SUMMARY OF MATERIAL MODIFICATIONS
TO THE
Diocese of La Crosse Priest Group
EMPLOYEE BENEFIT PLAN

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the Diocese of La Crosse Priest Group Employee Benefit Plan (the "Plan"). Please review this SMM carefully to familiarize yourself with the changes and please attach this SMM to the front of your SPD.

The following changes to the plan have been approved and are effective January 1, 2021:

1. **Important Updates Regarding Covid-19 Relief – Tolling of Certain Plan Deadlines –** amended for clarification:

   In no instance will the duration of an extension granted under this section exceed one Calendar Year.

2. **Covered Expenses** – amended for clarification:

   18. 2019 Novel Coronavirus (COVID-19). Covered Expenses associated with testing for COVID-19 include the following:

      1. Diagnostic Tests. The following items are covered at 100%, Deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require pre-certification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and Plan.
         a. In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
            - that are approved, cleared, or authorized by the FDA (including emergency authorization);

3. **Schedule of Benefits** – amended for clarification:

Preventive Care Services Routine x-ray and laboratory tests, prostate exams, colorectal screening including Cologuard, immunizations (including immunizations for the purpose of travel) and vision (including refraction) and hearing exams. *Preventive services are outlined in the Medical Covered Expenses section in their entirety.*	100% Deductible waived up to $700 maximum benefit per Calendar Year, then 90% after Deductible	80% after Deductible up to $700 maximum benefit per Calendar Year

4. **Medical Covered Expenses** – amended for clarification:

   PREVENTIVE CARE BENEFIT

   Covered Expenses will be reimbursed, as shown in the Schedule of Benefits, for the following services for Participants.

   Check-ups or routine examinations include the office visit and related charges for:

1. Routine x-ray and laboratory tests, including routine prostate exams;
2. Colorectal Screening
    a. Cologuard (sDNA-FIT), colonoscopy, CT colonography, flexible sigmoidoscopy, flexible sigmoidoscopy with FIT, gFOBT, FIT, and other tests and procedures that are medically recognized and are non-Experimental/Investigational in nature. This includes all related surgical and pathology services furnished in the same clinical encounter of the colorectal cancer screening should the screening (diagnostic) procedure be converted to a therapeutic procedure.
    b. Colonoscopies and Cologuard (sDNA-FIT) tests are limited to one every 3 years age 45 and over
    c. For those at increased risk due to family history or personal history there are no minimum age restrictions;

The following changes to the plan have been approved and are effective January 1, 2022 as follows:

5. **Preferred Provider Organization Provisions** – **Free Choice of Provider**– added due to the No Surprises Act:

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular provider is a Preferred Provider and the Participant receives such item or service in reliance on that information, the Participant's coinsurance, Copay, Deductible, and out-of-pocket maximum will be calculated as if the provider had been a Preferred Provider despite that information proving inaccurate.

6. **Preferred Provider Organization Provisions – Travel/Complimentary/Wrap PPO Network** - amended due to the No Surprises Act:

If You are traveling and are unable to access care from Your PPO Provider or the travel/complimentary/wrap network, benefits will be paid at the Non-Preferred Provider level unless otherwise specified in the Schedule of Benefits.

7. **Preferred Provider Organization Provisions – Travel/Complimentary/Wrap PPO Network** – amended for clarification:

Additional Preferred Provider Organizations, negotiation services or Multiplan's Data iSight Solutions (before or after services are rendered) may be utilized in order to optimize coverage and preserve Plan assets. When this occurs, the covered charges may be paid at the "Preferred Provider" rate. Please note that providers' status may change between Preferred and Non-Preferred at any time.

8. **Preferred Provider Organization Provisions** – added due to the No Surprises Act:

NO SURPRISES ACT – EMERGENCY SERVICES AND SURPRISE BILLS

For Non-Preferred Provider claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Preferred Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits providers from pursuing Participants for the difference between the Maximum Allowable Charge and the provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward Preferred Provider Deductibles and out-of-pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-Emergency services rendered by a Non-Preferred Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Preferred Provider air ambulance services.

CONTINUITY OF CARE

In the event a Participant is a continuing care patient receiving a course of treatment from a provider which is a Preferred Provider or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 7 calendar days after termination that the provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1) is undergoing a course of treatment for a serious and complex condition from a specific provider,
2) is undergoing a course of institutional or Inpatient care from a specific provider,
3) is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery,
4) is or was determined to be terminally sick and is receiving treatment for such Sickness from a specific provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the provider to continue to accept the previously contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the provider pursues a balance bill.

9. **Schedule of Benefits** – amended for clarification as out-of-network Air Ambulance must pay at the Preferred Provider level of benefits due to the No Surprises Act:

Ambulance Services-Air Emergency	90% after Deductible	90% after PPO Deductible
Non-Emergency	90% after Deductible	80% after Deductible
Ambulance Services-ground Emergency	90% after Deductible	80% after Deductible
Non-Emergency	90% after Deductible	80% after Deductible

10. **Schedule of Benefits** – amended the header Emergency Room Services to Emergency Services due to the No Surprises Act:

Emergency Services Includes facility charge, Physician fee and miscellaneous Hospital expenses. (Copay waived if admitted on Inpatient basis within 24 hours for same condition.)	$200 Copay, then 90% after PPO Deductible

11. **Schedule of Benefits** – removed due to the No Surprises Act:

If You are confined in a Non-Preferred Provider facility as a result of an Emergency, You will be eligible for Preferred Provider benefits until your attending Physician agrees it is safe to transfer You to a Preferred Provider facility.

12. **Schedule of Benefits** – amended for clarification:

Mental/Nervous Conditions and/or Substance Abuse		
Inpatient Treatment Including Qualified Treatment Facility services	90% after Deductible	80% after Deductible
Intensive Outpatient Services and Partial Hospitalization, Psychological Testing and other therapies	90% after Deductible	80% after Deductible
Outpatient Treatment	$25 Copay, then 100% Deductible waived	80% after Deductible

13. **How to File a Medical Claim – Prescription Drug Charges** – amended for clarification:

Retail Pharmacy
If You are without Your ID card or use a Non-Preferred Provider, You must pay for the prescription and submit a claim to the Prescription Drug Card service. A completed claim form and the paid receipt must be submitted as proof of claim. If the prescription Drug is covered under the Plan, reimbursement will be based on the contracted rate less the applicable Deductible/coinsurance/Copay.

Mail Order
The mail service program provides Participants with an easy and convenient way to obtain Your maintenance prescriptions. An order form, which explains the mail service program in greater detail, is available. Please contact Your Human Resource Department or Your Pharmacy Benefit Manager at the number shown on our ID card if You have any questions regarding this program.

14. **Utilization Review Program** – amended for clarification:

PRE-CERTIFICATION PENALTY

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to pre-certify the required services as identified above, **the allowed charges will result in a $100.00 non-compliance penalty per occurrence.** This penalty does not apply to the Deductible or maximum out-of-pocket expenses. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

15. **Medical Covered Expenses – Prescription Drug Benefit** - amended for clarification:

Definitions apply to this benefit only:

Non-Participating Pharmacy: any retail or mail order pharmacy that is not contracted by the Pharmacy Benefit Manager to be included in a network of pharmacies at a contracted amount.

Pharmacy Benefit Manager: an organization that manages payment for prescriptions and services under the Plan.

Drugs Covered
(For a complete list of covered Drugs, contact the Pharmacy Benefit Manager shown on your identification card)

17. Prescription digital therapeutics (PDTs) including reSET/re-SET-O;

Exclusions
(For a complete list of exclusions, contact the Pharmacy Benefit Manager shown on your identification card)

16. **Medical Covered Expenses –** amended header and description due to the No Surprises Act:

EMERGENCY SERVICES MEDICAL CARE

Covered Expenses will be reimbursed as shown in the Schedule of Benefits.

17. **Medical Covered Expenses – Ambulance Service** Benefit - amended due to the No Surprises Act:

Covered Expenses will be reimbursed as shown in the Schedule of Benefits for ambulance services. If Your Injury or Sickness requires special treatment not available in a local Hospital, appropriate transportation to the nearest Hospital equipped to provide the necessary treatment is covered. A return trip to Your local Hospital, via ambulance, is eligible if determined to be Medically Necessary.

18. **Limitations and Exclusions** – amended for clarification:

22. Recreational and educational therapy; learning disabilities; behavior modification therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships will not be considered eligible.

19. **Definitions** – added due to the No Surprises Act:

Certified IDR Entity:
Certified IDR Entity shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Independent Freestanding Emergency Department:
Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable State law, and which provides any Emergency Services.

Non-Preferred Provider (Non-PPO):
Non-Preferred Provider means any provider which does not satisfy the definition of Preferred Provider.

Participating Health Care Facility:
Participating Health Care Facility shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Preferred Provider/PPO:
Preferred Provider shall mean the facilities, providers and suppliers who have by contract via a medical provider network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the network's providers have agreed to accept assignment of benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Preferred Provider network (PPO) will be identified on the Participant's identification card. For prescription Drugs available through the prescription Drug and/or specialty Drug program (as applicable), Preferred Provider means the prescription Drug card program or specialty Drug program and does not include any other network of providers with which the Plan contracts.

Qualifying Payment Amount:
Qualifying Payment Amount means the median of the contracted rates recognized by the Plan or recognized by all plans serviced by the Plan's Claims Administrator (if calculated by the Claims Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Recognized Amount:
Recognized Amount shall mean, except for Non-Preferred Provider air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable State law. If no such amounts are available or applicable and for Non-Preferred Provider air ambulance services generally, the Recognized Amount shall mean the lesser of a provider's billed charge or the Qualifying Payment Amount.

20. **Definitions** – amended due to the No Surprises Act:

Emergency Services:
Emergency services shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Preferred Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines that the Participant is able to travel using non-medical transportation or non-Emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Preferred Provider.

Maximum Allowable Charge:
Maximum Allowable Charge means the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the section "Comprehensive Medical Coverages,") if no negotiated rate exists, the Maximum Allowable Charge will be the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

21. **Definitions** – amended for clarification:

Rescission or Rescind:
Rescission or Rescind is a cancellation of coverage or discontinuance of coverage under the Plan that has retroactive effect, unless attributable to:

1. Failure to timely pay the cost of coverage; or
2. Fraud or intentional misrepresentation of material fact, as those circumstances are described under the Affordable Care Act and regulatory guidance.

22. **Definitions** – removed the definition of PPO (Preferred Provider Organization) due to the No Surprises Act definition of Preferred Provider.

23. **Definitions** – removed the definition for ADA due to potential conflict with American Disabilities Act (ADA) and the definition for Legally Employed for it is no longer needed.

24. **General Information** – amended for clarification:

EMPLOYEE COVERAGE

Employee Eligibility
You are eligible for coverage under the Plan if You are an Employee of the Employer.

25. **Plan Description Information** – amended for clarification.

PLAN EFFECTIVE DATE January 1, 2022

26. **Health Claim Provisions** – **Requirements for First Level Appeal -** removed for clarification:

American Health Holding, Inc.
7400 West Campus Road
New Albany, OH 43054
Phone: (800) 641-3224 ext. 9377063
Fax: (866) 881-9648
Email: AHH_appeals@ahhinc.com

27. **Health Claim Provisions** – **Requirements for Second Level Appeal** – amended for clarification:

The Claimant must file an appeal regarding a Pre-Service Claim, Post-Service Claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

28. **Health Claim Provisions** – **External Review Process** added due to the No Surprises Act:

External Review Process
The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with applicable law, applies only to an Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

The following changes to the plan have been approved and are effective January 15, 2022 as follows:

29. **Prescription Drug Benefit -** amended due to COVID-19 Over-the-Counter (OTC) Testing:

Prescription Drugs are not subject to Deductible	**Drug Card – Retail (Copay per 34-day supply, maximum 90-day supply)**	**Mail Service (Copay per 90-day supply)**
Immunizations	**$0 Copay**	**Not Covered**
Generic	**$10 Copay**	**$20 Copay**
Brand Name	**$25 Copay**	**$50 Copay**

Specialty	Per applicable Copay. Maximum 34-day supply
Specialty **(IPC Copay Assistance Program)**	30% Copay per prescription Maximum 30-day supply
For those prescriptions in the Specialty IPC Copay Program, the manufacturer assistance program will cover most if not all of the Copay amount. Any actual out-of-pocket costs at the point of sale or Manufacturer Copay Assistance coinsurance charges that exceed the Plan Copay does not apply towards the major medical Deductible requirement or maximum out-of-pocket expense.	
2019 Novel Coronavirus (COVID-19) Over-the-Counter (OTC) Testing	100% not subject to Copay/Deductible/coinsurance Reimbursement for Non-Preferred Providers is limited to $12.00 per OTC test*. Maximum quantity limit 8 tests per Participant per 30 days**
*If the OTC Test is acquired with the involvement of or prescription by a provider or if the Plan has not arranged for adequate Preferred Provider access, the Plan will reimburse the Participant at full cost. **This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a provider.	
For COVID-19 OTC testing reimbursement if you are without your ID card or use a Non-Preferred Provider, you must pay for the prescription and submit a claim to the Prescription Drug Card service.	
For all other reimbursements, if You are without Your ID card or use a Non-Preferred Provider, You must pay for the prescription and submit a claim to the Prescription Drug Card service. A completed claim form and the paid receipt must be submitted as proof of claim. If the prescription Drug is covered under the Plan, reimbursement will be based on the contracted rate minus Copay.	

30. **Medical Covered Expenses** – amended due to COVID-19 Over-the-Counter (OTC) Testing:

Prescription Drug Benefit

Drugs Covered
(For a complete list of covered Drugs, contact the Pharmacy Benefit Manager shown on your identification card)

19. 2019 Novel Coronavirus (COVID-19) Over-the-Counter (OTC) Testing (quantity limits apply);

Exclusions
(For a complete list of exclusions, contact the Pharmacy Benefit Manager shown on your identification card)

9. non-legend Drugs except for those listed in the Drugs Covered section, except to the extent required by the FFCRA (Families First Coronavirus Response Act), as amended;
13. therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except for those listed in the Drugs Covered section, except to the extent required by the FFCRA (Families First Coronavirus Response Act), as amended;

31. **Medical Covered Expenses** – amended due to COVID-19 Over-the-Counter (OTC) Testing:

Prescription Drug Benefit

Dispensing Limitations
The amount normally prescribed by a Physician but not to exceed a 90-day supply for retail or mail order. Specialty Drugs will not exceed a 34-day supply regardless of whether they are retail or mail order.

COVID-19 Over the counter (OTC) tests will not exceed 8 tests per Participant per 30 days. **This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a provider.

32. **Medical Covered Expenses – Other Covered Expenses** - <u>added</u> COVID-19 Over-the-Counter (OTC) Testing to the Diagnostic tests section:

18. 2019 Novel Coronavirus (COVID-19). Covered Expenses associated with testing for COVID-19 include the following:

1. Diagnostic Tests. The following items are covered at 100%, Deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require pre-certification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and Plan.

c. Over-the-Counter Tests (OTC Tests). **Refer to prescription drug section for coverage.** Plan will cover OTC Tests for the detection of SARS-CoV-2 or the virus that causes COVID-19, which satisfy any one of the following conditions:

- that are approved, cleared, or authorized by the FDA (including an emergency authorization);
- for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
- that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
- that are deemed appropriate by the Secretary of Health and Human Services.

- OTC Tests neither require pre-certification nor involve an individualized clinical assessment from a provider. The Plan will cover up to 8 OTC Tests, per Participant per 30 days. This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a provider. OTC Tests purchased from a Preferred Provider are covered by the Plan at the point of sale at 100%, deductible waived. When the Plan is billed for a Non-Preferred Provider OTC Test, the Plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and Plan. If the Participant pays for a Non-Preferred Provider OTC Test, the Participant will be limited to reimbursement for the actual out-of-pocket cost of the OTC Test, up to a maximum of $12.00 per OTC Test If the OTC Test is acquired with the involvement of or prescription by a provider or if the Plan has not arranged for adequate Preferred Provider access, the Plan will reimburse the Participant at full cost.
- The following limitations also apply:
  - Coverage will be denied if reasonable evidence exists that the purchase was solely for employment purposes; and
  - Coverage will be denied if reasonable evidence exists of fraud, abuse, or that the purchase was made for use by someone other than the Participant or their dependents. NOTE: The Plan may require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC Test, including the UPC code for the OTC Test to verify that the item is one for which coverage is required under FFCRA, and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC Test. Further, the Plan may require a written attestation from the Participant describing the OTC Test, the price paid by the Participant, and the intended use (including for whom the OTC Test will be used).

33. **Limitations and Exclusions** – amended due to COVID-19 Over-the-Counter (OTC) Testing:

49. vitamins, appetite suppressants, nutritional supplements, tobacco dependency products, contraceptives, over-the-counter Drugs and prescription Drugs with exact over-the-counter equivalents, except as specifically provided in the Plan. See prescription Drug section for Covid-19 OTC testing coverage.