Summary of Material Modifications

To Participants of the Publix Super Markets, Inc. Group Health Benefit Plan

This Summary of Material Modifications is to inform you of changes and clarifications to the *BCBS PPO Member Handbook.* These changes and clarifications are effective **January 1, 2024**.

1. The **Schedule of Benefits** is as follows:

SCHEDULE OF BENEFITS

This Schedule of Benefits is subject to all other terms, conditions and exclusions of the Plan. To maximize benefits, seek medical services from a BCBS network provider. Please call 1-866-PUBLIX5 (1-866-782-5495) or visit the Plan's website at www.MyPublixHealthPlan.com to find out if a provider is participating.

Schedule of Benefits,	**Network Provider**	**Out-of-Network Provider[1]**
Calendar Year Deductible (Applies to all services unless otherwise indicated) Per Individual Per Family Aggregate	 $ 500 $1,500	 $1,000 $3,000
Member Coinsurance After Deductible **Plan Coinsurance After Deductible**	20% of Allowed Amount 80% of Allowed Amount	40% of Allowed Amount 60% of Allowed Amount
Calendar Year Out-Of-Pocket Maximum Per Individual Per Family Aggregate	 $4,000 $8,000	 $ 8,000 $16,000
Family Doctor Office Visit (Provided by Family Practice, General Practice, Internal Medicine or Pediatric Doctor)	$25 Copay – No Deductible	60%
Telehealth Visit (Provided through Amwell network) Urgent Care Mental Health Therapy and Psychiatry	 $25 Copay – No Deductible $25 Copay – No Deductible	 N/A N/A
Mental Health Specialist Office Visit	$25 Copay – No Deductible	60%
Specialist Office Visit	$50 Copay – No Deductible	60%
Preventive Care Services Adult Annual Physical (Family Doctor or OB/GYN) Annual Well Woman (Family Doctor or OB/GYN) Well Child (Family Doctor) Preventive Care Lab Services Routine Immunizations – administered at doctor's office Routine Adult Immunizations – administered at Publix Pharmacy Annual Mammogram Annual Prostate Specific Antigen (PSA) Screening Annual Osteoporosis Screening Annual Colonoscopy – performed at an Ambulatory Surgical Center (ASC) Annual Colonoscopy – ASC Specialist and ASC Anesthesiologist	 100% – No Deductible 100% – No Deductible 100% – No Deductible 100% – No Deductible 100% – No Deductible 100% – No Deductible 100% – No Deductible 100% – No Deductible 100% – No Deductible $100 Copay – No Deductible 100% – No Deductible	 60% 60% 60% 60% 60% N/A 60% 60% 60% 60% 60%

Schedule of Benefits, continued	**Network Provider**	**Out-of-Network Provider**[1]
Hospital Per Admission Copayment (PAC)	$50 Per Day (Days 1-5)	$100 Per Day (Days 1-5)
Maternity Care Services		
First OB/GYN Office Visit	$50 Copay – No Deductible	60%
Total Maternity Care (hospital and doctor charges; prenatal, delivery and most inpatient postnatal care)	PAC + 80%	PAC + 60%
Hospital Services		
Inpatient Hospital	PAC + 80%	PAC + 60%
Inpatient Doctor	80%	60%
Ambulatory Surgical Center (ASC)	$100 Copay – No Deductible	60%
Outpatient Hospital	80%	60%
Outpatient or ASC Doctor	80%	60%
All Ancillary and Lab Services	80%	60%
Emergency Services		
Urgent Care (including after hours)	$50 Copay – No Deductible	60%
Emergency Room (ER) (waived if admitted)	$200 Copay – No Deductible	$200 Copay – No Deductible
ER Doctor and All ER Ancillary and Lab Services	80%	80%
Ground Ambulance (most providers are out-of-network)	80%	60%
Air Ambulance (most providers are out-of-network)	80%	80%
Diagnostic X-Ray, Imaging and Lab Services	80%	60%
Chiropractic Services (including x-ray and imaging) *($750 maximum per year)*	80%	60%
Allergy Injections (without an office visit)	80%	60%
Specialty Drugs (covered under the medical benefit)	80%	60%
Outpatient Therapeutic Services		
Speech Therapy *(maximum of 30 sessions per year)*	80%	60%
Occupational Therapy *(maximum of 35 sessions per year)*	80%	60%
Physical Therapy *(maximum of 35 sessions per year)*	80%	60%
Cardiac Rehabilitation (Phase I and Phase II only)		
Specialist Office Visit	100% – No Deductible	60%
Outpatient Visit	100% – No Deductible	60%
Diabetic Services and Supplies		
Diabetic Self-Management Education	100% – No Deductible	60%
Diabetic Shoes/Inserts *(maximum of one pair per year up to $300)*	80%	60%
Other Services		
Home Health Care *(maximum of 30 visits per year)*	80%	60%
Hospice	80%	60%
Inpatient Rehabilitation *(maximum of 21 days per year)*	PAC + 80%	N/A
Skilled Nursing Facility *(maximum of 90 days per year)*	80%	60%
Residential Treatment Center *(maximum of 90 days per year)*	80%	60%
Prosthetic Devices *(maximum of $30,000 per prosthetic device)*	80%	60%
Durable Medical Equipment/Orthotic Devices *(maximum of $5,000 per piece of equipment or device)*	80%	60%
Varicose or Refluxing Vein Treatment *($5,000 lifetime maximum)*	80%	60%
Breast Pumps *($200 lifetime maximum)*	100%	100%
Preadmission certification or preauthorization certification may be required for the above services – please refer to the Managed Care Services section of this handbook.		

[1] When you receive emergency care or treatment from an Out-of-Network Provider at a Network Provider (hospital, ambulatory surgical center, outpatient facility), you are protected from surprise billing or balance billing. Please refer to the Your Rights and Protections Against Surprise Medical Bills section of this handbook.

Prescription Benefit – Administered by OptumRx (1-855-238-8295)	
Calendar Year Deductible	$100 Per Individual / $300 Per Family Aggregate
Maximum Benefit Per Prescription Filled	$6,000 Per Prescription Filled
	Network Pharmacy[1]
Generic Drug – up to a 30-day supply	$12 Copay
Preferred Brand Drug – up to a 30-day supply	$35 Copay[2]
Non-Preferred Brand Drug – up to a 30-day supply	50% of Cost[2] ($55 Minimum Copay)
Maintenance Drug – more than 30-day and up to 90-day supply at Publix Pharmacy only	$30 Copay – Generic Drug $87 Copay – Preferred Brand Drug[2]

[1] Prescriptions must be filled at a Publix Pharmacy with two exceptions. If a member needs an emergency, after-hours prescription or if a Publix Pharmacy is more than 10 miles from where the member is trying to fill a prescription, another network pharmacy may be used.

[2] When a generic drug is available and the member chooses a brand drug, the member pays the generic drug copay plus the difference in cost between the brand drug and generic drug.

2. The **Routine Adult Immunizations** bullet of the **Preventive Care** subsection of the **Covered Medical Services** section is changed to read as follows:

   Routine Adult Immunizations – Most routine adult immunizations generally are covered as recommended by the U.S. Centers for Disease Control and Prevention; verification of coverage of specific immunizations with BCBS is recommended prior to administration.

   Note: During specified time periods each year, the Life. Inspired. associate wellness program offers free influenza immunizations, commonly referred to as flu shots, at Publix Pharmacies to Publix associates, regardless of their health insurance enrollment. Publix associates and their family members enrolled in the BCBS PPO Plan can receive influenza immunizations annually at Publix Pharmacies or in a doctor's office. (Restrictions may apply at Publix Pharmacies; discuss coverage and restrictions with the Publix pharmacist.)

   Note: Adult Plan members can receive the following immunizations from Publix Pharmacies: chicken pox, COVID-19, hepatitis A, hepatitis B, human papillomavirus (HPV), measles, mumps and rubella (MMR), meningitis, pneumonia, respiratory syncytial virus (RSV), shingles, and tetanus, diphtheria and pertussis (whooping cough) (DTaP). (Restrictions may apply; discuss coverage with the Publix pharmacist.)

3. The **Residential Treatment Center** subsection of the **Covered Medical Services** section is changed to read as follows:

   Services and supplies provided for a covered medical condition in a residential treatment center (RTC). The RTC must have a registered nurse (RN) present onsite who is in charge of the member's care along with one or more RNs or licensed practical nurses (LPNs) onsite at all times twenty-four hours per day, seven days per week. The RTC also must provide behavioral health services under the supervision of a licensed psychiatrist, addictionologist, when applicable, or physician extender (treating provider). The treating provider is responsible for the diagnostic evaluation and must provide face-to-face evaluation services with documentation a minimum of once per week and as needed as indicated. Benefits are payable to the maximum specified in the Schedule of Benefits. This benefit is available only if all of the following criteria are met:

   - The member must receive from Companion Benefit Alternatives (CBA) preadmission certification in advance of the services being rendered or the supplies being received by the member. Failure to obtain preadmission certification will result in the denial of room and board charges.
   - The member's treating provider must provide the proposed treatment plan for the RTC stay upon request by CBA.
   - Periodically as deemed appropriate by CBA, the member's treating provider must provide substantiation of the progress being made under the submitted treatment plan to CBA.

   Note: Services and supplies received at a RTC for more than 90 days per year are not covered by this Plan. Additionally, any service or supply received at a custodial or long-term care facility is not covered by this Plan.

4. A new subsection entitled **Specialty Drugs** is added the **Covered Medical Services** section as follows:

   Specialty Drugs
   Certain medications infused or injected by an attending physician or provider are covered through the medical benefit administered by BCBS. This excludes self-administered injectable medications, oral medications or medications purchased at a retail pharmacy location; refer to the Exclusions and Prescription Benefits sections of this handbook. Preauthorization certification is required regardless of the place of service in which the specialty drugs are received; failure to obtain preauthorization certification will result in the denial of all charges for the specialty drug and its administration by the attending physician.

5. The **Preauthorization Certification Review** subsection of the **Managed Care Services** section is changed to read as follows:

   Preauthorization certification review is required for the following:
   - Applied Behavioral Analysis (ABA) therapy services related to Autism Spectrum Disorder, regardless of the place of service in which the services are received;
   - psychological and neuropsychological testing, regardless of the place of service in which the testing is received;
   - repetitive transcranial magnetic stimulation (rTMS), regardless of the place of service in which the service is received;
   - services and supplies provided in an outpatient place of service, including, but not limited to, a hospital or ambulatory surgical center, including all professional and physician charges, with the exception of emergency room visits;
   - colonoscopies performed after the first colonoscopy in each calendar year;
   - outpatient mammograms performed after the first mammogram in each calendar year;

- physical therapy, occupational therapy and speech therapy services, regardless of the place of service in which the services are received;
- home health care services and supplies;
- durable medical equipment;
- outpatient high-tech diagnostic imaging services and supplies;
- outpatient interventional pain management services and supplies;
- outpatient hip, knee, shoulder, lumbar and cervical spine surgeries and supplies;
- human organ transplant services and supplies; and
- Specialty Drugs infused or injected by an attending physician or provider and covered through the medical benefit administered by BCBS, regardless of the place of service in which the drug is received.

Preauthorization must be obtained in advance from the following:

- HCS for outpatient (with the exception of outpatient mental health, substance abuse, high-tech diagnostic imaging services and supplies, outpatient interventional pain management services and supplies and outpatient hip, knee, shoulder, lumbar and cervical spine surgeries and supplies), home health care and human organ transplant services and supplies;
- CBA for outpatient mental health and substance abuse services and supplies;
- NIA for outpatient high-tech diagnostic imaging services and supplies, outpatient interventional pain management services and supplies and outpatient hip, knee, shoulder, lumbar and cervical spine surgeries and supplies; and
- Optum Specialty Medical Benefit Management (SMBM) for Specialty Drugs infused or injected by an attending physician or provider and covered through the medical benefit administered by BCBS.

6. The **Where to Call for Preauthorization Certification Review** subsection of the **Managed Care Services** section is changed to read as follows:

- For outpatient, physical therapy, occupational therapy, speech therapy, home health care, durable medical equipment and human organ transplant services, call HCS toll-free at 1-888-376-6544.
- For outpatient mental health and substance abuse services, call CBA toll-free at 1-800-868-1032.
- For outpatient high-tech diagnostic imaging services, outpatient interventional pain management services and supplies and outpatient hip, knee, shoulder, lumbar and cervical spine surgeries and supplies, call NIA toll-free at 1-888-376-6544.
- For Specialty Drugs infused or injected by an attending physician or provider and covered through the medical benefit administered by BCBS, call Optum SMBM toll-free at 1-877-440-0089.

7. The **Important Note** at the end of the **Managed Care Services** section is changed to read as follows:

<u>Important Note</u>: Approval from BCBS Health Care Services (HCS), Companion Benefit Alternatives (CBA), NIA Magellan (NIA) or Optum SMBM means only that a service, supply or Specialty Drug is medically necessary under the Plan for coverage and payment purposes.

- **HCS, CBA, NIA or Optum SMBM approval is not a guarantee or verification of final benefits determination. Payment of benefits upon submission of a claim is subject to member eligibility and all other Plan limitations and exclusions.**
- **Final benefits determination is made when a claim is filed with BCBS and processed.**

8. The **Specialty Pharmacy Services** subsection of the **Prescription Benefits** section is changed to read as follows:

Specialty Pharmacy Services
Specialty drugs are infused, injectable and oral medications that are generally used to treat chronic and catastrophic health conditions such as cancer, rheumatoid arthritis, hemophilia and growth hormone disorders. The Plan has entered into a preferred pricing agreement with Publix Pharmacy. As a result, benefits under the Plan for covered specialty medications are only available if obtained from a Publix Pharmacy, including Publix Specialty Pharmacy. If Publix Specialty Pharmacy is unable to fill a covered specialty prescription, an alternate pharmacy may be used upon Plan approval and at the Plan's sole discretion.

After meeting the calendar year prescription deductible and subject to the maximum benefit per prescription filled, the member pays the applicable copayment.

When prescribed a specialty medication, the member should call OptumRx at 1-855-238-8295 and identify himself or herself as a Plan member to obtain information about drug availability under the Plan.

Some specialty infused or injectable drugs are covered through the medical benefit administered by BCBS under this Plan. Please refer to the Covered Medical Services and Managed Care Services sections of this handbook for more information.
