PLAN DOCUMENT AMENDMENT #2

FOR

NEW ORLEANS REGIONAL PHYSICIAN HOSPITAL ORGANIZATION, INC. D/B/A PEOPLES HEALTH

PHN EMPLOYEE PLAN

EFFECTIVE JANUARY 1, 2018

NOTICE IS HEREBY GIVEN that the New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health PHN Employee Plan document is amended effective January 1, 2018.

CHANGE 1. The notice, shown below, is hereby added to the PHN Employee Plan document:

NOTICE OF NONDISCRIMINATION

Discrimination is Against the Law
The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator, P.O. Box 998, Covington, LA 70433, Phone: 1-888-472-4352, TTY: 711, Fax:

985-898-1636, CivilRightsCoordinator@gilsbar.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish:	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-472-4352. (TTY: 711).
French:	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-472-4352. (ATS: 711).
Vietnamese:	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-472-4352. (TTY: 711).
Chinese:	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-472-4352。(TTY: 711).
Arabic:	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1--888-472-4352 (رقم هاتف الصم والبكم:711).
Tagalog:	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-472-4352. (TTY: 711).
Korean:	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-472-4352 (TTY: 711)번으로 전화해 주십시오.
Portuguese:	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-472-4352. (TTY: 711).
Laotian:	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ເສັຽຄ່າ ການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-472-4352 (TTY: 711).

Japanese:	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-472-4352（TTY:711）まで、お電話にてご連絡ください。
Urdu:	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-888-472-4352 (TTY: 711).
German:	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-472-4352 (TTY: 711).
Farsi:	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-472-4352 (TTY: 711) تماس بگیرید.
Russian:	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-472-4352 (телетайп: 711).
Thai:	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-472-4352 (TTY: 711).
Gujarati:	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-472-4352 (TTY: 711).
Hindi:	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-472-4352 (TTY: 711) पर कॉल करें।
Hmong:	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-472-4352 (TTY: 711).
Navajo:	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-888-472-4352 (TTY: 711.)
Syriac:	ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܩܒܠܝܬܘܢ ܚܠܝܬܐ ܕܗܝܠܦܬ ܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-888-472-4352 (TTY: 711)
Cambodian:	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-472-4352 (TTY: 711)។
Serbo-Croatian:	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-472-4352 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Amharic:	ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-472-4352 (መስማት ለተሳናቸው: 711).
Haitian Creole:	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-472-4352 (TTY: 711).

CHANGE 2. The subsection "Eligible Dependent" in the section entitled "HIGHLIGHTS OF THE PHN EMPLOYEE PLAN" is hereby deleted in its entirety and replaced with the following:

Eligible Dependent
The Plan Administrator determines status as an Eligible Dependent hereunder and reserves the right to require such documentation as it deems satisfactory that a dependent is an Eligible Dependent under the Plan. The term "Eligible Dependent" shall mean any one or more of the following except that no Participant covered as an employee shall also be covered as a dependent, regardless of eligibility.

1. The Spouse, as defined by the Plan in the Definitions section, of an Eligible Employee until the date of legal separation or divorce, whichever occurs first.

   A common law spouse is not eligible for coverage under the Plan, even in a state where common law marriage is recognized.

   A domestic partner is not eligible for coverage under the Plan, even in a state where domestic partnership is recognized.

2. Any Child of an Eligible Employee who is:

   a. under the age of 26; or

   b. incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age 26. Such Child must have had continuous coverage as a dependent prior to attainment of such age and have remained covered continuously thereafter. The Plan Administrator may require proof of prior coverage. Additionally, at reasonable intervals during the two years following the dependent's reaching limiting age, the Plan Administrator may require subsequent proof of the Child's disability and continued incapability of self-sustaining employment. After such two-year period, the Plan Administrator may not require proof more than once each year.

   "Child" includes:

   a. a natural child following birth; or

b. a legally adopted child; or

c. a child legally placed in the employee's home for the purpose of adoption by the employee; or

d. a stepchild; or

e. a child under the legal guardianship of the employee; or

f. a child of the employee for whom the employee is required to provide health benefits pursuant to a Qualified Medical Child Support Order (QMCSO) in accordance with procedures adopted by the Plan Administrator. (Special rules apply to QMCSOs. Contact the Plan Administrator in situations of divorce and child custody for information regarding QMCSOs.)

CHANGE 3. The definition "Domestic Partner" in the section entitled "DEFINITIONS" is hereby deleted in its entirety.

CHANGE 4. The definition "Domestic Partnership" in the section entitled "DEFINITIONS" is hereby deleted in its entirety.

CHANGE 5. The subsection "Schedule of Medical Benefits" in the section entitled "HIGHLIGHTS OF THE PHN EMPLOYEE PLAN" is hereby deleted in its entirety and replaced with the following:

Schedule of Medical Benefits

This is only a summary of the Plan's benefits and is not intended to be all-inclusive. Important information is contained in other sections, including benefit exclusions and limitations. You may find the Definitions section helpful in understanding some of the capitalized terms used throughout this Summary Plan Description, and within certain sections where a term is defined and used there. In addition, the Plan has other requirements and provisions that may affect benefits, such as those described in the sections for Utilization Management and Using the Provider Network, and it is strongly recommended that you read the entire Summary Plan Description to ensure a complete

understanding of the Plan provisions. You also may contact Gilsbar, L.L.C., the Benefit Services Manager, or the Plan Administrator for assistance. All maximums are per Participant, unless specifically noted as per family.

For any benefit subject to a Calendar Year and/or Lifetime maximum, Allowable Charges that accumulate toward the benefit limit include any ancillary Allowable Charges associated with that benefit, including but not limited to office visits, lab tests, X-rays, physician services, etc.

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
DEDUCTIBLE, PER CALENDAR YEAR		
Per Participant	$0	$1,000
Per Family	$0	$3,000
MAXIMUM OUT-OF-POCKET EXPENSES PER CALENDAR YEAR		
Out-of-pocket expenses are separate, that is, expenses applied toward the satisfaction of the PHN Employee Plan Network out-of-pocket amount will not be applied toward satisfaction of the Out-of-Network out-of-pocket amount, and vice versa.		
Per Participant	$1,500	Unlimited
Per Family	$4,500	Unlimited
NOTE: The following charges do not apply toward the out-of-pocket expense amount and are never paid at 100%: • Premiums • Balance-billed charges • Healthcare this Plan doesn't cover • Utilization Management penalties		
UTILIZATION MANAGEMENT PENALTY		
• Bariatric surgery • Brachytherapy • Diagnostic testing, including MRA scans, CTA scans, and angiograms • Durable medical equipment greater than $1,000 • Home infusion in excess of $2,000 • Injectable drugs in excess of $2,000 • Inpatient admissions • Organ transplants • Orthotics • Outpatient surgery • Prosthetics • Skilled Nursing Facility • Stereotactic/gamma knife procedures		

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
COPAYMENTS AND BENEFIT PERCENTAGES Copayments are the responsibility of the Covered Person. The benefit percentage is what the Plan will pay for covered expenses after you have satisfied any applicable deductible and copay.		
Ambulance	$100 copay, then 100%	$100 copay, then 100%, deductible waived
Behavioral/Mental Health and Substance Use Disorders – Inpatient (Includes residential treatment) (Precertification required) (Optum is the network and claims administrator for these services. All claims for these services must be filed with Optum. You may contact Optum toll-free at 1-877-566-7913 or visit www.peopleshealth.com/bhemp. To find a provider, choose "Find a provider" from the *Select a quick link* menu, then click the *Use quick link now* button)	$250 copay per day, up to 3 days per admission, then 100%	70% after deductible
Behavioral/Mental Health and Substance Use Disorders – Outpatient (Includes Partial Hospitalization) (Optum is the network and claims administrator for these services. All claims for these services must be filed with Optum. You may contact Optum toll-free at 1-877-566-7913 or visit www.peopleshealth.com/bhemp. To find a provider, choose "Find a provider" from the *Select a quick link* menu, then click the *Use quick link now* button) Office Visits (Covered services rendered by a Mental Health or Substance Abuse professional, including psychotherapy)	$20 copay, then 100%	70% after deductible
Services other than in a Physician's office	100%	70% after deductible
Blood and blood derivatives	100%	Not Covered

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Chemotherapy & Radiation Therapy (If services are billed with an office visit, the office visit copay will apply)	100%	70% after deductible
Chiropractic Treatment	$20 copay, then 100%	70% after deductible
Diabetes Self-management Training (1 session Lifetime maximum, unless additional visits are coordinated with the Primary Care Physician)	100%	Not Covered
Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.) (Precertification required for MRA and CTA)	$50 copay, then 100%	70% after deductible
Diagnostic Testing (X-ray, lab) – Inpatient	100%	70% after deductible
Diagnostic Testing (X-ray, lab) – Outpatient Hospital (Services other than in a Physician's office)	100%	70% after deductible
Diagnostic Testing (X-ray, lab) – Stand-alone Facility (Services other than in a Physician's office)	100%	70% after deductible
Diagnostic Testing (X-ray, lab) – Office	100%	70% after deductible
Durable Medical Equipment (Precertification is required for equipment in excess of $1,000)	100%	70% after deductible

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Emergency Room (Copay waived if admitted directly to Hospital from Emergency room within 24 hours) Emergency Services	$150 copay, then 100%	$150 copay, then 100%
Non-emergency services	$150 copay, then 100%	70% after deductible
If you are hospitalized for an Emergency, you, your family member, the medical care facility or attending Physician must contact the Utilization Management company within 48 hours of admission. If you are admitted to an Out-of-Network facility, the Plan reserves the right to require a transfer to a PHN Employee Plan Network Hospital and to transfer the responsibility for medical care to a Network provider. If it is determined you are able to transfer without medically harmful results, but you refuse to do so, you will pay for services at the Out-of-Network benefit level.		
Extended Care/Skilled Nursing Facility (60 days Calendar Year maximum) (Precertification required)	$250 copay per day, up to 3 days per admission, then 100%	70% after deductible
Home Health Care	100%	70% after deductible
Hospice Care	100%	Not Covered
Hospital / Facility Inpatient Expenses (Precertification required)	$250 copay per day, up to 3 days per admission, then 100%	70% after deductible
If you are hospitalized for an Emergency, you, your family member, the medical care facility or attending Physician must contact the Utilization Management company within 48 hours of admission. If you are admitted to an Out-of-Network facility, the Plan reserves the right to require a transfer to a PHN Employee Plan Network Hospital and to transfer the responsibility for medical care to a Network provider. If it is determined you are able to transfer without medically harmful results, but you refuse to do so, you will pay for services at the Out-of-Network benefit level.		
Hospital / Facility Outpatient Expenses (Precertification required for outpatient surgery)	$150 copay, then 100%	70% after deductible

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Infertility/Sterility (Covered up to diagnosis only; diagnostic procedures are limited to sperm count, endometrial biopsy, hysterosalpingography and diagnostic laparoscopy)	Refer to applicable service for benefit percentages	
Maternity Physician Office Services (Maternity related expenses for dependent Children are not covered, except as required by law for prenatal care) Prenatal care as required by federal law	See **Preventive Care**	See **Preventive Care**
Other Eligible Charges (Copay applies on first office visit only)	$50 copay, then 100%	70% after deductible
Newborn Care – Routine Inpatient	100%	70% after deductible
Organ Transplants (Out-of-Network services are covered only when pre-approved by the Plan)	Refer to applicable service for benefit percentages	
Orthotics/Prosthetics (Precertification required)	100%	70% after deductible
Physician Services		
Inpatient Visits	100%	70% after deductible
Inpatient Surgery	100%	70% after deductible
Outpatient Visits	100%	70% after deductible
Outpatient Surgery (Physician's fee for services not performed in a Physician's office) (Precertification required)	100%	70% after deductible

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Physician Services (continued)		
Office visits (Copay is per provider and applies to office visit charge, allergy testing, allergy treatment, injections, supplies, and minor office surgery, including vasectomies. The copay does not apply to allergy injections when no office visit is billed.) (Precertification is required for certain in-office surgeries. Members and providers may use the following link to determine whether the procedure to be performed is one that requires precertification: https://www.peopleshealth.com/for-providers/procedure-code-search/)	$20 copay, then 100%	70% after deductible
Prescription Drugs (Inpatient)	See **Hospital / Facility Inpatient Expenses**	
Prescription Drugs (Outpatient)	See the **Schedule of Prescription Drug Benefits** subsection	

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Preventive Care	100%	70% after deductible*

This benefit includes Preventive Care, as defined in the Definitions section, as well as the following:

- Colorectal screenings, including flexible sigmoidoscopy or screening barium enema, fecal occult blood test, and screening colonoscopy or screening barium enema (2 per Calendar Year)
- Gynecological exam, and well woman visit (1 per Calendar Year)
- Pap smear (1 per Calendar Year)*
- Prostatic/testicular exam (1 per Calendar Year)*
- Smoking cessation counseling and supplies
- Immunizations and inoculations
- Mammograms (1 per Calendar Year)*. Additional mammogram will be covered with precertification from the Plan.
- Hearing screening (1 per Calendar Year)
- Vision screening (1 per Calendar Year)
- Contraceptives (no coverage for contraceptives received Out-of-Network)
- Osteoporosis screening, including bone mass measurement.* "Bone mass measurement" means a radiological or radioisotope procedure, or other scientifically proven technology performed on an individual for the purpose of identifying bone mass or detecting bone loss. To receive this benefit, the Participant must be one of the following:
  - An estrogen-deficient woman at clinical risk of osteoporosis who is considering treatment
  - A Participant being monitored to assess to response to or efficacy of approved osteoporosis drug therapies

*The Out-of-Network deductible will not apply to services noted with the asterisk that are received out-of-network.

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Rehabilitation Services (Physical, Occupational, Speech, & Cardiac Rehab Therapies) (Cardiac Rehab is limited to Phases I and II only) (Physical, Occupational, and Speech Therapy are limited to a combined maximum of 60 visits per Calendar Year) (Additional visits may be approved if precertification is obtained)	$20 copay, then 100%	70% after deductible
Sterilization Vasectomy (Office visit copay applies if procedure is performed in the office) Female sterilization as required by federal law	100% See **Preventive Care**	70% after deductible See **Preventive Care**
Temporomandibular Joint Syndrome	Refer to applicable service for benefit percentage	
Urgent Care Facility (includes all covered charges billed by facility)	$75 copay, then 100%	$75 copay, then 100%, deductible waived
Other Covered Expenses	100%	70% after deductible

CHANGE 6. The subsection "Schedule of Prescription Drug Benefits" in the section entitled "HIGHLIGHTS OF THE PHN EMPLOYEE PLAN" is hereby deleted in its entirety and replaced with the following:

Schedule of Prescription Drug Benefits
The following schedule summarizes amounts paid by the Plan. Please refer to the Prescription Drug Benefit section for a description of covered expenses and benefit exclusions and limitations.

Prescription Card Options	Your copayment for a:	
	30-day supply	90-day supply
Retail Pharmacy Option		
Prescribed Preventive Medications and Contraceptives as required by federal law*	$0	$0
Tier 1 (includes Generic drugs)	$5	$10
Tier 2 (includes Preferred Brand Name drugs)	$35	$70
Tier 3 (includes Non-Preferred Brand Name drugs)	$55	$110
Tier 4 (includes Specialty drugs)	$85	$170
Mail Order Option		
Prescribed Preventive Medications and Contraceptives as required by federal law*	n/a	$0
Tier 1 (includes Generic drugs)	n/a	$10
Tier 2 (includes Preferred Brand Name drugs)	n/a	$70
Tier 3 (includes Non-Preferred Brand Name drugs)	n/a	$110
Tier 4 (includes Specialty drugs)	n/a	$170

*Contraceptives are not covered at Out-of-Network pharmacies.

Prescribed Preventive Medications and Contraceptives as required by federal law includes prescribed preventive medications that are recommended by the USPSTF, as well as all FDA-approved, prescribed female contraceptives (including but not limited to injectable, implants, IUDs, oral, and transdermal) at the following member cost:

- $0 cost for Generic
- $0 cost if there is no Generic equivalent or when Physician does not authorize Generic
- $0 cost for over-the-counter with a prescription
- Otherwise, refer to other existing drug costs.
- If the Plan imposes a penalty for choosing Brand Name when Generic is available and authorized by the Physician, such penalty continues to apply.
- If not obtainable from the pharmacy benefit manager, you may be required to pay in full then submit a claim form and receipt for full reimbursement.

Brand Name means a trade name medication.

Generic drug means a prescription drug that has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Preferred Brand Name drug means a trade name prescription medication that is on the Formulary Brand Name drug list, compiled by the third party payor, of safe, effective therapeutic drugs specifically covered by this Plan.

Non-Preferred Brand Name drug means a trade name prescription medication that is not on the Formulary Brand Name drug list.

Specialty drugs means prescription medications that require special handling, administration or monitoring. These drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. Specialty drugs are used to treat complex, chronic and often costly conditions, such as cancer, chronic kidney failure, post-transplant anti-rejection, multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. These drugs may have a limited distribution or may need prior authorization to have them ordered through a specialty pharmacy.

CHANGE 7. The subsection "Election of Coverage" in the section entitled "PERSONS COVERED AND EFFECTIVE DATES" is hereby deleted in its entirety and replaced with the following:

Election of Coverage
If you are an Eligible Employee as defined by the Plan in the Highlights section, you may elect coverage under the Plan by submitting a completed, valid enrollment form which you may obtain from the Plan Administrator. You may elect coverage for yourself only, you and your Spouse, you and your dependent children, or your whole family. The application process involves electing coverage and paying the required contribution, if any, for the type of coverage you've chosen. The Plan Administrator determines annually or more frequently if deemed appropriate, whether (and to what extent) employees will be required to contribute towards the cost of coverage under the Plan. Contributions may be required to obtain employee and/or dependent coverage.

CHANGE 8. The subsection "When Both Spouses or Domestic Partners Are Covered Employees" in the section entitled "PERSONS COVERED AND EFFECTIVE DATES" is hereby deleted in its entirety and replaced with the following:

When Both Spouses Are Covered Employees
When both you and your Spouse are Covered Employees and you have family coverage for dependent children, one Spouse will be treated as a dependent for billing purposes and in calculating the family deductible and out-of-pocket expense amount (when applicable). This provision allows families in which both Spouses are Covered Employees to get the full benefit of their family coverage. The Spouse who was hired last will be the one treated as a dependent for the purposes stated in this section unless the Plan Administrator determines otherwise.

Alternately, each Spouse may decide to enroll separately. In this situation, eligible dependent Children may be covered under one Spouse's enrollment. They may not be enrolled under both parents' coverage if both parents are Eligible Employees who have enrolled separately.

CHANGE 9. Item #12, which appears in the subsection "Covered Medical Expenses" in the section entitled "MEDICAL BENEFITS," is hereby deleted in its entirety.

CHANGE 10. Item "(a)," which appears in the subsection "Utilization Management" under the section entitled "UTILIZATION MANAGEMENT," is hereby deleted in its entirety and replaced with the following:

(a) Precertification of the Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:

- Bariatric surgery
- Brachytherapy
- Diagnostic testing, including MRA scans, CTA scans, and angiograms
- Durable medical equipment greater than $1,000
- Home infusion in excess of $2,000
- Injectable drugs in excess of $2,000
- Inpatient admissions
- Organ transplants

- Outpatient surgery (including certain surgeries performed in the Physician's office)
- Prosthetics and orthotics
- Skilled Nursing Facility
- Stereotactic/gamma knife procedures

CHANGE 11. Item #5, which appears in the subsection "Other General Exclusions" under the section entitled "GENERAL EXCLUSIONS AND LIMITATIONS," is hereby deleted in its entirety and replaced with the following:

5. **Behavioral health services as follows**:
   - Any care in lieu of legal involvement or incarceration
   - Conditions without a recognizable DSM IV diagnostic classification (such as adult child of alcoholics, ACOA, co-dependency) and self-help programs
   - Learning disorders
   - Behavioral disorders such as anti-social personality disorders, paraphilia, or social maladjustment

CHANGE 12. The second paragraph in the section entitled "TERMINATION OF COVERAGE" is hereby deleted in its entirety and replaced with the following:

Coverage for a dependent will cease at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;

2. Date the employee's coverage terminates;

3. Date the dependent enters active service with armed forces of any country;

4. Date the dependent ceases to be an Eligible Dependent (for any reason other than attaining the applicable age limit);

5. Date the dependent chooses Medicare as his sole coverage;

6. For a dependent Spouse, on the date of divorce or legal separation;

7. For a dependent child/children, the end of the month of attainment of the applicable age limit;

8. The end of the last period for which any required contribution was received; or

9. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

Copies of the Plan document and this Plan document amendment are maintained on file by the Plan Administrator and by the Benefit Services Manager.

This PHN Employee Plan document amendment is hereby adopted in its entirety.

By: _____ Date: 3/1/18
Plan Administrator

LEGAL PHN REVIEWED