SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #6
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, 2025** 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 following **Utilization Management Standards** subsection is hereby added under the **Medical Management Program** section as shown below:*

MEDICAL MANAGEMENT PROGRAM

Utilization Management Standards
Utilization review consists of targeted interventions designed to assist with the coordination of care across the continuum for covered persons. Under the supervision of a medical director, utilization review determines whether a service is medically necessary and a covered benefit according to the covered person's specific plan design. Compliance with utilization management requirements is mandatory for all providers delivering services to covered persons.

(1) Coverage Determination Principles
All coverage denial decisions for covered persons are made by Gulf Coast Medical Management medical directors.

(2) Utilization Management Guidelines
Gulf Coast Medical Management staff utilize evidence-based clinical guidelines to guide utilization review and decision-making. Clinical data submitted by providers is reviewed using recognized standards, including but not limited to:

- MCG Care Guidelines
- Aetna Clinical Policy Bulletins (CPB)
- Aetna Pharmacy Clinical Criteria
- National Comprehensive Cancer Network (NCCN) Guidelines

2. *The **Nutritional Counseling** and **Telemedicine** benefits in the **Medical Schedule of Benefits – Basic Plan** are hereby deleted and replaced with the following:*

MEDICAL SCHEDULE OF BENEFITS – BASIC PLAN

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
Nutritional Counseling	$35 Copay, then 100%; Deductible waived GCPN Select: Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision. Nutritional counseling related to the treatment of a Mental Disorder or Substance Use Disorder is payable at 100%; Deductible waived for all Participating Providers.	
Telemedicine	
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*
***Note:** The following Virtual Behavioral Health providers are covered at tier 1 without prior approval: Telemynd, Rula, Tava, and Equip Health.	
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)

3. *The **Nutritional Counseling** and **Telemedicine** benefits in the **Medical Schedule of Benefits – Comprehensive Plan** are hereby deleted and replaced with the following:*

MEDICAL SCHEDULE OF BENEFITS – COMPREHENSIVE PLAN

BENEFIT DESCRIPTION	SMH/GCPN SELECT (For Services Offered and/or Rendered)
Nutritional Counseling	$35 Copay, then 100% GCPN Select: Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision. Nutritional counseling related to the treatment of a Mental Disorder or Substance Use Disorder is payable at 100%; Deductible waived for all Participating Providers.	
Telemedicine	
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*
***Note:** The following Virtual Behavioral Health providers are covered at tier 1 without prior approval: Telemynd, Rula, Tava, and Equip Health.	
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)

4. *The **Genetic Testing**, **Nutritional Counseling** and **Telemedicine** benefits in the **Medical Schedule of Benefits – Extended Plan** are hereby deleted and replaced with the following:*

MEDICAL SCHEDULE OF BENEFITS – EXTENDED PLAN

EXTENDED PLAN	TIER 1: SMH/GCPN SELECT (For Services Offered and/or Rendered)	TIER 2: AETNA CPII PROVIDERS	TIER 3: NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
MEDICAL BENEFITS			
Genetic Testing	$500 Copay per occurrence, then 85%	70% after Deductible	Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.			
Nutritional Counseling			
Nutritional counseling related to the treatment of a Mental Disorder or Substance Use Disorder	100%	$50 Copay, then 100%; Deductible waived (No Copay applies only to the first Plan Year evaluation performed by MD, PA, or APRN)	40% after Deductible
All Other Nutritional Counseling	$35 Copay, then 100% GCPN Select: Not Covered	Not Covered	Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.			
Telemedicine			
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders*
***Note:** The following Virtual Behavioral Health providers are covered at tier 1 without prior approval: Telemynd, Rula, Tava, and Equip Health.			
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)

5. *Under **the Eligible Medical Expenses** section, numbers **(26) – Genetic Testing for Hereditary Cancer Syndrome**, **(35) – Maternity** and **(39) – Nutritional Counseling** are hereby deleted and replaced as shown below; In addition, the following **Genetic Testing** benefit is hereby added alphabetically as shown below:*

ELIGIBLE MEDICAL EXPENSES

(26) **Genetic Education, Counseling, and Testing for Hereditary Cancer:** Genetic education, counseling, and testing for hereditary cancer are covered benefits only when provided through SMH Cancer Institute Hereditary Cancer and Genetic Testing office. All Covered Persons must receive these services though SMH Cancer Institute Hereditary Cancer and Genetic Testing office and be seen by board-certified genetic counselors affiliated with SMH Cancer Institute Hereditary Cancer and Genetic Testing office. Genetic testing for hereditary cancer is considered a covered benefit only if:

It is determined to be Medically Necessary, and

It is ordered by provider within SMH Cancer Institute Hereditary Cancer and Genetic Testing office. Genetic education, counseling, and testing for hereditary cancer are not covered if they performed through SMH Cancer Institute Hereditary Cancer and Genetic Testing office.

For more information, covered persons may contact SMH Cancer Institute for Hereditary Cancer and Genetic Testing office at (941) 262-7570.

Genetic education, counseling, and testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(#) **Genetic Testing:** Genetic testing is covered benefit when it is Medically Necessary to establish a diagnosis of inheritable disease. The testing must be Medically Necessary and not considered Experimental and/or Investigational, or unproven. Coverage is provided for eligible expenses related to covered genetic testing services as shown in the schedule of benefits or included under the preventative services benefits.

(a) Genetic testing must be Medically Necessary, and the results will directly impact or influence the treatment or management of the covered person's disease.

(b) The Covered Person must display clinical features of the condition or be at direct risk of inheriting the mutation in question.

(c) The Covered Person meets defined criteria that places him or her at high genetic risk for the condition.

(d) The test must be performed by CLIA-certified laboratory.

(e) Genetic testing must be performed by an Participating Provider.

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

(35) **Maternity:** Expenses Incurred by all Covered Persons for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center

(d) Amniocentesis testing when Medically Necessary.

(e) Up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary).

(f) When not prohibited by state or local laws, elective induced abortions when the pregnancy is the result of documented rape or incest, when carrying the fetus to full term would seriously endanger the life of the mother, or if due to fatal fetal abnormality.

If complications arise after the performance of any abortion for any Covered Person, any expenses Incurred to treat those complications will be eligible, whether the abortion was eligible or not.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

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

(39) **Nutritional Counseling:** Services related to nutritional counseling for medical and mental health conditions (e.g., eating disorders such as bulimia and anorexia, diabetes mellitus, gastro-intestinal disorders, chronic obstructive pulmonary disease), in which dietary adjustment has a therapeutic role, when furnished by a provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) recognized under the Plan. Medically Necessary nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

All other provisions of this Plan shall remain unchanged.