SUMMARY OF MATERIAL MODIFICATIONS
TO THE
SCHOOL DISTRICT OF SPRING VALLEY
EMPLOYEE BENEFIT PLAN

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the School District of Spring Valley Employee Benefit Plan (the "Plan"). Please review this SMM carefully to familiarize yourself with the changes and please attach this SMM to the front of your SPD.

The following changes to the plan have been approved and are effective July 1, 2019:

1. **Plan Document** – amended "covered person" to "Participant" and "covered individual" to "covered Participant" throughout plan document for clarification.

2. **Schedule of Benefits** – amended for clarification.

Organ Transplants	Refer to United HealthCare Insurance Company Transplant Benefit Policy	Not Covered
Transplant related services and expenses not covered under the UHIC Transplant Benefit Policy will be considered as any other covered expense subject to all Plan provisions, limitations and exclusions.		

3. **Schedule of Benefits** – amended for clarification.

ReforMedicine Services	Covered services, including prescription drugs, received from providers at ReforMedicine will be processed at the PPO Provider level of benefits and subject to all Plan provisions, limitations and exclusions.

Shared Medical Technology	Covered services, including prescription drugs, received from providers at Shared Medical Technology will be processed at the PPO Provider level of benefits and subject to all Plan provisions, limitations and exclusions.

4. **Schedule of Benefits** – amended for clarification.

Renal Dialysis – Outpatient	100% after Deductible	80% after Deductible
Dialysis is a covered service only up to 150% of the regional Medicare allowable amount, adjusted for the geographic wage index. Charges that exceed this amount are not a covered service and are not eligible for reimbursement under the Plan. Covered Expenses will be payable, as shown in the Schedule of Benefits.		

5. **Schedule of Benefits** – amended for clarification.

The Joyful Doc Clinic	Covered services, including prescription drugs, received from providers at The Joyful Doc Clinic will be processed at the PPO Provider level of benefits and subject to all Plan provisions, limitations and exclusions.

6. **Comprehensive Medical Coverage** – added section for clarification.

PROVIDER PROVISIONS

D. All providers contracted with the PPO Preferred Provider Network as identified on your health benefits identification card or directly with the Plan through BPA/UCS will be considered “Preferred Providers”. Covered expenses incurred by “Preferred Providers” (hospital or physician) will be covered at a higher rate than “non-Preferred Providers”.

Additional Preferred Provider Organizations or negotiation services (before or after services are rendered) may be utilized in order to optimize coverage and preserve plan assets. When this occurs, the covered charges may be paid at the “Preferred Provider” rate. Please note that providers’ status may change between Preferred and non-Preferred at any time.

7. **Covered Expenses** – removed vitamin D supplements from Drugs covered section due to the change in mandated services.

8. **Covered Expenses** – amended mandated preventive benefits: updated prevention of falls, removed Vitamin D supplements, updated and combined pap smear and HPV and updated osteoporosis screen

VV. **Preventive Care services**

Preventive Services for Adults

- Prevention of falls – exercise interventions for community-dwelling adults ages 65 and older who are at increased risk for falls
- ~~Vitamin D supplements OTC only, to prevent falls in community-dwelling adults ages 65 and older~~

Preventive Services for Women, including Pregnant Women or Women Who May Become Pregnant

- Cervical cancer and dysplasia screening for women ages 21 to 65 with cytology (Pap smear) every 3 years. For women aged 30 to 65 years every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
- ~~Human papillomavirus (HPV) DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.~~
- Osteoporosis screening for women ages 65 and older and in post menopausal younger women who are at increased risk, as determined by a formal clinical risk assessment tool.

9. **Covered Expenses** – amended for clarification.

Y. **Renal Dialysis.** Charges for outpatient renal dialysis services. Dialysis is a covered service only up to 150% of the regional Medicare allowable amount, adjusted for the geographic wage index. Charges that exceed this amount are not a covered service and are not eligible for reimbursement under the Plan. Covered Expenses will be payable, as shown in the Schedule of Benefits.

10. **Charges Not Covered** – removed and replaced for clarification.

~~17. **Developmental Delays.** Expenses in connection with the treatment of developmental delays, including, but not limited to Speech Therapy, Occupational Therapy, Physical Therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD or autism disorder, Asperger's syndrome, and any pervasive development disorder not otherwise specified. Coverage does not include services that are considered Experimental, Investigational and/or not Medically Necessary in the assessment and/or treatment of Autism Spectrum Disorders (ASD's).~~

~~42. **Recreational/Educational Therapy.** Expenses for recreational and educational therapy; learning disabilities; behavior modification therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships will not be considered eligible. This exclusion will not apply to diabetic self-management education programs or expenses related to the diagnosis, testing and treatment of ADD or ADHD or autism disorder, Asperger's syndrome, and any pervasive development disorder not otherwise specified. Coverage does not include services that are considered Experimental, Investigational and/or not Medically Necessary in the assessment and/or treatment of Autism Spectrum Disorders (ASD's).~~

17. **Developmental Delays/Recreational/Educational Therapy.** Expenses and services in connection with:
    a. developmental delay including but not limited to Speech Therapy, Occupational Therapy, Physical Therapy and any related diagnostic testing
    b. recreational and educational therapy
    c. learning disabilities
    d. behavior modification therapy
    e. non-medical self-care or self-help training including any diagnostic testing
    f. music therapy
    g. health club memberships

This exclusion will not apply to expenses related to the diabetic self-management education programs, diagnosis, testing and treatment of ADD or ADHD or autism disorder, Asperger's syndrome, and any pervasive development disorder not otherwise specified. However, coverage does not include services that are considered Experimental, Investigational and/or not Medically Necessary in the assessment and/or treatment of Autism Spectrum Disorders (ASD's).

11. **Charges Not Covered** – added for clarification.

    29. **Medical Marijuana.** Charges for marijuana or marijuana-derived substances or compounds (like THC/CBD oil), even if the Participant has a prescription and marijuana is legal under the laws of the state in which he or she lives.

    35. **Nutritional Supplement.** Total parenteral nutrition, dietary medical treatment of phenylketonuria (PKU), and amino acid-based elemental formulas.

12. **Coordination of Benefits** – amended for clarification.

EFFECTS ON BENEFITS

Coordination of benefits does not apply to Medicare Part D.

The benefits payable under this Plan for expenses Incurred (as determined by the Expenses section of this Plan) by a Fully Covered Person shall be reduced by the amount such Fully Covered Person is eligible for benefits under Full Medicare Coverage. Any benefits received from Full Medicare Coverage not covered by this Plan shall not reduce benefits payable under this Plan.

Except that:

For working Employees age 65 and older who continue to participate in this Plan, this Plan will provide its full regular benefits first and Medicare coverage may provide supplemental benefits for those expenses not paid by this Plan. If the working Employee's Spouse is also enrolled in this Plan, this provision would apply to the Spouse during the period of time both the Employee and the Spouse are age 65 and older. If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges Incurred on or after February 1, 1991 and before August 5, 1997) and for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law. This provision intends to comply with the TEFRA Act of 1982.

The Participant has the right to voluntarily enroll in Medicare due to an ESRD diagnosis and has the right not to be requested or encouraged to disenroll from this Plan, except in circumstances specified in federal law. The Plan will not reduce benefits where federal law requires that benefits are determined without regard to benefits available under Medicare.

13. **General Information** – replaced Covered Individual with covered Participant and amended sections for clarification.

DEFINITION OF COVERED PARTICIPANT

A covered Participant as to each benefit means only an Employee or dependent who is covered for such benefit.

DEFINITION OF WORK ON A FULL-TIME BASIS

An Employee shall be deemed working on a full-time basis if the Employee is absent from work due to a health factor. An Employee shall be deemed working on a full-time basis on any Employer-approved holiday, vacation, or paid leave provided that the Employee was working on a full-time basis on his last regularly scheduled working day before such vacation, holiday, or paid leave. In no event will an Employee be considered working on a full-time basis if he has effectively terminated employment.

14. **Subrogation/Reimbursement** – amended the following sections for clarification.

Payment Condition

3. In the event a Participant(s) settles, recovers, or is reimbursed by any coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

Obligations

1. It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the Illness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
    g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    h. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
    i. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    j. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
    k. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

15. **Subrogation/Reimbursement** – added the following section for clarification.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.