AMENDMENT #6

TO

YMCA OF THE FOX CITIES
EMPLOYEE HEALTH AND WELFARE PLAN

Effective January 1, 2021, the **YMCA OF THE FOX CITIES EMPLOYEE HEALTH AND WELFARE PLAN** (the "Plan") is hereby amended in the following manner:

ARTICLE III – DEFINITIONS

The following language should be DELETED:

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's present spouse, married within the parameters set by applicable law, and thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one whom is divorced from the Employee.
2. An Employee's Child who is less than 26 years of age. ***NOTE:*** *Coverage for a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.*
3. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in #2 above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in #2 above. The time limit for written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

Active duty members of any armed force shall not be deemed to be "Dependents."

Residents of a country other than the United States shall not be deemed to be "Dependents."

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

The following language should REPLACE the above:

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's present spouse, married within the parameters set by applicable law, and thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one whom is divorced or Legally Separated from the Employee.
2. An Employee's Child who is less than 26 years of age. ***NOTE:*** *Coverage for a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.*
3. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in #2 above, who is mentally or physically incapable of sustaining his or her own living. Such Child

must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in #2 above. The time limit for written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

Active duty members of any armed force shall not be deemed to be "Dependents."

Residents of a country other than the United States shall not be deemed to be "Dependents."

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

The following definition should be DELETED:

"Maximum Allowable Charge"
"Maximum Allowable Charge" will be a negotiated rate, if one exists. In the absence of a negotiated rate, the Maximum Allowable Charge will be calculated by the Plan Administrator taking into account any or all of the following:

1. The Usual and Customary amount.
2. The Reasonable charge specified under the terms of the Plan.
3. The allowable charge specified under the terms of the Plan.
4. The actual billed charges for the covered services.

The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

The following language should REPLACE the definition listed above:

"Maximum Allowable Charge"
The "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

With respect to Non-Network Emergency Services, the Plan allowance is the greater of:

1. The negotiated amount for In-Network Providers (the median amount if more than one amount to In-Network Providers).
2. The Plan's normal Non-Network payable amount after consideration of the criteria described below (reduced for cost sharing).
3. The amount that Medicare Parts A or B would pay (reduced for cost sharing).

If and only if there is no negotiated rate for a given claim, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another is, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The following definition should be ADDED, in alphabetical order, in the Definitions Article:

"Open Enrollment Period"
"Open Enrollment Period" shall mean the timeframe that takes place in the fourth quarter of each year.

The following language should be ADDED, in alphabetical order, in the Definitions Article:

"Primary Care Physician"
"Primary Care Physician" means a Physician engaged in family practice, general practice, nonspecialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/substance use disorders. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat children.

The following language should be ADDED, in alphabetical order, in the Definitions Article:

"Specialist"
"Specialist" means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder treatment providers.

The following definition should be ADDED, in alphabetical order, in the Definitions Article:

"Specialty Drug(s)"
"Specialty Drug(s)" shall mean high-cost prescription medications used to treat complex, chronic conditions including, but not limited to, cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

The following language should be DELETED:

"Reasonable"
"Reasonable" and/or "Reasonableness" shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).
This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) the national medical associations, societies, and organizations; and (b) the Food and Drug Administration. To be

Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

The following language should be DELETED:

"Usual and Customary"
"Usual and Customary" (U&C) shall mean Covered Expenses which are identified by the Plan Administrator, taking into consideration any or all of the following: the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply; the cost to the Provider for providing the services; the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply; and/or the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

ARTICLE IV – ELIGIBILITY FOR COVERAGE

The following provision should be ADDED after 4.04C (all remaining provisions in section 4.04 shall be renumbered accordingly):

4.04D Open Enrollment

Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

"Open Enrollment Period" shall mean the timeframe that takes place in the fourth quarter of each year.

ARTICLE VII – SUMMARY OF BENEFITS

In section 7.06 Summary of Medical Benefits, as previously revised by the July 1, 2019 Amendment:

The following line items should be DELETED from the benefit grid:

Covered Medical Expenses	Network	Non-Network	Limits
Chiropractic Care	$35 copay, then 100%	Deductible, then 60%	Limited to 10 visits and $1,000 per Plan Year.
Psychiatric Expenses			Inpatient Requires Pre-Certification.
Residential Treatment	Deductible, then 80%	Deductible, then 60%	
Inpatient Treatment			
Partial Day Program		Deductible, then 60%	
Outpatient Office Visit	$70 copay, then 100%		
Substance Abuse Benefits			Inpatient Requires Pre-Certification.
Residential Treatment	Deductible, then 80%	Deductible, then 60%	
Inpatient Treatment			
Partial Day Program		Deductible, then 60%	
Outpatient Office Visit	$70 copay, then 100%		
Temporomandibular Joint Disorder (TMJ)	Deductible, then 80%	Deductible, then 60%	Diagnostic procedures and non-surgical treatment limited to $2,500 per lifetime.

The following line items should REPLACE the line items above:

Covered Medical Expenses	Network	Non-Network	Limits
Chiropractic Care	$35 copay, then 100%	Deductible, then 60%	

Psychiatric Expenses			Inpatient Requires Pre-Certification.
Residential Treatment	Deductible, then 80%	Deductible, then 60%	
Inpatient Treatment			
Partial Day Program		Deductible, then 60%	
Outpatient Office Visit	$35 copay, then 100%		

Substance Abuse Benefits			Inpatient Requires Pre-Certification.
Residential Treatment	Deductible, then 80%	Deductible, then 60%	
Inpatient Treatment			
Partial Day Program		Deductible, then 60%	
Outpatient Office Visit	$35 copay, then 100%		

Temporomandibular Joint Disorder (TMJ)	Deductible, then 80%	Deductible, then 60%	

In section 7.06 Summary of Medical Benefits:

The following plan option is being ADDED, in addition to the current plan:

High Deductible Health Plan

	Network	Non-Network	Limits
Deductible			
Individual	$6,350	$12,700	
Family Unit (Embedded)	$12,700	$25,400	
Payment Level (unless otherwise stated)	100%	100%	
Out-of-Pocket Maximum			Out-of-Pocket Maximum, per Calendar Year, includes Deductible and Coinsurance
Individual	$6,350	$12,700	
Family Unit (Embedded)	$12,700	$25,400	
The following charges do not apply toward the Out-of-Pocket Maximum: • Cost containment penalties, ineligible charges, and amounts over the Maximum Allowable Charge.			

Covered Medical Expenses	Network	Non-Network	Limits
Allergy Services			
Office Visit	Deductible, then 100%	Deductible, then 100%	
Injections	Deductible, then 100%	Deductible, then 100%	
Serum	Deductible, then 100%	Deductible, then 100%	
Ambulance	Deductible, then 100%	Deductible, then 100%	
Ambulatory Surgical Center	Deductible, then 100%	Deductible, then 100%	
Anesthesia	Deductible, then 100%	Deductible, then 100%	
Birthing Center	Deductible, then 100%	Deductible, then 100%	

Covered Medical Expenses	Network	Non-Network	Limits
Chiropractic Care	Deductible, then 100%	Deductible, then 100%	
Diabetic Supplies/Insulin Pumps	Deductible, then 100%	Deductible, then 100%	
Dialysis	Deductible, then 100%	Deductible, then 100%	Requires Pre-Certification.
Durable Medical Equipment	Deductible, then 100%	Deductible, then 100%	Requires Pre-Certification.
Genetic Testing	Deductible, then 100%	Deductible, then 100%	Requires Pre-Certification.
Glaucoma, Cataract Surgery	Deductible, then 100%	Deductible, then 100%	After Cataract Surgery the Plan with pay for one set of lenses.
Home Health Care	Deductible, then 100%	Deductible, then 100%	Requires Pre-Certification. Limited to 40 visits per Plan Year.
Hospice Care	Deductible, then 100%	Deductible, then 100%	Requires Pre-Certification.
Hospital Inpatient Treatment Physician Charges Outpatient Treatment	 Deductible, then 100% Deductible, then 100% Deductible, then 100%	 Deductible, then 100% Deductible, then 100% Deductible, then 100%	 Requires Pre-Certification. All surgical procedures require Pre-Certification.
Infertility Treatment	Not Covered	Not Covered	
Outpatient Diagnostic Services: X-ray and Lab, Pathology MRI, PET Scans, MRA, CT Scans, Mammography, Stress Tests Ultrasounds/Echocardiograms Colonoscopy	 Deductible, then 100% Deductible, then 100% Deductible, then 100%	 Deductible, then 100% Deductible, then 100% Deductible, then 100%	 MRI, PET, EGD, CT MRA require Pre-Certification.
Outpatient Emergency Services	Deductible, then 100%	Network Benefits Apply	
Physician Services Includes office visit services, lab and x-ray if provided the same day by the same provider or clinic.	Deductible, then 100%	Deductible, then 100%	Does not include surgical procedures, magnetic resonance imaging (MRI), and computerized axial tomography (CAT scan).
Preventive Care - Well Child Care Routine Physical Exam Lab and X-rays Routine Immunizations	 100% No Cost Share 100% No Cost Share 100% No Cost Share	 Deductible, then 100% Deductible, then 100% Deductible, then 100%	
Preventive Care - Well Adult Care Routine Exams Mammograms – must be over the age of 40 unless Medically Necessary Pap Smears Prostate Exam – must be over age 40 unless Medically Necessary Routine Immunizations	 100% No Cost Share 100% No Cost Share 100% No Cost Share 100% No Cost Share 100% No Cost Share	 Deductible, then 100% Deductible, then 100% Deductible, then 100% Deductible, then 100% Deductible, then 100%	Routine Exam and Mammograms are limited to one per calendar year. Routine Exam includes all related x-ray and lab tests, immunizations and other diagnostic tests (i.e. colonoscopies).
Prosthetics, Orthotics, Supplies and Surgical Dressings	Deductible, then 100%	Deductible, then 100%	Prosthetics require Pre-Certification.

Covered Medical Expenses	Network	Non-Network	Limits
Psychiatric Expenses			
Residential Treatment	Deductible, then 100%	Deductible, then 100%	Inpatient Requires Pre-Certification.
Inpatient Treatment	Deductible, then 100%	Deductible, then 100%	
Partial Day Program	Deductible, then 100%	Deductible, then 100%	
Outpatient Office Visit	Deductible, then 100%	Deductible, then 100%	
Pulmonary and Cardiac Rehabilitation	Deductible, then 100%	Deductible, then 100%	Requires Pre-Certification.
Skilled Nursing Facility / Inpatient Rehabilitation	Deductible, then 100%	Deductible, then 100%	Requires Pre-Certification. Limited to 30 days per calendar year.
Substance Abuse Benefits			
Residential Treatment	Deductible, then 100%	Deductible, then 100%	Inpatient requires Pre-Certification.
Inpatient Treatment	Deductible, then 100%	Deductible, then 100%	
Partial Day Program	Deductible, then 100%	Deductible, then 100%	
Outpatient Office Visit	Deductible, then 100%	Deductible, then 100%	
Temporomandibular Joint Disorder (TMJ)	Deductible, then 100%	Deductible, then 100%	
Testing for the 2019 Novel Coronavirus (COVID-19)	100%, Deductible, Coinsurance & Copayments waived	100%, Deductible, Coinsurance & Copayments waived	No Prior Authorization is required. Medically Necessary treatment of COVID-19 shall be covered by the Plan in accordance with the Plan's guidelines.
Therapy			
Chemotherapy	Deductible, then 100%	Deductible, then 100%	All Therapies require Pre-Certification.
Occupational Therapy	Deductible, then 100%	Deductible, then 100%	
Physical Therapy	Deductible, then 100%	Deductible, then 100%	
Radiation Therapy	Deductible, then 100%	Deductible, then 100%	
Speech Therapy	Deductible, then 100%	Deductible, then 100%	
Transplants	Refer to Transplant Carve-Out Policy		Requires Pre-Certification.
All Other Covered Services	Deductible, then 100%	Deductible, then 100%	

ARTICLE VIII – MEDICAL BENEFITS

In section 8.01 Medical Benefits:

The following benefit language should be ADDED, and all other benefits in this section have been renumbered accordingly:

34. **Sex Assignment/Reassignment.** The Plan covers the following sex assignment/reassignment services when ordered by a Provider or Physician.

1. Psychotherapy.
2. Pre- and post-surgical hormone therapy.
3. Sex reassignment surgery/ies. Surgery must be performed by a qualified Provider. The service requires Pre-Certification.

In section 8.02 Exclusions:

The following language should be DELETED:

23. **Foreign Travel.** That are received outside of the United States if travel is for the sole purpose of obtaining medical services, unless otherwise approved by the Plan Administrator.

The following language should REPLACE the above:

23. **Foreign Travel.** All Plan benefits Incurred outside the United States of American will be excluded from coverage unless:

1. The service(s) would have been a Covered Expense if the service(s) had been provided in the United States, and
2. The Participant is not covered by any other country's national health program or any employer's foreign voluntary compensation coverage.

The following language should be DELETED:

26. **Hair Pieces.** For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness, except for Wigs or hairpieces after radiation or chemotherapy, or diagnosed with Alopecia Areata. Limited to $500.

The following language should REPLACE the above:

26. **Hair Pieces.** For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness, except for Wigs or hairpieces after radiation or chemotherapy, or diagnosed with Alopecia Areata.

The following language should be DELETED:

31. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, surrogate mother and donor eggs. Also charges related to or in connection with fertility testing and studies, sterility testing and studies, consultations, examinations, medications and procedures to restore or enhance fertility;

The following language should REPLACE the above:

31. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, surrogate mother (unless the surrogate is a Participant, in which case the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions), and donor eggs. Also charges related to or in connection with fertility testing and studies, sterility testing and studies, consultations, examinations, medications and procedures to restore or enhance fertility;

The following language should be DELETED:

44. **Nutritional Supplements.** For nutritional supplements.

The following language should REPLACE the above:

44. **Nutritional Supplements.** For nutritional supplements, except as specified under Preventive Care.

The following language should be DELETED:

45. **Obesity.** Related to care and treatment of obesity, weight loss or dietary control, unless related to morbid obesity (BMI indicating morbid obesity which can include other clinical factors). Specifically excluded, even if related to morbid obesity, are charges for bariatric Surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.

The following language should REPLACE the above:

45. **Obesity.** Related to care and treatment of obesity, weight loss or dietary control, unless related to morbid obesity (BMI indicating morbid obesity which can include other clinical factors). Specifically excluded, even if related to morbid obesity, are charges for bariatric Surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. This Exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit.

The following language should be DELETED:

60. **Sex Assignment/Reassignment.** Related to a sex change operation.

The following language should be DELETED:

64. **Vitamins.** For charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

The following language should REPLACE the above:

64. **Vitamins.** For charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements, except as specified under Preventive Care.
All other benefits in this section have been renumbered accordingly.

ARTICLE IX – UTILIZATION MANAGEMENT

In section 9.01 Services that Require Pre-Certification:

Number 16 should be added to this section:

16. Sex assignment/reassignment surgery and/or treatment.

ARTICLE X – PRESCRIPTION DRUG BENEFITS

The following should be DELETED:

Covered Prescription Drug Expenses	Participating Pharmacy
Copayment, per prescription or refill, for generic	$10
Copayment, per prescription or refill, for formulary name brands	$20 plus 10%
Copayment, per prescription or refill, for non-formulary name brands	$40 plus 20%
Mail Order Option:	
Copayment, per prescription or refill, for generic	$10

Copayment, per prescription or refill, for formulary name brands	$40 plus 10%
Copayment, per prescription or refill, for non-formulary name brands	$80 plus 20%

The following language should REPLACE the above:

Traditional PPO Plan

Prescription Drug Plan	
Deductible	Not Applicable
Out-of-Pocket Maximum	Cost shares for prescription drugs apply towards satisfaction of the Total Out-of-Pocket Maximum. Please refer to the Medical Summary of Benefits for details.

Covered Prescription Drug Expenses	**Participating Pharmacy**
Retail Option:	
Generic	$10 Copay
Formulary Brand	$25 Copay plus 10% Coinsurance
Non-Formulary Brand	$45 Copay plus 20% Coinsurance
Mail Order Option:	
Generic	$20 Copay
Formulary Brand	$50 Copay plus 10% Coinsurance
Non-Formulary Brand	$90 Copay plus 20% Coinsurance
Specialty Option:	
Specialty Tier 1	$75 Copay
Specialty Tier 2	$80 Copay plus 10% Coinsurance
Specialty Tier 3	$100 Copay plus 20% Coinsurance

High Deductible Health Plan

Prescription Drug Plan	
Deductible	Cost shares for prescription drugs apply towards satisfaction of the medical Deductible. Please refer to the Medical Summary of Benefits for details.
Out-of-Pocket Maximum	Cost shares for prescription drugs apply towards satisfaction of the Total Out-of-Pocket Maximum. Please refer to the Medical Summary of Benefits for details.

Covered Prescription Drug Expenses	**Participating Pharmacy**
Retail Option:	
Generic	0% Coinsurance after Deductible
Formulary Brand	0% Coinsurance after Deductible
Non-Formulary Brand	0% Coinsurance after Deductible
Mail Order Option:	
Generic	0% Coinsurance after Deductible
Formulary Brand	0% Coinsurance after Deductible
Non-Formulary Brand	0% Coinsurance after Deductible
Specialty Option:	
Specialty Tier 1	0% Coinsurance after Deductible
Specialty Tier 2	0% Coinsurance after Deductible
Specialty Tier 3	0% Coinsurance after Deductible

The following language should be ADDED:

Manufacturer Copay Assistance Program (MCAP): Some specialty medications may qualify for third-party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, you will not receive credit toward your maximum out of pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

In section 10.03 Prescription Drug Exclusions:

The following language should be DELETED:

22. **Smoking Deterrents.** A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches.

The following language should REPLACE the above:

22. **Smoking Deterrents.** A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches, except to the extent required by the Affordable Care Act.

All other sections of the Plan remain unchanged.

APPROVED AND ACCEPTED

By: William R Bruder III
Signature

Title: President / CEO

Date: 2/16/21