NCOT Mohawk Board of Education Non-Grandfathered Employee Benefit Plan

PLAN AMENDMENT AND SUMMARY OF MATERIAL MODIFICATIONS

This Amendment amends your employee benefit plan (Plan) and becomes a part of your Plan as of January 1, 2024. Please place this Amendment with your Plan Document/Summary Plan Description for future reference.

1. **The Medical and Prescription Drug Schedules of Benefits for TIER 3 is renamed to the "PPO Plan". Any reference in the Plan to "Tier 3" is amended to state "PPO Plan". The benefits will remain as currently written.**

2. **The Medical Schedule of Benefits for TIER 4 is amended as follows:**

   a. **The name of the Plan is amended to the: "High Deductible Health Plan". Any reference in the Plan to "Tier 4" is amended to state "High Deductible Health Plan".**

   b. **The Medical Schedule of Benefits is amended in its entirety as follows:**

SCHEDULE OF BENEFITS- HIGH DEDUCTIBLE HEALTH PLAN
COMPREHENSIVE MAJOR MEDICAL BENEFITS

Precertification Review: Precertification review is required for all inpatient Hospital Confinements. For elective stays, certification is required at least 24 hours prior to admission. No precertification is required for Emergency Services. If a Hospital Confinement is needed for an Emergency Medical Condition, you or your authorized representative must notify the Claims Administrator within 48 hours following admission.

Failure to follow the precertification review procedure, as required, may reduce reimbursement received from the Plan.

All benefits will be based upon Allowed Amount

Overall Maximum Amount Payable per Individual.....Unlimited

Network (PPO Network Providers)

Calendar Year Deductible:
- Per Individual.....$3,200.00
- Per Family.....$6,400.00

After the Deductible is met, then 100% payment on eligible charges thereafter for that Individual for the remainder of that Calendar Year.

Out-of-Pocket Maximum per Calendar Year (including any applicable Deductible and Coinsurance):
- Per Individual.....$3,200.00
- Per Family.....$6,400.00

Non-Network (Non-PPO Network Providers)

Calendar Year Deductible:
- Per Individual.....$6,000.00
- Per Family.....$12,000.00

After the Deductible is met, all eligible charges will be paid at 60% until the Out-of-Pocket Maximum has been satisfied.

Then: 100% payment on eligible charges thereafter for that Individual for the remainder of that Calendar Year.

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Out-of-Pocket Maximum per Calendar Year (including the Deductible and Coinsurance):
Per Individual.....Unlimited
Per Family.....Unlimited

Deductibles and Out-of-Pocket Maximums do not cross apply

COVERED SERVICES- HIGH DEDUCTIBLE HEALTH PLAN

Subject to Deductible unless otherwise stated:	**Percentage Payable Network**	**Non-Network**
Inpatient Maximum Daily Semi-Private Room Charge	100%	60%
Private Room Rate (The Hospital's average semi-private room rate)	100%	60%
Special Care Unit (ICU & CCU)	100%	60%
Inpatient Miscellaneous Charges	100%	60%
Inpatient Physicians Visits	100%	60%
Newborn Care	100%	60%
Preadmission Testing	100%	60%
Diagnostic X-ray and Lab/Medical tests	100%	60%
Consultation Expenses	100%	60%
Surgical Expense Benefits (including oral)	100%	60%
Abortions (spontaneous miscarriages and therapeutic only)	100%	Not Covered
Second Surgical Opinion	100%	60%
Outpatient Surgery	100%	60%
Durable Medical Equipment	100%	60%
Anesthesia	100%	60%
Ambulance Services	100%	60%
Urgent Care (includes facility)	100%	60%
Use of an Emergency Room (Emergency or Non-Emergency)	100%	
Emergency Room Ancillaries/Physician	100%	
Physician/Specialists Office Visits (Injury/Illness) Including Scheduled Telehealth Services.	100%	60%
Office Related Diagnostic Charges (X-Ray, Lab and Injections)	100%	60%
On-Demand, Virtual Telehealth Services	100%	60%
Allergy Testing/Treatment	100%	60%
Medically Necessary Immunizations (not required by PPACA)	100%	60%

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COVERED SERVICES- HIGH DEDUCTIBLE HEALTH PLAN

Subject to Deductible unless otherwise stated:	Percentage Payable Network	Non-Network
Health Care Reform Preventive Benefits	100% no Deductible	Not Covered
Women's Preventive Health Benefits	100% no Deductible	Not Covered
Family Planning Exam (ages 21 and over)	100% no Deductible	Not Covered
Preventive/Routine Immunizations (required by PPACA)	100% no Deductible	Not Covered
Physical Exam (ages 21 and over)	100% no Deductible	Not Covered
Colorectal cancer screenings, including colonoscopy, sigmoidoscopy and fecal occult blood test ages 40 through 75	100% no Deductible	Not Covered
Mammogram (all ages: 1 per Calendar Year)	100% no Deductible	Not Covered
Supplemental Breast Cancer Screening	Benefits are paid based on the services rendered	
Pap Test (all ages: 1 per Calendar Year; includes GYN exam)	100% no Deductible	Not Covered
PSA Test/Prostate Exam (all ages: 1 per Calendar Year)	100% no Deductible	Not Covered
Well Child Benefit (Birth to age 21) Including, but not limited to: exams, immunizations, hearing exams, vision exams (including refractions) and labs	100% no Deductible	Not Covered
Physical Medicine and Rehabilitation	100%	60%
Therapy Services Including Cardiac Rehabilitation, Chemotherapy, Dialysis Treatment, Hyperbaric Therapy, Radiation Therapy and Respiratory/Pulmonary Therapy	100%	60%
Occupational/Physical Therapy Services for Mental Illness, Drug Abuse and Alcoholism: Limits do not apply Other Conditions: 40 visits per Calendar Year maximum combined	100%	60%
Chiropractic Care (12 visit maximum per Calendar Year)	100%	60%
Speech Therapy Services for Mental Illness, Drug Abuse and Alcoholism: Limits do not apply Other Conditions: 20 visits per Calendar Year maximum	100%	60%
Skilled Nursing Care (100 days per confinement)	100%	60%
Private Duty Nursing	100%	60%
Home Health Care	100%	60%
Hospice Care	100%	60%
Transplants	100%	60%
Sleep Disorders	Benefits are paid based on the services rendered	
Learning Disorders	Benefits are paid based on the services rendered	

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COVERED SERVICES- HIGH DEDUCTIBLE HEALTH PLAN

Subject to Deductible unless otherwise stated:	Percentage Payable Network	Non-Network
Infertility Testing (diagnosis only)	100%	60%

Mental Illness, Alcoholism and Drug Abuse
In accordance with Federal Mental Health Parity requirements, this Plan will not apply any financial requirement or treatment limitation to Mental Illness, Alcoholism or Drug Abuse benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification.

Attention Deficit Disorder (ADHD).....Benefits are paid based on the services rendered

Autism Spectrum Disorders, including Applied Behavior Analysis (ABA).....Benefits are paid based on the services rendered
Outpatient visit limits do not apply.

Gender Affirming Surgery .....Benefits are paid based on the services rendered

Temporomandibular Joint Disorder ..... . Not Covered

Sterilization.....Not Covered

Prescription Drug Benefits- combined with the Medical Benefits; subject to the Network Deductible and Out-of-Pocket Maximum

Preventive Drug Benefits as required by PPACA.....100% no Deductible Not Covered
(With a valid prescription)

Preventive immunizations (as required by PPACA) medicine and administration that are performed at a pharmacy.....100% no Deductible Not Covered

Prescription Drugs (other than required by PPACA).....100% Not Covered

This Plan covers three 30-day fills of medications you take regularly at any pharmacy in our network. After that, you can choose to have 90-day supplies of your long-term medications delivered by CVS Caremark Mail Service Pharmacy or pick them up at any CVS Pharmacy. After three fills, you can continue to receive 30-day supplies of long-term medications at any network pharmacy. You must first contact us at 800-334-8134 to opt-out of 90-day refills. If you continue to fill in 30-day supplies without first opting-out of 90-day refills, you will pay 100% of the cost of your long-term medications.

This Plan includes a specialty medication program through ImpaxRx Medication Under Management™ Service (hereafter referred to as "ImpaxRx").

ImpaxRx assists Covered Persons with their prescribed specialty medications to get them approved for a Pharmaceutical Manufacturers Prescription Assistance Plan (PAP). ImpaxRx does this by working directly with the Covered Person to obtain their specialty medications for no cost by coordinating and facilitating their application and approval to receive their specialty medication directly from the manufacturer.

Specialty medications are required to be filled through ImpaxRx unless the drug manufacturer or Covered Person's application result in a denial for that medication through ImpaxRx, in which case it will be covered under the Plan at the applicable cost-share as shown above in the Prescription Drug Schedule of Benefits.

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Please contact ImpaxRx for more information at 1-844-467-2979.

This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated. NCOT, Mohawk Board of Education adopts the terms and conditions set forth in this Amendment as of the Effective Date, regardless of the date signed below.

Rhonda Feasel

Signature on behalf of the Plan

Rhonda Feasel, treasurer/CFO

Printed Name and Title

10/5/2023

Date

Multi-Language Interpreter Services & Nondiscrimination Notice

MUTUAL HEALTH SERVICES℠

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-367-3762 (TTY: 711).

Chinese
注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-367-3762 (TTY: 711)。

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-367-3762 (TTY: 711).

Arabic
تر الكتحدث اذامغة، فإن خدات ال ةعدالمسا غوية تتوافر لك
حوظةكنت: ما ذا إ). قرم هاتف الصم الب وكم 711
3762-367-800-1 برقم المجال .بص تن)

Pennsylvania Dutch
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-367-3762 (TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-367-3762 (телетайп: 711).

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-3762 (ATS: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-367-3762 (TTY: 711).

Navajo
Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-367-3762 (TTY: 711).

Oromo
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-367-3762 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-367-3762 (TTY: 711)번으로 전화해 주십시오.

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-367-3762 (TTY: 711).

Japanese
注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-367-3762 (TTY: 711) まで、お電話にてご連絡ください。

Dutch
AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-367-3762 (TTY: 711).

Ukrainian
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-367-3762 (телетайп: 711).

Romanian
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-367-3762 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-367-3762 (TTY: 711).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-367-3762.

Nondiscrimination Notice

Mutual Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Mutual Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Mutual Health Services provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Mutual Health Services provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Mutual Health Services failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
100 American Road
Cleveland, OH 44141
Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.