AMENDMENT #1
TO THE
SUMMARY PLAN DESCRIPTION
for the
MEDICAL PLAN SPONSORED BY ALL CHILDREN'S HEALTH SYSTEM, INC. - 2003007

Effective January 1, 2025, the Medical Plan Sponsored by All Children's Health System, Inc. OAP Option is amended as follows (red and *italics* means change or addition and ~~strikeout~~ means deletion):

Within "**SCHEDULE OF MEDICAL BENEFITS**", "**DIABETIC EDUCATION AND NUTRITIONAL COUNSELING**" is replaced as follows:

TYPE OF SERVICE / LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT		
	TIER 1 ALL CHILDREN'S HOSPITAL	TIER 2 NETWORK	TIER 3 NON-NETWORK
DIABETIC EDUCATION AND NUTRITIONAL COUNSELING (All places of services)			
	100%	90% after Deductible	50% after Deductible
Nutritional Counseling is covered for diabetes, Obesity *and Mental Illness conditions* only.			

Within "**MEDICAL BENEFITS**", "DIABETIC EDUCATION AND NUTRITIONAL COUNSELING BENEFIT", "INFERTILITY SERVICES", "OCCUPATIONAL THERAPY - OUTPATIENT" and "PHYSICAL THERAPY - OUTPATIENT" are replaced as follows:

DIABETIC EDUCATION AND NUTRITIONAL COUNSELING BENEFIT

Coverage under this benefit includes charges for the following:

1. Diabetic Outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes. A family member who will be the primary care giver may attend the training on behalf of the Covered Person with diabetes.

2. Nutritional counseling rendered by a registered dietician, or other Licensed Healthcare Provider, for individuals with diabetes, Obesity *or Mental Illness that require a special diet or counseling (e.g., anorexia, bulimia nervosa)*.

Nutritional Counseling is covered for diabetes, Obesity *and Mental Illness conditions* only.

INFERTILITY SERVICES

Benefit limits apply as stated in the Schedule of Medical Benefits.

Charges are payable as specifically outlined in the Schedule of Benefits. Coverage under this benefit includes charges for infertility services (such as artificial insemination (AI) and in-vitro fertilization (IVF) and is available to female Employees and covered Dependent female spouses. The following requirements in all cases must be met:

~~1. The Employee must have one (1) continuous year of coverage by the Plan before treatment begins;~~

~~2~~*1*. Preauthorization is required.

~~3~~*2*. There must be a Physician recommended treatment plan.

~~4~~3. Treatment must be provided at a Network Provider approved by the Care Management Program.

~~5~~4. The order of infertility treatment options must have followed a logical succession of medically appropriate and cost-effective care.

~~6~~5. The Covered Person must first pay a separate Lifetime Deductible for infertility services as stated in the Schedule of Medical Benefits.

~~7~~6. All expenses connected with obtaining donor sperm or donor eggs are not covered; expenses for acquisition, freezing, storing or thawing of sperm, eggs or embryos, whether or not from a donor, are not covered; coverage is provided for implantation only.

~~8~~7. Infertility must not be related to a previous sterilization by the Employee or his/her spouse.

~~9~~8. No coverage is provided for surrogate motherhood or gestational carrier purposes. This exclusion does not apply to charges for treatment of the newborn child if the child is a covered eligible Dependent of the Covered Person.

For married opposite sex couples:

1. The husband's sperm and the wife's egg must be used, unless there is a documented medical condition unrelated to age whereby use of the husband's sperm and/or the wife's egg is not possible.

~~2. The mother must be covered by the Plan for one (1) continuous year before treatment begins.~~

~~3~~2. Medications required to be taken by the husband are covered if the husband is covered by the Plan.

For single females:

1. The Employee's egg must be used, unless there is a documented medical condition unrelated to age whereby use of the female's egg is not possible.

For married female same sex couples:

~~1. If the Employee's spouse will be the birth mother, she must be covered by the Plan for one (1) continuous year before treatment begins.~~

~~2~~1. The birth mother's egg must be used, unless there is a documented medical condition unrelated to age whereby use of the birth mother's egg is not possible.

OCCUPATIONAL THERAPY - OUTPATIENT

Coverage includes charges for Occupational Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Occupational Therapy must be ~~ordered by a Physician and~~ rendered by a licensed occupational therapist.

PHYSICAL THERAPY - OUTPATIENT

Coverage includes charges for Physical Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Outpatient basis. Physical Therapy must be ~~ordered by a Physician and~~ rendered by a licensed physical therapist.

Within "**GENERAL DEFINITIONS**", "OCCUPATIONAL THERAPY", "PHYSICAL THERAPY" and "SPEECH THERAPY" are replaced as follows:

OCCUPATIONAL THERAPY

"Occupational Therapy" means a program of care ~~ordered by a Physician which is~~ for the purpose of improving the physical, cognitive and perceptual disabilities that influence the Covered Person's ability to perform functional tasks related to normal life functions or occupations, and which is for the purpose of assisting the Covered Person in performing such functional tasks without assistance.

PHYSICAL THERAPY

"Physical Therapy" means a plan of care ~~ordered by a Physician and~~ provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

SPEECH THERAPY

"Speech Therapy" means a course of treatment~~, ordered by a Physician,~~ to treat speech deficiencies or impediments.

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

ALL CHILDREN'S HEALTH SYSTEM, INC.

BY: DocuSigned by: _____
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TITLE: VP/Chief Financial Officer

Approved Legal - JHACH