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?	Network providers and Out-of-network providers **$1,000** individual / **$2,000** 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?	Network providers: **$4,000** individual / **$8,000** family Out-of-network providers: **$10,000** individual / **$20,000** 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.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay; deductible does not apply	50% coinsurance	Telemedicine through HealthTap – no charge, deductible does not apply.
	Specialist visit	$45 copay; deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not Covered	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)	$45 copay; deductible does not apply	50% coinsurance	No charge for lab work done outside of the hospital facility
	Imaging (CT/PET scans, MRIs)	$45 copay; deductible does not apply	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 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.
	Preferred brand drugs	Retail: $30 copay/prescription Mail Order: $60 copay/prescription	25% of purchase price plus $30 copay/ prescription Mail Order: Not covered	
	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.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgical center: $250 copay per surgery and 20% coinsurance All other Outpatient: $500 copay per surgery and 20% coinsurance	50% coinsurance, up to $350 of allowed amount per day	Prior Authorization is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$75 copay/visit and 20% coinsurance	$75 copay/visit 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	$45 copay; deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay per plan year and 20% coinsurance	50% coinsurance, up to $600 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	Office: $45 copay; deductible does not apply Partial Hospital: $250 copay; 20% coinsurance All other services: 20% coinsurance	Partial Hospital: 50% coinsurance up to $350 per day All others: 50% coinsurance	Prior Authorization is required except for office visits.
	Inpatient services	$1,000 copay per visit per plan year and 20% coinsurance	50% coinsurance, up to $600 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	$1,000 copay per plan year and 20% coinsurance	50% coinsurance, up to $600 of allowed amount per day	

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Prior Authorization is required. Limited to 100 visits per plan year
	Rehabilitation services	$45 copay; after deductible	Office: 50% coinsurance Outpatient Hospital: 50% coinsurance up to $350 maximum of allowed amount	Speech Therapy limited to 23 visits per plan year
	Habilitation services	$45 copay; after deductible	Office: 50% coinsurance Outpatient Hospital: 50% coinsurance up to $350 maximum of allowed amount	Speech Therapy limited to 23 visits per plan year
	Skilled nursing care	20% coinsurance	Free Standing SNF: 20% coinsurance Inpatient SNF: 50% coinsurance up to $600 of allowed amount per day	Prior Authorization is required. Up to 100 days per plan year
	Durable medical equipment	50% coinsurance Breast pump: No charge; deductible does not apply Prosthetic/Orthotic: 20% coinsurance	50% coinsurance Breast pump: Not covered	Prior Authorization is required.
	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.)		
• Acupuncture • Cosmetic Surgery • Dental Care (Adult)	• Infertility Treatment • Long-term Care • Non-emergency care when traveling outside the U.S.	• Private Duty Nursing • 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.)		
• Bariatric Surgery	• Chiropractic Care (limited to 12 visits per plan year)	• 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 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, kwiijigo 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 copay** **$45**
- **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	$600
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,660**

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 copay** **$45**
- **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	$800
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$1,000**
- **Specialist copay** **$45**
- **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	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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.

Mendocino County Schools (Staywell, JPA)
Retiree Plan
Amendment #1

Effective beginning on July 1, 2020

Mendocino County Schools (Staywell, JPA) Employee Benefit Plan (the "Plan") is hereby amended as follows:

NOTE: The Outpatient Dialysis Carveout Program shown in this amendment applies to California Participants only. It does not apply to Participants outside of California.

On pages 18 and 19, DEFINITIONS, the definition of "Maximum Allowable Charge" is hereby amended:

"Maximum Allowable Charge"
The "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

With respect to Non-Network Emergency Services, the Plan allowance is the greater of:

- If applicable, the negotiated amount for In-Network Providers (the median amount if more than one amount to In-Network Providers).
- The Plan's normal Non-Network payable amount after consideration of the criteria described below (reduced for cost-sharing).
- For outpatient dialysis (California Participants only), the Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based on the average payment actually made for reasonably comparable services and/or supplies to all Providers of the same services and/or supplies by all types of plans in the applicable market during the preceding Calendar Year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.
- The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

If and only if there is no negotiated rate for a given claim, 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.

On page 27, ELIGIBILITY FOR COVERAGE, the "Eligibility for Individual Coverage" section is hereby amended:

Eligibility for Individual Coverage

Each Non-Variable Hour Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following completion of a Service Waiting Period of 30 days, provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work.

> If an Employee changes schools within the district, such change will not be considered a break in service and a new Service Waiting Period will not be applied when such Employee changes schools.

Each Variable Hour Employee who has averaged the requisite Hours of Service, as defined herein, will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period, as defined herein.

Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

On page 79, SUMMARY OF BENFEITS, the following is added to the Plan, before the "Out-of-Area Services" section:

Dialysis Treatment – Outpatient

Note: This program applies to California Participants only.

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:
    1. the concentration of dialysis providers in the market in which Plan reside may allow such providers to exercise control over prices for dialysis-related products and services,
    2. the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
    3. evidence of (i) significant inflation of the prices charged to Plan by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of non-governmental and non-commercial plans, such as the Plan, by dialysis providers as profit centers, and

4. the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the interests of Plan members, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

1. Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").
2. Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan for expenses incurred on or after July 1, 2020, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.
3. Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:
    a. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
    b. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.
4. In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services.

    Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the member, to the following payment limitations, under the following conditions:
    a. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
    b. Maximum Benefit. Except as provided in the preceding subsection or where an acceptable provider agreement is entered into, the maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.
    c. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

d. Additional Information related to Value of Dialysis-Related Services and Supplies. The member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.
e. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.
6. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of this Section, to make determinations regarding issues which relate to eligibility for benefits under this Section, to decide disputes which may arise relative to a Plan's rights under this Section, and to decide questions of interpretation of this Section and those of fact relating to the application of this Section. The decisions of the Plan Administrator will be final and binding on all interested parties.
7. Provider Acceptance. A provider that accepts the payment from the Plan under this Section will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan member, and (ii) it shall not "balance bill" a Plan member for any amount billed but not paid by the Plan.

On page 82, MEDICAL BENEFITS, SUMMARY OF BENEFIT, the Pre-Authorization list is hereby amended.

Note: The following services must be Pre-Authorized or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain Pre-Authorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

- **Home Infusion/Home Injection Therapy**
- **Radiological and Nuclear Imaging Procedures (CT, MRI, MRA, PET, Diagnostic Cardiac procedures utilizing nuclear medicine)**
- **Inpatient Hospital Admissions**
- **Skilled Nursing Facility Admissions**
- **Transplant Services**
- **Bariatric Surgery**
- **Mental Health and Substance Use Disorder Hospital Admissions (Partial Hospitalization Programs, Intensive Outpatient Program, Electroconvulsive Therapy and Psychological Testing)**
- **Transcranial Magnetic Stimulation**
- **Home Health Services.**

- **California Participant Only: Outpatient Dialysis Services.**

Please see the Utilization Management section of this booklet for details.

On page 87, MEDICAL BENEFITS, SUMMARY OF BENFEITS, the "Dialysis Services" benefit is hereby amended:

	Participating Providers	Non-Participating Providers
Dialysis Services (Outpatient) – for California Participants only.	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. **NOTE: Outpatient Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims. Please refer to the Dialysis Treatment Outpatient Description**	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. **NOTE: Outpatient Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims. Please refer to the Dialysis Treatment Outpatient Description**

On page 88, MEDICAL BENEFITS, SUMMARY OF BENEFITS, the "Routine Well Woman" section of the Preventive Care benefit is hereby amended. (The mammogram limits are new.)

	Participating Providers	Non-Participating Providers
Preventive Care		
Colorectal Cancer Screening – Outpatient/Ambulatory	100%, deductible waived	Not Covered
Routine Well Adult Care	100%, deductible waived	Not Covered
All preventive care services as recommended by the U.S. Preventive Services Task Force. For a complete listing go to: www.uspreventiveservicestaskforce.org/		
Rouinte Well Child Care – Includes all Immunizations	100%, deductible waived	Not Covered
All preventive care services as recommended by the U.S. Preventive Services Task Force. For a complete listing go to: www.uspreventiveservicestaskforce.org/		
Routine Well Woman	100%, deductible waived	Not Covered
All preventive care services as recommended by the U.S. Preventive Services Task Force. For a complete listing go to: www.uspreventiveservicestaskforce.org/. (**Mammograms**: one every other year for ages 50-74. If authorized by the Participant's Physician in writing, mammograms will be allowed as often as annually for ages 40-49 as preventive. Mammograms prior to age 40 will be considered diagnostic and will be subject to the deductible and coinsurance.)		

On page 88, MEDICAL BENEFITS, SUMMARY OF BENEFITS, the "Renal Dialysis" benefits under the Therapeutic Services are for the Non-California Participants only. (Outpatient dialysis benefits for the California Participants are part of a separate dialysis benefit, as shown on the previous page.)

On page 88, MEDICAL BENEFITS SUMMARY OF BENEFITS, the "Telemedicine (Health Tap)" benefit is deleted and replaced with the following benefits:

	Participating Providers	**Non-Participating Providers**
Telemedicine	Paid the same as any office visit	Paid the same as any office visit
Telemedicine (Health Tap)	100% (deductible waived)	Not Applicable

In the MEDICAL BENEFITS, SUMMARY OF BENEFITS section of the Plan, the following benefit for Independent Labs is added to the Summary of Benefits

	Participating Providers	**Non-Participating Providers**
Independent Lab (including blood draw)	100% (deductible waived)	50% after deductible

On page 99, Medical Exclusions, the "Obesity" exclusion is hereby amended:

Obesity. Charges related to the care and treatment of obesity, weight loss or dietary control through medication and/or nutritional counseling/diet programs are excluded, unless related to morbid obesity (which is the lesser of 100 pounds over normal weight or twice normal weight). This exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit. This exclusion does not apply to the Bariatric Surgery Services benefit that is shown on the Schedule of Benefits.

On page 102, UTILIZATION MANAGEMENT, the "Services that Require Pre-Certification" list is hereby amended.

Services that Require Pre-Certification

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

The attending Physician does not have to obtain Pre-Authorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

- Home Infusion/Home Injection Therapy.
- Radiological and Nuclear Imaging Procedures:
    a. CT,
    b. MRI,
    c. MRA,
    d. PET,
    e. Diagnostic Cardiac Procedures utilizing nuclear medicine.
- Inpatient Hospital Admissions.
- Skilled Nursing Facility Admissions.

- Transplant Services.
- Bariatric Surgery.
- Mental Health and Substance Use Disorder Hospital Admissions:
    a. Partial Hospitalization Program,
    b. Intensive Outpatient Program,
    c. Electroconvulsive Therapy,
    d. Psychological Testing.
- Transcranial Magnetic Stimulation
- Home Health Services.
- **California Participants Only**: Outpatient Dialysis Services.

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:
Mendocino County Schools – Staywell (Retiree)
Amendment #1
Effective July 1, 2020

By: ___________________________

Title: __________________________

Date: _____________________

Mendocino County Schools (Staywell, JPA)
Retiree Plan
Amendment #2

Effective beginning on July 1, 2020

Mendocino County Schools (Staywell, JPA) Employee Benefit Plan (the "Plan") is hereby amended as follows:

On page 83, MEDICAL BENEFITS, the last paragraph about the deductible is deleted and replaced with the following language:

Deductible: The Deductible is the amount Participants must pay each Plan Year before the Plan will begin paying benefits for Covered Expenses, as shown on the Schedule of Benefits ("Employee-Only Coverage" and "Family Coverage"). Each July 1st, the Deductible amounts start over. Deductibles accrue toward the maximum out-of-pocket amounts. **The family coverage Deductible is considered an aggregate amount.** The Plan will not begin paying benefits for Covered Expenses until the entire family coverage Deductible has been met. The family coverage Deductible may be met by only one person in the family or by multiple members in the family.

Maximum Out-of-Pocket: The maximum out-of-pocket amount is the most Participants will pay for Covered Expenses each Plan Year, as shown on the Schedule of Benefits ("Employee-Only Coverage" and "Family Coverage". Each July 1st, the maximum out-of-pocket amounts start over. **The family coverage maximum out-of-pocket amount is considered an aggregate amount**. The Plan does not begin paying benefits for Covered Expenses at 100% until the entire family coverage maximum out-of-pocket amount has been met. The family coverage maximum out-of-pocket amount may be met by only one person in the family or by multiple members in the family.

On page 84, MEDICAL BENEFITS, SUMMARY OF BENEFITS, the "Deductible, Per Plan Year" and "Maximum Out-of-Pocket Amount, Per Plan Year" sections are hereby amended:

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
DEDUCTIBLE, PER PLAN YEAR		
Employee-Only Coverage	$1,000	
Family Coverage (Aggregate)	$2,000	
Family Coverage Deductible (Aggregate): The Plan does not begin paying benefits until the entire family coverage Deductible has been met. The family coverage Deductible may be met by only one person in the family or by multiple members in the family.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (Combined for Participating and Non-Participating Providers)		
Employee-Only Coverage	$4,000	$10,000
Family Coverage (Aggregate)	$8,000	$20,000
Family Coverage Maximum Out-of-Pocket (Aggregate): The Plan does not begin paying at 100% until the entire family coverage maximum out-of-pocket amount has been met. The family coverage maximum out-of-pocket amount may be met by only one person in the family or by multiple members in the family.		
The Plan will pay the designated percentage of Covered Charges until Out-of-Pocket amount are reached; at which time the plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the Out-of-Pocket maximum and are never paid at 100%: Cost containment penalties Amounts over Usual and Reasonable Charges		

On page 84, MEDICAL BENEFITS SUMMARY OF BENEFITS, the "Ambulance (Air Ambulance)" benefit is hereby amended:

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Ambulance Services	80% after deductible	
	Transportation by ambulance for other than an emergency is only covered if medically necessary to transport you from one medical facility to another.	
Ambulance (Air Ambulance)	100%, deductible waived (Must be enrolled with Air Med Care Contract)	50% after deductible

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:
Mendocino County Schools – Staywell (Retiree)
Amendment #2
Effective July 1, 2020

By: ___________________________

Title: Staywell CFO

Date: 11-12-2020

Mendocino County Schools (Staywell, JPA)
Retiree Plan
Amendment #3

Effective beginning on July 1, 2021

Mendocino County Schools (Staywell, JPA) Employee Benefit Plan (the "Plan") is hereby amended as follows:

All references in the Plan to Blue Cross, Blue Shield, Blue Card, Host Blue are deleted in their entirety. (The new Network is Anthem JAA.)

In the SUMMARY OF BENEFITS section of the Plan, the sections entitled "Out-of-Area Services", "Inter-Plan Arrangements" , "Blue Shield Global Core" Special Cases: Value Based Programs" are deleted in their entirety.

On page 82, MEDICAL BENEFITS, SUMMARY OF BENEFITS, the Pre-Authorization list is hereby amended:

Services That Require Pre-Certification

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

1. Inpatient hospitalization.
2. Skilled Nursing Facility
3. Transplants (needed at the time of evaluation).
4. Outpatient Surgery
5. Cardiac Therapy.
6. Home Health Care.
7. Infusion Services.
8. Pain Management.
9. Pulmonary Therapy.
10. Residential Treatment Facility Programs.
11. Durable Medical Equipment.

Remember that although the Plan will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has their Physician call to obtain Pre-Certification if there is a need to have a longer stay.

Pre-Certification does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined.

Please see the UTILIZATION REVIEW section of the Plan details.

On page 82, MEDICAL BENFEITS, SUMMARY OF BENEFITS, Participating Provider Organization section (Blue Shield of CA) is deleted and replaced with Anthem JAA.

On page 102, UTILIZATION MANAGEMENT, the "Services that Require Pre-Certification" list is hereby amended:

Services That Require Pre-Certification

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

1. Inpatient hospitalization.
2. Skilled Nursing Facility
3. Transplants (needed at the time of evaluation).
4. Outpatient Surgery
5. Cardiac Therapy.
6. Home Health Care.
7. Infusion Services.
8. Pain Management.
9. Pulmonary Therapy.
10. Residential Treatment Facility Programs.
11. Durable Medical Equipment.

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:
Mendocino County Schools – Staywell (Retiree)
Amendment #3
Effective July 1, 2021

By: Becky Jeffries

Title: Staywell CFO

Date: 6-29-2021

Mendocino County Schools (Staywell, JPA)
Active Plan
Amendment #4

Effective beginning on July 1, 2021

Mendocino County Schools (Staywell, JPA) Employee Benefit Plan (the "Plan") is hereby amended as follows:

In the **MEDICAL BENFEITS** section of the Plan, the following benefit is added to the **SUMMARY OF BENEFITS**:

Active $1,000 Plan			
Covered Medical Expenses	**Participating Providers**	**Non-Participating Providers**	**Limits**
Birthing Centers			
Thrive Birthing Center (Santa Rosa)	80% after deductible and $100 copay per day, up to three days per Plan Year		
Bloom Birthing Center (Ukiah)	80% after deductible and $100 copay per day, up to three days per Plan Year		
All Others	80% after deductible and $100 copay per day, up to three days per Plan Year	50% after deductible, up to $1,500 maximum per day of allowable	

In the **MEDICAL BENEFITS** section of the Plan, the following benefit is added to the list of **<u>Medical Benefits</u>**:

Birthing Center. Services of a birthing center for Medically Necessary care provided within the scope of its license.

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:
Mendocino County Schools – Staywell (Active)
Amendment #4
Effective July 1, 2021

By: Traci Doster

Title: Confidential Benefits Specialist, Staywell

Date: 5/26/2022

Mendocino County Schools (Staywell, JPA)
Retiree Plan
Amendment #6

Effective beginning on May 1, 2022

Mendocino County Schools (Staywell, JPA) Employee Benefit Plan (the "Plan") is hereby amended as follows:

In the **PRESCRIPTION DRUG BENEFITS** section of the Plan, the following program is added:

SCCConcepts, LLC
Strategic Cost Containment Concepts

The Plan Administrator has entered into an affiliated arrangement to implement a program to reduce high-cost medications and process them through manufacturer programs. This benefit would provide a $0 (zero) copayment to the Participant and up to a 60% savings to the Plan based on prescription drugs over $1,500 for a 30-day fill. Such programs may include, but are not limited to, data collection, consulting with the Participant and the Physician, and research. This program is not a guarantee of coverage and is subject to additional prior authorization and approval by the manufacturer. Participants may speak to the Specialty Drug Administrator with questions about these programs by contacting a representative at 1-912-452-9232.

All Plan Participants who are prescribed any specifically identified drug are required to complete an administrative review by the Prescription Assistance Program (PAP) Provider. The Plan shall direct the PAP vendor to seek those drugs from the manufacturer through PAP or other alternative funding means.

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:
Mendocino County Schools – Staywell JPA (Retiree)
Amendment #6
May 1, 2022

By: Traci Doster

Title: Confidential Benefits Specialist, Staywell

Date: 5/26/2022

Mendocino County Schools (Staywell, JPA)
Retiree Plan
Amendment #7

Effective beginning on March 1, 2022

The Mendocino County Schools (Staywell, JPA) Employee Benefit Plan (the "Plan") is hereby amended as follows:

In the **COORDINATION OF BENEFITS** section of the Plan, the **Standard Coordination of Benefits** section is hereby amended:

Standard Coordination of Benefits

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges. (*Note*: This Plan will use the lesser Allowable Expense(s) between this Plan and the other plan to coordinate benefits. As secondary payer, this Plan will reimburse the Participant's responsibility with the primary plan at 100% (no Deductible Copays or Coinsurance) up to the lesser Allowable Expenses.)

In the **COORDINATION OF BENEFITS** section of the Plan, the first paragraph of **Effect on Benefits** is hereby amended:

Effect on Benefits

Application of Benefit Determinations

The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. (*Note*: Refer to the "Standard Coordination of Benefits" section above for details.) When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:
Mendocino County Schools – Staywell JPA
Amendment #7
May 1, 2022

By: Traci Doster *Traci Doster*

Title: Confidential Benefits Specialist, Staywell

Date: 08.09.2022

Mendocino County Schools (Staywell, JPA)
Employee Benefit Plan
Retiree Plan
Amendment #9

Effective beginning on January 1, 2023

The Mendocino County Schools (Staywell, JPA) Employee Benefit Plan (the "Plan") is hereby amended as follows:

In the MEDICAL BENEFITS section of the Plan, the "Preventive Care" section of the SUMMARY OF BENEFITS is hereby amended. (The mammogram limits are updated.)

	Participating Providers	Non-Participating Providers
Preventive Care		
Colorectal Cancer Screening – Outpatient/Ambulatory	100%, deductible waived	Not Covered
Routine Well Adult Care	100%, deductible waived	Not Covered
All preventive care services as recommended by the U.S. Preventive Services Task Force. For a complete listing go to: www.uspreventiveservicestaskforce.org/		
Rouinte Well Child Care – Includes all Immunizations	100%, deductible waived	Not Covered
All preventive care services as recommended by the U.S. Preventive Services Task Force. For a complete listing go to: www.uspreventiveservicestaskforce.org/		
Routine Well Woman	100%, deductible waived	Not Covered
All preventive care services as recommended by the U.S. Preventive Services Task Force. For a complete listing go to: www.uspreventiveservicestaskforce.org/. (**Mammograms**: If authorized by the Participant's Physician in writing, mammograms will be allowed as often as annually for ages 40-74 as preventive. Mammograms prior to age 40 will be considered diagnostic and will be subject to the deductible and coinsurance.)		

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:
Mendocino County Schools – Staywell JPA
Amendment #9
January 1, 2023

By: Becky Jeffries

Title: Staywell CFO

Date: 3.28.23