




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.lucenthealth.com/capitol or call 1-800-331-5301. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-331-5301 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,000 individual / \$1,000 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, Prescription drugs \$150 / individual for all brand name drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$2,000 individual / \$3,000 for family Rx Copays: \$4,500 individual / \$9,000 for family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit ?	Copayments on certain services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.anthem.com/ca or call 1-888-650-6566 for a list of participating providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without permission from this plan .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Telemedicine through HealthTap – no charge, deductible does not apply.
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No charge; deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	No charge for lab work done outside of the hospital facility
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Prior authorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.costcohealthsolutions.com or 877-908-6024.	Generic drugs	Retail: \$10 copay /prescription Mail Order: \$20 copay /prescription	25% of purchase price plus \$10 copay / prescription Mail Order: Not covered	Retail: up to a 90-day supply Mail Order: up to a 90-day supply
	Preferred brand drugs	Retail: \$30 copay /prescription Mail Order: \$60 copay /prescription	25% of purchase price plus \$30 copay / prescription Mail Order: Not covered	When a coupon is used, the copay is increased to the amount of the coupon, but the member only has to pay the lesser of regular copay amount or amount offered in the coupon, and the remainder of the coupon would apply to the plan.
	Non-preferred brand drugs	Retail: \$50 copay /prescription Mail Order: \$100 copay /prescription	25% of purchase price plus \$50 copay / prescription Mail Order: Not covered	
	Specialty drugs	Retail: 20% coinsurance up to \$150 copay maximum/prescription Mail Order: 20% coinsurance up to \$300 maximum/prescription	Not covered	Retail: 30-day supply Mail Order: 90-day supply Specialty Drugs over \$1,500 for a 30-day supply require additional Plan Authorization by contacting SCCC at 912-452-9232.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	\$50 copay per surgery and 20% coinsurance	50% coinsurance , up to \$350 of allowed amount per day	Prior Authorization is required.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.lucenthealth.com/capitol

Common Medical Event		What You Will Pay		Limitations, Exceptions, & Other Important Information
Services You May Need		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$100 copay and 20% coinsurance	\$100 copay and 20% coinsurance	Network deductible applies to Out-of-Network benefits
	Emergency medical transportation	20% coinsurance	20% coinsurance	Network deductible applies to Out-of-Network benefits
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay per day up to 3 days and 20% coinsurance	50% coinsurance , up to \$1,500 of allowed amount per day	Prior Authorization is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	\$100 copay per day up to 3 days and 20% coinsurance	50% coinsurance , up to \$1,500 of allowed amount per day	Prior Authorization is required.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, copay , coinsurance , and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior Authorization may be required.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	\$100 copay per day up to 3 days and 20% coinsurance	50% coinsurance , up to \$1,500 of allowed amount per day	
If you need help recovering or have	Home health care	20% coinsurance	Not covered	Prior Authorization is required. Limited to 100 visits per plan year
	Rehabilitation services	20% coinsurance	Office: 50% coinsurance Outpatient Hospital: 50% coinsurance up to \$350 maximum of allowed amount	Speech Therapy limited to 23 visits per plan year

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.lucenthealth.com/capitol

other special health needs	Habilitation services	20% coinsurance	Office: 50% coinsurance Outpatient Hospital: 50% coinsurance up to \$350 maximum of allowed amount	Speech Therapy limited to 23 visits per plan year
What You Will Pay				
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	20% coinsurance	50% coinsurance up to \$1,500/day of allowed amount	Prior Authorization is required. Up to 100 days per plan year
	Durable medical equipment	20% coinsurance Breast pump: No charge; deductible does not apply	50% coinsurance Breast pump: Not covered	None
	Hospice services	20% coinsurance	Not covered	Prior Authorization is required. Includes Family bereavement counseling
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care (Adult) • Infertility Treatment 	<ul style="list-style-type: none"> • Long-term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing 	<ul style="list-style-type: none"> • Routine Eye Care (Adult) • Routine Foot Care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture (limited to 24 visits per plan year) • Bariatric Surgery 	<ul style="list-style-type: none"> • Chiropractic Care (limited to 25 visits per plan year) 	<ul style="list-style-type: none"> • Hearing Aids (1 hearing aid per ear per 36 months up to a maximum of \$2,000 in covered charges.)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the [plan](#) at 1-877-236-0844. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits

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Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the plan at Mendicino County Schools (Staywell) c/o Lucent Health Solutions, LLC at 10951 White Rock Road Suite 100, Rancho Cordova, CA 95670 or call 1-800-331-5301. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. “Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-487-2365 or <http://www.dol.gov/ebsa/>.” A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers> and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-331-5301

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-331-5301

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-331-5301

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-331-5301

To see examples of how this [plan](#) might cover costs for a sample medical situation,

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$10
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,410

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

SUMMARY OF MATERIAL MODIFICATIONS

Important Notice

Effective beginning with Plan Years on and after January 1, 2022

This Summary of Material Modification (“SMM”) describes changes to this health plan required by the Consolidated Appropriations Act of 2021, including the No Surprises Act. The following shall be deemed to be an amendment to the Plan.

The following definitions are added to the Summary Plan Description:

“Certified IDR Entity”

“Certified IDR Entity” shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

“Independent Freestanding Emergency Department”

“Independent Freestanding Emergency Department” means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

“Participating Health Care Facility”

“Participating Health Care Facility” shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

“Qualifying Payment Amount”

“Qualifying Payment Amount” means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan’s Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law

“Recognized Amount”

“Recognized Amount” shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider’s billed charge or the Qualifying Payment Amount.

The definition of Emergency Services is changed to the following:

Emergency Services”

“Emergency Services” shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a

Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

The definition of Maximum Allowable Charge is changed to the following:

“Maximum Allowable Charge”

The “Maximum Allowable Charge” shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see “No Surprises Act – Emergency Services and Surprise Bills” within the section “Summary of Benefits,”) if no negotiated rate exists, the Maximum Allowable Charge will be the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, 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, 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.

In the Claims Procedures; Payment of Claims section, the External Review Process is changed to the following:

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

In the Network and Non-Network Provider Arrangement provision of the Summary of Benefits section of the Plan, the following changes are made:

Except as outlined in “No Surprises Act – Emergency Services and Surprise Bills” below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

In the Network and Non-Network Provider Arrangement provision of the Summary of Benefits section of the Plan, the following is added:

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, “continuing care patient” means an individual:

1. Who is undergoing a course of treatment for a serious and complex condition from a specific Provider;
2. Who is undergoing a course of institutional or Inpatient care from a specific Provider;
3. Who is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery;
4. Who is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider; or
5. Who is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act (“NSA”), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan’s Allowable Expense was the Recognized Amount, regardless of the Plan’s actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider’s billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

1. Emergency Services;
2. Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
3. Covered Non-Network air ambulance services.

For further information about your rights and protection under the No Surprises Act visit the following website <https://www.cms.gov/nosurprises/consumers>. To report potential violations of the Consolidated Appropriations No Surprise Act, contact Health and Human Services at 1-800-985-3059.

Please note that this is a modification to all applicable Summary Plan Descriptions for health (medical, dental and vision, as applicable) and shall be deemed to amend the Plan Document. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged. In the event of conflict, this document controls.