SUMMARY OF MATERIAL MODIFICATION AND AMENDMENT #1 TO THE JIM ELLIS ATLANTA, INC. HEALTH BENEFIT PLAN GROUP NO. 17753

This Summary of Material Modification and Amendment describes changes to the Jim Ellis Atlanta, Inc. Health Benefit Plan effective January 1, 2021. These changes are effective as of **May 1, 2021** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Jim Ellis Atlanta, Inc. (the "Plan Sponsor") is amending the Jim Ellis Atlanta, Inc. Health Benefit Plan (the "Plan") as follows:

1. *The **Prescription Drug Schedule of Benefits** section is hereby deleted and replaced as shown in **Exhibit A**.*

2. *The **Paydhealth Select Drugs and Products Program** subsection, and the **Step Therapy** subsection are hereby added under the **Prescription Drug Card Program** section as follows:*

PRESCRIPTION DRUG CARD PROGRAM

Paydhealth Select Drugs and Products Program
The Plan requires Covered Persons to enroll in the Select Drugs and Products Program when individuals are prescribed Prescription Drugs listed on the Select Drugs and Products List. This program is paid for by the Plan and provides matching of alternate funding programs to Covered Persons. All Covered Persons using listed Specialty Drugs are required to meet prior authorization, step therapy, and administrative review criteria, which includes enrollment in the program and adjudication of their Specialty Drug cost by an alternate funding program prior to meeting Plan coverage criteria. Failure to prior authorize and complete the requirements of the Select Drugs and Products Program will result in a cost containment penalty equal to a 100% reduction in your payable benefit for Specialty Drugs. This will be treated as an adverse benefit determination under the Plan and the Covered Person will have an opportunity to (1) appeal that decision; or (2) comply with the requirements of the program to avoid the cost containment penalty.

Some alternate funding programs require verification of income as a condition of meeting alternate funding program criteria. In such cases, the Covered Person will be asked to provide this information directly to the alternate funding program, and such information will not be provided to the Plan and is not considered in determining coverage by the Plan.

All Specialty Drug prescriptions paid for by the Plan through the appeals process must be dispensed or coordinated by Magellan Rx Pharmacy. Questions related to the Select Drugs and Products Program may be made directly to the Plan Specialty Contact Center by calling (877) 869-7772.

Step Therapy

What is Step Therapy?

Certain Prescription Drug classes are subject to Step Therapy. Step Therapy is a type of prior authorization. In most cases, you must first try a less expensive drug on the formulary (also called a drug list) that has been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. This might mean trying a similar, more affordable Brand Name Drug. The more affordable drugs in the first phase are known as "Step 1" Prescription Drugs. Please note the formulary may change at any time. You will receive notice when necessary.

However, if you have already tried the more affordable drug and it didn't work or if your Physician believes it is Medically Necessary for you to be on a more expensive drug, he or she can contact the Plan Administrator to request an exception. If your Physician's request is approved, the Plan will cover the more expensive drug. The more expensive drugs are known as "Step 2" Prescription Drugs.

Step Therapy is a program especially for people who take Prescription Drugs regularly for ongoing conditions like arthritis and high blood pressure.

In Step Therapy, drugs are grouped in categories based on cost:

- Front-line drugs - the first step - are generic drugs proven to be safe, effective and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

- Back-up drugs - Step 2 and Step 3 drugs - are brand-name drugs. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs typically cost more than front-line drugs.

How does Step Therapy work?

The next time the Physician writes a prescription, ask the Physician if a Generic Drug listed by the Plan as a front-line drug is appropriate. It makes good sense to ask for these drugs first because, for most everyone, they work as well as Brand Name drugs - and they almost always cost less.

If the Covered Person already tried a front-line drug, or his or her Physician decides one of these drugs isn't appropriate, then the Covered Person's Physician can prescribe a back-up drug. The Covered Person should ask his or her Physician if one of the lower-cost Brand Name Drugs (Step 2 drugs) listed by the Plan is appropriate. Remember, the Covered Person can always get a higher-cost Brand Name Drug at a higher Copay if the front-line or Step 2 back-up drugs are not appropriate.

If on May 1, 2021, the Covered Person is currently using a medication that requires Step Therapy he or she may continue using that medication. If the Covered Person is trying to fill a medication for the first time in 6 months, he or she may be required to use the first-line therapy before the Step Therapy medication can be filled. Please contact the Prescription Drug Card Program Administrator for more information on the Step Therapy program.

Failure to use the Step Therapy program may result in the Covered Person being responsible for the entire cost of the drug.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Jim Ellis Atlanta, Inc. has caused this Amendment to take effect, be attached to, and form a part of their Health Benefit Plan.

DocuSigned by:
Brooke Gatlin
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Authorized Signature	Date	Vice President of of Human Resources	Title
Annette Griffin		Totem Solutions Account Executive	
Witness	Date		Title

EXHIBIT A

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (combined with major medical Out-of-Pocket)	
Single	$8,150
Family	$16,300
Retail Pharmacy: 31-day supply	
Generic Drug	$5 - $35
Preferred Drug	$20 - $160
Non-Preferred Drug	$40 - $240
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 (100% paid)
Mandatory Specialty Pharmacy Program: 30-day supply	
Specialty Drug	$100
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
NOTE: Specialty Drugs listed on the Specialty Drug List are subject to the Copays listed above and require prior authorization. All Specialty Drugs must be ordered through e-prescribe Magellan Rx Pharmacy-Specialty or fax prescription at (866) 364-2673. **Covered Persons using Specialty Drugs included on the Select Drugs and Product List must enroll in the Plan Select Drugs and Products Program. Contact the Specialty Contact Center for additional information at (877) 869-7772. Failure to meet prior authorization criteria, including enrollment in the Select Drugs and Products Program when applicable, will result in a cost containment penalty equal to a 100% reduction in benefits payable.**	
Mail Order Pharmacy: 90-day supply	
Generic Drug	$20
Preferred Drug	$80
Non-Preferred Drug	$160
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 (100% paid)

NOTE: Certain Prescription Drug classes are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)

NOTE: Certain Prescription Drugs require approval before the drug can be dispensed. A current list of drugs that require prior authorization can be obtained by contacting the Prescription Drug Card Program Administrator.

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Paydhealth Select Drugs and Products Program
The Plan requires Covered Persons to enroll in the Select Drugs and Products Program when individuals are prescribed Prescription Drugs listed on the Select Drugs and Products List. This program is paid for by the Plan and provides matching of alternate funding programs to Covered Persons. All Covered Persons using listed Specialty Drugs are required to meet prior authorization, step therapy, and administrative review criteria, which includes enrollment in the program and adjudication of their Specialty Drug cost by an alternate funding program prior to meeting Plan coverage criteria. Failure to prior authorize and complete the requirements of the Select Drugs and Products Program will result in a cost containment penalty equal to a 100% reduction in your payable benefit for Specialty Drugs. This will be treated as an adverse benefit determination under the Plan and the Covered Person will have an opportunity to (1) appeal that decision; or (2) comply with the requirements of the program to avoid the cost containment penalty.

Some alternate funding programs require verification of income as a condition of meeting alternate funding program criteria. In such cases, the Covered Person will be asked to provide this information directly to the alternate funding program, and such information will not be provided to the Plan and is not considered in determining coverage by the Plan.

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Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.