AMENDMENT AND SUMMARY OF MATERIAL MODIFICATION (SMM)
TO THE
ST. LAWRENCE COUNTY HEALTH PLAN

St. Lawrence County (the "Employer") maintains the St. Lawrence County Health Plan (the "Plan") for the benefit of its eligible employees and their dependents and expressly reserves the right to amend the Plan at any time. As such, the Employer desires to amend the Plan to comply with the consumer protections of Division BB of the Consolidated Appropriations Act, 2021 (the "Act") and to make certain other changes as described herein. The provisions of this Amendment are intended to provide for good faith compliance with applicable requirements of the Act and, in case of any ambiguity between the provisions of this Amendment and the requirements of the Act, shall be interpreted to be consistent with the requirements of the Act. Effective as of January 1, 2022 (unless otherwise stated herein), the Plan is amended in the following respects:

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1. The ***"Allowed Amount"*** definition under ***"Definitions"*** section of the Plan is deleted and replaced with the following:

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

   The Allowed Amount for Participating Providers will be the amount the Plan has negotiated with the Participating Provider or the Participating Provider's charge, whichever is less. However, when the Participating Provider's charge is less than the amount the Plan has negotiated with the Participating Provider, your Coinsurance, Copayment or Deductible amount will be based on the Participating Provider's charge.

   The Allowed Amount for Non-Participating Providers is as follows:

   (1) **Facilities in the Service Area.**
   For Facilities in the Service Area, the Allowed Amount will be an amount based on the Participating Providers negotiated rate, or the Facility's charge, if less.

   (2) **Facilities outside the Service Area.**
   For Facilities outside the Service Area, the Allowed Amount will be an amount based on the Participating Provider negotiated rate, or the Facility's charge, if less.

(3) **For a Health Care Professional or a Provider of Additional Health Services in the Service Area.**
For a Health Care Professional or a Provider of Additional Health Services outside the Service Area, the Allowed Amount will be the 75th percentile of the Usual, Customary and Reasonable ("UCR") rate or charge, as supplied by Fair Health, or the Health Care Professional or Provider of Additional Health Services charge, if less.

(4) **For a Health Care Professional or a Provider of Additional Health Services Outside the Service Area.**
For a Health Care Professional or a Provider of Additional Health Services outside the Service Area, the Allowed Amount will be the 75th percentile of the Usual, Customary and Reasonable ("UCR") rate or charge, as supplied by Fair Health, or the Health Care Professional or Provider of Additional Health Services charge, if less.

(5) **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.

(6) **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.

(7) **Physician-Administered Pharmaceuticals.**
For Physician-administered pharmaceuticals, the Plan uses gap 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 RJ Health Systems, Thomson Reuters (published in its Red Book), or the Plan based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

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.

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 ***"Emergency Services"*** definition under the ***"Definitions"*** section of the Plan is amended to read as follows:

Emergency Services. With respect to an Emergency Condition, a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA) or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) which is within the capability of the emergency department of a Hospital (or Independent Freestanding Emergency Department), including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital (or Independent Freestanding Emergency Department) and such further medical examination and treatment as are required to stabilize the patient, regardless of the department of the Hospital in which further examination or treatment is furnished. Emergency Services also includes certain post-stabilization services, unless the following conditions are met:

(1) The attending emergency physician or treating provider has determined that you are able to travel using nonmedical transportation or non-emergency medical transportation to an available Participating Provider or Facility located within a reasonable travel distance, taking into account your medical condition and any other relevant factor;

(2) If the Provider is a Non-Participating Provider, (a) the Provider gives you notice that the services rendered will be performed by a Non-Participating Provider and you consent to waive your rights to the protections under the surprise bill requirements, and (b) you or your authorized representative are in a condition to provide informed, voluntary consent. See the section of this document entitled Protections from Surprise Bills for additional information; and

(3) The Provider satisfies any additional applicable state law requirements and any additional requirements provided in guidance issued by the Department of Health and Human Services.

3. A new definition of ***"Independent Freestanding Emergency Department"*** is added alphabetically under the ***"Definitions"*** section of the Plan to read as follows:

   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.

4. A new section entitled ***"Protection from Surprise Bills"*** is added 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 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 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 Allowed Amount with respect to the Plan's normal reimbursement rules.

For any surprise bills, the 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 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 Plan will comply with the additional or modified requirements as required by such guidance.

5. **Air Ambulance.** To the extent your Plan provides coverage for air ambulance or Emergency Services for an Emergency Condition and the Cost-Sharing applied to such air ambulance services or Emergency Services when rendered by a Non-Participating Provider is different than the Cost-Sharing applied when such services are rendered by a Participating Provider, to the extent necessary to comply with the No Surprises Act, the Plan is amended to apply the same Cost-Sharing to air ambulance services or Emergency Services for an Emergency Condition when rendered by a Non-Participating Provider as the Cost-Sharing that is applied to such services when rendered by a Participating Provider.

6. The definition of **"*Participating Provider"*** under the **"*Definitions"*** section of the Plan is amended to read as follows:

Participating Provider. A Facility, Health Care Professional, or Provider of Additional Health Services who has a contract with the Claims Administrator or another Blue Cross and/or Blue Shield plan to provide services to you at a discounted rate. Participating Providers have agreed to accept the discounted rate as payment in full for services Covered under the Plan. A list of Participating Providers is included in a provider directory and is available at www.excellusbcbs.com or upon request by calling the customer service number located on your identification card. The list may be revised from time to time.

The Participating Provider directory will give you the following information about Participating Providers:
(1) Name, address, and telephone number;
(2) Specialty;
(3) Board certification (if applicable);
(4) Languages spoken; and
(5) Whether the Participating Provider is accepting new patients.

You are only responsible for any Participating Provider Copayment, Deductible or Coinsurance that would apply to the Covered Services, and you will not be responsible for paying for any Non-Participating Provider charges that exceed your Participating Provider Copayment, Deductible or Coinsurance, if you receive Covered Services from a provider who is not a Participating Provider because you reasonably relied on incorrect information provided to you about whether the provider was a Participating Provider in the following situations:

(1) The provider is listed as a Participating Provider in the online provider directory;
(2) The paper provider directory listing the provider as a Participating Provider is incorrect as of the date of publication;
(3) You were given written notice that the provider is a Participating Provider in response to your telephone request for network status information about the provider; or
(4) You are not provided with written notice within one business day of your telephone request for network status information.

7. A new section entitled **"*Transitional Care"*** is added to the Plan to read as follows:

TRANSITIONAL CARE

If you are in an ongoing course of treatment when your Participating Provider leaves the network then you may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date your Provider's contractual obligation to provide services to you under the Plan

terminates. If you are pregnant, you may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of the relationship of the Provider with the network. The Provider must also provide the Plan with necessary medical information related to your care and adhere to any policies and procedures established by the Plan, including those for assuring quality of care and obtaining preauthorization and a treatment plan approved by the Plan. You will receive Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable Cost-Sharing.

In addition to the above, if you are considered a "continuing care patient" and any benefits under the Plan are terminated because of a change in the terms of participation of your provider in the network, you will be given notice of such change or termination and will have the right to elect to continue coverage under the Plan, with respect to that provider, under the same terms and conditions that were in effect on the date you are given notice of the provider's change in network status or termination of benefits as a results of a change in network participation. If you elect to continue such coverage under the Plan, coverage for transitional care with respect to that provider will be provided under those same terms and conditions only for the period ending on the earlier of (1) 90 days from the date the notice is provided or (2) the date you are no longer considered a "continuing care patient". In addition, coverage under those same terms and conditions during this period of transitional care is limited to the condition for which you were receiving care from your provider, that qualifies you as a "continuing care patient", prior to the provider's change in network status.

For purposes of this section, you are a "continuing care patient" if you meet any of the following conditions:

(1) You are undergoing a course of treatment for a serious and complex condition. Serious and complex condition means:
   a. An acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
   b. A chronic illness that is life threatening, degenerative, potentially disabling or congenital and requires specialized medical care for a prolonged period of time.

(2) Undergoing a course of institutional or inpatient care from the provider.

(3) You are scheduled to undergo non-elective surgery, including post-operative care from the provider.

(4) You are pregnant and undergoing a course of treatment for the pregnancy from the provider.

(5) You are terminally ill (as defined in Section 1861 of the Social Security Act) and receiving treatment for the terminal illness from the provider

Please note, if the Provider was terminated by the network due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

If you have any questions with respect to this Transitional Care provision, please contact your Plan Administrator or the Claims Administrator at the telephone number listed on your identification card.

8. The ***"Claim and Appeal Procedures"*** section of the Plan is revised as follows:

   a) The following is added to the ***"Claim and Appeal Procedures"*** section to replace the sentence that begins with "Payments for services rendered by a Non-Participating Provider":

      Payments for services rendered by a Non-Participating Provider (other than those that are subject to the surprise bill protections) may be made payable to the Employee. Payment for services rendered by a Non-Participating Provider that are subject to the surprise billing protections as described in the **Protections from Surprise Bills** section of the Plan will be made directly to the Non-Participating Provider.

   b) You have a right to external review for situations in that a involve consideration of whether the plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act. As such, the **"*External Review"*** subsection under the **"*Claim and Appeals Procedure"*** section is revised to extend the right to external review in this situation. In addition, the **"*Coverage Determinations Subject to External Review"*** subsection is revised to read as follows:

      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 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 based on a determination:

i. that the requested service does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered benefit, or
ii. that the requested service is experimental or investigational,
iii. for a rescission of coverage, or
iv. involving consideration of whether the 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**): or
v. involving whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan's wellness program (if any); or
vi. involving whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) and its implementing regulations.

For purposes of this section a rescission of coverage is a retroactive termination of coverage under the Plan, except in cases where you fail to pay any required contribution to the cost of coverage under the Plan. You do not have the right to an external review of any other determinations, even if those other determinations affect your coverage.

9. The ***"Temporary Tolling of Certain Timeframes"*** provision is revised to read as follows:

TEMPORARY TOLLING OF CERTAIN TIMEFRAMES

Effective as of March 1, 2020, the Plan will disregard days occurring during the "Outbreak Period" (as defined below), for purposes of determining the date by which an individual (e.g., a participant, claimant, dependent, qualified beneficiary) has to:

(a) request mid-year enrollment in medical coverage due to a HIPAA special enrollment event where the special enrollment period otherwise would include any day of the Outbreak Period;
(b) elect to initially enroll in COBRA continuation coverage if the 60-day initial election period otherwise would include any day of the Outbreak Period;
(c) make an initial or any subsequent COBRA premium payment if the time period (or the grace period) for making the COBRA premium payment otherwise would include any day of the Outbreak Period;
(d) provide a required notice to the Plan of a COBRA qualifying event, if the time period for providing the notice otherwise would include any day of the Outbreak Period;

(e) file an initial claim for benefits under the Plan if the timely filing period otherwise would include any day of the Outbreak Period;
(f) file an internal or external appeal (if applicable) in response to an adverse benefit determination if the time period for filing an internal or external appeal otherwise would include any day of the Outbreak Period; or
(g) perfect a request for external review (if applicable) in response to a notice that the request is not complete if the time period for perfecting the request otherwise would include any day of the Outbreak Period.

In all cases where a time period referred to in (a)-(g) above began before March 1, 2020, in determining the extended time period based on the above rule, any period of time prior to March 1, 2020 will be subtracted from the time period that would apply without the extension to determine the remaining time frame in which a covered person has to act after the end of the Outbreak Period. For example, for a special enrollment request that is subject to a 30-day special enrollment period, if the special enrollment period started on February 15, 2020, (i) the period from February 15 through February 29 will count as the first 14 days of the 30-day period (leaving 16 days in the special enrollment period), (ii) the entire Outbreak Period (March 1, 2020 through February 28, 2021) will be disregarded and (iii) the special enrollment period will end 16 days after the end of the Outbreak Period, on March 16, 2021.

Coverage with respect to (b) and (d) above, may be retroactive to the date of the qualifying event; provided the covered person makes any required premium payments prior to the end of the extended time period provided for above.

For purposes of this section, the “Outbreak Period” is the period beginning on the later of (1) March 1, 2020 or (2) the “Applicable Event Date” (as defined below) and ending on the earlier of (A) one year from the Applicable Event Date or (B) 60 days after the announced end of the “National Emergency” described in the next sentence (or on a different date announced by the Internal Revenue Service and the Employee Benefits Security Administration (the “Agencies”)) and will be interpreted to be consistent with the meaning of that term under the Notice issued by the Agencies and published in the Federal Register on May 4, 2020 (and any subsequent guidance from the Agencies). The “National Emergency” for this purpose is the National Emergency declared on March 13, 2020 (with a March 1, 2020 effective date) as a result of the COVID-19 outbreak. If the National Emergency is determined by the Agencies to end on different dates in different parts of the country, the Outbreak Period with respect to a specific event or all events, if applicable, will be interpreted to end on the date that is determined by the Plan Administrator to be appropriate for the Plan. In no case will the Outbreak Period for any event last longer than one year or begin before March 1, 2020 or after the date described in (B) above.

For purposes of this section, the "Applicable Event Date" is determined under the following chart, based on which event (from events (a) through (g) above) has occurred:

Event	Event type	Applicable Event Date
(a)	Special enrollment event	First day of special enrollment period
(b)	Initial COBRA election	First day of 60-day COBRA election period
(c)	Initial COBRA payment Monthly COBRA payment	First day of 45-day initial payment period First day of 30-day payment grace period
(d)	COBRA qualifying event notice	First day of 60-day period for providing notice
(e)	Initial claim	Date of claim
(f)	Internal or external appeal	Date of receipt of claim denial
(g)	Perfection of external appeal	Date of receipt of notice of need for information

10. The ***Medical Necessity and Preauthorization*** section is revised as follows:

a) The ***Care Must Be Medically Necessary*** subsection is renamed ***Medical Necessity*** and revised to read as follows:

Medical Necessity.
Coverage will be provided under the Plan as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "Service") is Medically Necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that the Plan has to provide coverage for it. The Plan may base its decision on a review of:

(1) Your medical records;
(2) Medical policies and clinical guidelines;
(3) Medical opinions of a professional society, peer review committee or other groups of Physicians;
(4) Reports in peer-reviewed medical literature;
(5) Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
(6) Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;
(7) The opinion of Health Care Professionals in the generally recognized health specialty involved;
(8) The opinion of the attending providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

(1) They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
(2) They are required for the direct care and treatment or management of that condition;
(3) Your condition would be adversely affected if the services were not provided;
(4) They are provided in accordance with generally accepted standards of medical practice;
(5) They are not primarily for the convenience of you, your family, or your provider;
(6) They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
(7) When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

b) The ***"Services subject to Preauthorization", "Preauthorization Procedure",*** and ***"Failure to Seek Preauthorization"*** subsections are revised to read as follows:

Services subject to Preauthorization. If Services are rendered by a Participating Provider in the Service Area, your provider is required to obtain Preauthorization for certain services Covered under this Plan. If Services are rendered by a Participating Provider outside the Service Area or a Non-Participating Provider, you are required to obtain Preauthorization for certain services Covered under this Plan. A list of Services that require Preauthorization can be obtained by visiting www.excellusbcbs.com. This list is subject to change and is updated from time to time. To verify whether or not a specific Service requires Preauthorization, or to request a paper copy (free of charge) of the list of Services that require Preauthorization, please contact the customer service number listed on your ID card.

Preauthorization Procedure. If you or your provider seek coverage for the Services listed in paragraph 3 above, you or your provider must call the Claims Administrator at the number indicated on your ID card to have the care pre-approved. It is requested that your provider call at least seven days prior to a planned inpatient admission.

If you are hospitalized in cases of an Emergency Condition involving any of

these services, you or your provider should call within 24 hours after your admission or as soon thereafter as reasonably possible. The availability of an organ for transplantation resulting in the necessity for an immediate admission for implantation shall be considered an Emergency Condition for purposes of this paragraph.

After receiving a request for Preauthorization, the Claims Administrator will review the reasons for your planned treatment and determine if benefits are available. The Claims Administrator will notify you and your Health Care Professional of the decision by telephone and in writing within three business days of receipt of all necessary information. If your treatment involves continued or extended health care services, or additional services for a course of continued treatment, the Claims Administrator will notify you and your Health Care Professional within one business day of receipt of all necessary information.

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 or by 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.

c) **"Utilization Review"** and **"Medical Management"** subsections are added to read as follows:

Utilization Review.
The Plan reviews health services to determine whether the services are or were Medically Necessary or experimental or investigational. This process is called utilization review. Utilization review includes all review activities, whether they take place prior to the Service being performed (Preauthorization); when the Service is being performed (concurrent); or after the Service is performed (retrospective). If you have any questions about the utilization review process, please call the number on your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary or are experimental or investigational will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the provider who

typically manages your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment.

The Plan has specific guidelines and protocols to assist in this process. It will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient. Specific guidelines and protocols are available for your review upon request. For more information, call the number on your ID card or visit www.excellusbcbs.com.

You may request that the Plan send you electronic notification of a utilization review determination instead of notice in writing or by telephone. You must tell the Plan in advance if you want to receive electronic notifications. To opt into electronic notifications, call the number on your ID card or visit www.excellusbcbs.com. You can opt out of electronic notifications at any time.

Medical Management.
The benefits available to you under the Plan are subject to pre-service (Preauthorization), concurrent and retrospective reviews to determine when services should be Covered. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. In addition, any benefits available to you are subject to medical policies, administrative policies or billing policies of the Plan. Services must be Medically Necessary for benefits to be covered under the Plan.

11. The ***"Government Hospitals"*** exclusion under the ***"General Exclusions"*** section of the Plan is revised to read as follows:

    Government Hospitals. Except as otherwise required by law (or specifically identified as being Covered elsewhere in this Plan), the Plan will not provide coverage for care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, unless you are taken to the Hospital because it is close to the place where you were injured or became ill and Emergency Services are provided to treat your Emergency Condition.

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

This amendment and summary of material modification is hereby adopted by St. Lawrence County as of the effective date set forth above.

ST. LAWRENCE COUNTY

_____
Signature

_____
Printed Name

_____
Title

_____
Date