SUMMARY OF MATERIAL MODIFICATION (SMM)
TO THE
SYRACUSE CITY SCHOOL DISTRICT HEALTH BENEFITS PLAN
HDHP OPTION

This document is intended to notify you of important plan changes to the HDHP Option of the Syracuse City School District Health Benefits Plan (the "Plan") to clarify the intent and continued intent of certain provisions under the Plan and to make certain other changes as described herein, effective as of July 1, 2022 (unless otherwise stated herein). This SMM supplements the July 1, 2019 Syracuse City School District Health Benefits Plan-HDHP Option Summary Plan Description ("SPD").

1. The Prescription Drug Benefits and Medical Benefits provisions of the ***"Allowed Amount"*** definition under the ***"Definitions"*** section of the SPD are deleted and replaced with the following:

   Allowed Amount. The Allowed Amount means the maximum amount the Plan will pay for the services or supplies Covered under this Plan, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. The Allowed Amount is determined as follows:

   Prescription Drug Benefits. The Allowed Amount for Prescription Drug benefits under the Plan from a Participating Pharmacy is the Prescription Drug Cost before any applicable Coinsurance, Copayment and Deductible Amounts are subtracted. To the extent the Allowed Amount is less than your Copayment, you will pay the Allowed Amount.

   Medical Benefits. The Allowed Amount for Participating Providers will be determined as follows:

   (1) **Participating Facilities in the Service Area**.
   For a participating Facility in the Service Area, the Allowed Amount will be the amount the Plan has negotiated with the Facility.

   (2) **Participating Facilities Outside the Service Area.**
   For a participating Facility outside the Service Area, the Allowed Amount will be the amount the Plan has negotiated with the Facility or the amount approved by another Blue Cross and/or Blue Shield plan.

   (3) **For All Other Participating Providers in the Service Area**.
   For all other Participating Providers in the Service Area, the Allowed Amount will be the amount the Plan has negotiated with the Participating Provider.

(4) **For All Other Participating Providers Outside the Service Area.**
For all other Participating Providers outside the Service Area, the Allowed Amount will be the amount the Plan has negotiated with the Participating Provider or the amount approved by another Blue Cross and/or Blue Shield plan.

When the Participating Provider's charge is less than the amount the Plan has negotiated with the Participating Provider, the Covered Person's Copayment, Deductible or Coinsurance amount will be based on the Participating Provider's charge.

The Plan's payments to Participating Providers may include financial incentives to help improve the quality or coordination of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to you. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

The Allowed Amount for Non-Participating Providers will be determined as follows:

(1) **Facilities in the Service Area.**
For Facilities in the Service Area, the Allowed Amount will be 150% of the Centers for Medicare and Medicaid Services Prospective Payment System ("CMSPS") amount unadjusted for geographic locality, or the Facility's charge, if less.

If the Plan is unable to price the services at the CMSPS rate because of insufficient claims data or there is no CMSPS rate, the Allowed Amount will be 80% of the average amount the Plan has negotiated with Facilities that are Participating Providers of the same type as the non-participating Facility ("Average Amount") or the Facility's charge, if less.

If there is no Average Amount as described above, the Allowed Amount will be the Facility's charge.

(2) **Facilities outside the Service Area.**
For Facilities outside the Service Area, the Allowed Amount will be the average amount negotiated with participating Facilities that are of the same type as the non-participating Facility ("Average Amount"), or the Facility's charge, if less.

If there is no Average Amount, as described above, the Allowed Amount will be the Facility's charge.

(3) **For all other Non-Participating Providers in the Service Area.**
For all other Non-Participating Providers in the Service Area, the Allowed Amount will be the 90th percentile of the Usual, Customary and Reasonable ("UCR") rate or charge, as supplied by Fair Health, or the Non-Participating Provider's charge, if less.

If there is no UCR amount as described above, the Allowed Amount will be 75% of the Non-Participating Providers charge.

(4) **For all other Non-Participating Providers Outside the Service Area.**
For all other Non-Participating Providers outside the Service Area, the Allowed Amount will be the 90th percentile of the Usual, Customary and Reasonable ("UCR") rate or charge, as supplied by Fair Health, or the Non-Participating Provider's charge, if less.

If there is no UCR amount as described above, the Allowed Amount will be 75% of the Non-Participating Providers charge.

(5) **Ground Ambulance.** The Allowed Amount for a Non-Participating Provider for ground ambulance will be the Non-Participating Provider's charge.

(6) **Air Ambulance.** The Allowed Amount for a Non-Participating Provider for air ambulance will be 500% of the Centers for Medicare and Medicaid Services Prospective Payment System ("CMSPS") amount unadjusted for geographic locality, or Non-Participating Provider's charge, if less.

(7) **Surprise Bills.** The Allowed Amount for surprise bills for a Non-Participating Provider will be the lesser of the Non-Participating Provider's charge or the "qualifying payment amount". Please refer to the section entitled "Protection from Surprise Bills" for what constitutes a surprise bill and for how the "qualifying payment amount" is determined.

(8) **In Vitro Diagnostic Test for the Detection of SARS-CoV-2.** Effective as of March 13, 2020, the Allowed Amount for a Non-Participating Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the Non-Participating Provider's publicly listed price for such test, or such lower rate as the Claims Administrator may negotiate with the Non-Participating Provider.

(9) **Physician-Administered Pharmaceuticals.**
For Physician-administered pharmaceuticals, the Plan uses methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or Average Wholesale Price for the pharmaceuticals. These methodologies are currently created by the Plan

and reviewed on a periodic basis to ensure the appropriate payment methodology is assigned to all drugs. Pricing resources can include references such as IPD Analytics, Medispan, First Data Bank, or Thomson Reuters (published in its Red Book).

The Non-Participating Provider's actual charge may exceed the Allowed Amount. For anything other than surprise bills, you must pay the difference between the Allowed Amount and the Non-Participating Provider's charge. Please refer to the section entitled "Protection from Surprise Bills" for what constitutes a surprise bill. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

The Plan reserves the right to negotiate a lower rate (other than with respect to surprise bills) with Non-Participating Providers or to pay a Blue Cross and/or Blue Shield host plan's rate, if lower.

2. The ***"Failure to Seek Preauthorization"*** subsection under the ***"Medical Necessity and Preauthorization"*** section of the SPD is amended to read as follows:

Failure to Seek Preauthorization. If your Participating Provider in the Service Area fails to seek Preauthorization for the Services described in paragraph (3) above, other than with respect to any Services received due to an Emergency Condition, the Plan will not provide any coverage for those services; however, you will be held harmless and not subject to any penalties. If you fail to seek Preauthorization for Services rendered by a Participating Provider outside the Service Area (other than a Participating Provider inpatient Facility that is outside the Service Area) or a Non-Participating Provider, no penalty will apply. The Plan will pay the amount specified above only if it is determined that the Services were Medically Necessary. If it is determined that Services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

3. The ***"Utilization Review and Medical Management"*** section of the SPD is amended to add a ***"Case Management"*** subsection to read as indicated below. As such, the ***"Utilization Review and Medical Management"*** section of the SPD has been changed to ***"Utilization Review, Medical Management and Case Management"***.

UTILIZATION REVIEW, MEDICAL MANAGEMENT AND CASE MANAGEMENT

Case Management Program.
The case management program ("Program") under the Plan helps coordinate services for a Covered Person with health care needs due to a serious, complex, and/or a chronic health condition. The Program coordinates benefits and educates a Covered Person who agrees to take part in the Program to help meet their health-related needs.

Participation in the Program is confidential and voluntary. The Program is given at no extra cost to you and do not change Covered Services. If you meet Program criteria and agree to take part, the Program helps you meet your identified health care needs. This is reached through contact and teamwork with you and/or your authorized representative, treating Health Care Professional(s), Physician(s), and other Provider(s) of Additional Health Services. In addition, the Program may assist in coordinating care with existing community-based programs and services to meet your needs, which may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care through the Program that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the benefit maximums listed in the Schedule of Benefits. The Plan will make a decision on alternate care or extend benefits on a case-by-case basis if it determines that the alternate or extended benefit is in the best interest of you and the Plan.

The Plan's decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Covered Person. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Plan will notify you or your representative in writing. Nothing in this provision shall prevent you from appealing the Plan's decision. Please see the Claim and Appeal Procedures section of this SPD for instructions on how to appeal the Plan's decision.

4. The ***"Transitional Care"*** section of the SPD is amended to add an ***"Access to Care"*** subsection to read as indicated below. As such, the ***"Transitional Care"*** section of the SPD has been changed to ***"Access to Care and Transitional Care"***.

ACCESS TO CARE AND TRANSITIONAL CARE

Access to Care.
If the Plan does not have a Participating Provider that has the appropriate training and experience to treat your condition, the Plan will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider or you must request prior approval from the Medical Claims Administrator of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of you or another treating provider and may not necessarily be to the specific Non-Participating Provider you requested. If the Plan approves the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by the Plan in consultation with your PCP, the Non-Participating Provider and you. Covered Services rendered by the Non-Participating Provider will be

Covered as if they were provided by a Participating Provider. You will be responsible only for any applicable Participating Provider Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered at the Non-Participating Provider benefit level, if available.

5. The ***"Human and Organ Bone Marrow Transplants"*** section of the SPD is deleted and replaced with the following:

TRANSPLANTS

Transplants. The Plan Covers only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants.

All transplants must be prescribed by your Specialist(s). Additionally, all transplants must be performed at Hospitals that are specifically approved and designated to perform these procedures.

The Plan Covers the Hospital and medical expenses of the Covered Person-recipient, including any Hospital and medical expenses required by you when you serve as an organ donor if the recipient is a Covered Person. This includes organ procurement, pre-transplant and post-transplant services.

The Plan also Covers pre-transplant and post-transplant services required by a non-Covered Person acting as a donor for you, only when such non-Covered Person does not have other coverage. Post-transplant services are limited to 90 days after the surgical procedure for the donor.

The Plan does not Cover: travel expenses, lodging, meals, or other accommodations for you, a donor or guest; donor search, screening or fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

If you have questions about these Plan changes, this SMM, or your SPD, please contact the Plan Administrator.