Amendment 01
Effective July 1, 2023
HILLTOP COMMUNITY RESOURCES, INC.

The Health Benefit Summary Plan Description is amended as follows:

1. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 003 – PPO $2,500 Plan, is amended to revise the following:**

	TIER 1 MONUMENT HEALTH NETWORK	TIER 2 PARTICIPATING PROVIDERS	TIER 3 NON-PARTICIPATING PROVIDERS
Infertility Treatment: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible ***Note: Medical And Pharmacy Expenses Are Subject To The Same Infertility Maximum Benefit Per Lifetime.***	90%	$20,000 80%	50%

2. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 001 – PPO $1,000 Plan, is amended to revise the following:**

	TIER 1 MONUMENT HEALTH NETWORK	TIER 2 PARTICIPATING PROVIDERS	TIER 3 NON-PARTICIPATING PROVIDERS
Infertility Treatment: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible ***Note: Medical And Pharmacy Expenses Are Subject To The Same Infertility Maximum Benefit Per Lifetime.***	90%	$20,000 80%	50%

3. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 009 – PPO $1,000 Delta Monstrose Plan, is amended to revise the following:**

	TIER 1 MONUMENT HEALTH NETWORK	TIER 2 PARTICIPATING PROVIDERS	TIER 3 NON-PARTICIPATING PROVIDERS
Infertility Treatment: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible ***Note: Medical And Pharmacy Expenses Are Subject To The Same Infertility Maximum Benefit Per Lifetime.***	90%	$20,000 80%	50%

4. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 010 – PPO $2,500 Delta Monstrose Plan, is amended to revise the following:**

	TIER 1 MONUMENT HEALTH NETWORK	TIER 2 PARTICIPATING PROVIDERS	TIER 3 NON-PARTICIPATING PROVIDERS
Infertility Treatment:			
• Maximum Benefit Per Lifetime		$20,000	
• Paid By Plan After Deductible	90%	80%	50%
Note: Medical And Pharmacy Expenses Are Subject To The Same Infertility Maximum Benefit Per Lifetime.			

5. **The PRESCRIPTION SCHEDULE OF BENEFITS, Benefit Plan(s) Medical/Rx, is amended to add the following:**

Infertility Products:	
• Maximum Benefit Per Lifetime	$20,000
Note: Medical And Pharmacy Expenses Are Subject To The Same Infertility Maximum Benefit Per Lifetime.	

6. **The COBRA CONTINUATION OF COVERAGE provision is amended to revise the following:**

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT FOR CONTINUATION COVERAGE

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

7. The PROTECTION FROM BALANCE BILLING provision is amended to revise the following:

ALLOWED AMOUNTS

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency Physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the Out-of-Network facility, if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

- For non-Emergency covered health care services received at certain network facilities from Out-of-Network Physicians when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary of Health and Human Services (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

8. The PROVIDER NETWORK provision is amended to delete the following:

A provider may enter into an agreement to provide only certain covered health services, but not all covered health services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the covered health services and products included in the participation agreement, and a non-Network provider for other covered health services and products. The participation status of providers may change from time to time.

9. The PROVIDER NETWORK provision is amended to revise the following:

EXCEPTIONS TO THE PROVIDER NETWORK BENEFITS

- Non-air Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider. The Covered Person will not be subject to amounts above the applicable member cost-sharing requirements.

10. The COVERED MEDICAL BENEFITS provision is amended to revise the following:

Gender Dysphoria:

Benefits for the treatment of Gender Dysphoria, limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described in the Mental Health Benefits section of this SPD.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example, during an office visit) as described in the Mental Health Benefits section of this SPD.
  - Cross-sex hormone therapy dispensed from a pharmacy as described in the Prescription Drug Benefits section of this SPD.
- Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:
  Male to Female:
  - Clitoroplasty (creation of clitoris)
  - Facial bone remodeling for facial feminizations
  - Hair removal
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Thyroid cartilage reduction, reduction thyroid chondroplasty, or trachea shave (removal or reduction of the Adam's apple)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)

  Female to Male:
  - Bilateral mastectomy or breast reduction
  - Hair removal
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
  - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
  - The Covered Person must be 18 years of age or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
  - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
  - The Covered Person must be 18 years of age or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - The Covered Person must complete at least 12 months of successful, continuous, full-time, real-life experience in the desired gender.
  - The Covered Person must complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

- The treatment plan must be based on identifiable external sources, including the *World Professional* Association *for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Coverage does not include procedures that are cosmetic as stated in the General Exclusions section of this SPD. Cosmetic procedures include, but are not limited to, the following:

- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Face lift, forehead lift, or neck tightening.
- Hair transplantation.
- Injection of fillers or neurotoxins.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Voice lessons and voice therapy.
- Voice modification surgery.

Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers). The following services are covered:

- Semi-private and private room and board services:
  - For network charges, this rate is based on the network agreement. Semi-private rate reductions may apply.
  - For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable.

Infertility Treatment to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person. Once the patient is receiving fertility treatment to achieve pregnancy, diagnostic tests and treatments are then considered part of the infertility benefit.

Covered Infertility Treatment includes genetic testing to diagnose infertility.

11. The TELADOC SERVICES provision is amended to delete the following:

Behavioral Health Program

Covered Person Follow-Up: Under the Behavioral Health Program, Teladoc's nurse team will make proactive efforts to contact the Covered Person by telephone after the second and sixth consultations to assess the effectiveness of the Covered Person's treatment.

12. The TELADOC SERVICES provision is amended to revise the following:

Behavioral Health Program

Clarifications: Unlike the consultations provided under the general medicine program, the behavioral health consultations under the Behavioral Health Program:

- Are currently not available to Covered Persons under the age of 13.

13. The COORDINATION OF BENEFITS provision is amended to delete the following:

The Plan will coordinate benefits with the following types of medical or dental plans:

- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.

14. The COORDINATION OF BENEFITS provision is amended to revise the following:

ORDER OF BENEFIT DETERMINATION RULES

- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

15. The RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET provision is amended to add the following:

- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement, including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

16. The GENERAL EXCLUSIONS provision is amended to revise the following:

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

Excess Charges: Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule. This exclusion does not apply to payments that may be required under the No Surprises Act

Infertility Treatment:

- Fertility tests.
- Surgical reversal of a sterilized state that was a result of a previous surgery.
- Artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT).
- Embryo transfer.
- Genetic testing.

This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition of, slow the harm to, alleviate the symptoms of, or maintain the current health status of the Covered Person.

Self-Administered Services or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion.

17. The CLAIMS AND APPEAL PROCEDURES provision is amended to revise the following:

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as <u>required</u> by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person or provider, when applicable, is required to obtain approval from the Plan ***before*** obtaining medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See “Pre-Determination” above.) The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

HOW HEALTH BENEFITS ARE CALCULATED

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

18. The CLAIMS AND APPEAL PROCEDURES provision is amended to add the following:

Reimbursement for covered services received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials based on the 80th percentile, or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor.

19. The CLAIMS AND APPEAL PROCEDURES provision is amended to delete the following:

Usual And Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 80th percentile. See "Surgery and Assistant Surgeon Services" in the Covered Medical Benefits section for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term "Usual and Customary" means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

20. The GLOSSARY OF TERMS is amended to revise the following:

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

BY THIS AGREEMENT,

The HILLTOP COMMUNITY RESOURCES, INC. Health Benefit Summary Plan Description

is amended July 1, 2023.

Authorized Signature _____

Print Name _____

Title _____

Date _____

IMPORTANT NOTICE:

The employer agrees to all provisions of this amendment as the basis for Plan administration. Except as specifically stated above, nothing in this amendment will alter or amend the summary plan description.

Any applicable stop loss policies typically rely on formally approved amendments or updated summary plan descriptions when determining whether reimbursement is appropriate. Failure to notify the stop loss carrier of plan changes may result in a stop loss gap or lapse in coverage. Notice to the stop loss carrier of all plan changes is required.

Please sign and return this amendment to your strategic account executive as soon as possible. Note, however, that since the corresponding system changes have been implemented, these changes are considered final, regardless of whether or not a signature is received. If you have any questions, please contact your strategic account executive.

Contingent upon your signed approval of the initial plan document, this amendment will be posted to the member portal upon receipt of your signature, or within 14 days of your receipt of the amendment if a signature is not received. Please note that amendments or booklets will not be printed until a signature is received.

Remember to keep a copy for your records.