SUMMARY OF MATERIAL MODIFICATION (SMM)
TO THE
ONPOINT PRE-65 RETIREE OPTION
UNDER THE
ONONDAGA COUNTY MEDICAL BENEFITS PLAN

This document is intended to notify you of important plan changes to the OnPoint Pre-65 Retiree Option under the Onondaga County Medical Benefits Plan (the "Benefit Plan") to clarify the intent and continued intent of certain provisions under the Benefit Plan and to make certain other changes as described herein, effective as of January 1, 2023 (unless otherwise stated herein). This SMM supplements the January 1, 2018 OnPoint Pre-65 Retiree Option under the Onondaga County Medical Benefits Plan booklet ("Booklet").

1. The ***"Allowable Expense"*** definition under ***"Introduction and Definitions"*** section of the Booklet is deleted and replaced with the following:

   Allowable Expense. The Allowable Expense means the maximum amount the Benefit Plan will pay for the services or supplies covered under the Benefit Plan, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. The Allowable Expense is determined as follows:

   The Allowable Expense for Participating Providers will be determined as follows:

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

   (2) **Participating Facilities Outside the Service Area.**
   For a participating Facility outside the Service Area, the Allowable Expense will be the amount the Benefit 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 Allowable Expense will be the amount the Benefit 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 Allowable Expense will be the amount the Benefit 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 Benefit 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 Benefit 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 Allowable Expense for Non-Participating Providers will be determined as follows:

(1) **Facilities in the Service Area.**
For Facilities in the Service Area, the Allowable Expense will be 80% 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 there is no CMSPS amount, as described above, the Allowable Expense will be 75% of the Facility's charge.

(2) **Facilities outside the Service Area.**
For Facilities outside the Service Area, the Allowable Expense 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 there is no CMSPS amount, as described above, the Allowable Expense will be 75% of 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 Allowable Expense will be 80% of the Centers for Medicare and Medicaid Services Provider ("CMMSP") fee schedule, as applicable to the provider type unadjusted for geographic locality, or the Non-Participating Providers charge, if less.

If there is no CMMSP amount as described above, the Allowable Expense 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 Allowable Expense will be 150% of the Centers for Medicare and Medicaid Services Provider ("CMMSP") fee schedule, as applicable to the provider type unadjusted for geographic locality, or the Non-Participating Providers charge, if less.

If there is no CMMSP amount, as described above, the Allowable Expense will be 75% of the Non-Participating Providers charge.

(5) **Surprise Bills.** The Allowable Expense 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.

(6) **In Vitro Diagnostic Test for the Detection of SARS-CoV-2.** Effective as of March 13, 2020, the Allowable Expense 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.

(7) **Physician-Administered Pharmaceuticals.** For Physician-administered pharmaceuticals, the Benefit 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 Benefit 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 Allowable Expense is not based on UCR. The Non-Participating Provider's actual charge may exceed the Allowable Expense. For anything other than surprise bills, you must pay the difference between the Allowable Expense 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 Benefit 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 definition of ***"Medical Necessity"*** *under the* ***"Introduction and Definitions"*** section of the Booklet is renamed to ***"Medical Necessity or Medically Necessary"***.

3. The ***"Failure to Seek Approval"*** subsection under the ***"Medical Necessity and Prior Approval"*** section of the Booklet is amended to read as follows:

   Failure to Seek Approval. 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 Benefit 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 Benefit 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.

4. A **"*Case Management Program"*** subsection is added to the ***"Medical Necessity and Prior Approval"*** section of the Booklet to read as follows:

   Case Management Program.
   The case management program ("Program") under the Benefit Plan helps coordinate services for a Member with health care needs due to a serious, complex, and/or a chronic health condition. The Program coordinates benefits and educates a Member 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 team work 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 Benefit Plan may provide benefits for alternate care through the Program that is not listed as a covered service. The Benefit Plan may also extend covered services beyond any maximums listed in this Booklet. The Benefit 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 Benefit Plan.

The Benefit Plan's decision to provide extended benefits or approve alternate care in one case does not obligate the Benefit Plan to provide the same benefits again to you or to any other Member. The Benefit Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Benefit Plan will notify you or your representative in writing. Nothing in this provision shall prevent you from appealing the Benefit Plan's decision. Please see the Grievance Procedures subsection of the General Provisions section of this Booklet.

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

ACCESS TO CARE AND TRANSITIONAL CARE

Access to Care.
If the Benefit Plan does not have a Participating Provider that has the appropriate training and experience to treat your condition, the Benefit Plan will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider or you must request prior approval from the 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 Benefit Plan approves the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by the Benefit Plan in consultation with your primary care physician, 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.

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

TRANSPLANTS

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

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

The Benefit 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.

7. Effective as of January 1, 2022, a new definition of **"*Independent Freestanding Emergency Department*"** is added, alphabetically, to the "***Introduction and Definitions***" section of the Booklet to read as follows:

DEFINITIONS

Independent Freestanding Emergency Department: A health care facility that provides Emergency Services and is geographically separate and distinct and licensed separately from a Hospital under applicable State law.

8. Effective as of January 1, 2022, a new section, entitled "***Protection from Surprise Bills***", is added to the Booklet to read as follows:

PROTECTION FROM SURPRISE BILLS

A surprise bill is a bill you receive for covered services in the following circumstances:

(1) Emergency Services performed by a Non-Participating Provider with respect to an Emergency Condition;
(2) Air ambulance services performed by a Non-Participating Provider; and
(3) For certain non-Emergency Services performed by a Non-Participating Provider at a participating Hospital, ambulatory surgical center and Independent Free Standing Emergency Department .

There are special reimbursement rules that apply to surprise bills when determining the Benefit Plan's payment to the Non-Participating Provider. These special reimbursement rules will always apply to the following covered non-Emergency Services when performed by a Non-Participating Provider at a participating Hospital, ambulatory surgical center and Independent Free Standing Emergency Department:

(1) Covered services performed by a Non-Participating Provider when a Participating Provider is unavailable at the time the health care services are performed at the participating Hospital, ambulatory surgical center and Independent Free Standing Emergency Department;
(2) Covered services performed by a Non-Participating Provider as a result of unforeseen, urgent medical issues that arise at the time such services are performed, even if you previously consented to the Non-Participating Provider performing such services;
(3) Covered services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
(4) Covered services provided by assistant surgeons, hospitalists and intensivists; and
(5) Diagnostic services, including radiology and laboratory services.

A surprise bill does not include a bill for health care services when a Participating Provider is available and you elected to receive services from a Non-Participating Provider or, with respect to non-Emergency Services (other than those specified above) performed by a Non-Participating Provider in a participating Hospital, ambulatory surgical center and Independent Free Standing Emergency Department if the Non-Participating Provider has obtained your consent to receive the services after providing you with required notice and satisfying all other consent requirements applicable to the Non-Participating Provider. If the Non-Participating Provider follows the notice and consent requirements and you consent to receiving the services, the Benefit Plan's normal reimbursement rules with respect to Non-Participating Provider's will apply with regard to those services and you may be balance billed. Please see the definition of Allowable Expense with respect to the Benefit Plan's normal reimbursement rules.

For any surprise bills, the Benefit Plan will reimburse the Non-Participating Provider an initial payment equal to the Recognized Amount. You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed your Cost-Sharing (i.e. Copayment, Deductible or Coinsurance) for Participating Providers. Your Cost-Sharing will be calculated based off of the Recognized Amount and will count towards your Participating Provider Deductible, if any, and your Participating Provider Out-of-Pocket Limit.

For purposes of this section, the Recognized Amount means the lesser of billed charges or the "qualifying payment amount." The "qualifying payment amount" is

the amount determined by the Benefit Plan in accordance with the requirements of 26 CFR 54.9816-6T.

The provisions specified in this section and elsewhere in this amendment/SMM are designed to comply with the group health plan requirements of the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021 (the "No Surprises Act"). The provisions are based on regulations published by the U.S. Department of the Treasury, Department of Labor, and Department of Health and Human Services (the "Departments") and will be interpreted to be consistent with those regulations. If the Departments issue additional guidance regarding the requirements of the No Surprises Act, the Benefit Plan will comply with the additional or modified requirements as required by such guidance.

9. An ***"External Review"*** section is added to read as follows:

External Review

You have the right to an "external review" of certain coverage determinations made by the Benefit Plan. An external review is a request for an independent review of a coverage determination by a third party known as an Independent Review Organization (IRO). IROs must be accredited by a nationally recognized accrediting organization and must be assigned to review appeals pursuant to independent, unbiased selection methods. "Requested service" or "requested services" refers to the service or services for which you are requesting coverage. You may request an external review only if the requested service is covered by the Benefit Plan.

You may have the right to an expedited external review if the timeframe for completion of an expedited internal appeal or a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function. Also, you have the right to an expedited external review in connection with final adverse determinations concerning an admission, availability of care, continued stays, or health care services for which you received Emergency Services, but have not been discharged from a Facility. The timeframes for determining expedited external reviews are shorter than the timeframes for standard external reviews.

Coverage Determinations Subject to External Review. This subparagraph describes the general conditions for external review.

In general, you may not request an external review unless the Benefit Plan has issued a "final adverse determination" of your request for coverage through the internal appeal process. However, if you qualify for an expedited external review, you may also file an expedited external review at the same time as filing an expedited internal appeal. You are also eligible for an external review if both parties have agreed to an external review even though you have not obtained a final adverse determination.

To be eligible for external review, the final adverse determination issued through the first level of the internal appeal process must be a determination involving consideration of whether the Benefit Plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act (See the section of this document entitled **Protection from Surprise Bills**).

Requesting an External Review. If you meet the conditions described above, you or your authorized representative may request an external review by completing and filing a self-insured external review request form with the Benefit Plan. The Benefit Plan will send the external review application to you with the notice of final adverse determination. You or your authorized representative will have the opportunity to submit additional information on the requested service; and you may be required to authorize the release of any medical records needed to reach a decision on the external review.

You must file your request for an external review with the Claims Administrator within four months of receiving a final adverse determination.

Upon receipt of a request for an external review, the Benefit Plan must determine if the request meets the requirements for external review and will notify you of its eligibility determination. Upon a determination that the request is eligible for external review, the Benefit Plan will assign the appeal to an IRO for review.

Effect of External Review Determination
A determination on external review is binding on the Benefit Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Benefit Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Benefit Plan to provide benefits or payment on a claim, the Benefit Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Benefit Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Questions. If you do not understand any part of the external review process or if you have questions regarding your right to external review, you may contact the Employee Benefits Security Administration at 1-866-444-3272.

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