

# Summary of Material Modifications (SMM)

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## What are the Modifications to the Plan?

These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this SMM with your SPD since this material plus the SPD is your complete SPD. In the event of any discrepancy between this SMM and the SPD, the provisions of this SMM shall govern.

### 1. About Your Benefits

**1. When Coverage ends: Coverage for you on page 1-23 is clarified to read:**

- coverage under the Company's benefit plans will end on the last day of the month in which you have not actively returned to work and either (i) your Short-term Disability benefits end prior to your eligible STD period; (ii) you are denied for Long-Term Disability benefits; or (iii) your Long-Term Disability benefits end.

### 2. Medical Plans

**1. The Network Benefits and Non-Network Benefits provisions under the Accessing Benefits section in How the Consumer Choice Plan Works on page 2-3 are replaced in their entirety with the following:**

**“Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

**Non-Network Benefits** apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, non-Network Benefits may also be referred to as Out-of-Network Benefits.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

**2. *The fourth and fifth paragraphs under the Network Providers section in How the Consumer Choice Plan Works on page 2-4 are replaced in their entirety with the following:***

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card to request a copy. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

**3. *The Eligible Expenses section in How the Consumer Choice Plan Works beginning on page 2-5 is replaced in its entirety with the following:***

UT-Battelle, LLC has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a

Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

- For non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Coinsurance or Deductible which is based on the Recognized Amount as defined in the SPD.
  - For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

### **Designated Network Benefits and Network Benefits**

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance or any Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

### **Non-Network Benefits**

**When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:**

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary, the Eligible Expense is based on one of the following in the order listed below as applicable:



- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

**IMPORTANT NOTICE:** For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Coinsurance or Deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

**IMPORTANT NOTICE:** You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Coinsurance or Deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

**IMPORTANT NOTICE:** You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Coinsurance or Deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

**When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expense are determined as follows:** an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance or any Deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance or any Deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, and Deductible) is yours.

4. **The Advocacy Services section is added directly after the Eligible Expenses section in How the Consumer Choice Plan Works on page 2-6 to read as follows:**

### **Advocacy Services**

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable coinsurance.

When Covered Health Services are received from a non-Network provider in the following cases:

- non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have satisfied the notice and consent criteria as described below; and
- Emergency ground ambulance transportation provided by a non-Network provider;

then, in such circumstances, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

When Covered Health Services are received from a non-Network provider that are not:

- *Ancillary Services received at certain Network facilities on a non-Emergency basis;*
- *non-Ancillary Services received at certain Network facilities on a non-Emergency basis;*
- *Emergency Health Services;*
- *Air Ambulance services; or*
- *Emergency ground ambulance transportation;*

then, in such circumstances, the Claims Administrator, or its designee, will either work with the provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your Coinsurance, and Deductible.

**5. *The first paragraph of the Annual Deductible section in How the Consumer Choice Plan and Prime Select Plans Works beginning on page 2-6 is replaced in its entirety with the following:***

The Annual Deductible is the amount of Eligible Expenses or the Recognized Amount you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

**6. *The section titled Coinsurance in How the Consumer Choice Plan and Prime Select Plans Works beginning on page 2-6 is replaced in its entirety with the following:***

Coinsurance is the percentage of Eligible Expenses or the Recognized Amount that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

- 7. The fourth row of the Plan Features column in the chart that beginning on page 2-6 is replaced in its entirety to read as follows:**

Charges that exceed Eligible Expenses or the Recognized Amount.

- 8. The amounts which you are required to pay paragraph after the Schedule of Benefits heading on page 2-10 is replaced in its entirety with the following:**

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Eligible Expenses or, for specific Covered Health Services as described in the definition of Recognized Amount in in Section 14, Glossary.

- 9. The limitations described in the Ambulance Services – Non-Emergency Ambulance benefit category in the Schedule of Benefits table on page 2-10 is replaced in its entirety with the following:**

Ground Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for Air Ambulance transport provided by a non-Network provider will be determined as described in the Eligible Expenses Section of How the Consumer Choice Plan Works.

- 10. The limitations described in the Emergency Health Services – Outpatient benefit category in the Schedule of Benefits table on page 2-11 is replaced in its entirety with the following:**

If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or Deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described in the Eligible Expenses will be determined as described in the Eligible Expenses Section of How the Consumer Choice Plan Works.

- 11. Limitations for Physician Fees for Surgical and Medical Services benefit category in the Schedule of Benefits table on page 2-12 is added as follows:**

Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Coinsurance and applicable Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in the Eligible Expenses Section of How the Consumer Choice Plan Works.

- 12. The COVID-19 Testing provision in the Additional Coverage Details section on page 2-19 is replace in its entirety with the following:**

### **COVID-19 Testing**

Effective for testing incurred on or after 2/4/2020 and before the end of the National Emergency, the Plan pays for Benefits for COVID-19 and SARS-CoV-2 diagnostic testing and the office visit associated with the testing without cost sharing (Deductibles and Coinsurance), for Covered Persons. This coverage includes the diagnostic test as well as items and services furnished to the Covered Person during the health care provider office visit, whether in-person or a telehealth visit, but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such Covered Person for purposes of determining the need of such product. Covered services can be provided at a Physician's office, an Alternate Facility or a Hospital. There will also be



a zero cost share for Virtual visits related to the diagnosis of COVID-19 as described under the Virtual Visit Section.

In addition, effective for over-the-counter tests purchased on or after 1/15/2022 and before the end of the National Emergency, the Plan pays for Benefits for COVID-19 and SARS-CoV-2 diagnostic testing without cost sharing (Deductibles and Coinsurance), for Covered Persons, including tests obtained without the involvement of a health care provider. The Plan will cover up to eight tests per Covered Person per calendar month. The Plan may require reasonable documentation and proof of purchase with a claim for reimbursement for the cost of an over-the-counter COVID-19 test.

**13. *The eligibility requirements in the Obesity Services benefit category within the Additional Coverage Details section beginning on page 2-33 is replaced in its entirety with the following:***

### **Obesity Surgery**

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.
- You have a 3-month physician supervised diet documented within the last 2 years.

**14. *The Payment of Benefits provision in the Claims Procedures section on page 2-64 is replaced in its entirety with the following:***

### **Payment of Benefits**

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to “third parties” include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan’s obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans’ overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* provision in the *Coordination of Benefits* section.

**15. The Incentives to Providers provision is added to the Other Important Information section on page 2-78 to read as follows:**

**Incentives to Providers**

Network providers may be provided financial incentives by the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person’s health care is less than or more than the payment.
- Bundled payments- certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or



arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Coinsurance as described in your Schedule of Benefits.

- The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

**16. The below definitions in the Glossary section beginning on page 2-78 are updated or replaced in their entirety with the following:**

**Air Ambulance** – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in 42 CFR 414.605.

**Ancillary Services** – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

**Coinsurance** – the charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in *How the Consumer Choice Plan Works*.

**Eligible Expenses** – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the UnitedHealthcare as stated below and as detailed in Section 3, *How the Consumer Choice Plan Works*.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.

**Emergency Health Services** – with respect to an Emergency, both of the following:

- An appropriate medical screening examination (as 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) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)), 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 exam or treatment is provided). For the purpose of this definition, “to stabilize” has the meaning as given such term in section 1867(e)(3) of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)).
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
  - a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
  - b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
  - c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
  - d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
  - e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

**Independent Freestanding Emergency Department** – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.



**Recognized Amount** – the amount which Coinsurance and applicable Deductible is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center as described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

- 1) An *All Payer Model Agreement* if adopted,
- 2) State law, or
- 3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

**Secretary** – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act* (P.L. 116-260).

**17. All references to Air Ambulance in the SPD are capitalized as this is now a defined term.**

**18. All references to Shared Savings are removed as this is no longer included within the Plan design.**

## 11. Pension Plan

1. ***The Single Lump-Sum Payment subsection is added to the Option Forms of Payment section that begins on page 11-8 to read as follows:***

### **Single Lump-Sum Payment**

If upon your termination of employment your actuarially equivalent lump-sum value is \$150,000 or less, you will have a 90-day window to elect to have your benefit paid in either a single lump sum payment or in the form of an immediate annuity. If you fail to elect a distribution during the 90-day period, you will not be eligible to receive your benefit until your Early or Normal Retirement Age.



## 12. Pension Plan

1. *The Single Lump-Sum Payment subsection is added to the Option Forms of Payment section that begins on page 12-7 to read as follows:*

### **Single Lump-Sum Payment**

If upon your termination of employment your actuarially equivalent lump-sum value is \$150,000 or less, you will have a 90-day window to elect to have your benefit paid in either a single lump sum payment or in the form of an immediate annuity. If you fail to elect a distribution during the 90-day period, you will not be eligible to receive your benefit until your Early or Normal Retirement Age.

This Summary of Material Modifications should be retained with your other benefits information. Your Benefits Summary Plan Description is available to view or download at <https://benefits.ornl.gov/>.

If you have any questions about this SMM, you should contact the Benefits Plans Office by phone at 865-576-7766 or email [ornlbenefits@ornl.gov](mailto:ornlbenefits@ornl.gov).