

MEMO

DATE: June 29, 2023

TO: NTCA–The Rural Broadband Association Members

FROM: Shirley Bloomfield, Chief Executive Officer

SUBJECT: Important Notice of NTCA Board-Approved Group Health Program and Retirement & Security Program Specification Changes

The NTCA Board of Directors has approved amendments to the Group Health Program and Retirement & Security (R&S) Program specifications. These changes were recommended by the benefit plans' trust committees to ensure compliance with regulatory requirements and to add new services and enhancements in response to member requests. The amendments are generally effective on January 1, 2024.

I encourage you to carefully review this information and email proposedspecifications@ntca.org if you have any questions.

Here are several procedural reminders about the amendment process:

- The NTCA Board has the authority to amend the specifications at any time and adopt changes effective prospectively, immediately or retroactively.
- Generally, changes may not become effective until at least 30 days for GHP, and 60 days for the R&S Program, after a notice like this is provided to each participating company.
- Members have the right to comment or object to specification changes. The NTCA Board provides 45 days (**which will end on August 13, 2023**) for your comments or objections. Email me at sbloomfield@ntca.org or write to me at the address shown below if you have any comments or objections.
- The NTCA Board has the right to take no action on any objection received, and if that occurs, the specifications will be amended as presented.
- Members will be notified if the Board takes official action to revise or withdraw any of the changes.

Thank you for your membership and participation in our benefits programs.

SB: jav

The NTCA Board of Directors has approved the recommendations of the Group Health Program (GHP) Trust Committee for the following specification amendments.

Group Health Program Specification Changes			
Change # Effective January 1, 2024	Summary of Change	Reason for Change	Amendment Language
Change #1	Amends the specifications to establish a certain number of physical and occupational therapy visits that would not require review by the Medical Review Company.	Currently, all physical therapy and occupational therapy benefits must go through the Medical Review Company for determination on the appropriate number of visits the Program will cover. This change would allow for a certain number of physical therapy and occupational therapy visits without prior authorization from the Medical Review Company. Among other benefits, this would eliminate delays for Participants that require physical therapy immediately after surgery.	Attachment B Pages 4 – 5
Change #2	Amends the specifications to increase the number of months of Hospice Care the Program will cover from six months to nine months if the Participant or Dependent remains terminally ill.	Currently, hospice benefits are limited to six months of Inpatient or Outpatient treatment for a terminally ill Participant or Dependent. This change expands the limit from six months to nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months.	Attachment B Pages 5 – 11
Change #3	Amends the specifications to clarify that the limits contained in this Program provision are applicable only to hearing aids and not cochlear and auditory implants and to clarify that only prescription hearing aids are covered, and not over-the-counter hearing aids.	Currently, the Program limits the benefits for hearing aids to three hearing aids every four calendar years, not to exceed a maximum payment of between \$5,000 and \$6,250, depending on the Plan option. This change clarifies that these limits only apply to hearing aids and not cochlear and auditory implants. This change also clarifies that only prescription hearing aids are covered, and not over-the-counter hearing aids.	Attachment B Pages 11 – 17

Change # Effective January 1, 2024	Summary of Change	Reason for Change	Amendment Language
Change #4	Amends the specifications to clarify that the exception to the pre-existing condition exclusions also applies to Short-term disability benefits for Participants at certain companies that adopt disability benefits.	Currently, pre-existing conditions exclusions are in effect for disability benefits. However, for companies that adopt disability benefits, pre-existing conditions exclusions do not apply if a Participant enrolling when a Member Company initially adopts such disability benefits can demonstrate they were enrolled in Short-term or Long-term disability group coverage through the adopting Participating Member Company and that coverage was in effect when the injury or Illness first manifested with no lapse in coverage prior to the effective date of Short-term or Long-term disability coverage under the Program. This change further clarifies that the exception also extends to Short-term disability benefits.	Attachment B Page 17
Change #5	Amends the specifications to comply with the Mental Health Parity and Addiction Equity Act.	Health plans providing Mental Health and Substance Use Disorder benefits must provide those benefits in parity with Medical/Surgical benefits. The change is being made to the Advantage Plans and Select HDHP in order to comply with respect to the financial requirements in the in-network outpatient “all other” benefit category.	Attachment B Pages 17 – 26
Change #6	Amends the specifications to clarify that with the end of the public health emergency, the Program will no longer cover COVID-19 tests and related items and services at 100% without cost share.	During the public health emergency for COVID-19, group health plans were required to cover COVID-19 tests and related items and services without cost sharing. With the end of the public health emergency the Program will no longer cover COVID-19 tests at 100%. Additionally, the Program will no longer cover OTC COVID-19 tests.	Attachment B Pages 26 – 28

GROUP HEALTH PROGRAM SPECIFICATION CHANGES

Bolded wording connotes language to be added and lined-out wording connotes language to be deleted.

CHANGE #1 PROPOSED SPECIFICATION LANGUAGE

TRUSTEE-APPROVED LANGUAGE TO ACCOMPLISH THIS CHANGE

Article III.B(2)(c) in the A Advantage Plan to read as follows:

- (c) Physical, occupational, and speech therapy rendered on a full time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

Article III.B(2)(c) in the AA Advantage Plan to read as follows:

- (c) Physical, occupational, and speech therapy rendered on a full time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

Article III.B(2)(b) in the AAA Advantage Plan to read as follows:

- (b) Physical, occupational, and speech therapy rendered on a full time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

Article III.B(2)(c) in the Select High Deductible Health Plan to read as follows:

- (c) Physical, occupational, and speech therapy rendered on a full time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

Article III.B(2)(c) in the Bronze PPO Plan to read as follows:

- (c) Physical, occupational, and speech therapy rendered on a full time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

Article III.B(2)(c) in the Silver PPO Plan to read as follows:

- (c) Physical, occupational, and speech therapy rendered on a full time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

Article III.B(2)(c) in the Gold PPO Plan to read as follows:

- (c) Physical, occupational, and speech therapy rendered on a full time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

Article III.B(2)(c) in the Platinum PPO Plan to read as follows:

- (c) Physical, occupational, and speech therapy rendered on a full time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

Article III.B(2)(c) in the Diamond PPO Plan to read as follows:

- (c) Physical, occupational, and speech therapy rendered on a full time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

Article III.B(2)(c) in the Preferred High Deductible Health Plan to read as follows:

- (c) Physical, occupational, and speech therapy rendered on a full-time or shift basis by a registered therapist (R.P.T., O.T.R., S.L.P.). ~~Therapies are subject to medical review by the Medical Review Company.~~ **Annually, up to ten physical therapy and occupational therapy visits, combined, are not subject to medical review by the Medical Review Company. After the tenth visit, physical and occupational therapy visits will be subject to review by the Medical Review Company.**

CHANGE #2 PROPOSED SPECIFICATION LANGUAGE

TRUSTEE-APPROVED LANGUAGE TO ACCOMPLISH THIS CHANGE

Article III.D(3) in the A Advantage Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:
- (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;
 - (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his or her~~ **the Participant's or Dependent's** life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

Article III.D(3) in the AA Advantage Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:

- (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;
- (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his or her~~ **the Participant's or Dependent's** life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

Article III.D(3) in the AAA Advantage Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:
 - (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;
 - (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his or her~~ **the Participant's or Dependent's** life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

Article III.D(3) in the Select High Deductible Health Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:
- (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;
 - (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his or her~~ **the Participant's or Dependent's** life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

Article III.D(3) in the Bronze PPO Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:
- (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;
 - (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his or her~~ **the Participant's or Dependent's** life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

Article III.D(3) in the Silver PPO Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:
- (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;
 - (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his or her~~ **the Participant's or Dependent's** life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

Article III.D(3) in the Gold PPO Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:
- (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;

- (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his or her~~ **the Participant's or Dependent's** life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

Article III.D(3) in the Platinum PPO Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:
 - (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;
 - (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his or her~~ **the Participant's or Dependent's** life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

Article III.D(3) in the Diamond PPO Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:

- (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;
- (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his or her~~ **the Participant's or Dependent's** life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

Article III.D(3) in the Preferred High Deductible Health Plan to read as follows:

- (3) Hospice Care - The Program will pay for the following charges for a terminally ill Participant or Dependent (as defined below) for up to six months **(or nine months if the provider recertifies the Participant or Dependent is still terminally ill after six months)** ~~of treatment as an Inpatient or Outpatient at a~~ of Hospice in a Hospice Care Program:

- (a) 80% of the Usual, Customary and Reasonable Inpatient and Outpatient charges, as outlined in Hospital charges of Article III.A;
- (b) 80% of the Usual, Customary and Reasonable charges as outlined in major medical Charges of Article III.B for supplies that are provided or administered as part of the Hospice Care Program.

Out-of-pocket payments for expense charges in excess of those covered under (a) and (b) above are not Eligible Expenses for purposes of the 100% coverage that begins once the limit on maximum out-of-pocket expenses is reached.

For the purposes of this provision, a Participant or Dependent will be considered terminally ill if his or her Physician certifies, to the satisfaction of the Committee, that ~~his~~

~~or her~~ the Participant's or Dependent's life expectancy is six (6) months or less. **If at the end of the six-month period, should the Participant or Dependent need up to an additional 3 months of Hospice coverage, the Physician must recertify the terminally ill status of the Participant or Dependent. Hospice coverage will not extend past a total of 9 months.**

CHANGE #3 PROPOSED SPECIFICATION LANGUAGE

TRUSTEE-APPROVED LANGUAGE TO ACCOMPLISH THIS CHANGE

Article III.D(6) in the A Advantage Plan to read as follows:

(6) Hearing Care - ~~The Program will pay:~~

- (a) **The Program will pay the following for cochlear and auditory implants: 80% of the Usual, Customary, and Reasonable charges for cochlear implants.**

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.

- (b) ~~The Program will pay the following 80% of the lesser of the Negotiated Rate or billed charges for hearing aids and/or other auditory implants for up to the lesser of three prescription hearing aids or implant procedures every four calendar years not to exceed a maximum payment of \$5,000 per individual every four calendar years;~~ **80% of the lesser of the Negotiated Rate or billed charges. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017, will not be covered.**

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

Article III.D(6) in the AA Advantage Plan to read as follows:

(6) Hearing Care - ~~The Program will pay:~~

- (a) **The Program will pay the following for cochlear and auditory implants: 80% of the Usual, Customary, and Reasonable charges for cochlear implants.**

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but

not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.

- (b) ~~The Program will pay the following 80% of the lesser of the Negotiated Rate or billed charges for hearing aids and/or other auditory implants for up to the lesser of three prescription hearing aids or implant procedures every four calendar years not to exceed a maximum payment of \$5,000 per individual every four calendar years. 80% of the lesser of the Negotiated Rate or billed charges. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017, will not be covered.~~

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

Article III.D(6) in the AAA Advantage Plan to read as follows:

- (6) Hearing Care - ~~The Program will pay:~~

- (a) **The Program will pay the following for cochlear and auditory implants: 80% of the Usual, Customary, and Reasonable charges for cochlear implants.**

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.

- (b) ~~The Program will pay the following 80% of the lesser of the Negotiated Rate or billed charges for hearing aids and/or other auditory implants for up to the lesser of three prescription hearing aids or implant procedures every four calendar years not to exceed a maximum payment of \$6,250 per individual every four calendar years. 80% of the lesser of the Negotiated Rate or billed charges. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017, will not be covered.~~

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

Article III.D(6) in the Select High Deductible Health Plan to read as follows:

(6) Hearing Care - ~~The Program will pay:~~

- (a) **The Program will pay the following for cochlear and auditory implants:** 80% of the Usual, Customary, and Reasonable charges ~~for cochlear implants.~~

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.

- (b) **The Program will pay the following** ~~80% of the lesser of the Negotiated Rate or billed charges for hearing aids and/or other auditory implants for up to the lesser of three prescription hearing aids or implant procedures every four calendar years not to exceed a maximum payment of \$5,000 per individual every four calendar years;~~ **80% of the lesser of the Negotiated Rate or billed charges. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017, will not be covered.**

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

Article III.D(6) in the Bronze PPO Plan to read as follows:

(6) Hearing Care –

- (a) The Program will pay the following for cochlear **and auditory** implants:

- (ai) 100% of In-Network charges; or,
(bii) 50% of the Usual, Customary, and Reasonable charges when Out-of-Network.

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy.

- (b) The Program will pay the following **for up to the lesser of three prescription hearing aids or implant procedures every four calendar years, not to exceed a maximum payment of \$6,250 per individual every four calendar years:**

- (ei) 100% of In-Network charges

Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. ~~Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017 will not be covered. Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance~~

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

Article III.D(6) in the Silver PPO Plan to read as follows:

(6) Hearing Care –

(a) The Program will pay the following for cochlear **and auditory** implants:

- (ai) 80% of In-Network charges; or,
- (bii) 60% of the Usual, Customary, and Reasonable charges when Out-of-Network.

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy.

(b) The Program will pay the following **for up to the lesser of three prescription** hearing aids or ~~implant procedures~~ every four calendar years, not to exceed a maximum payment of \$5,000 per individual every four calendar years:-:

- (ei) 80% of In-Network charges

Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. ~~Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017 will not be covered. Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance.~~

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

Article III.D(6) in the Gold PPO Plan to read as follows:

(6) Hearing Care –

(a) The Program will pay the following for cochlear **and auditory** implants:

(ai) 80% of In-Network charges; or,

(bii) 60% of the Usual, Customary, and Reasonable charges when Out-of-Network.

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy.

(b) The Program will pay the following **for** up to ~~the lesser of three~~ **prescription** hearing aids ~~or implant procedures~~ every four calendar years, not to exceed a maximum payment of \$5,000 per individual every four calendar years-:

(ei) 80% of In-Network charges

Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017 will not be covered. Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance.

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

III.D(6) in the Platinum PPO Plan to read as follows:

(6) Hearing Care –

(a) The Program will pay the following for cochlear **and auditory** implants:

(ai) 90% of In-Network charges; or,

(bii) 70% of the Usual, Customary, and Reasonable charges when Out-of-Network.

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy.

(b) The Program will pay the following **for up to ~~the lesser of~~ three prescription** hearing aids ~~or implant procedures~~ every four calendar years, not to exceed a maximum payment of 5,625 per individual every four calendar years.:

(ei) 90% of In-Network charges

Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017 will not be covered. Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance.

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

Article III.D(6) in the Diamond PPO Plan to read as follows:

(6) Hearing Care –

(a) The Program will pay the following for cochlear **and auditory** implants:

(ai) 100% of In-Network charges; or,

(bii) 70% of the Usual, Customary, and Reasonable charges when Out-of-Network.

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy.

(b) The Program will pay the following **for up to ~~the lesser of~~ three prescription** hearing aids ~~or implant procedures~~ every four calendar years, not to exceed a maximum payment of \$6,250 per individual every four calendar years.:

(ei) 100% of In-Network charges

Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017 will not be covered. Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance.

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

Article III.D(6) in the Preferred High Deductible Health Plan to read as follows:

(6) Hearing Care –

(a) The Program will pay the following for cochlear **and auditory** implants:

(ai) 100% of In-Network charges; or,

(bii) 50% of the Usual, Customary, and Reasonable charges when Out-of-Network.

Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy.

(b) The Program will pay the following **for up to the lesser of three prescription** hearing aids ~~or implant procedures~~ every four calendar years, not to exceed a maximum payment of \$6,250 per individual every four calendar years:-

(ei) 100% of In-Network charges

Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance. Allowable amounts include repairs and replacements of such devices. Batteries for such devices are not a covered expense. Hearing aids or auditory implants for Participants who have already reached the lifetime maximum as of January 1, 2017 will not be covered. Benefits are not subject to the Out-of-Network Deductible or Out-of-Network Coinsurance.

~~Allowable amounts include any Hospital, medical or other charges incurred in connection with or related to the implantation of the device, including but not limited to charges for pre-screening, testing and therapy. Allowable amounts also include repairs and replacements of such devices.~~

CHANGE #4 PROPOSED SPECIFICATION LANGUAGE

TRUSTEE-APPROVED LANGUAGE TO ACCOMPLISH THIS CHANGE

Article VII.D(1) in all plans to read as follows:

- (1) if the disability is the result of injuries sustained or Illness which first manifested itself before the effective date of coverage under this option, unless the loss of time commenced after the Employee was covered under this option for 90 consecutive days

without receiving treatment or without consulting a Physician for that injury or Illness. After the Employee has been actively at work for 18 consecutive months while participating in this option, this limitation shall not apply.

Effective for Member Companies adopting disability benefits on or after January 1, 2015 this exclusion shall not apply to Section A, Section B or Section C of this Article if a Participant enrolling at the time a Member Company initially adopts disability benefits can demonstrate previous group Short-term or Long-term insured disability coverage through the adopting Participating Member Company was effective when the injury or Illness first manifested with no lapse in coverage prior to the effective date of **Short-term or Long-term** disability coverage under the Program;

CHANGE #5 PROPOSED SPECIFICATION LANGUAGE

TRUSTEE-APPROVED LANGUAGE TO ACCOMPLISH THIS CHANGE

Article III.B(1) in the A Advantage Plan to read as follows:

- (1) Payment will be made, subject to the Deductible and to the limitations and exclusions outlined in this Article's Sections D. and I., for 100% of the Usual, Customary and Reasonable charges incurred for **the following services and supplies.** ~~Outpatient surgery, including surgery fees, anesthesia charges, laboratory charges and radiology charges. Payment for assistant surgeon fees shall be based upon the assistant surgeon's Negotiated Rate; should a Negotiated Rate not exist, payment will be based on the Usual, Customary, and Reasonable charge for assistant surgeon services.~~ Payment will be the Out-of-Network Rate for certain Out-Of-Network providers practicing at In-Network facilities, when required by ERISA section 716(b).
 - (a) Outpatient surgery, including surgery fees, anesthesia charges, laboratory charges and radiology charges. Payment for assistant surgeon fees shall be based upon the assistant surgeon's Negotiated Rate; should a Negotiated Rate not exist, payment will be based on the Usual, Customary, and Reasonable charge for assistant surgeon services.
 - (b) **Outpatient charges for the treatment of psychiatric/mental or nervous disorders not including Mental Health Provider's fees which are covered under Article III.B(2)(i)(19).**
 - (c) **Outpatient charges for alcohol/drug-related treatment not including Mental Health Provider's fees which are covered under Article III.B(2)(i)(20).**
 - (d) **Behavioral services for autism spectrum disorder (including intensive behavioral therapies such as applied behavioral analysis (ABA)) that are the following:**
 - (i) **Focused on the treatment of core deficits of autism spectrum disorder.**

- (ii) **Provided by an applied behavioral analyst certified by the Behavior Analyst Certification Board (BACB) or other qualified provider under the appropriate supervision.**
- (iii) **Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.**

This section describes only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical categories in this Article. Appropriate treatment is subject to medical review by the Medical Review Company for applied behavioral analysis.

Outpatient benefits payable at 100% subject to deductible include the following levels of care:

- **Partial Hospitalization/Day Treatment.**
- **Intensive Outpatient Treatment.**
- **Outpatient Treatment**

Article III.B(1) in the AA Advantage Plan to read as follows:

- (1) Payment will be made, subject to the Deductible and to the limitations and exclusions outlined in this Article's Sections D. and I., for 100% of the Usual, Customary and Reasonable charges incurred for the following services and supplies. Payment will be the Out-of-Network Rate for certain Out-Of-Network providers practicing at In-Network facilities, when required by ERISA section 716(b).
 - (a) Outpatient surgery, including surgery fees, anesthesia charges, laboratory charges and radiology charges. Payment for assistant surgeon fees shall be based upon the assistant surgeon's Negotiated Rate; should a Negotiated Rate not exist, payment will be based on the Usual, Customary, and Reasonable charge for assistant surgeon services.
 - (b) Outpatient charges for the treatment of psychiatric/mental or nervous disorders not including Mental Health Provider's fees which are covered under Article III.B(2)(i)(19).
 - (c) Outpatient charges for alcohol/drug-related treatment not including Mental Health Provider's fees which are covered under Article III.B(2)(i)(20).

- (d) **Behavioral services for autism spectrum disorder (including intensive behavioral therapies such as applied behavioral analysis (ABA)) that are the following:**
- (i) **Focused on the treatment of core deficits of autism spectrum disorder.**
 - (ii) **Provided by an applied behavioral analyst certified by the Behavior Analyst Certification Board (BACB) or other qualified provider under the appropriate supervision.**
 - (iii) **Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.**

This section describes only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical categories in this Article. Appropriate treatment is subject to medical review by the Medical Review Company for applied behavioral analysis.

Outpatient benefits payable at 100% subject to deductible include the following levels of care:

- **Partial Hospitalization/Day Treatment.**
- **Intensive Outpatient Treatment.**
- **Outpatient Treatment**

Article III.B(1) in the AAA Advantage Plan to read as follows:

- (1) Payment will be made, subject to the limitations and exclusions outlined in this Article's Sections D and I., for 100% of the Usual, Customary and Reasonable charges incurred for the following services and supplies. Payment will be the Out-of-Network Rate for certain Out-Of-Network providers practicing at In-Network facilities, when required by ERISA section 716(b):
- (a) Surgery fees. Payment for assistant surgeon fees shall be based upon the assistant surgeon's Negotiated Rate; should a Negotiated Rate not exist, payment will be based on the Usual, Customary, and Reasonable charge for assistant surgeon services.
 - (b) Anesthesia charges
 - (c) Laboratory charges, provided they are identified as such and provided they are strictly laboratory charges and do not include a consultative procedure.

- (d) Radiology charges
- (e) Health Care Provider's fees for Inpatient and Outpatient visits and consultations.
- (f) Outpatient charges for the treatment of psychiatric/mental or nervous disorders not including Mental Health Provider's fees which are covered under Article III.B(2)(g)(19).
- (g) Outpatient charges for alcohol/drug-related treatment not including Mental Health Provider's fees which are covered under Article III.B(2)(g)(20).
- (h) **Behavioral services for autism spectrum disorder (including intensive behavioral therapies such as applied behavioral analysis (ABA)) that are the following:**
 - (i) **Focused on the treatment of core deficits of autism spectrum disorder.**
 - (ii) **Provided by an applied behavioral analyst certified by the Behavior Analyst Certification Board (BACB) or other qualified provider under the appropriate supervision.**
 - (iii) **Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.**

This section describes only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical categories in this Article. Appropriate treatment is subject to medical review by the Medical Review Company for applied behavioral analysis.

Outpatient benefits payable at 100% include the following levels of care:

- **Partial Hospitalization/Day Treatment.**
- **Intensive Outpatient Treatment.**
- **Outpatient Treatment**

Article III.B(1) in the Select High Deductible Health Plan to read as follows:

- (2) Payment will be made, subject to the Deductible and to the limitations and exclusions outlined in this Article's Sections D. and I., for 100% of the Usual, Customary and Reasonable charges incurred for **the following services and supplies.** ~~Outpatient surgery, including surgery fees, anesthesia charges, laboratory charges and radiology charges. Payment for assistant surgeon fees shall be based upon the assistant surgeon's Negotiated Rate; should a Negotiated Rate not exist, payment will be based on the Usual,~~

~~Customary, and Reasonable charge for assistant surgeon services.~~ Payment will be the Out-of-Network Rate for certain Out-Of-Network providers practicing at In-Network facilities, when required by ERISA section 716(b).

- (b) Outpatient surgery, including surgery fees, anesthesia charges, laboratory charges and radiology charges. Payment for assistant surgeon fees shall be based upon the assistant surgeon's Negotiated Rate; should a Negotiated Rate not exist, payment will be based on the Usual, Customary, and Reasonable charge for assistant surgeon services.
- (b) **Outpatient charges for the treatment of psychiatric/mental or nervous disorders not including Mental Health Provider's fees which are covered under Article III.B(2)(i)(19).**
- (c) **Outpatient charges for alcohol/drug-related treatment not including Mental Health Provider's fees which are covered under Article III.B(2)(i)(20).**
- (d) **Behavioral services for autism spectrum disorder (including intensive behavioral therapies such as applied behavioral analysis (ABA)) that are the following:**
 - (i) **Focused on the treatment of core deficits of autism spectrum disorder.**
 - (ii) **Provided by an applied behavioral analyst certified by the Behavior Analyst Certification Board (BACB) or other qualified provider under the appropriate supervision.**
 - (iii) **Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.**

This section describes only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical categories in this Article. Appropriate treatment is subject to medical review by the Medical Review Company for applied behavioral analysis.

Outpatient benefits payable at 100% subject to deductible include the following levels of care:

- **Partial Hospitalization/Day Treatment.**
- **Intensive Outpatient Treatment.**
- **Outpatient Treatment**

Article III.B(i)(19) in the A Advantage Plan to read as follows:

19. ~~Psychiatric/Mental or Nervous Disorder Charges—Outpatient and other related Outpatient charges for services of a Mental Health Provider. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.~~ **Mental Health Provider’s fees for outpatient office visits and consultations (including any related facility or similar charges or fees) for the treatment of psychiatric/mental or nervous disorders. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.**

Article III.B(i)(19) in the AA Advantage Plan to read as follows:

19. Mental Health Provider’s fees for outpatient **office** visits and consultations (including any related facility or similar charges or fees) for the treatment of psychiatric/mental or nervous disorders. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.

Article III.B(g)(19) in the AAA Advantage Plan to read as follows:

19. Mental Health Provider’s fees for outpatient **office** visits and consultations (including any related facility or similar charges or fees) for the treatment of psychiatric/mental or nervous disorders. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.

Article III.B(i)(19) in the Select High Deductible Health Plan to read as follows:

19. ~~Psychiatric/Mental or Nervous Disorder Charges—Outpatient and other related Outpatient charges for services of a Mental Health Provider. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.~~ **Mental Health Provider’s fees for outpatient office visits and consultations (including any related facility or similar charges or fees) for the treatment of psychiatric/mental or nervous disorders. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.**

Article III.B(i)(20) in the A Advantage Plan to read as follows:

20. ~~Alcohol/Drug-Related Charges—Outpatient and other related Outpatient charges for services of a Mental Health Provider. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.~~ **Mental Health Provider’s fees for outpatient office visits and consultations (including any related facility or similar charges or fees) for alcohol/drug related treatment. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.**

Article III.B(i)(20) in the AA Advantage Plan to read as follows:

20. Mental Health Provider's fees for outpatient **office** visits and consultations (including any related facility or similar charges or fees) for alcohol/drug related treatment. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.

Article III.B(g)(20) in the AAA Advantage Plan to read as follows:

20. Mental Health Provider's fees for outpatient **office** visits and consultations (including any related facility or similar charges or fees) for alcohol/drug related treatment. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.

Article III.B(i)(20) in the Select High Deductible Health Plan to read as follows:

20. ~~Alcohol/Drug Related Charges—Outpatient and other related Outpatient charges for services of a Mental Health Provider. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.~~ **Mental Health Provider's fees for outpatient office visits and consultations (including any related facility or similar charges or fees) for alcohol/drug related treatment. Covered charges may include charges for family counseling conducted in the course of treatment for a diagnosed condition.**

Article III.B(i)(23) in the A Advantage Plan to read as follows:

23. ~~Behavioral services for autism spectrum disorder (including intensive behavioral therapies such as applied behavioral analysis (ABA)) that are the following:~~
- ~~(i) Focused on the treatment of core deficits of autism spectrum disorder.~~
 - ~~(ii) Provided by an applied behavioral analyst certified by the Behavior Analyst Certification Board (BACB) or other qualified provider under the appropriate supervision.~~
 - ~~(iii) Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.~~

~~This section describes only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical categories in this Article. Appropriate treatment is subject to medical review by the Medical Review Company for applied behavioral analysis.~~

~~Benefits include the following levels of care:~~

- ~~• Inpatient treatment.~~

- ~~Residential Treatment.~~
- ~~Partial Hospitalization/Day Treatment.~~
- ~~Intensive Outpatient Treatment.~~
- ~~Outpatient Treatment~~

Services include the following:

- ~~Diagnostic evaluations, assessment and treatment planning~~
- ~~Treatment and/or procedures.~~
- ~~Medication management and other associated treatments.~~
- ~~Individual, family, and group therapy.~~
- ~~Provider-based case management services.~~
- ~~Crisis intervention.~~
- ~~Enhanced autism spectrum disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as applied behavioral analysis (ABA)).~~

Article III.B(i)(23) in the AA Advantage Plan to read as follows:

23. ~~Behavioral services for autism spectrum disorder (including intensive behavioral therapies such as applied behavioral analysis (ABA)) that are the following:~~

- (iv) ~~Focused on the treatment of core deficits of autism spectrum disorder.~~
- (v) ~~Provided by an applied behavioral analyst certified by the Behavior Analyst Certification Board (BACB) or other qualified provider under the appropriate supervision.~~
- (vi) ~~Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.~~

~~This section describes only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical categories in this Article. Appropriate treatment is subject to medical review by the Medical Review Company for applied behavioral analysis.~~

~~Benefits include the following levels of care:~~

- ~~Inpatient treatment.~~
- ~~Residential Treatment.~~
- ~~Partial Hospitalization/Day Treatment.~~

- ~~Intensive Outpatient Treatment.~~
- ~~Outpatient Treatment~~

~~Services include the following:~~

- ~~Diagnostic evaluations, assessment and treatment planning~~
- ~~Treatment and/or procedures.~~
- ~~Medication management and other associated treatments.~~
- ~~Individual, family, and group therapy.~~
- ~~Provider-based case management services.~~
- ~~Crisis intervention.~~
- ~~Enhanced autism spectrum disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as applied behavioral analysis (ABA)).~~

Article III.B(g)(23) in the AAA Advantage Plan to read as follows:

23. ~~Behavioral services for autism spectrum disorder (including intensive behavioral therapies such as applied behavioral analysis (ABA)) that are the following:~~

- (vii) ~~Focused on the treatment of core deficits of autism spectrum disorder.~~
- (viii) ~~Provided by an applied behavioral analyst certified by the Behavior Analyst Certification Board (BACB) or other qualified provider under the appropriate supervision.~~
- (ix) ~~Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.~~

~~This section describes only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical categories in this Article. Appropriate treatment is subject to medical review by the Medical Review Company for applied behavioral analysis.~~

~~Benefits include the following levels of care:~~

- ~~Inpatient treatment.~~
- ~~Residential Treatment.~~
- ~~Partial Hospitalization/Day Treatment.~~
- ~~Intensive Outpatient Treatment.~~
- ~~Outpatient Treatment~~

Services include the following:

- ~~Diagnostic evaluations, assessment and treatment planning~~
- ~~Treatment and/or procedures.~~
- ~~Medication management and other associated treatments.~~
- ~~Individual, family, and group therapy.~~
- ~~Provider based case management services.~~
- ~~Crisis intervention.~~
- ~~Enhanced autism spectrum disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as applied behavioral analysis (ABA)).~~

Article III.B(i)(23) in the Select High Deductible Health Plan to read as follows:

23. ~~Behavioral services for autism spectrum disorder (including intensive behavioral therapies such as applied behavioral analysis (ABA)) that are the following:~~

- (x) ~~Focused on the treatment of core deficits of autism spectrum disorder.~~
- (xi) ~~Provided by an applied behavioral analyst certified by the Behavior Analyst Certification Board (BACB) or other qualified provider under the appropriate supervision.~~
- (xii) ~~Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.~~

~~This section describes only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical categories in this Article. Appropriate treatment is subject to medical review by the Medical Review Company for applied behavioral analysis.~~

~~Benefits include the following levels of care:~~

- ~~Inpatient treatment.~~
- ~~Residential Treatment.~~
- ~~Partial Hospitalization/Day Treatment.~~
- ~~Intensive Outpatient Treatment.~~
- ~~Outpatient Treatment~~

~~Services include the following:~~

- ~~Diagnostic evaluations, assessment and treatment planning~~
- ~~Treatment and/or procedures.~~
- ~~Medication management and other associated treatments.~~
- ~~Individual, family, and group therapy.~~
- ~~Provider based case management services.~~
- ~~Crisis intervention.~~
- ~~Enhanced autism spectrum disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as applied behavioral analysis (ABA)).~~

CHANGE #6 PROPOSED SPECIFICATION LANGUAGE

TRUSTEE-APPROVED LANGUAGE TO ACCOMPLISH THIS CHANGE

Article III.B(5) in the A Advantage Plan will be removed as follows:

- (5) ~~Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

Article III.B(5) in the AA Advantage Plan will be removed as follows:

- (5) ~~Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

Article III.B(5) in the AAA Advantage Plan will be removed as follows:

- (5) ~~Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is~~

~~limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

Article III.B(5) in the Select High-Deductible Health Plan will be removed as follows:

- ~~(5) — Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

Article III.B(6) in the Bronze PPO Plan will be removed as follows:

- ~~(6) — Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

Article III.B(6) in the Silver PPO Plan will be removed as follows:

- ~~(6) — Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

Article III.B(6) in the Gold PPO Plan will be removed as follows:

- ~~(6) — Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

Article III.B(6) in the Platinum PPO Plan will be removed as follows:

- (6) — ~~Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

Article III.B(6) in the Diamond PPO Plan will be removed as follows:

- (6) — ~~Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

Article III.B(6) in the Preferred High-Deductible Health Plan will be removed as follows:

- (6) — ~~Payment will be made, subject to the limitations and exclusions outlined in this Article, where permitted by applicable law, for 100% of the Negotiated Rate (or if there is no Negotiated Rate, the cash price for such service that is listed by the provider on a public website), for COVID-19 tests and related items and services, to the extent required by law. These charges are not subject to Deductible, Co-Pay or Coinsurance. Coverage is limited to the period of the COVID-19 public health emergency declared by the Department of Health and Human Services.~~

The NTCA Board of Directors has approved the recommendations of the Retirement & Security (R&S) Program and Savings Plan Trust Committee for the following amendments to the Retirement & Security Program.

R&S Program Specification Changes

Change # and Effective Date	Summary of Change	Reason for Change	Amendment Language
Change 1 Effective January 1, 2024	Amends the specifications to clarify how death benefits are calculated when the participant dies before age 55, but the beneficiary commences benefits after age 55 and addresses other clarifying language in Article IV.F(2)(b)	Currently, the specifications are unclear how to calculate the death benefit payable to a surviving spouse where the participant died before age 55, but the spouse does not start their benefit until a later time. The Program Actuary and ERISA Counsel recommend clarifying the Specifications to provide the surviving spouse with a survivor benefit calculated as of the commencement date (<i>i.e.</i> , as if the participant had died immediately before commencement).	Attachment A Page 3
Change 2 Effective January 1, 2024	Amends the specifications to rename and correct certain paragraph references.	In 2022 the Specifications were amended to move the language regarding the designation of beneficiary from Article IV.F(2)(g) to its own paragraph IV.L. When the specifications were updated, the subsequent paragraphs and paragraph references were not renamed. This change would correct the paragraphs, renaming paragraph (h) to (g), (i) to (h), and correcting the reference from IV.F(2)(g) to IV.L. where referenced throughout the Specifications.	Attachment A Pages 3 – 4
Change 3 Effective January 1, 2024	Amends the specifications to further clarify the meaning of Period of Severance within the context of the Soft Freeze.	Currently, a participant who terminates employment with a participating member and is rehired by the participating member prior to a Period of Severance is not subject to the Soft Freeze if the participating member has adopted the Soft Freeze. This change will further clarify the meaning of Period of Severance.	Attachment A Pages 4 – 5

Change # and Effective Date	Summary of Change	Reason for Change	Amendment Language
Change 4 Effective January 1, 2024	Amends the specifications to reduce the estimated annuity purchase cost from 90% to 85% if a member company withdraws from the R&S Program and is part of an annuity purchase.	Currently, if a member company withdraws from the R&S Program and is part of an annuity purchase, they are required to pay 90% of the excess, if any, of the estimated Annuity Purchase cost over the Program actuary's estimate of the Member's Allocable Assets. ("Estimated Payment"), if the Provider Selection Date is expected to be more than 30 days from the Member's withdrawal date. This change reduces the amount from 90% to 85%.	Attachment A Page 5

RETIREMENT & SECURITY PROGRAM SPECIFICATION AMENDMENTS

Bolded wording connotes language to be added and lined-out wording connotes language to be deleted.

CHANGE #1 PROPOSED SPECIFICATION LANGUAGE (EFFECTIVE JANUARY 1, 2024)

Article IV.F(2)(b) to read as follows:

- (b) Death before earliest retirement age - Effective for deaths on or after January 1, 2022, if a married Participant dies on or before the earliest retirement age, the Participant's surviving spouse will, except as provided in paragraph (c) below, receive the same benefit that would be payable if the Participant had:
 - (i) survived to the first day of the calendar month in which he would have attained age 55 (the earliest retirement age),
 - (ii) retired with an immediate qualified joint and 100% survivor annuity at the earliest retirement age, and
 - (iii) died on the day after the earliest retirement age.

In the event the benefit to the surviving spouse commences after the participant would have attained his earliest retirement age, such benefit shall be calculated as if the participant had survived until such later date.

Effective for deaths on or after September 30, 1985, the benefit payable to a surviving spouse shall not be less than (i) the annuity that would be payable to the surviving spouse under the preceding sentence had the deceased Participant withdrawn his entire Participant Contributions Account Balance immediately prior to his death, increased by (ii) the full value to the surviving spouse of such Participant Contributions Account Balance in the form of an annuity. A surviving spouse will ordinarily begin to receive payments at the Participant's Normal Retirement Age; however, a surviving spouse may elect, in writing, to receive payments beginning on the first of any month on or after the deceased Participant's Early Retirement Date. Further, a surviving spouse of a Participant who dies prior to age 55 may elect, in writing, to immediately receive a single sum equal to the present value of such payments. For purposes of this option, present value shall be determined as provided in Section (G)(2) of this Article IV.

CHANGE #2 PROPOSED SPECIFICATION LANGUAGE (EFFECTIVE JANUARY 1, 2024)

Article IV.F(2)(h) to read as follows:

- ~~(hg)~~ Death benefit for certain unmarried participants - This paragraph (h) applies solely with respect to unmarried Participants who were not accruing benefits at the date of death and who die on or after January 1, 1997. If the Participant dies after attaining the earliest retirement age, the death benefit payable to the Participant's beneficiary shall have a value equal to the actuarial equivalent of the annuity determined under the first two sentences of Section F(2)(a). If the Participant dies on or before the earliest retirement age, the death benefit payable to the Participant's beneficiary shall have a value equal to the actuarial equivalent of the annuity determined under the first two sentences of Section F(2)(b). A beneficiary to whom this paragraph (h) applies may elect to begin receiving a

distribution in the form of a single life annuity commencing no later than December 31 of the calendar year immediately following the calendar year in which the Participant dies, or a lump sum, payable no later than 5 years after the date of the Participant's death, consistent with the requirements of Article IV.E.

Article IV.F(2)(i) to read as follows:

- (ih) Form of death benefit payable to non-spousal beneficiary of a married Participant – If, in accordance with Article IV.F(2)(g)L, a married Participant designates a non-spousal beneficiary to receive the death benefit provided for in accordance with Article IV.F(2)(a) or (b), the death benefit is paid in the form of either a single life annuity, commencing no later than December 31 of the calendar year immediately following the calendar year in which the Participant dies, or a lump sum, payable no later than five years after the date of the Participant's death, consistent with the requirements of IV.E.

CHANGE #3 PROPOSED SPECIFICATION LANGUAGE (EFFECTIVE JANUARY 1, 2024)

Article III.M(1) to read as follows:

M. Freeze of Program Eligibility (“Soft Freeze”)

- (1) A Participating Member shall be permitted to elect to exclude from Program Eligibility all Employees hired or rehired on or after the first day of any month (“Freeze Date”). A Participating Member desiring to implement a Soft Freeze shall, prior to the first day of the Plan Year in which the Freeze Date shall occur, execute an Adoption Agreement, effective as of the first day of such Plan Year, that reflects the Soft Freeze. Notwithstanding Article V.B(2)(c), such Adoption Agreement shall reflect that any top-heavy minimum benefit due for a Plan Year under Article V.B(2)(a) to a Participant covered under any other plan or plans of the Participating Member, including the Savings Plan for Employees of NTCA and Its Members (if applicable), shall be satisfied under the other plan or plans. An Employee hired or rehired before the Freeze Date but who has not satisfied the eligibility requirements in Article II as of such Freeze Date, shall not be eligible to become a Participant in the Program. In addition, a Participant who terminates employment with a Participating Member and is employed by another Participating Member that is not a member of the first Participating Member's Controlled Group and has adopted a Soft Freeze shall be excluded from Program Eligibility.

Notwithstanding the foregoing, a Participant who

- (a) terminates employment with a Participating Member but remains employed within the Participating Member's Controlled Group before returning to employment with the Participating Member; or
- (b) terminates employment with a Participating Member and its Controlled Group and ~~is rehired by~~ **returns to service with** the Participating Member (or a member of its Controlled Group that is a Participating Member) prior to ~~a Period of Severance,~~ **the expiration of 12 months from the date the Participant terminated service (or the first date the Participant was otherwise absent from service, as applicable),** shall again become a Participant in accordance with Article II.C(3) regardless of whether the

Participating Member that rehires the Participant has adopted a Soft Freeze.

CHANGE #4 PROPOSED SPECIFICATION LANGUAGE (EFFECTIVE JANUARY 1, 2024)

Article VII.C(4)(d)(1) to read as follows:

- (d) Timing of Payment - The withdrawing Member shall pay to the Program the withdrawal liability described in (b) within 30 days of the Provider Selection Date. However, if the projected Provider Selection Date is expected to be more than 30 days from the Member's withdrawal date-
- (i) The Member shall pay the Program, within 30 days of the date the Program provides the Participating Member a written estimate of the Annuity Purchase Cost, an amount equal to ~~90~~ **85** percent (or a lower percentage determined by the Committee based on the particular facts and circumstances of the Participating Member) of the excess, if any, of the estimated Annuity Purchase cost over the Program actuary's estimate of the Member's Allocable Assets ("Estimated Payment").