SUMMARY OF MATERIAL MODIFICATIONS
TO THE
SCHOOL DISTRICT OF SPRING VALLEY
EMPLOYEE BENEFIT PLAN

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the School District of Spring Valley Employee Benefit Plan (the "Plan"). Please review this SMM carefully to familiarize yourself with the changes and please attach this SMM to the front of your SPD.

The Plan is modified effective July 1, 2022 as follows:

1. **Schedule of Benefits** – amended for clarification:

Autism Spectrum Disorder *(therapy services are not subject to visit limitations)*	See specific service as outlined in the Schedule of Benefits *(For example: Physician/Clinic office visit or Therapy Services, et al)*	See specific service as outlined in the Schedule of Benefits *(For example: Physician/Clinic office visit or Therapy Services, et al)*

2. **Schedule of Benefits** – amended the header Emergency Room Services to Emergency Services for clarification due to the No Surprises Act:

Emergency Services Includes facility charge, Physician fee and ancillary services	100% after Deductible

3. **Schedule of Benefits** - removed due to the No Surprises Act:

If you are confined in a non-Preferred Provider facility as a result of an Emergency, you will be eligible for Preferred Provider benefits until your attending Physician agrees it is safe to transfer you to a Preferred Provider facility

4. **Schedule of Benefits** – amended due to HHS Notice of Benefit and Payment Parameters for 2023 and lack of available evidence-based rationale:

Hearing Aids Limited to one aid per ear every 36 months. Also includes cochlear implants.	100% after Deductible	80% after Deductible

5. **Schedule of Benefits** – amended for clarification:

Home Health Care	100% after Deductible	80% after Deductible
Plan Year maximum *(excluding and autism spectrum disorder therapies).*	40 visits	

6. **Schedule of Benefits** - amended for clarification:

Mental/Nervous Disorders and/or Substance Abuse Inpatient Treatment Including Residential Treatment Facility services Intensive Outpatient, Partial Hospitalization services, psychological testing and other therapies Outpatient Treatment	100% after Deductible	80% after Deductible

7. **Schedule of Benefits –** amended for clarification:

Preventive Care Services Preventive services not included under the Affordable Care Act (ACA). • Breast cancer mammography screening coverage is increased to include: a. screenings without age limitations b. digital breast tomosynthesis (DBT/3D mammograms) c. screening mammograms that are converted to a medical diagnosis at the clinical encounter the screening is performed, and any additional mammograms required for clarity	100% Deductible waived	80% after Deductible
• Cervical cancer and dysplasia screening is increased to include screenings without age or frequency limitations	100% Deductible waived	80% after Deductible
• Cholesterol screening coverage is increased to include screenings without age limitations	100% Deductible waived	80% after Deductible
• Diabetes screening coverage is increased to include screenings without age or risk limitations	100% Deductible waived	80% after Deductible
• Prostate-specific antigen (PSA) test	100% Deductible waived	80% after Deductible
• immunizations for the purpose of travel.	100% after Deductible	80% after Deductible

8. **Schedule of Benefits** – amended for clarification:

Temporomandibular Joint Dysfunction (TMJ)	See specific service as outlined in the schedule of benefits *(For example: Physician/Clinic office Visit or Mental/Nervous Disorder Outpatient Treatment)*	See specific service as outlined in the schedule of benefits *(For example: Physician/Clinic office Visit or Mental/Nervous Disorder Outpatient Treatment)*

9. **Schedule of Benefits** – amended for clarification:

Therapy Services	100% after Deductible	80% after Deductible
Plan Year maximum benefit *(excluding autism spectrum disorder therapies)*		
Physical Therapy	20 visits	
Speech Therapy	20 visits	
Occupational Therapy	20 visits	

10. **Utilization Review Program** – amended for clarification:

Pre-Certification Penalty
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to pre-certify the required services as identified above, **the allowed charges will be reduced by 25% up to a maximum of $250.00 per occurrence.** This penalty does not apply to the deductible or maximum out-of-pocket expenses. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

11. **Comprehensive Medical Coverages - Provider Provisions** – amended due to the No Surprises Act:

D. All providers contracted with the PPO Preferred Provider Network as identified on your health benefits identification card or directly with the Plan through BPA/Valenz (including dialysis) will be considered "Preferred Providers". Covered expenses incurred by "Preferred Providers" (hospital or physician) will be covered at a higher rate than "non-Preferred Providers", except as outlined in the "No Surprises Act – Emergency Services and Surprise Bills" provision below.

Additional Preferred Provider Organizations, negotiation services or MultiPlan's Data iSight Solutions (before or after services are rendered) may be utilized in order to optimize coverage and preserve plan assets. When this occurs, the covered charges may be paid at the "Preferred Provider" rate. Please note that providers' status may change between Preferred and Non-Preferred at any time.

12. **Comprehensive Medical Coverages - Provider Provisions –** added due to No Surprises Act:

E. 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 a Preferred Provider and the Participant receives such item or service in reliance on that information, the Participant's coinsurance, Copay, deductible, and out-of-pocket maximum will be calculated as if the provider had been a Preferred Provider despite that information proving inaccurate.

13. **Comprehensive Medical Coverages** – added for clarification due to the No Surprises Act:

NO SURPRISES ACT – EMERGENCY SERVICES AND SURPRISE BILLS

For Non-Preferred Provider 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 Preferred 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 Preferred Provider 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-Preferred Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Preferred Provider air ambulance services.

CONTINUITY OF CARE

In the event a Participant is a continuing care patient receiving a course of treatment from a provider which is a Preferred Provider 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, but in no event later than 7 calendar days 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.

14. **Covered Expenses** – amended for clarification:

F. **Autism.** Charges for the diagnosis and treatment of or in connection with autism spectrum disorder (ASD) which includes autistic disorder, Asperger's syndrome and any pervasive developmental disorder not otherwise specified. Applied behavior analysis (ABA), Occupational, Physical, and Speech Therapy are included for rehabilitative care and care deemed habilitative or non-restorative. Does not include services that are Experimental or Investigational, or otherwise not covered by the Plan.

15. **Covered Expenses** – amended due to HHS Notice of Benefit and Payment Parameters for 2023 and lack of available evidence-based rationale:

I. **Dental Services.** The Plan will cover only these dental services:

3. Hospital and Ambulatory Surgical Center charges, including Anesthesia charges, if you have a chronic Disability or medical condition that requires Hospitalization or general Anesthesia for dental care.

16. **Covered Expenses** – amended for clarification:

J. **Diabetes.** Insulin infusion pumps, other equipment and supplies (which are not covered under the prescription drug program) including blood glucose testing monitors and continuous glucose monitors (CGMs) including sensor, transmitter and receiver and diabetic self-management education programs. One pump is covered per year and the pump must be in use 30 days before purchase. For prescribed drugs, refer to the prescription drug benefit section.

17. **Covered Expenses** – amended due to HHS Notice of Benefit and Payment Parameters for 2023 and lack of available evidence-based rationale:

L. **Hearing Services.** Covered hearing-related services are limited to:

5. hearing aids for a Participant who is certified as deaf or hearing impaired by a Physician or licensed audiologist, but only if the Plan has approved the hearing aid in advance.

A hearing aid is an instrument or device, including related parts, attachments, or accessories, that is worn externally and designed to aid or compensate for impaired hearing. The Plan will cover the examinations, tests, or services for prescribing or fitting a hearing aid or device. The benefit is limited to one hearing aid per ear in each three-year period.

18. **Covered Expenses -** amended for clarification:

M. **Home Health Care**. Eligible charges are covered by the Plan if approved in writing by an attending Physician as follows:

8. each visit by any of the above providers is for up to 4 hours in any 24-hour period and up to a maximum of 40 visits per Plan Year *(excluding autism spectrum disorder therapies).* In no event will more be paid than would have been paid had treatment been provided in a Skilled Nursing Facility during any weekly period.

19. **Covered Expenses** – amended for clarification:

U. Prescription Drugs and Medicines

Exclusions
(For a complete list of exclusions, contact the Pharmacy Benefit Manager shown on your identification card.)

10. blood glucose monitors and continuous glucose monitors (CGM) including sensor, transmitter and receiver.

20. **Covered Expenses –** amended mandated preventive benefits and clarifying language:

V. **Preventive Care services** to comply with the Affordable Care Act (ACA), and in accordance with the recommendations and guidelines, the Plan will provide coverage for:

Preventive Services for Adults

- Bowel preps for use in colorectal cancer screening for adults ages 45 to 75
- Diabetes screening for adults ages 35 to 70 who are overweight or obese
- Preexposure prophylaxis (PrEP) with antiretroviral therapy to persons who are at high risk of HIV. This also includes coverage of associated testing for HIV, Hepatitis B and C, creatinine, pregnancy, and sexually transmitted infection, as well as adherence counseling, and associated office visits.

21. **Charges not covered –** removed the exclusion for Autism Spectrum Disorder Treatment due to mental health parity considerations. All other terms and conditions of the plan document continue to apply.

22. **Charges not covered –** amended for clarification:

17. **Developmental Delays/Recreational/Educational Therapy.** Expenses and services in connection with:

a. developmental delay
b. recreational and educational therapy
c. learning disabilities

d. behavior modification therapy
e. non-medical self-care or self-help training including any diagnostic testing
f. music therapy
g. health club memberships

This exclusion will not apply to expenses related to the diabetic self-management education programs, the initial diagnosis and testing of developmental delays or if the developmental delay is caused by an Illness, disease, Injury or surgery and any pervasive development disorder not otherwise specified.

23. **Charges not covered –** removed due to HHS Notice of Benefit and Payment Parameters for 2023 and lack of available evidence-based rationale:

22. **Hearing Services.** Except as specifically provided in the Plan, following are examples of services that are not covered:

a. batteries and cords.
b. routine hearing exams except as outlined in the the Preventive Care benefit

24. **Definitions** – removed the definition for Legally Employed for it is no longer needed.

25. **Definitions** – amended the following definitions due to the No Surprises Act:

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-Preferred 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-Preferred Provider.

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 claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the section "Comprehensive Medical Coverages,") 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 the above 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.

PREFERRED PROVIDER shall mean the facilities, providers and suppliers who have by contract via a medical provider network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the network's providers have agreed to accept assignment of benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Preferred Provider network (PPO) will be identified on the Participant's identification card. For prescription drugs available through the prescription drug and/or specialty drug program (as applicable), Preferred Provider means the prescription drug card program or specialty drug program and does not include any other network of providers with which the Plan contracts.

26. **Definitions** – added the following due to QMCSO:

ALTERNATE RECIPIENT means any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

NATIONAL MEDICAL SUPPORT NOTICE (NMSN) means a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) means a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible dependent is entitled under this Plan.

27. **Definitions** – added due to the No Surprises Act:

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.

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.

NON-PREFERRED PROVIDER means any provider which does not satisfy the definition of Preferred Provider.

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 means the median of the contracted rates recognized by the Plan or recognized by all plans serviced by the Plan's Claims Administrator (if calculated by the Claims 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 shall mean, except for Non-Preferred Provider 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-Preferred Provider air ambulance services generally, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

28. **General Information** – amended for clarification:

ELIGIBILITY

Employees who were covered by a group health insurance policy of the School District of Spring Valley on August 31, 2011 are eligible for coverage under this Plan under the same terms and conditions as previously applied if they continue to meet the previous eligibility standards.

All Employees of School District of Spring Valley (or an Associated Company included for coverage in the policy contract) are eligible if:

A. they are doing work on a full-time basis;
B. they are not temporary Employees;

29. **General Information** – added for clarification:

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This Plan will provide for immediate enrollment and benefits to the Child or children of a Participant, not including an ex-stepchild or ex-stepchildren, who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or children reside with the Participant, provided the Child or children are not already enrolled as an eligible dependent as described in this Plan. If a QMCSO is issued, then the Child or children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.
To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of "National Medical Support Notice."
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
   a. Whether the Child is covered under the Plan.
   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
   a. Be in writing.
   b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
   c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

30. **Continuation of Coverage** – removed "The American Rescue Plan Act of 2021 related to COVID-19/COBRA" due to the Act expiring on September 30, 2021.

31. **Health Claim Provisions** – **Requirements for First Level Appeal** - removed for clarification:

American Health Holding, Inc.
7400 West Campus Road
New Albany, OH 43054
Phone: (800) 641-3224 ext. 9377063
Fax: (866) 881-9648
Email: AHH_appeals@ahhinc.com

32. **Health Claim Provisions** – amended for clarification:

Requirements for Second Level Appeal
The Claimant must file an appeal regarding a Pre-Service Claim, a Post-Service Claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

33. **Health Claim Provisions – External Review Process** removed due to the No Surprises Act:

External Review Process

A. Scope

1. 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 Participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.
2. The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

   (a) 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; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

and replaced with:

External Review Process

A. Scope

1. 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.
2. The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

   (a) 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.

   (b) 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.

   (c) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time

The Plan is modified effective January 15, 2022 as follows:

34. **Schedule of Benefits** –Prescription Drugs - amended due to COVID-19 Over the Counter (OTC) Testing:

<table>
<tr><td>Prescription Drugs
Generic and Brand Name

2019 Novel Coronavirus (COVID-19) Over the Counter (OTC) Testing
• Maximum quantity limit 8 tests per Participant per 30 days**</td><td>100% after Deductible

100% Deductible waived</td><td>80% after Deductible

100% Deductible waived
Reimbursement for Non-Preferred Providers is limited to $12.00
per OTC test*</td></tr>
<tr><td colspan="3">*If the OTC Test is acquired with the involvement of or prescription by a provider or if the Plan has not arranged for adequate Preferred Provider access, the Plan will reimburse the Participant at full cost.
**This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a provider.</td></tr>
<tr><td colspan="3">For COVID-19 OTC testing reimbursement if you are without your ID card or use a Non-Preferred Provider, you must pay for the prescription and submit a claim to the Prescription Drug Card service.</td></tr>
<tr><td colspan="3">Affordable Care Act (ACA) – Preventive drugs are covered 100%, not subject to Deductible or Copay (Generic and single source Brand only).</td></tr>
<tr><td colspan="3">For all other reimbursements, if you are without your ID card or at a Non-Preferred Provider, you must pay for the prescription and submit a claim to Benefit Plan Administrators to be considered for reimbursement. A completed claim form and the paid receipt must be submitted as proof of claim. If the prescription drug is covered under the Plan, reimbursement will be based on the contracted rate less the applicable deductible/coinsurance. Note that no coverage is available for mail order or specialty drugs from a Non-Preferred Provider.</td></tr>
</table>

35. **Covered Expenses** – amended due to COVID-19 Over the Counter (OTC) Testing:

M. Prescription Drugs and Medicines

Drugs Covered
(For a complete list of covered drugs, contact the Pharmacy Benefit Manager shown on your identification card)

26. **2019 Novel Coronavirus (COVID-19) Over the Counter (OTC) Testing** (quantity limits apply)

Exclusions
(For a complete list of exclusions, contact the Pharmacy Benefit Manager shown on your identification card)

17. **Non-legend drugs.** except for those listed in the Drugs Covered section, except to the extent required by the FFCRA (Families First Coronavirus Response Act), as amended;

22. **Therapeutic devices.** Appliances or devices, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except for those listed in the Drugs Covered section, except to the extent required by the FFCRA (Families First Coronavirus Response Act), as amended;

36. **Covered Expenses** – amended due to COVID-19 Over the Counter (OTC) Testing

Dispensing Limitations
The amount normally prescribed by a Physician but not to exceed a 90-day supply for retail or a 90-day supply for mail order. Specialty drugs will not exceed a 30-day supply regardless of whether they are retail or mail order.

*COVID-19 Over the counter (OTC) tests will not exceed 8 tests per Participant per 30 days. **This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a provider.

37. **Covered Expenses** – added COVID-19 Over the Counter (OTC) Testing to the Diagnostic tests section:

QQ. 2019 Novel Coronavirus (COVID-19). Covered Expenses associated with testing for COVID-19 include the following:

d. Over-the-Counter Tests (OTC Tests). **Refer to prescription drug section for coverage.** The Plan will cover OTC Tests for the detection of SARS-CoV-2 or the virus that causes COVID-19, which satisfy any one of the following conditions:

- that are approved, cleared, or authorized by the FDA (including an emergency authorization);
- for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
- that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
- that are deemed appropriate by the Secretary of Health and Human Services.

o OTC Tests neither require pre-certification nor involve an individualized clinical assessment from a provider. The Plan will cover up to 8 OTC Tests, per Participant per 30 days. This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a provider. OTC Tests purchased from a Preferred Provider are covered by the Plan at the point of sale at 100% deductible waived. When the Plan is billed for a Non-Preferred Provider OTC Test, the Plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and Plan. If the Participant pays for a Non-Preferred Provider OTC Test, the Participant will be limited to reimbursement for the actual out-of-pocket cost of the OTC Test, up to a maximum of $12.00 per OTC Test. If the OTC Test is acquired with the involvement of or prescription by a provider or if the Plan has not arranged for adequate Preferred Provider access, the Plan will reimburse the Participant at full cost.

o The following limitations also apply:

- Coverage will be denied if reasonable evidence exists that the purchase was solely for employment purposes; and

- Coverage will be denied if reasonable evidence exists of fraud, abuse, or that the purchase was made for use by someone other than the Participant or their dependents. NOTE: The Plan may require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC Test, including the UPC code for the OTC Test to verify that the item is one for which coverage is required under FFCRA, and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC Test. Further, the Plan may require a written attestation from the Participant describing the OTC Test, the price paid by the Participant, and the intended use (including for whom the OTC Test will be used).

The Plan is modified effective January 1, 2022 as follows:

38. **Comprehensive Medical Coverages - Provider Provisions –** added for clarification:

D. All providers contracted with the PPO Preferred Provider Network as identified on your health benefits identification card or directly with the Plan through BPA/Valenz (including dialysis) will be considered “Preferred Providers”. Covered expenses incurred by “Preferred Providers” (hospital or physician) will be covered at a higher rate than “non-Preferred Providers”.

Additional Preferred Provider Organizations, negotiation services or MultiPlan’s Data iSight Solutions (before or after services are rendered) may be utilized in order to optimize coverage and preserve Plan assets. When this occurs, the covered charges may be paid at the “Preferred Provider” rate. Please note that providers’ status may change between Preferred and non-Preferred at any time.

The Plan is modified effective July 1, 2021 as follows:

39. **Covered Expenses –** added for clarification:

MM. **2019 Novel Coronavirus (COVID-19).** Covered Expenses associated with testing for COVID-19 include the following:

1. Diagnostic Tests. The following items are covered at 100%, deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require pre-certification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the Provider’s website, or such other amount as may be negotiated by the Provider and Plan.

a. In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
- that are approved, cleared, or authorized by the FDA (including an emergency authorization);