SUMMARY OF MATERIAL MODIFICATIONS
To the Summary Plan Description for Valley Schools Employee Benefits Trust Choice Bronze Base Plan
Tolleson Union High School
Effective: July 1, 2015
Group Number: 729766

A Summary Plan Description (SPD) was published effective July 1, 2014. The following are modifications and clarifications that are effective July 1, 2015 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

A. Effective July 1, 2015, the Eligible Expenses provision in Section 3, *How the Plan Works,* is deleted in its entirety and replaced with the following:

Eligible Expenses

Valley Schools Benefits Trust has delegated to the Claims Administrator the initial 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 Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

B. Effective July 1, 2015, the definition for Eligible Expenses in Section 14, *Glossary*, is deleted in its entirety and replaced with the following:

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

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator'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 the Claims Administrator accepts.

C. Effective July 1, 2015, the following clarification is added to the SPD regarding Network Providers.

The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

D. Effective July 1, 2015, Section 5, *Plan Highlights*, is amended as follows:

Plan Features	Network
Copays[1]	
■ Emergency Health Services	$500
■ Physician's Office Services - Primary Physician (Tier 1)	$20
■ Physician's Office Services - Primary Physician (Tier 2)	$35
■ Physician's Office Services – Specialist (Tier 1)	$40
■ Physician's Office Services – Specialist (Tier 2)	$55

Plan Features	Network
■ Urgent Care Center Services	$50

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Emergency Health Services - Outpatient Emergency services received at a non-Network Hospital are covered at the Network level. If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a $500 Copay
Hearing Testing Up to $2,500 per plan year combined with Hearing Aid limit.	100% after you pay a $40/$55 Copay
Mental Health Services	
■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible
■ Physician's Office Services (per individual visit)	100% after you pay a $40/$55 Copay
■ Physician's Office Services (per group therapy visit)	100% after you pay a $40/$55 Copay
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders	
■ Hospital - Inpatient Stay	80% and after you meet the Annual Deductible
■ Physician's Office Services (per individual visit)	100% after you pay a $40/$55 Copay
■ Physician's Office Services (per group therapy visit)	100% after you pay a $40/$55 Copay

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Nutritional Counseling (Copay is per visit)	100% after you pay a $20/$35 or $40/$55 Copay
Physician's Office Services - Sickness and Injury (Copay is per visit) ■ Primary Physician ■ Specialist Physician In addition to the Copay stated in this section, the Copays and Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed in a Physician's office: ■ lab, radiology/x-rays and other diagnostic services described under Lab, X-Ray and Diagnostics – Outpatient; ■ major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient; ■ diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic; ■ outpatient surgery procedures described under Surgery – Outpatient; ■ outpatient therapeutic procedures described under Therapeutic Treatments – Outpatient; and ■ rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.	100% after you pay a $20/$35 Copay 100% after you pay a $40/$55 Copay

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Reconstructive Procedures	
■ Physician's Office Services	100% after you pay a $20/$35 or $40/$55 Copay
■ Hospital - Inpatient Stay	80% and after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible
■ Prosthetic Devices	80% after you meet the Annual Deductible
■ Surgery - Outpatient	80% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Copay is per visit) See Section 6, *Additional Coverage Details*, for visit limits.	100% after you pay a $40/$55 Copay
Substance Use Disorder Services	
■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible
■ Physician's Office Services (per individual visit)	100% after you pay a $40/$55 Copay
■ Physician's Office Services (per group therapy visit)	100% after you pay a $40/$55 Copay

E. Effective July 1, 2015, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* transitions to the use of DSM-5 diagnostic criteria.

The Mental Health Services, and Neurobiological Disorders - Autism Spectrum Disorder Services and Substance Use Disorder Services provisions in the SPD, Section 6 – Additional Coverage Details are deleted* in their entirety and replaced *with the following:

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric 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 Covered Health Services categories as described in this section.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.

- Individual, family, therapeutic group and provider-based case management.
- Crisis intervention.
- Partial Hospitalization/Day Treatment;
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

The Definitions of Autism Spectrum Disorders, Experimental or Investigational Services, Intensive Outpatient Treatment, Sickness , Specialist Physician and Substance Use Disorder Services in the SPD under Section 14, Glossary, are deleted **in their entirety and replaced** *with the following:*

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Exclusions for Mental Health, Neurobiological Disorders - Autism Spectrum Disorders and Substance Use Disorders in the SPD under Section 8, Exclusions, are deleted* in their entirety and replaced *with the following:

Mental Health and Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorder - Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.

3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, sexual dysfunctions, binge eating disorders, neurological disorders and other disorders with a known physical basis.

5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

8. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

9. Intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

11. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

12. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.

13. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.

14. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

F. Effective July 1, 2015, Section 15, *Outpatient Prescription Drugs*, under *Prescription Drug Product Coverage Highlights*, is amended to add the following:

Coupons: UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance or apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

G. Effective July 1, 2015, Section 15, *Outpatient Prescription Drugs*, under *Prescription Drug Product Coverage Highlights*, is amended as follows:

Covered Health Services[1,3]	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Retail - up to a 31-day supply[2]	100% after you pay a:	
■ tier-1	$0 Copay	$0 Copay
■ tier-2	$30 Copay	$30 Copay
■ tier-3	$50 Copay	$50 Copay
Mail order - up to a 90-day supply[2]	100% after you pay a:	
■ tier-1	$0 Copay	
■ tier-2	$75 Copay	
■ tier-3	$125 Copay	

H. Effective July 1, 2015, the Mail Service Maintenance Medication Program applies as follows:

Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications.

The Definition of Maintenance Medication is added to the SPD under Section 14, Glossary, as follows:

Maintenance Medication – a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card

I. The If Your Provider Does Not File Your Claim provision within the *Claims Procedures* section of the SPD is deleted in its entirety and replaced with the following:

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the number on your ID card or contacting the Benefits Department. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

When you assign your Benefits under the Plan to a provider with UnitedHealthcare's consent, and the provider submits a claim for payment, you and the provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person’s agreement that the provider will be entitled to all the Covered

Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a provider is made, Valley Schools Employee Benefits Trust reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Valley Schools Employee Benefits Trust pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

J. The Overpayment and Underpayment of Benefits provision within the *Coordination of Benefits* section of the SPD, is deleted in its entirety and replaced with the following:

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Claims Administrator should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that the Claims Administrator will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

K. Effective July 1, 2015, the When COBRA Ends provision in Sectionn12, *When Coverage Ends*, is deleted in its entirety and replaced with the following:

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- The date coverage ends for failure to make the first required premium (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

L. Effective July 1, 2015, the definition for Certificate of Creditable Coverage in Section 14, *Glossary*, is deleted in its entirety.