SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #1
TO THE
SARASOTA MEMORIAL HEALTH CARE SYSTEM
HEALTH AND WELLNESS PLAN
GROUP NO. 18095

This Summary of Material Modification and Amendment describes changes to the Sarasota Memorial Health Care System Health and Wellness Plan effective October 1, 2021. These changes are effective as of **October 1, 2022** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

SMH Health Care, Inc. (the "Plan Sponsor") is amending the Sarasota Memorial Health Care System Health and Wellness Plan (the "Plan") as follows:

1. *The list of **Non-Participating Provider Exceptions** under **General Overview of the Plan** is hereby deleted and replaced with the following:*

GENERAL OVERVIEW OF THE PLAN

Non-Participating Provider Exceptions
Unless otherwise described herein, covered services rendered by a Non-Participating Provider are paid at the Participating Provider level (SMH/GCPN Select tier), subject to the Usual and Customary provision of the Plan when a:

(1) Covered Person has an Emergency Medical Condition requiring immediate care.*

(2) Covered Person receives services by a Non-Participating Provider who is under agreement with a Network facility.*

(3) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon when approved by Medical Management.

(4) Covered Person receives lactation consultations from a Non-Participating Provider, except at SMH.

(5) Service not available at a SMH/GCPN provider but available with Aetna CP2 (with prior approval by medical management) will be considered at the SMH/GCPN tier level of benefits.

***NOTE**: In the case of a Surprise Bill for covered services from a Non-Participating Provider who is under agreement with a Network facility and the Covered Person had no control of the Non-Participating Providers participation in their care or when a Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider, the cost share will be based on the median contract rate.

2. *The following **Continuity of Care** section is hereby added under **General Overview of the Plan**:*

GENERAL OVERVIEW OF THE PLAN

Continuity of Care (Keeping a provider you go to now)
You may have to find a new provider when:

(1) The Plan's Network changes and the provider you have now is not in the new Network; or

(2) You are already enrolled in the Plan and your provider stops participating in the Plan's Network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. Routine procedures, minor Illnesses and elective Surgical Procedures generally are not covered under this provision.

Contact the phone number on the back of your identification card to obtain further information on how to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Reimbursement for approved continuity of care will be at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan.

3. *In the **Medical Schedule of Benefits – Basic Plan**, the **Ambulance Service** benefit and the **Genetic Testing** benefit are hereby deleted and replaced with the following:*

MEDICAL SCHEDULE OF BENEFITS – BASIC PLAN

BASIC PLAN	**SMH/GCPN** (For Services Offered and/or Rendered)	**AETNA CPII PROVIDERS*** **(All are required to use the GCPN Select. Can ONLY use the Aetna CPII with prior approval by Medical Management or if an Out-of-Area Dependent Child only)**
Ambulance Services	85% after Deductible	Paid at SMH level of benefits
Genetic Testing	$500 Copay per occurrence, then Deductible, then 80%	$500 Copay per occurrence, then Deductible, then 80%
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		

4. *In the **Medical Schedule of Benefits – Comprehensive Plan**, the **Ambulance Service** benefit, the **Genetic Testing** benefit, the **Morbid Obesity (see Eligible Medical Expenses)** benefit, and the **Wig** benefit are hereby deleted and replaced with the following:*

MEDICAL SCHEDULE OF BENEFITS – COMPREHENSIVE PLAN

COMPREHENSIVE PLAN	**SMH/GCPN** (For Services Offered and/or Rendered)	**AETNA CPII PROVIDERS*** **(All are required to use the GCPN Select. Can ONLY use the Aetna CPII with prior approval by Medical Management or if an Out-of-Area Dependent Child or in a Rural area)**
Ambulance Services	85%	Paid at SMH level of benefits
Genetic Testing	$500 Copay per occurrence, then Deductible, then 80%	$500 Copay per occurrence, then Deductible, then 80%
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		

COMPREHENSIVE PLAN	SMH/GCPN (For Services Offered and/or Rendered)	AETNA CPII PROVIDERS* (All are required to use the GCPN Select. Can ONLY use the Aetna CPII with prior approval by Medical Management or if an Out-of-Area Dependent Child or in a Rural area)
Morbid Obesity (see Eligible Medical Expenses)	$2,000 Copay per procedure, then 85%	80% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Wig (see Eligible Medical Expenses)	85%	80% after Deductible
Maximum Benefit every 2 Years	$500	

5. *In the **Medical Schedule of Benefits – Extended Plan** is hereby deleted and replaced as shown in **Exhibit A.***

6. *The **Prescription Drug Schedule of Benefits – Basic Plan & Comprehensive Plans** is hereby deleted and replaced as shown in **Exhibit B**.*

7. *The **Prescription Drug Schedule of Benefits – Extended Plan** is hereby deleted and replaced as shown in **Exhibit C**.*

8. *In the **Prescription Drug Program** section, the **Copay Max Plus Program (provided by Navitus)** is hereby added as shown below:*

PRESCRIPTION DRUG PROGRAM

Copay Max Plus Program (provided by Navitus)
The Plan works with the Copay Max Plus Program to obtain copay assistance on your behalf. This program applies to certain drugs that have manufacturer-funded copay assistance programs available.

Under the Copay Max Plus Program, if the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, you will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including copay assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your Out-of-Pocket Maximum or Deductible. Instead, only those payments made directly by you will count toward your Out-of-Pocket Maximum or Deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design. Your Copay will default to the formulary's current tiered Copay if a drug does not qualify or is removed from the program.

9. *Number **(24) – Emergency Services** under **Eligible Medical Expenses** is hereby deleted and replaced with the following:*

ELIGIBLE MEDICAL EXPENSES

(24) **Emergency Services/Emergency Room**: When you experience an Emergency Medical Condition, coverage for Emergency Services will continue until your condition is Stabilized and:

(a) Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care; and

(b) You are in a condition to be able to receive from the Non-Participating Provider delivering services the notice and consent criteria with respect to the services; and

(c) Your Non-Participating Provider delivering the services meets the notice and consent criteria with respect to the services.

If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the Medical Schedule of Benefits and the General Exclusions and Limitations for specific Plan details. If your Physician decides you need to stay in the Hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

10. *In the **General Exclusions and Limitations** section, number **(54) – Pain Treatment (Basic Plan Only**) is hereby deleted and not replaced.*

11. *The 3rd paragraph under the **External Review of Adverse Benefit Determinations** section under **Claims Procedures** is hereby deleted and replaced with the following:*

CLAIMS PROCEDURES

External Review of Adverse Benefit Determinations

Note that the federal external review process (including the expedited external review process described later in these procedures) is not available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer;

(1) A rescission of coverage; and

(2) An adverse determination for Surprise Bills (medical and air ambulance bills), including determination of whether an adverse determination is subject to Surprise Bill provisions.

12. *In the **Definitions** section, **Emergency Services** is hereby deleted and replaced as shown below. In addition, **Surprise Bill/Surprise Billing** is added alphabetically, and **Usual and Customary Charge (U&C)** is deleted and replaced as shown below:*

DEFINITIONS

Emergency Services means treatment given in a Hospital’s emergency room for an Emergency Medical Condition. This includes evaluation of, and treatment to Stabilize an Emergency Medical Condition.

Surprise Bill/Surprise Billing happens when people unknowingly get care from providers that are outside of their health Plan's Network and can happen for both emergency and non-emergency care.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan's Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

(1) The duration and complexity of a service;

(2) Whether multiple procedures are billed at the same time, but no additional overhead is required;

(3) Whether an Assistant Surgeon is involved and necessary for the service;

(4) If follow up care is included;

(5) Whether there are any other characteristics that may modify or make a particular service unique; and

(6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

The Usual and Customary Charge for covered services will be based on the median contract rate when a Covered Person had no control over the services performed by a Non-Participating provider who is under agreement with a Network facility or when the Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider.

All other provisions of this Plan shall remain unchanged.