSA claims, once the Plan makes its initial payment (or denial) of a claim and it is received by the provider, the provider may accept the payment or must send an Open Negotiation Notice to the plan within the within 30 business days to begin the Open Negotiation Period.

The Open Negotiation Period is a 30-business day period where the Provider and the payer attempt to settle upon an agreed amount as payment in full.

When a provider or a health plan cannot agree on a final reimbursement amount, the NSA allows for an Independent Dispute Resolution process.

Independent Dispute Resolution Defined

The NSA established an independent dispute resolution process (IDR) when the payer and the provider cannot agree on the payment for services for the specific situations defined above.

The IDR process is sometimes referred to baseball arbitration, whereby the IDR entity (arbitrator) will pick one offer from either the provider or the payer. The party whose offer was not chosen will assume the cost associated with the arbitration/ IDR process.

The arbitrator will start with consideration of the Qualified Payment Amount established by the payer and will take into consideration various other elements/ facts such as patient acuity, market share of the provider and the insurer in the geographic area, teaching status, case mix, and scope of services of the facility, and demonstration of good faith efforts of the provider to participate in the insurer or plan network.

The IDR cannot consider billed charges, provider UCR fees, or Medicare/ Medicaid rates.

No Surprises Act - Key Terms

Timeframes

There are three distinct timeframes under the payment process as defined in the Interim Final Rule that was issued on July 1, 2021.

The three timeframes are as follows:

- Timeframe #1—Initial Payment or Denial
  The payer is required to process/ finalize claims within 30 days of receipt of a claim.
- Timeframe #2 – Open Negotiation Period
  A 30-business day period whereby the provider and payer work to come to a settlement agreement on an accepted payment.
- Timeframe #3 – Federal IDR/ Arbitration Period
  The 4 business-day period beginning the 1st business day after the END of the Open Negotiation Period where either the payer or the provider can choose to take the other party to arbitration.

NOTE: The Open Negotiation Period must have been exhausted before going to arbitration.

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Questions?

January 10, 2022 FAQ

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January 10, 2022 FAQ Issued by DOL, HHS and Treasury

- Coverage for At-Home Over-the-Counter COVID-19 Tests
  - No prescription or order is required.
  - UnitedAg can pay up front and the cost is set at $12 per test (or less if the test actually costs less) or, if UnitedAg can't implement covering up front, then we are required to reimburse 100% of the cost.
  - If UnitedAg sets up a process for participants to obtain the tests through our pharmacy network with no upfront out of pocket cost and they choose to go out of network, UnitedAg only has to reimburse the participant $12 per test.
  - Keep in mind, most of the over-the-counter tests available come in a 2 pack so the cost would be $24.
  - There can be NO copay, deductible, coinsurance, prior auth or any medical management related to the benefit.
  - 8 tests per person on the plan per month are covered for most people. All 8 tests per person can be purchased at once each month.
  - We can choose to apply the 8 per person limitation per 30 days or per calendar month. We have not yet made this determination.
  - If someone has an underlying medical condition requiring more frequent testing, there is no limit. This unlimited benefit does require an order or prescription from a health care provider.

- Colorectal Screening Clarification for Follow-Up Testing
  - If a person has a positive fecal test and has a follow up colonoscopy to determine the extent of abnormalities the follow-up test is covered with no cost sharing.

Contact Information

Jayson Welter, J.D., M.A.
General Counsel and Corporate Secretary
949.593.0184
jwelter@unitedag.org