New York State Nurses Association

NYSNA Benefits Fund

Summary of Material Modifications – 2023

All modifications outlined below are effective April 1, 2023.

These modifications are intended to serve as a summary of changes recently adopted by the NYSNA Benefits Fund Board of Trustees and as a supplement to the NYSNA Benefits Fund's ("Fund") most recent Summary Plan Description *(effective July 2019). 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.*

MENTAL HEALTH COPAYMENTS LOWERED

This portion of the SMM refers to Chapter 4: Schedule of Benefits of your Summary Plan Description, *Page 18 under "Mental Health" and "Substance Abuse."* ***This update is applicable to participants covered under all Benefit Coverage Plans.***

The Fund is reducing in-network copayments for outpatient mental health and substance use disorder care as follows:

Plan A

- Participants will pay a $10 in-network copayment per visit for outpatient mental health and substance use disorder care. The copayment is currently $25 per visit.

Plan B

- Participants will pay a $10 in-network copayment per visit for outpatient mental health and substance use disorder care. The copayment is currently $30 per visit.

OUT-OF-NETWORK PARTICIPANT COST SHARING

This portion of the Summary of Material Modifications refers to Chapter 4: Schedule of Benefits of your Summary Plan Description *starting on Page 14.* ***It is applicable to participants covered under all Benefit Coverage Plans.***

Participant cost sharing will be 30 percent of the allowed amount for the following out-of-network services and care:

Out-of-Network Benefit	Plan A	Plan B
Maternity Care (Routine obstetrical, prenatal care, delivery, and postnatal care for mother)	Paid at 70% of the allowed amount	Paid at 70% of the allowed amount
Inpatient Surgery (physician surgical services and anesthesia)	Paid at 70% of the allowed amount	Paid at 70% of the allowed amount
Outpatient Surgery (physician services and anesthesia)	Paid at 70% of the allowed amount	Paid at 70% of the allowed amount
Non-Emergent Ambulance Transport	Paid at 70% of the allowed amount	Paid at 70% of the allowed amount
Second Surgical Opinion	Paid at 70% of the allowed amount	Paid at 70% of the allowed amount
Skilled Home Health Care	Paid at 70% of the allowed amount	Paid at 70% of the allowed amount
Home Hospice Care	Paid at 70% of the allowed amount	Paid at 70% of the allowed amount
Medically Necessary Dental Surgical Care or Treatment	Paid at 70% of the allowed amount	Paid at 70% of the allowed amount

Participant cost sharing will continue to be 30 percent of the allowed amount for other out-of-network services and care. Exceptions continue to apply as required by law for services covered under the No Surprises Act (see the Summary of Material Modifications – 2022 "No Surprises Act" published in January 2022). Participants can reduce this cost sharing by choosing an in-network provider for services instead of an out-of-network provider

COVERAGE OF APPLIED BEHAVIORAL ANALYSIS (ABA) SERVICES

This portion of the Summary of Material Modifications refers to Chapter 9: Medical Benefits of your Summary Plan Description, *Page 40 under "Outpatient and Professional Services."* ***It is applicable to participants covered under all Benefit Coverage Plans.***

Effective April 1, 2023, the Fund will cover applied behavioral analysis (ABA) services for the treatment of autism. Cost sharing for this benefit will be the same as other mental health and substance use disorder benefits.

Applied behavioral analysis services are available to Fund participants of any age and all services will require preauthorization. Services should be provided by a provider licensed or certified by the national Behavior Analyst Certification Board.

Benefits available through the Fund may include coverage of assistive communications devices (ACDs) and coverage for software to enable a personal computer or laptop to act as an ACD.

Participant cost-sharing for ABA services is as follows for Plan A and Plan B:

- In-network outpatient office visits are covered with a $10 copayment
- In-network outpatient facility care is covered at no cost to the participant
- Out-of-network outpatient visits are covered at 70 percent of the allowed amount
- Out-of-network outpatient facility care is covered at 70 percent of the allowed amount

CHANGE TO MEDICAL PROVIDER NETWORK

The medical provider network available through Empire BlueCross BlueShield is being changed to the Blue Access network from the current Empire PPO network for all Fund participants except those residing in Suffolk County, New York*. This network change **does not** affect the benefits available to Fund participants or the level of care that you will receive. All network hospitals, with the exception of University of Stony Brook Health System and SUNY Downstate Brooklyn, and substantially all providers that are network providers under the Empire PPO network, are also network providers under the Blue Access network.

All Fund participants, except those living in Suffolk County, will be mailed new medical identification cards prior to April 1, 2023, which will reflect the change to the Blue Access network. <u>However, your personal identification number will not change.</u>

**Only Benefits Fund participants that reside in Suffolk County, New York, will remain in the Empire PPO network in order for these participants to maintain the ability to use University of Stony Brook hospitals on an in-network basis. The Fund will base this determination on the home address we have on file at the Fund office for each employee participant.*

New York State Nurses Association
NYSNA Benefits Fund
PO Box 12430 - Albany, NY 12212-2430 - (877) RN BENEFITS

Summary of Material Modifications – 2024

Maximum network pharmacy out-of-pocket cost
January 2024

The NYSNA Benefits Fund Board of Trustees has established a new maximum network pharmacy out-of-pocket cost for participants effective January 1, 2022. 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 and coinsurance. The out-of-pocket network pharmacy maximum has been set at $8,450 for individuals and $16,900 for families for 2024.

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.

Please add this Summary Material Modification to the Pharmacy Drug Benefits section (Chapter 10) of your most recent Benefits Fund Summary Plan Description (published July 1, 2019). It should be inserted on Page 77 after the "In-network copayments" subheading. In addition, the information should be added within the Summary of Benefits (Chapter 4) on Page 19 under the "Prescription Drugs" heading. The plan documents should be read together for a complete description of your 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 any conflict arises between this notice and the terms of the SPD (other than with respect to the specific terms and provisions this notice is modifying) or if any point is not discussed in this notice or is only partially discussed, the terms of the SPD will govern in all cases.

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NYSNA Benefits Fund

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Summary of Material Modifications – 2022

No Surprises Act
January 1, 2022

This Summary of Material Modifications (SMM) is intended to satisfy the requirement for issuance of an SMM. You should take the time to read this SMM carefully and add it to your most recent Benefits Fund Summary Plan Description (published July 1, 2019, with subsequent SMMs, the "SPD). The Plan documents should be read together for a complete description of your Plan 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 terms and provisions it is modifying. If any conflict arises between this notice and the terms of the SPD (other than with respect to the terms and provisions this notice is modifying) or if any point is not discussed in this notice or is only partially discussed, the terms of the SPD will govern in all cases.

Beginning January 1, 2022, the New York State Nurses Association Benefits Fund (the "Fund") is implementing improvements to its plan of benefits (the "Plan") as required by the No Surprises Act, which is a new federal law that protects healthcare consumers from receiving surprise bills from Out-of-Network Providers in certain situations. This Summary of Material Modifications describes these changes, which are effective January 1, 2022.

IN-NETWORK COST-SHARING/NO BALANCE BILLING FOR SERVICES COVERED UNDER THE NO SURPRISES ACT

Typically under the Plan, if you receive medical services from an Out-of-Network Provider, you are responsible for Out-of-Network Cost-Sharing amounts (including any Copayments, Coinsurance and Deductible) plus the amount, if any, by which the Out-of-Network Provider's actual charge exceeds the Plan's Eligible Expense (Allowed Amount) for the Covered Services.

However, beginning January 1, 2022, if you received Covered Services that are also covered under the No Surprises Act, your Cost-Sharing will be the same as if you had received those services from an In-Network Provider.

This means that you will not have to satisfy the Out-of-Network Deductible, Copayment or Coinsurance for these services and you will not have to pay the amount billed by the Out-of-Network Provider that exceeds the Plan's normal Eligible Expense (Allowed Amount) for the Covered Service. Instead, you will only pay the In-Network Cost-Sharing, which generally is only the In-Network Copayment. (In the very limited cases in which there is In-Network Coinsurance, your Coinsurance is based on a percentage of the amount required by the No Surprises Act, which will usually be the qualifying payment amount. The qualifying payment amount is generally the median contracted rate for the item or service in the same geographic region, as adjusted under Department of Labor Regulations.)

Further, typically, Cost-Sharing for Out-of-Network services other than Emergency Services does not apply to your In-Network Out-of-Pocket Maximum under the Plan. Beginning January 1, 2022, the Plan will apply to your In-Network Out-of-Pocket Maximum any Cost-Sharing for Out-of-Network services covered under the No Surprises Act.

In addition, if you receive Covered Services covered by the No Surprises Act, the Plan pays the Out-of-Network Provider directly, based on the terms of the No Surprises Act. In that case, the Out-of-Network Provider is generally prohibited from sending you a "balance bill" for charges billed for otherwise Covered Services in excess of the amount on which the Plan based its payment.

SERVICES COVERED BY THE NO SURPRISES ACT

The following services are covered under the No Surprises Act:

- Emergency Services at an Out-of-Network health care facility or provided by an Out-of-Network Provider (unless you consent to be treated by the Out-of-Network Provider for certain post-stabilization services – see below)
- Non-emergency services provided by an Out-of-Network provider at an In-Network health care facility (unless you consent to be treated by the Out-of Network Provider, if applicable – see below)
- Out-of-Network air ambulance services

Please keep in mind that the special rules described above only apply to Covered Services covered by the No Surprises Act. Other Out-of-Network Covered Services remain subject to the normal rules of the Plan.

Please also note that regardless of whether a Covered Service is also covered under the No Surprises Act, you are always responsible for any expenses or charges billed by any provider or facility that are not medically necessary or are otherwise not Covered Services under the Plan.

DEFINITION OF EMERGENCY SERVICES

The Plan covers Emergency Services for the treatment of an Emergency condition. Effective January 1, 2022, and the special rules for the No Surprises Act apply as described above, and Emergency Services and Emergency condition are defined as follows:

Emergency condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of a body part.

Emergency Services means, with respect to an Emergency condition:

- An appropriate medical screening examination that is within the capability of an emergency room of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency condition; and

- Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable (regardless of the department of the hospital in which such further examination or treatment is furnished); and

- Post-stabilization services, which are services furnished by Out-of-Network providers or Out-of-Network facilities after the patient is stabilized as part of outpatient observation or an inpatient/outpatient stay related to the Emergency condition (regardless of the department of the hospital in which such further examination or treatment is furnished), until: (1) the treating provider or facility determines that the individual is able to travel using non-medical transportation or non-emergency medical transportation; and (2) the individual is provided with appropriate written notice to consent to Out-of-Network treatment (see below) and gives informed consent to such Out-of-Network treatment.

Ground ambulance services are not Emergency Services for the purposes of the No Surprises Act and will be covered under the normal terms set forth the SPD.

Please remember that if you go to the emergency room for medical services or treatment for a condition that is not an Emergency condition, as defined above, it may not be covered by the Plan. See the SPD for more information.

CONSENT REQUIREMENTS

The special rules for services covered under the No Surprises Act will not apply in certain circumstances if you consent to receiving treatment from an Out-of-Network Provider. These consent rules apply to (i) non-emergency services provided at an In-Network facility other than ancillary services (described below) or (ii) Emergency Services that are post-stabilization services. If you do consent, as with other Out-of-Network services, you will be responsible for payment of the applicable Out-of-Network Cost-Sharing, as well as any balance bills for amounts in excess of the Plan's Eligible Expense (Allowed Amount) for those services.

In order for the consent to be valid, certain regulatory requirements must be satisfied, including the following:

- You are provided with written notice: (1) that the provider is an Out-of-Network Provider; (2) of any estimated charges for treatment; (3) of any applicable advance limitations under the Plan; (4) that consent to receive treatment by such Out-of-Network Provider is voluntary; and (5) that you may instead seek care from an In-Network Provider. In the case of non-Emergency Services this notice must be provided at least 72 hours before the appointment (or three hours in advance of services rendered in the case of a same-day appointment), and on the day of the appointment.

- You give signed, informed consent (consistent with regulatory requirements) to treatment by the Out-of-Network Provider, acknowledging that you understand that treatment by the Out-of-Network Provider may result in greater out-of-pocket costs compared to treatment by an In-Network provider.

For non-emergency services, the "notice and consent" exception above does not apply to ancillary services or to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished. For this purpose, ancillary services include (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a physician or non-physician practitioner); (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services, including radiology and laboratory services; and (iv) items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such items or services at the facility.

CLAIM DETERMINATIONS FOR CLAIMS SUBJECT TO SURPRISE BILLING PROTECTIONS

The Claims Administrator will make an initial payment or notice of denial of payment for emergency services at Out-of-Network health care facilities, non-emergency services provided by Out-of-Network providers at In-Network facilities, and Out-of-Network air ambulance services within (30) calendar days of receiving a claim from the Out-of-Network provider or facility that includes all necessary information to decide the claim.

EXTERNAL REVIEW OF ADVERSE DETERMINATIONS BASED ON NO SURPRISES ACT PROTECTIONS

Currently, the Plan provides that, if, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator (and the Trustees, if you pursued a voluntary Trustee level appeal), or if the Claims Administrator does not respond to your appeal in accordance with applicable regulations (regardless of timing), you may be entitled to request (at no charge to you) an external review of the determination.

This is only available for Adverse Benefit Determinations based on certain specified reasons (including, for example, clinical reasons, the exclusions for Experimental or Investigational Services or unproven Services, and rescission of coverage). Beginning January 1, 2022, external review will also be available for Adverse Benefit Determinations based on compliance with the surprise billing protections under the No Surprises Act or its implementing regulations.

See the SPD for more information on the external review process.

PROVIDER DIRECTORY UPDATES

To help you find care from In-Network providers and facilities, Empire maintains a provider directory. Empire updates its provider directory every ninety (90) days and will respond to your inquiry about the network status of a provider or facility within one business day. If you receive inaccurate information from Empire or the Fund office about a provider or facility's network status, you will be liable only for In-Network Cost-Sharing for the services underlying your inquiry. However, it is your responsibility to confirm that the provider or facility that you have selected is In-Network at the time you receive services.

To find an In-Network provider, call the Fund office at (877) RN BENEFITS [762-3633] or view the Empire network's provider listings at **www.empireblue.com/find-care**.

CONTINUITY OF COVERAGE

Beginning January 1, 2022, the Plan will provide "continuity of coverage" in certain situations where a termination of a contractual arrangement changes the In-Network status of a provider or facility to Out-of-Network (except in the case of a termination of the contract for failure to meet applicable quality standards or for fraud).

Specifically, if you are a "Continuing Care Patient," you will be notified of the contract termination and your right to elect continued transitional care from the provider or facility; and, you will be allowed ninety (90) days of transitional care from the provider or facility at In-Network Cost-Sharing to allow you time to transition to a new In-Network provider or facility (provided you remain eligible for Plan coverage).

A Continuing Care Patient is an individual, who, with respect to a provider or facility, (i) is undergoing a course of treatment for an acute illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time); (2) is undergoing a course of institutional or inpatient care from the provider or facility; (3) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility; (4) is pregnant or undergoing a course of treatment for the pregnancy from the provider or facility; or, (5) is or was determined to be terminally ill (under SSA § 1862(dd)(3)(A)) and is receiving treatment for such illness from such provider or facility.