

CORRECTED AMENDMENT #1
TO THE
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION
for the
THE DISTRICT SCHOOL BOARD OF COLLIER COUNTY
HEALTH BENEFITS PLAN - GROUP 2003022

The District School Board of Collier County Health Benefits Plan is amended as follows (**red** and *italics* means change or addition and ~~strikeout~~ means deletion):

The following changes are effective May 17, 2025:

Within "TITLE PAGE", "Claims Processed By:" is replaced as follows:

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.

2806 South Garfield Street

~~P.O. Box 3048~~

Missoula, MT 59806***1***-3048

Toll-Free Number: (855) 333-1012

Within "INTRODUCTION", "The Plan Supervisor address" is replaced as follows:

Allegiance Benefit Plan Management, Inc.

2806 South Garfield Street

~~P.O. Box 3048~~

Missoula, MT 59806***1***-3048

Within "PROCEDURES FOR CLAIMING BENEFITS", the second paragraph is replaced as follows:

When completed, the claim must be sent to the Third Party Administrator, Allegiance Benefit Plan Management, Inc. at ~~P.O. Box 3048, Missoula, Montana 59806-3048~~, ***PO Box 21074, Eagan, Minnesota 55121***, (855) 333-1012 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

Within "PROCEDURES FOR CLAIMING BENEFITS", the following paragraphs within "APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM" and "APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM" are replaced as follows:

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to ~~P.O. Box 4269, Missoula, MT 59806-4269~~ ***Allegiance Benefit Plan Management Appeals, PO Box 21222, Eagan, Minnesota 55121***. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

Within "PLAN SUMMARY", item #11 is replaced as follows:

11. THIRD PARTY ADMINISTRATOR

Name: Allegiance Benefit Plan Management, Inc.

Address: ~~P.O. Box 3048~~ ***2806 South Garfield Street***

Missoula, MT 59806***1***

The following changes are effective January 1, 2026:

Within "BASIC PATHWAY (no incentives) SCHEDULE OF MEDICAL BENEFITS", the "MEDICAL BENEFIT COST SHARING PROVISIONS" table is replaced, "AMBULATORY SURGICAL CENTER" is added alphabetically, "CHIROPRACTIC CARE" and "HOSPITAL SERVICES" are replaced, "NUTRITIONAL COUNSELING" is added alphabetically, and "PREVENTIVE CARE" is replaced as follows:

MEDICAL BENEFIT COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE (Embedded)		
Per Covered Person per Benefit Period	\$3,750	\$6,0006,400
Per Family per Benefit Period	\$7,500	\$12,00012,400
The Deductible applies to all Eligible Expenses, unless specifically stated otherwise. An individual Covered Person cannot receive credit toward the Family Deductible for more than the individual Annual Deductible.		
In-Network charges apply only toward the In-Network Deductible and Out-of-Network charges apply only toward the Out-of-Network Deductible.		
BENEFIT PERCENTAGE (The Plan Pays)		
Before satisfaction of Out-of-Pocket Maximum	60%	50%
After satisfaction of Out-of-Pocket Maximum	100%	100%
The Benefit Percentage applies to all Eligible Expenses, unless specifically stated otherwise. Eligible Expenses will be paid by the Plan according to the applicable Benefit Percentage.		
~~PHYSICIAN REGIONAL HOSPITAL COPAYMENT~~	\$1,000	
~~Copayment applies to any non-emergent or scheduled Inpatient admission or Outpatient service. Copayment is waived for Preventive Care services or screenings performed at Physicians Regional.~~		
OUT-OF-POCKET MAXIMUM (Embedded)		
Per Covered Person per Benefit Period	\$5,500	\$16,00018,000
Per Family per Benefit Period	\$11,000	\$32,000
The Out-of-Pocket Maximum includes amounts applied towards the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments do apply toward the applicable Pharmacy Benefit Deductible and Out-of-Pocket Maximum.		
In-Network charges apply only toward the In-Network Out-of-Pocket Maximum and Out-of-Network charges apply only toward the Out-of-Network Out-of-Pocket Maximum.		
MAXIMUM ANNUAL OR LIFETIME BENEFIT FOR ALL CAUSES	Unlimited	

MEDICAL BENEFITS / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
AMBULATORY SURGICAL CENTER		
	100% after Deductible	50% after Deductible
CHIROPRACTIC CARE		
	60% after Deductible	50% after Deductible
Benefit Limits: 24 Maximum Number of Treatments per Benefit Period "Treatment" includes all services provided during a calendar day Benefit limits are for services received from Network and Non-Network Providers.		
HOSPITAL SERVICES		
Inpatient Facility Services	60% after Deductible	50% after Deductible
Inpatient Professional Provider Services	60% after Deductible	50% after Deductible
Outpatient Facility Services	~~60% after Deductible~~ \$400 Copayment, then 100% after Deductible	50% after Deductible
Outpatient Professional Provider Services	60% after Deductible	50% after Deductible
Pre-certification is required for all Inpatient admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		
NUTRITIONAL COUNSELING (Not otherwise covered under Preventive Care)		
	60% after Deductible	50% after Deductible

MEDICAL BENEFITS / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE (See Medical Benefits Section)		
	100%, Deductible Waived	No Coverage
Covered Services: ◆ Well-Child Care ◆ Physical examinations ◆ Pelvic examination and pap smear ◆ Laboratory and testing ◆ Hearing and vision screening ◆ ~~Breast cancer screening (e.g., Mammograms, Magnetic Resonance Imaging (MRIs); Ultrasounds and similar breast cancer screening services)~~ ◆ <i>Mammogram. If additional imaging (e.g. magnetic resonance imaging (MRI), ultrasound or another mammogram) and pathology evaluation are indicated, these services are also recommended to complete the screening process for malignancies after initial mammogram.</i> ◆ <i>Individualized patient navigation services for breast and cervical cancer screening and follow-up</i> ◆ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ◆ Cardiovascular screening blood tests ◆ Colorectal cancer screening tests ◆ Vaccinations and Immunizations recommended by Physician ◆ BRCA1 and BRCA2 when medically indicated ◆ Nutritional counseling ◆ Well Women Preventive Care subject to Plan limitations on sterilization procedures ◆ <i>Screening for adolescent and adult women for intimate partner and domestic violence, at least annually, and when needed, providing or referring to intervention services.</i> Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.		

Within "CUSTOM PATHWAY (partial incentives) SCHEDULE OF MEDICAL BENEFITS", the "MEDICAL BENEFIT COST SHARING PROVISIONS" table is replaced, "AMBULATORY SURGICAL CENTER" is added alphabetically, "CHIROPRACTIC CARE" and "HOSPITAL SERVICES" are replaced, "NUTRITIONAL COUNSELING" is added alphabetically, and "PREVENTIVE CARE" is replaced as follows:

MEDICAL BENEFIT COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE (Embedded) Per Covered Person per Benefit Period Per Family per Benefit Period	\$1,250 \$2,500	~~\$1,300~~ 2,600 ~~\$2,600~~ 5,200
The Deductible applies to all Eligible Expenses, unless specifically stated otherwise. An individual Covered Person cannot receive credit toward the Family Deductible for more than the individual Annual Deductible.		
In-Network charges apply only toward the In-Network Deductible and Out-of-Network charges apply only toward the Out-of-Network Deductible. Copayments do not apply towards the Deductible.		
BENEFIT PERCENTAGE (The Plan Pays) Before satisfaction of Out-of-Pocket Maximum After satisfaction of Out-of-Pocket Maximum	70% 100%	55% 100%
The Benefit Percentage applies to all Eligible Expenses, unless specifically stated otherwise. Eligible Expenses will be paid by the Plan according to the applicable Benefit Percentage.		
PHYSICIAN REGIONAL HOSPITAL COPAYMENT	\$1,000	
~~Copayment applies to any non-emergent or scheduled Inpatient admission or Outpatient service. Copayment is waived for Preventive Care services or screenings performed at Physicians Regional.~~		
OFFICE VISITS Primary Care Physician (PCP) Specialty Care Physician (SCP)	\$50 Copayment/Visit \$75 Copayment/Visit	55% after Deductible 55% after Deductible
Copayment is a flat dollar amount paid for medical services by a Covered Person per office visit. Services for which a Copayment applies are covered at 100% after the Covered Person pays the Copayment. The Copayment applies to all services performed in the office in conjunction or associated with the office visit charge, not to exceed \$500 per visit. Charges exceeding \$500 will be subject to the Deductible and Benefit Percentage.		
If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		
URGENT CARE FACILITY, URGENT CARE CENTER OR CONVENIENCE WALK-IN-CLINIC Primary Care Physician (PCP) Specialty Care Physician (SCP)	\$50 Copayment/Visit \$75 Copayment/Visit	55% after Deductible 55% after Deductible
Copayment is a flat dollar amount paid for medical services by a Covered Person per office visit. Services for which a Copayment applies are covered at 100% after the Covered Person pays the Copayment. The Copayment applies to all services performed in the office in conjunction or associated with the charge for the urgent care visit, not to exceed \$500 per visit. Charges exceeding \$500 will be subject to the Deductible and Benefit Percentage.		
If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		

MEDICAL BENEFIT COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
OUT-OF-POCKET MAXIMUM (Embedded) Per Covered Person per Benefit Period Per Family per Benefit Period	\$5,000 \$10,000	~~\$8,500~~ 12,500 \$17,000
The Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayment and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments do apply toward the applicable Pharmacy Benefit Deductible and Out-of-Pocket Maximum. In-Network charges apply only toward the In-Network Out-of-Pocket Maximum and Out-of-Network charges apply only toward the Out-of-Network Out-of-Pocket Maximum.		
MAXIMUM ANNUAL OR LIFETIME BENEFIT FOR ALL CAUSES	Unlimited	

MEDICAL BENEFITS / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK

AMBULATORY SURGICAL CENTER

	100% after Deductible	55% after Deductible
--	-----------------------	----------------------

CHIROPRACTIC CARE

	~~70% after Deductible~~ 100% after SCP Copayment up to \$500, then 70% after Deductible	55% after Deductible
--	--	----------------------

Benefit Limits:

24 Maximum Number of Treatments per Benefit Period

"Treatment" includes all services provided during a calendar day

Benefit limits are for services received from Network and Non-Network Providers.

HOSPITAL SERVICES

Inpatient Facility Services	70% after Deductible	55% after Deductible
Inpatient Professional Provider Services	70% after Deductible	55% after Deductible
Outpatient Facility Services	~~70% after Deductible~~ \$400 Copayment, then 100% after Deductible	55% after Deductible
Outpatient Professional Provider Services	70% after Deductible	55% after Deductible

Pre-certification is required for all Inpatient admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.

NUTRITIONAL COUNSELING (Not otherwise covered under Preventive Care)

	70% after Deductible	55% after Deductible
--	----------------------	----------------------

MEDICAL BENEFITS / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE (See Medical Benefits Section)		
	100%, Deductible Waived	No Coverage
Covered Services: ◆ Well-Child Care ◆ Physical examinations ◆ Pelvic examination and pap smear ◆ Laboratory and testing ◆ Hearing and vision screening ◆ ~~Breast cancer screening (e.g., Mammograms, Magnetic Resonance Imaging (MRIs), Ultrasounds and similar breast cancer screening services)~~ ◆ <i>Mammogram. If additional imaging (e.g. magnetic resonance imaging (MRI), ultrasound or another mammogram) and pathology evaluation are indicated, these services are also recommended to complete the screening process for malignancies after initial mammogram.</i> ◆ <i>Individualized patient navigation services for breast and cervical cancer screening and follow-up</i> ◆ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ◆ Cardiovascular screening blood tests ◆ Colorectal cancer screening tests ◆ Vaccinations and Immunizations recommended by Physician ◆ BRCA1 and BRCA2 when medically indicated ◆ Nutritional counseling ◆ Well Women Preventive Care subject to Plan limitations on sterilization procedures ◆ <i>Screening for adolescent and adult women for intimate partner and domestic violence, at least annually, and when needed, providing or referring to intervention services.</i> Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.		

Within "ENHANCED PATHWAY (full incentives) SCHEDULE OF MEDICAL BENEFITS", the "MEDICAL BENEFIT COST SHARING PROVISIONS" table is replaced, "AMBULATORY SURGICAL CENTER" is added alphabetically, "CHIROPRACTIC CARE" and "HOSPITAL SERVICES" are replaced, "NUTRITIONAL COUNSELING" is added alphabetically, and "PREVENTIVE CARE" is replaced as follows:

MEDICAL BENEFIT COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE (Embedded) Per Covered Person per Benefit Period Per Family per Benefit Period	\$500 \$1,000	~~\$800~~ 1,600 ~~\$1,600~~ 3,200
The Deductible applies to all Eligible Expenses, unless specifically stated otherwise. An individual Covered Person cannot receive credit toward the Family Deductible for more than the individual Annual Deductible.		
In-Network charges apply only toward the In-Network Deductible and Out-of-Network charges apply only toward the Out-of-Network Deductible. Copayments do not apply towards the Deductible.		
BENEFIT PERCENTAGE (The Plan Pays) Before satisfaction of Out-of-Pocket Maximum After satisfaction of Out-of-Pocket Maximum	80% 100%	60% 100%
The Benefit Percentage applies to all Eligible Expenses, unless specifically stated otherwise. Eligible Expenses will be paid by the Plan according to the applicable Benefit Percentage.		
PHYSICIAN REGIONAL HOSPITAL COPAYMENT	\$1,000	
~~Gopayment applies to any non-emergent or scheduled Inpatient admission or Outpatient service. Gopayment is waived for Preventive Care services or screenings performed at Physicians Regional.~~		
OFFICE VISITS Primary Care Physician (PCP) Specialty Care Physician (SCP)	\$30 Copayment per Visit \$50 Copayment per Visit	60% after Deductible 60% after Deductible
Copayment is a flat dollar amount paid for medical services by a Covered Person per office visit. Services for which a Copayment applies are covered at 100% after the Covered Person pays the Copayment. The Copayment applies to all services performed in the office in conjunction or associated with the office visit charge, not to exceed \$500 per visit. Charges exceeding \$500 will be subject to the Deductible and Benefit Percentage.		
If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		

MEDICAL BENEFIT COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
<u>URGENT CARE FACILITY, URGENT CARE CENTER OR CONVENIENCE WALK-IN-CLINIC</u> Primary Care Physician (PCP) Specialty Care Physician (SCP)	\$30 Copayment per Visit \$50 Copayment per Visit	60% after Deductible 60% after Deductible
Copayment is a flat dollar amount paid for medical services by a Covered Person per office visit. Services for which a Copayment applies are covered at 100% after the Covered Person pays the Copayment. The Copayment applies to all services performed in the office in conjunction or associated with the charge for the urgent care visit, not to exceed \$500 per visit. Charges exceeding \$500 will be subject to the Deductible and Benefit Percentage. If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		
<u>OUT-OF-POCKET MAXIMUM</u> (Embedded) Per Covered Person per Benefit Period Per Family per Benefit Period	\$3,000 \$6,000	~~\$4,800~~ \$9,600 \$9,600
The Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of the Benefit Percentage. Pharmacy Copayments do not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Copayments do apply toward the applicable Pharmacy Benefit Deductible and Out-of-Pocket Maximum. In-Network charges apply only toward the In-Network Out-of-Pocket Maximum and Out-of-Network charges apply only toward the Out-of-Network Out-of-Pocket Maximum.		
MAXIMUM ANNUAL OR LIFETIME BENEFIT FOR ALL CAUSES	Unlimited	

MEDICAL BENEFITS / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
AMBULATORY SURGICAL CENTER		
	100% after Deductible	60% after Deductible
CHIROPRACTIC CARE		
	~~80% after Deductible~~ 100% after SCP Copayment up to \$500, then 80% after Deductible	60% after Deductible
Benefit Limits: 24 Maximum Number of Treatments per Benefit Period "Treatment" includes all services provided during a calendar day Benefit limits are for services received from Network and Non-Network Providers.		

MEDICAL BENEFITS / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
HOSPITAL SERVICES		
Inpatient Facility Services	80% after Deductible	60% after Deductible
Inpatient Professional Provider Services	80% after Deductible	60% after Deductible
Outpatient Facility Services	~~80% after Deductible~~ <i>\$400 Copayment, then 100% after Deductible</i>	60% after Deductible
Outpatient Professional Provider Services	80% after Deductible	60% after Deductible
Pre-certification is required for all Inpatient admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		
<i>NUTRITIONAL COUNSELING (Not otherwise covered under Preventive Care)</i>		
	<i>80% after Deductible</i>	<i>60% after Deductible</i>
PREVENTIVE CARE (See Medical Benefits Section)		
	100%, Deductible Waived	No Coverage
Covered Services: ◆ Well-Child Care ◆ Physical examinations ◆ Pelvic examination and pap smear ◆ Laboratory and testing ◆ Hearing and vision screening ◆ ~~Breast cancer screening (e.g., Mammograms, Magnetic Resonance Imaging (MRIs), Ultrasounds and similar breast cancer screening services)~~ ◆ <i>Mammogram. If additional imaging (e.g. magnetic resonance imaging (MRI), ultrasound or another mammogram) and pathology evaluation are indicated, these services are also recommended to complete the screening process for malignancies after initial mammogram.</i> ◆ <i>Individualized patient navigation services for breast and cervical cancer screening and follow-up</i> ◆ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ◆ Cardiovascular screening blood tests ◆ Colorectal cancer screening tests ◆ Vaccinations and Immunizations recommended by Physician ◆ BRCA1 and BRCA2 when medically indicated ◆ Nutritional counseling ◆ Well Women Preventive Care subject to Plan limitations on sterilization procedures ◆ <i>Screening for adolescent and adult women for intimate partner and domestic violence, at least annually, and when needed, providing or referring to intervention services.</i> Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services.		

Within "MEDICAL BENEFITS", item #12 and item ##16 are replaced, "NUTRITIONAL COUNSELING" is added alphabetically, and "WEIGHT LOSS SURGERY PROGRAM" is replaced as follows:

12. Charges for chiropractic services. *Benefit limits apply as stated in the Schedule of Medical Benefits.*
16. ~~Charges for Weight Loss Program. The program must be under the supervision of a licensed Physician. Patient must have a diagnosis of Morbid Obesity. Eligible Expenses include Physician office visits and services provided by the weight loss clinics, such as FDA approved medications, supplements, injections, blood pressure monitoring and dietary counseling. Charges in connection with services provided for the medical diagnosis of Obesity (Class I, II, and III). Note: These should be covered with no co-morbidities.~~

NUTRITIONAL COUNSELING

Charges for treatment rendered by a registered dietician, or other Licensed Healthcare Provider, for individuals with medical conditions or Mental Illness that require a special diet or counseling. Such conditions include but may not be limited to, diabetes mellitus, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, hyperlipidemias, and Mental Illness (e.g., anorexia, bulimia nervosa).

WEIGHT LOSS SURGERY PROGRAM

A Covered Person diagnosed with Morbid *Class III* Obesity and interested in a surgical weight loss (bariatric) procedure that is considered Medically Necessary must actively participate in and successfully complete the SmartChoice Bariatric Program through Community Health Partners. Prior to consideration for pre-certification of any bariatric surgery, active participation in eight (8) consecutive monthly sessions must be successfully completed. Active participation and responsibilities of the Covered Person are defined in the Active Participation Agreement that is signed by the Covered Person at the initial SmartChoice session. Active participation is also required after surgery. Said active participation includes four (4) SmartChoice sessions scheduled within one (1) year following the bariatric surgery. Failure to participate in the four (4) after-surgery sessions may result in the denial of some or all claims related to this program. Surgery must be performed within six (6) months following successful completion of the pre-surgery SmartChoice sessions.

Recommendation regarding request for gastric procedures limited to: Bariatric Surgery, Gastric Stapling, Laparoscopic Gastric Bypass, Roux-en-Y Gastric Bypass (RYGB), Gastric Sleeve Surgery (Vertical Sleeve Gastrectomy) or other medical policy standard technique.

The following criteria will be used for pre-certifying benefits for the above procedures:

1. A clinical history of unsuccessful diet and other weight management programs.
2. Must complete the SmartChoice 8-consecutive month pre-surgery bariatric program.
3. Must be at least eighteen (18) years of age and certified by a qualified medical provider within this program.
4. *Participant must have a diagnosis of Class III Obesity with:*
 - A. *Body Mass Index (BMI) of 40 kg/m² or more without comorbidities.*
 - B. *Body Mass Index (BMI) of 35-39.9 kg/m² with one or more comorbidities:*
 1. *Type 2 diabetes.*
 2. *Hypertension.*
 3. *Dyslipdemia.*
 4. *Cardiovascular risks (i.e., coronary heart disease, heart failure, prior stroke or stroke risk).*

5. *Obstructive sleep apnea.*
6. *Venous stasis disease.*

The following are specifically excluded:

1. Surgical procedures except for Bariatric Surgery, Gastric Stapling, Laparoscopic Gastric Bypass, Roux-en-Y Gastric Bypass (RYGB), Gastric Sleeve Surgery (Vertical Sleeve Gastrectomy) or other medical policy standard technique.
2. Any Expenses Incurred for which all of the conditions of the Weight Loss Surgery Program have not been met.
3. Any redo or revision of a prior weight loss surgical procedure, unless the indication for surgery is to treat or manage a diagnosis or condition unrelated to further weight loss.
4. A second weight loss surgical procedure, whether or not the first procedure was performed while covered under this Plan.

Additional information and prior authorization is provided by calling Community Health Partners at (239) 659-7770.

Within "MEDICAL BENEFIT EXCLUSIONS", item #15 is deleted in its entirety and the remaining items are renumbered accordingly as follows:

- ~~15. Charges in connection with services or supplies provided for the surgical treatment of obesity and weight reduction, except as otherwise covered under the Weight Loss Surgery Program.~~

"COVERAGE FOR A MILITARY RESERVIST" is replaced as follows:

COVERAGE FOR A MILITARY RESERVIST

To the extent required by the Uniform Services Employment and Reemployment Rights Act (USERRA), the following provisions will apply:

1. If a Participant is absent from employment with Employer by reason of service in the uniformed services *or by reason for service as a reservist in the Federal Emergency Agency (FEMA) who is deployed for disaster response*, the Participant may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:
 - A. The twenty-four (24) month period beginning on the date on which the Participant's absence begins; or
 - B. The period beginning on the date on which the Participant's absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment, as required by USERRA.
2. A Participant who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.

3. In the case of a Participant whose coverage under the Plan is terminated by reason of service in the uniformed services, an exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon re-employment if an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who notifies the Employer of his or her intent to return to employment in a timely manner as defined by USERRA, and is re-employed and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee. This provision will not apply to the coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.
4. The requirements of this section shall not supersede any anti discrimination in coverage requirement promulgated by TRICARE or CHAMPVA related to eligibility for those coverages.

Within "GENERAL DEFINITIONS", "MORBID OBESITY" is deleted in its entirety as follows:

MORBIDOBESITY

~~"Morbid Obesity" means a diagnosed condition in which the Body weight exceeds the normal weight by either 100 pounds or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed.~~

~~The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes or heart disease.~~

Nothing in this amendment is deemed to change any other provision of the Plan Document/Summary Plan Description of which it becomes a part.

THE DISTRICT SCHOOL BOARD OF COLLIER COUNTY

BY:

Valerie Warrick

TITLE:

Chief Human Resource Officer