

**ST. LAWRENCE COUNTY HEALTH PLAN
SUMMARY OF MATERIAL MODIFICATION AND AMENDMENT 1
EFFECTIVE DATE: JANUARY 1, 2021**

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. Effective as of January 1, 2021, the Plan is amended as follows:

1. **The *PPO Option* is being removed in its entirety; including all references in the documentation.**

2. **The *Services subject to Preauthorization* provision under the “Medical Necessity and Preauthorization” section has been updated as follows:**
Services subject to Preauthorization. If Services are rendered by a Participating Provider, your provider is required to obtain Preauthorization for certain services Covered under this Plan. If Services are rendered by 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.
***Exhibit A-Utilization Management Standard Clinical Review Preauthorization List* has been removed in its entirety.**

3. **The *Signature Copay Option* is amended in the following respects:**

The Non-Participating Provider Out-of-Pocket Limit is changed from Individual- \$1,000, Individual + Dependent(s)- \$2,000 and Family- \$3,000 to **Individual-\$1,100, Individual + Dependent(s)- \$2,200 and Family- \$3,300.**

	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
CALENDAR YEAR OUT-OF-POCKET LIMIT		
Individual	\$1,000	\$1,100
Individual + Dependent(s)	\$2,000	\$2,200
Family	\$3,000	\$3,300

The Telemedicine-MD Live service for Participating Providers is changed from a \$10 Copayment to a **\$0 Copayment**.

	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Telemedicine Program-MD Live	\$0 Copayment	40% Coinsurance, after Deductible

The following Participating Provider services have been changed from a \$100 Copayment to a **\$0 Copayment**: Inpatient hospital (Facility), Mental Health and Substance Use (Inpatient), Newborn Nursery Care-Routine (Facility), Observation Stays, Inpatient Physical Rehabilitation (Facility), Prosthetic devices (Implanted), and Inpatient Surgical Procedures (Facility).

	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
Inpatient Hospital Services (Facility services)	\$0 Copayment	40% Coinsurance, after Deductible
Mental Health and Substance Use Services (Inpatient services)	\$0 Copayment	40% Coinsurance, after Deductible
Newborn Nursery Care-Routine (Facility services)	\$0 Copayment	40% Coinsurance, after Deductible
Observation Stays	\$0 Copayment	40% Coinsurance, after Deductible
Physical Rehabilitation (Inpatient) (Facility services)	\$0 Copayment	40% Coinsurance, after Deductible
Prosthetic Devices (Implanted)	\$0 Copayment	40% Coinsurance, after Deductible
Surgical Procedures-Inpatient (Facility services)	\$0 Copayment	40% Coinsurance, after Deductible

The following services have been added to the Signature Copay Option medical schedule of benefits: In vitro diagnostic tests for the detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19, COVID-19 Vaccine (under the *Preventive Care* heading), and telehealth.

	PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) You Pay
In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19 Effective as of 03/13/2020 and during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g))	\$0 Copayment	\$0 Copayment, not subject to Deductible
Preventive Care COVID-19 Vaccine Effective as of 15 business days after a recommendation is made by the U.S. Preventive Services Task Force or CDC Advisory Committee on Immunization Practices	\$0 Copayment	\$0 Copayment, not subject to Deductible
Telehealth*	\$0 Copayment	40% Coinsurance, after Deductible
*Note: Coverage for telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is provided in accordance with the sections of this Plan entitled "In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19".		

4. **The *Allowed Amount* definition has been updated to include:**
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.

5. **The *Preventive Services* provision of the “Additional Benefits” section has been updated to include:**

COVID-19 Vaccine: Effective as of 15 business days after a recommendation is made from the United States Preventive Services Task Force or CDC Advisory Committee on Immunization Practices, the Plan will provide coverage for vaccines and other services intended to prevent COVID-19.

6. **The “Additional Benefits” section has been updated to include the following:**

In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19.

Effective as of March 13, 2020, during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), or until such other date determined to be appropriate by the Employer, the Plan will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such a test for members suspected of a COVID-19 infection, or suspected of having recovered from COVID-19 infection, that—

- (a) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb-3);
- (b) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb-3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
- (c) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
- (d) other tests that the Secretary determines appropriate in guidance.

and which have been determined to be medically appropriate for you by your attending provider. In addition to the above, the Plan will provide coverage for any items and services provided during an office visit (including telehealth), urgent care center visit, or emergency room visit that relates to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will be provided when rendered by a Participating Provider or Non-Participating Provider and will not be subject to any Cost-Sharing (i.e. Coinsurance, Copayments or Deductibles), Preauthorization requirements or any other medical management requirements. Other services that you may receive during such a visit that are not related to determining the need for a test or administration of a test, will be subject to the normal Plan Cost-Sharing, Preauthorization and medical management requirements.

Except as amended by this amendment and summary of material modification (“Amendment”), all terms, conditions, limitations and exclusions of the Plan will remain in full force and effect. In the event of any discrepancy between this Amendment and the Plan, the provisions of the Amendment shall govern.

This Amendment describes important changes to the Plan and your Summary Plan Description (SPD). You should retain a copy of this Amendment with your SPD.

This Amendment is hereby adopted by the Employer as of the effective date set forth above.

ST. LAWRENCE COUNTY

Signature

Printed Name

Title

Date