New York State Nurses Association

NYSNA Benefits Fund

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The following modifications are intended as a summary to supplement the NYSNA Benefits Fund's most recent Summary Plan Description ***with an effective date of January 1, 2014. These modifications should be added to the SPD and read together for a complete description of your NYSNA Benefits Fund benefits. While we have tried to make this notice as complete and accurate as possible, it does not restate the existing terms and provisions of the SPD other than the specific terms and provisions it is modifying. If there are any discrepancies between these Summary of Material Modifications and the SPD, the provisions of these Summaries shall govern.***

2017

Maximum network pharmacy out-of-pocket cost

Effective January 1, 2017

Please add this Summary of Material Modifications to Chapter 10: Pharmacy Drug Benefits of your SPD. It should be inserted on Page 90 after the "In-network copayments" subheading. In addition, the information should be added within Chapter 4: Summary of Benefits ***on Page 20 under the "Prescription Drugs" heading.***

The NYSNA Benefits Fund Board of Trustees has established a new maximum network pharmacy out-of-pocket cost for participants effective January 1, 2017. This amount represents the most you will pay each calendar year for your share of the cost of covered prescription drug benefits, including pharmacy copayments, coinsurance, and deductibles. The out-of-pocket network pharmacy maximum has been set at $6,150 for individuals and $12,300 for families for 2017.

Penalties incurred under the Benefits Funds' clinical pharmacy programs will not accumulate toward the maximum network pharmacy out-of-pocket cost. In addition, the cost difference between the brand-name drug and the generic drug that you must pay under the Benefit Fund's mandatory generic program (if there is a direct generic alternative available) is not a covered prescription drug benefit and will not accumulate toward the maximum network pharmacy out-of-pocket cost. The out-of-pocket network pharmacy maximum will change each year based on the maximum out-of-pocket allowable under the Affordable Care Act.

The out-of-pocket maximum helps you plan for pharmacy expenses. The maximum provides some financial protection for those participants who incur significant qualifying out-of-pocket costs for prescription drugs under Benefits Fund coverage if you use a network pharmacy. If your covered prescription drug out-of-pocket expenses in a calendar year exceed the annual maximum, the Fund pays 100 percent of eligible expenses for covered services through the end of the calendar year. Please note that the pharmacy out-of-pocket maximum is separate from the out-of-pocket maximum for hospital and medical costs.

2014 Summary of Material Modifications
Lower Copayments, Enteral Nutrition, Dependent Reinstatement Rule

Lower Copayments

The NYSNA Benefits Fund Board of Trustees voted to lower copayments for the following outpatient services and medication when provided in-Network, effective Sept. 1, 2014, through Aug. 31, 2017:

- Chiropractic care;
- Restorative physical, occupational, and speech therapy; and
- Insulin.

Effective Sept. 1, 2014, through Aug. 31, 2017, individuals covered by Benefit Coverage Plan A will pay a:

- $10 copayment per visit for Chiropractic care;
- $10 copayment per visit for outpatient Restorative physical, occupational, and speech therapy; and
- $0 copayment for Insulin.

Again, these copayments apply only when services are rendered in-Network. As of Sept. 1, 2017, the copayments will return to the Aug. 31, 2014, levels ($25 per visit for Chiropractic Care and outpatient Restorative physical, occupational and speech therapy: $10 for insulin at retail and $20 for insulin through mail order [three-month supply]).

Enteral Nutrition

The NYSNA Benefits Fund Board of Trustees has determined that effective May 1, 2014, the Benefits Fund will cover Medically Necessary[1] enteral formulas or modified solid food products for home use (whether administered orally or via tube feeding) for which a physician has issued a written order under the Fund's Medical Benefits, provided that the following criteria are established:[2]

A. The enteral formula or modified solid food product is being used as part of disease-specific treatment; and

B. The treatment is for one of the following:
   a. Inherited diseases of amino acid and /or organic acid metabolism;
   b. Crohn's Disease;
   c. Gastroesophageal reflux disease with failure to thrive;
   d. Disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction;
   e. Eosinophilic Esophagitis and related Eosinophilic disorders;
   f. Multiple, severe food allergies; and

C. One of the following:
   a. The patient is malnourished;
   b. The patient will become malnourished without treatment;
   c. The patient's condition, if left untreated, will cause one of the following:
   - Chronic physical disability;
   - Mental retardation;
   - Death. Nutritional supplements that are taken electively are not included in this coverage.[1] [2]

[1] As defined in the NYSNA Benefits Fund Summary Plan Description effective Jan. 1, 2014, as amended.

[2] Although the Fund, as a self-funded health plan, is not subject to state insurance laws, the Trustees of the Fund determined to offer this benefit to the extent currently mandated by Hannah's Law, a New York state law that requires insurance companies to provide coverage for enteral formulas under certain circumstances. Therefore, the Fund coverage for enteral formula is limited to that required by Hannah's Law.

Special Reinstatement Rule for Claimed Dependents Whose Benefit Coverage is Terminated as a Result of Not Providing Appropriate Verification During a Dependent Eligibility Audit

The NYSNA Benefits Fund Board of Trustees has approved a special rule for the reinstatement of a participant's dependent if the dependent's Benefits Fund coverage was terminated for failure to verify his/her eligibility during a dependent eligibility verification audit. Under the rule, Benefits Fund coverage for a terminated dependent who provides appropriate documentation verifying his/her eligibility for coverage will be reinstated, retroactively up to 120 days from the date of submission of the necessary documentation, such as a certified birth certificate. Thus, if Benefits Fund coverage of a claimed dependent terminated on June 30, 2014, as a result of his/her failure to provide appropriate verification, and the necessary documentation is submitted on or before Oct. 28, 2014, Benefits Fund coverage will be reinstated retroactive to June 30, 2014, the date it was terminated. If documentation is submitted after Oct. 28, 2014, Benefits Fund coverage will be reinstated up to 120 days retroactive to the date of submission of the necessary documentation.

2017 Summary of Material Modifications - Subrogation and Reimbursement - *Effective July 1, 2017*

Please replace in its entirety SECTION 6: Subrogation and Reimbursement *beginning on Page 70 and concluding on Page 73 within Chapter 9: Medical Benefits of the SPD with the following:*

SECTION 6 - SUBROGATION AND REIMBURSEMENT

The Benefits Fund has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate, and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that the Benefits Fund is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Fund has paid that are related to the sickness or injury for which any third party is considered responsible.

Subrogation – example

Suppose you are injured in a car accident that is not your fault and you receive benefits under the Benefits Fund to treat your injuries. Under subrogation, the Fund has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Fund 100 percent of any benefits you receive for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

Reimbursement – example

Suppose you are injured in a boating accident that is not your fault and you receive benefits under the Benefits Fund as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Fund 100 percent of any benefits you received to treat your injuries.

Third parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages;
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury, or damages;
- Your employer in a workers' compensation case or other matter alleging liability;
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, other insurance carriers or third party administrators;
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party; or
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

Subrogation and reimbursement provisions

You agree as follows:

1.You will cooperate with the Benefits Fund in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including but not limited to:

- Notifying the Fund, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
- Providing any relevant information requested by the Fund.
- Signing and/or delivering such documents as the Fund or its agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining the Fund's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Benefits Fund is considered a breach of contract. As such, the Fund has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Fund has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Fund due to you or your representative not cooperating with the Fund. If the Fund incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Fund has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Fund.

2. The Benefits Fund has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Fund's first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including but not limited to, hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

3. The Fund's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Fund is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including

attorneys' fees, shall be deducted from the Fund's recovery without the Fund's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

4. Regardless of whether you have been fully compensated or made whole, the Fund may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Fund may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Fund's subrogation and reimbursement rights.

5. Benefits paid by the Fund may also be considered to be benefits advanced.

6. If you receive any payment from any party as a result of sickness or injury and the Fund alleges some or all of those funds are due and owed to the Fund, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

7. By participating in and accepting benefits from the Fund, you agree that: any amounts recovered by you from any third party shall constitute Fund assets to the extent of the amount of Fund benefits provided on behalf of the participant; you and your representative shall be fiduciaries of the Benefits Fund (within the meaning of ERISA) with respect to such amounts; and you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Fund to enforce its reimbursement rights.

8. The Fund's rights to recovery will not be reduced due to your own negligence.

9. By participating in and accepting benefits from the Fund, you agree to assign to the Fund any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the benefits the Fund has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Fund's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

10. The Fund may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment, or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Fund in any way to pay you part of any recovery the Fund might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Fund is governed by a six-year statute of limitations.

11. You may not accept any settlement that does not fully reimburse the Fund, without its written approval.

12. The Fund has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

13. In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death, the Fund's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Fund is not extinguished by a release of claims or settlement agreement of any kind.

14. No allocation of damages, settlement funds, or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries, or any other person or party, shall be valid if it does not reimburse the Fund for 100 percent of its interest unless the Fund provides written consent to the allocation.

15. The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

16. If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Fund, the provisions of this section continue to apply, even after you are no longer covered.

17. In the event that you do not abide by the terms of the Fund pertaining to reimbursement, the Fund may terminate benefits to you or your dependents or deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Fund has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Fund due to your failure to abide by the terms of the Fund. If the Fund incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Fund has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Fund.

18. The Fund and all Administrators administering the terms and conditions of the Fund's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to construe and enforce the terms of the Fund's subrogation and reimbursement rights and make determinations with respect to the subrogation amounts and reimbursements owed to the Benefits Fund.

Right of recovery

The Benefits Fund also has the right to recover benefits it has paid on you or your dependent's behalf that were:

- Made in error;
- Due to a mistake in fact.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Fund provides a benefit for you or your Dependent that exceeds the amount that should have been paid, the Fund will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

The Fund has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Fund.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Fund.

2017
Summary of Material Modifications – Treatment of Gender Dysphoria
Effective July 1, 2017

Please add the following information to SECTION 2: Covered Services within Chapter 9: Medical Benefits of the SPD beginning on Page 39 and concluding on Page 55.

The NYSNA Benefits Fund Board of Trustees has voted to provide surgical benefits for the treatment of gender dysphoria, effective as of July 1, 2017.*

**Participants covered under facilities adhering to principles of the Ethical and Religious Directives for Catholic Health Services as approved by the United States Conference of Catholic Bishops do not have coverage for the treatment of gender dysphoria.*

TREATMENT OF GENDER DYSPHORIA

The Plan pays benefits for the treatment of gender dysphoria as described under "Non-surgical treatment" or "Surgical treatment" for gender dysphoria below.

Non-surgical treatment of gender dysphoria

- **Psychotherapy** for gender dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services on Page 53.
- **Continuous hormone replacement therapy** – Hormones of the desired gender injected by a medical provider

Please note: *Coverage is available for oral and self-injected hormones under the prescription drug benefits portion of the Plan provided through OptumRx as outlined in Chapter 10: Prescription Drug Benefits starting on Page 87 of the SPD.*

- **Laboratory testing** to monitor the safety of continuous hormone therapy.

Surgical treatment of gender dysphoria *Effective 7/1/2017

The Plan covers surgical treatment for gender dysphoria, subject to medical necessity and in accordance with the guidelines adopted by the Fund for such treatment. The following are covered when the qualifications for surgery are met below:

Genital surgery and surgery to change secondary sex characteristics (including thyroid chondroplasty [also known as tracheal shave], bilateral mastectomy, and augmentation mammoplasty) and related services.

- The treatment plan must conform to identifiable external sources, including the World Professional Association for Transgender Health standards and/or evidence-based professional society guidance; and
- For irreversible surgical interventions, the participant must be 18 years of age or older;
- Prior to surgery, the participant must complete 12 months of successful, continuous, full-time real life experience in the desired gender.

Please note: *Participants may be required to complete continuous hormone therapy prior to surgery. In consultation with the participant's physician, this will be determined on a case-by-case basis.*
Augmentation mammoplasty is allowed if the physician prescribing hormones and the surgeon have documented that the breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.

Please delete the exclusion, "#40. Sex Transformations," within SECTION 3: Exclusions and Limitations on Page 59 of your SPD.

In addition, the following exclusions now apply in SECTION 3: Exclusions and Limitations:

49. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
50. Voice modification surgery
51. Facial feminization surgery, including but not limited to, facial bone reduction, face "lift," facial hair removal, and certain facial plastic procedures

Summary of Material Modifications

Effective September 1, 2017

This notice is intended to serve as a summary of changes recently adopted by the Board of Trustees of the NYSNA Benefits Fund and as a supplement to the Benefits Fund's most recent Summary Plan Description *(effective January 1, 2014). These modifications should be added to the SPD and read together for a complete description of your NYSNA Benefits Fund benefits. While we have tried to make this notice as complete and accurate as possible, it does not restate the existing terms and provisions of the SPD other than the specific terms and provisions it is modifying. If there is any discrepancy between this Summary of Material Modifications and the SPD, the provisions of this Summary shall govern.*

Lower Copayments

This portion of the Summary of Material Modifications refers to Chapter 4: Summary of Benefits of your Summary Plan Description, *Page 17 under "Outpatient Care."* ***It is applicable to participants covered under Benefit Coverage Plan A only.***

We are pleased to report that the NYSNA Benefits Fund Board of Trustees has agreed to maintain the following reduced copayments for the specified outpatient services when provided in-network. These copayments have currently been in effect since September 1, 2014, and this modification is a benefit improvement since the copayments had been scheduled to increase as of September 1, 2017. The copayment amounts are:

- $10 per visit for Chiropractic care;
- $10 per visit for outpatient Restorative physical, occupational, and speech therapy

In addition, the Board of Trustees has lowered the copayment for Cardiac Rehabilitation to $10 per visit when provided in-network.

Insulin Copayment

The following section is applicable to participants covered under Benefit Coverage Plan A only.

We are further pleased to report that the NYSNA Benefits Fund Board of Trustees has agreed to maintain the $0 copayment for Insulin (filled at retail or through mail-order in a three-month supply) as administered through OptumRx, which has been in effect since September 1, 2014. This modification is also a benefit improvement since the copayment had been scheduled to increase as of September 1, 2017.

Please refer to Chapter 10: Prescription Drug Benefits on Page 87 for information regarding approved diabetic medicines and supplies.

Private Room

This portion of the Summary of Material Modifications refers to Chapter 9: Medical Benefits of your Summary Plan Description *starting on Page 33.* ***It is applicable to participants covered under all Benefit Coverage Plans.***

Coverage under the NYSNA Benefits Fund will be allowed for Private Rooms for inpatient hospitalizations only if the Private Room is medically necessary. As a result, all references to "private room" in Section 2: Covered Services of Chapter 9, no longer apply to this coverage. This includes:

- Page 51 under "Hospital services"
- Page 52 under "Skilled Nursing Facility"
- Page 53 under "Mental Health Services"
- Page 54 under "Substance Use Disorder Services"

In addition, the definition of "Private Room" should be removed from Section 8: Glossary on Page 82.

The reference to "Private Room" should also be removed from the "Inpatient Care" portion of Chapter 4: Summary of Benefits on Page 16.

Prescription Drugs

The following portion of the Summary of Material Modifications refers to Chapter 10: Prescription Drug Benefits of your Summary Plan Description *starting on Page 87.* ***It is applicable to participants covered under all Benefit Coverage Plans.***

The NYSNA Benefits Fund Board of Trustees has made a change to the refill requirements for prescription drugs. Therefore, the related bulleted item under "Exclusions" on Page 88 should now read:

- Refills on a prescription (retail or mail-order) unless the Centers for Medicare and Medicaid Services utilization rate of the predicted days of use for the current prescription (currently 70 percent) has been met.

In addition, the Board of Trustees has made a change regarding the coverage of new drugs approved by the Food and Drug Administration. As a result, the bulleted item "New Drugs" on Page 87 should now read:

- New drugs coming on the market will be covered or excluded pursuant to the NYSNA Benefits Fund plan design as described in this chapter. New drugs approved by the Food and Drug Administration will not be covered by the Fund until the Fund's pharmacy benefit manager completes an assessment of the new drug, which may take up to 180 days after the date of market launch. In extenuating circumstances, a participant may request on appeal that the medication be covered prior to completion of the assessment. Participants should call a Fund participant service representative at (877) RN BENEFITS to request an appeal, which will be adjudicated in a prompt and timely manner.

Also, please add the following item to the "Exclusions" bulleted list on Page 88:

- New drugs approved by the Food and Drug Administration until completion of an assessment of the new drug by the Fund's pharmacy benefit manager, which may take up to 180 days from the date of market launch of the drug.