Summary of Material Modification

To all Participants under the

South Central Ohio Insurance Consortium Health Plan

This is a Summary of Material Modifications ("SMM") regarding the South Central Ohio Insurance Consortium Health Benefit Plan for Employees of Washington Court House City Schools (the "Plan"). This SMM supplements and amends the Summary Plan Description ("SPD") previously provided to you. The effective date of the changes in this SMM is January 1, 2024, unless an alternative effective date is specified below. Please do three things:

(1) Carefully read this SMM. If you have any questions, contact the Plan Administrator;
(2) Keep this SMM with your Summary Plan Description; and
(3) Mark the sections of your Summary Plan Description that have been changed, so when you look at that section of your Summary Plan Description, you will be reminded that the change described in this SMM has occurred.

I. In the SPD under "Schedule of Benefits", "Medical Benefits Schedule – HSA Plan", the Deductible Section is replaced with the following:

DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$3,200	$6,400
Per Family Unit	$6,400	$12,800
MAXIMUM COINSURANCE LIMIT, PER CALENDAR YEAR (including deductible)		
Per Covered Person	$3,200	$8,000
Per Family Unit	$6,400	$16,000

If you have questions about this Summary of Material Modification or about the Plan, or need a copy of the Summary Plan Description, please check with your employer's benefits office.

MEDICAL BENEFITS SCHEDULE
HSA PLAN

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$3,000	$6,000
Per Family Unit	$6,000	$12,000
Amounts applied to the Network Deductible and the Non-Network Deductible do not cross-apply.		
The Calendar Year deductible is waived for the following Covered Charges: - Network Preventive Care - Flu Shots		
MAXIMUM COINSURANCE LIMIT, PER CALENDAR YEAR (includes deductible)		
Per Covered Person	$3,000	$8,000
Per Family Unit	$6,000	$16,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (includes deductible)		
Per Covered Person	$4,000	$8,000
Per Family Unit	$8,000	$16,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum: Non-Precertification penalties Amounts over Usual and Reasonable Charge Amounts for products included in the ACMS Rx Assistance Program		
COVERED CHARGES		
Inpatient Hospital Services		
Room, Board, and Miscellaneous Expenses	100% after deductible	80% after deductible
Intensive Care Unit	100% after deductible	80% after deductible
Outpatient Hospital Services		
Surgical Facilities	100% after deductible	80% after deductible
Other Outpatient Services	100% after deductible	80% after deductible
Emergency Room Visit	$300 copay after deductible	Not Covered
Urgent Care Facility	$100 copay after deductible	Not Covered
Skilled Nursing Facility	100% after deductible 180 day Calendar Year maximum	80% after deductible 60 day Calendar Year maximum
Physician Services		
Inpatient visits	100% after deductible	80% after deductible
Office visits (including related services billed by the Physician)	$20 copay after deductible	Not Covered
Specialist visits	$50 copay after deductible	Not Covered
Surgery	100% after deductible	80% after deductible
Anesthesia	100% after deductible	Paid Same As Network
Allergy services	100% after deductible	80% after deductible
Diagnostic Testing (X-ray & Lab)	100% after deductible	80% after deductible
Independent Laboratory expenses	100% after deductible	Paid Same As Network
Radiology/Pathology interpretation	100% after deductible	Paid Same As Network

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Home Health Care/Private Duty Nursing	100% after deductible 100 visit Calendar Year maximum	80% after deductible 50 visit Calendar Year maximum
Hospice Care	100% after deductible 180 day Lifetime maximum	Not Covered
Bereavement Counseling	2 visit Lifetime maximum	Not Covered
Ambulance Service	100% after deductible	Paid Same As Network
Jaw Joint/TMJ	100% after deductible	Not Covered
Wig After Chemotherapy	100% after deductible $400 Lifetime maximum	80% after deductible $400 Lifetime maximum
Physical/Occupational Therapy	100% after deductible Limited to 20 visits for each therapy per Calendar Year	80% after deductible Limited to 10 visits for each therapy per Calendar Year
Speech & Vision Therapy	100% after deductible Limited to 20 visits for each therapy per Calendar Year	80% after deductible Limited to 10 visits for each therapy per Calendar Year
Spinal Manipulation/ Chiropractic	100% after deductible 15 visit Calendar Year maximum	80% after deductible 15 visit Calendar Year maximum
Mental Disorders/Substance Abuse	Paid based on the type of service(s) received.	
Preventive Care		
Routine Well Adult Care	100%	50% after deductible
Includes: office visits, pap smear, mammogram, gynecological exam, routine physical examination, x-rays, laboratory tests, prostate specific antigen test, colonoscopies, sigmoidoscopies and anoscopy, proctosigmoidoscopy, medical tests and other preventive services as required by law.		
Routine Well Child Care	100%	50% after deductible
Includes: office visits, routine physical examination, laboratory tests, x-rays, immunizations, and other Preventive services as required by law.		
Flu Shot	100%	Paid Same As Network
Eye Exam (including refractive exams)	100% after deductible Limited to 1 per Calendar Year, unless otherwise required by law	Not Covered
Organ Transplants	100% after deductible	Not Covered
Prescription Drugs (Mail Order or Retail Pharmacy)	100% after deductible	Paid Same As Network
Other Medical Services and Supplies	100% after deductible	80% after deductible
Products included in the ACMS Rx Assistance Program	Requires enrollment in the ACMS Rx Assistance Program	

PRESCRIPTION DRUG BENEFIT SCHEDULE
HSA PLAN

PRESCRIPTION DRUG BENEFIT	
	NETWORK
Pharmacy Option (30 Day Supply)	
Generic Drugs	$10 copayment after deductible
Formulary Brand Name Drugs	$50 copayment after deductible
Non-Formulary Brand Name Drugs	$100 copayment after deductible
Specialty Drugs	$100 copayment Requires enrollment in the ACMS Rx Assistance Program
Mail Order Option (90 Day Supply)	
Generic Drugs	$10 copayment after deductible
Formulary Brand Name Drugs	$50 copayment after deductible
Non-Formulary Brand Name Drugs	$100 copayment after deductible

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

NOTE: Charges for Prescription Drugs obtained through the Prescription Drug Benefit section will not apply to the Calendar Year Deductible. Prescription Drug expenses do apply to the Out-of-Pocket Maximum under Medical Benefits section of this Plan.

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, call 614-766-5800 or visit us at www.mycarefactor.com. 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 www.mycarefactor.com or call 614-766-5800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,200/Individual or $6,400/family Out-of-network: $6,400/individual or $12,800/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary 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?	No.	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?	For network providers $4,000 individual / $8,000 family For Out-of-Network providers $8,000 individual / $16,000 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Non-Precertification Penalties; Amounts over Usual and Reasonable.	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.mycarefactor.com or call 614-766-5800 for a list of network 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.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 (includes tele-health services)	Primary care visit to treat an injury or illness	$20 copay after deductible	Not Covered	None
	Specialist visit	$50 copay after deductible	Not Covered	None.
	Preventive care/screening/ immunization	No charge	20% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Routine Well Adult Care Out-of-network services not covered
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	20% coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	20% coinsurance after deductible	
	COVID-19	No Charge	No Charge	Out-of-Network will be paid at the Usual, Reasonable, and Customary rate
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Generic drugs (Tier 1)	$10 copay after deductible	$10 copay after deductible	Covers up to a 30-day supply (retail subscription); Mail order and Retail (for 90-day supply) Specialty drugs limited to a 30-day supply whether mail order or retail.
	Preferred brand drugs (Tier 2)	$50 copay after deductible	$50 copay after deductible	
	Non-preferred brand drugs (Tier 3)	$100 copay after deductible	$100 copay after deductible	
	Specialty Drugs	May be available under the Select Drugs and Products Program	May be available under the Select Drugs and Products Program	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	20% coinsurance after deductible	
	Physician/surgeon fees	0% coinsurance after	20% coinsurance after	

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)	
		deductible	deductible	
If you need immediate medical attention	Emergency room care	$300 copay after deductible	Not Covered	
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after deductible	
	Urgent care	$100 copay after deductible	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	20% coinsurance after deductible	Non Pre-Cert Penalty 50% up to $500
	Physician/surgeon fees	0% coinsurance after deductible	20% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	20% coinsurance after deductible	Inpatient - Non Pre-Cert Penalty 50% up to $500
	Inpatient services	0% coinsurance after deductible	20% coinsurance after deductible	
If you are pregnant	Office visits	0% coinsurance after deductible	20% coinsurance after deductible	Non Pre-Cert Penalty 50% up to $500 if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean delivery
	Childbirth/delivery professional services	0% coinsurance after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	20% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	20% coinsurance after deductible	In Network 100 visit maximum Out-of-Network 50 visit maximum Out-of-Network Pre-Cert Penalty 50% up to $500
	Rehabilitation services	0% coinsurance after deductible	20% coinsurance after deductible	In Network 20 visit maximum Out-of-Network 10 visit maximum Out-of-Network Pre-Cert Penalty 50% up to $500
	Habilitation services	0% coinsurance after deductible	20% coinsurance after deductible	
	Skilled nursing Facility	0% coinsurance after deductible	20% coinsurance after deductible	In-Network 180 day maximum Out-of-Network 60 visit maximum Out-of-Network Pre-Cert Penalty 50% up to $500
	Durable medical equipment	0% coinsurance after deductible	20% coinsurance after deductible	No coverage for charges in excess of the purchase price. Non-Pre-Cert Penalty 50% up to $500 if costs exceed $2000
	Hospice services	0% coinsurance after	20% coinsurance after	180 day lifetime maximum

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)	
		deductible	deductible	
If your child needs dental or eye care	Children's eye exam	Paid at 100%	Not Covered	Limited to 1 per Calendar Year, unless otherwise required by law.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Paid at 100%	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Infertility Treatment
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Organ Transplants
- Chiropractic Care (15 visit Calendar year maximum)
- Bariatric Surgery (subject to Medical Necessity requirements)

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 614-766-5800. 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, 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: www.mycarefactor.com or by calling 614-766-5800.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.

Questions: Call 614-766-5800 or visit us at www.mycarefactor.com

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 614-766-5800.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 614-766-5800.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 614-766-5800

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 614-766-5800.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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** **$3,200**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$3,200
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,250**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,200**
- **Specialist copayment** **$50**
- **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*	$3,200
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,250**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3,200**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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*	$3,200
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$3,250**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.