SUMMARY OF MATERIAL MODIFICATIONS

This notice contains important information regarding changes to the Voluntary Hospitals House Staff Benefits Plan (the "Plan"). This Summary of Material Modifications ("SMM") is issued to notify you of changes to the Voluntary Hospitals House Staff Benefits Plan Summary Plan Description ("SPD"), which was previously distributed to you. Please take the time to read this carefully and share it with your covered family members. Keep this notice with your Plan documents. Please contact the Benefits Office at 212-356-8180 if you have any questions.

CHANGES TO MEDICAL BENEFITS PURSUANT TO THE NO SURPRISES ACT

Effective Date of Changes

Effective **January 1, 2022**, the Plan is implementing a number of changes to its medical benefits to comply with a new federal law called the No Surprises Act (the "NSA"). This SMM advises you of such changes.

Defined Terms

Capitalized terms used below are defined at the end of this SMM, or, if not, in the SPD.

Background

The NSA was signed into law in December 2020 and protects patients from "balance billing" for Out-of-Network Emergency Services at certain independent freestanding emergency departments, Out-of-Network air ambulance services, and certain Non-Emergency Services performed by an Out-of-Network Provider at an In-Network facility (collectively "No Surprise Services").

You are still encouraged to use In-Network facilities and Providers whenever possible. Please review these changes carefully and contact the Benefits Office with any questions that you may have.

Effective January 1, 2022, covered employees and dependents receiving No Surprises Services will only be responsible for paying their In-Network cost-sharing, and cannot be balance billed by the Provider or facility except in the limited situations where the notice and consent exception is appliable, as described below.

NSA Requirements

<u>Emergency Services</u>

The NSA requires Emergency Services to be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;

2. Without regard to whether the health care Provider furnishing the Emergency Services is an In-Network Provider or an In-Network emergency facility, as applicable, with respect to the services;

3. Without imposing any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers and In-Network emergency facilities;

4. Without imposing cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or In-Network emergency facility;

5. By calculating the cost-sharing requirement for Out-of-Network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and;

6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from an In-Network Provider.

Non-Emergency Services Performed by an Out-of-Network Provider at an In-Network Facility

The No Surprises Act requires Non-Emergency Services performed by an Out-of-Network Provider at an In-Network Health Care Facility to be covered as follows:

1. With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network Provider;

2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the Recognized Amount for the items and services; and

3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network Provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on the Out-of-Network cost-sharing if:

1. At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the Provider is an Out-of-Network Provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

2. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services (see the Definitions at the end of this SMM) and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

Out-of-Network Air Ambulance Services

If you receive air ambulance services that are otherwise covered by the Plan from an Out-of-Network Provider, those services will be covered by the Plan as follows:

1. The air ambulance services received from an Out-of-Network Provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network Provider.

2. In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network Provider of air ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.

3. Any cost-sharing payments you make with respect to covered air ambulance services will count toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network Provider.

Continuity of Coverage

If you are a Continuing Care Patient (see the Definitions at the end of this SMM), and the Plan terminates its In-Network contract with an In-Network Provider or facility, or your benefits are terminated because of a change in terms of the Providers' and/or facilities' participation in the Network:

1. You will be notified in a timely manner of the contract termination and of your and of your right to elect continued transitional care from the Provider or facility; and

2. You will be allowed up to ninety (90) days of continued coverage at In-Network cost-sharing to allow for a transition of care to an In-Network Provider.

Provider Directory

A list of In-Network Providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The Network consists of Providers, including hospitals of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a Provider is an In-Network Provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the Provider was an Out-of-Network Provider at the time the service was rendered.

New ID Cards

The Plan will include in clear writing, on any physical or electronic Plan identification (ID) card issued to participants and beneficiaries, any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance. To obtain a new Empire ID card via the Empire website at www.empireblue.com or the Sydney Health application. The Sydney Health application can be downloaded onto your smart phone and be used to view or request a new member ID, find doctors near you, obtain important information about benefits and claims and more.

Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act, you may contact the federal government's NSA Helpdesk at 1-800-985-3059 or the Employee Benefits Security Administration ("EBSA") toll free number at 1-866-444-3272. If you have a question about an explanation of benefits issued by the Plan, you may contact the Benefits Office at 212-356-8180.

External Review Process of Certain Coverage Determinations

If your initial claim for benefits related to an Emergency Service, Non-Emergency Service provided by an Out-of-Network Provider at an In-Network facility, and/or air ambulance service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome

of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Benefits Office for a copy of the Plan's External Review procedures.

New Definitions Implemented from the NSA

To implement the protections of the No Surprises Act, effective January 1, 2022, the Plan is adopting the following new/revised definitions of terms in the SPD.

Ancillary Services means, with respect to an In-Network Health Care Facility, the following:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

2. Items and services provided by assistant surgeons, hospitalists, and intensivists;

3. Diagnostic services, including radiology and laboratory services; and

4. Items and services provided by an Out of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility.

Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a "Serious and Complex Condition;" (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the Provider or facility.

Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested 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:

1. Serious impairment to bodily functions; or

2. Serious dysfunction of any bodily organ or part; or

3. With respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy.

Emergency Services means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency

department (some urgent care facilities, but not all, qualify), 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 to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

3. Emergency Services furnished by an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized)) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

   a. The Provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and

   b. You are supplied with a written notice, as required by federal law, that the Provider is an Out-of-Network Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and

   c. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

Health Care Facility (for Non-Emergency Services) means each of following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);

2. A hospital outpatient department;

3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

No Surprises Services means the following, to the extent covered under the Plan:

1. Out-of-Network Emergency Services;

2. Out-of-Network air ambulance services;

3. Non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an Out-of-Network Provider at an In-Network facility; and

4. Other Out-of-Network Non-Emergency Services performed by an Out-of-Network Provider at an In-Network Health Care Facility with respect to which the Provider does not comply with federal notice and consent requirements.

Recognized Amount means one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

2. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or

3. If there is no applicable All-Payer Model Agreement or state law, the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount ("QPA").

For air ambulance services furnished by Out-of-Network Providers, the Recognized Amount is the lesser of the amount billed by the Provider or facility or the QPA.

Qualifying Payment Amount or QPA means generally the median contracted rates of the plan or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR 716-6(c).

Serious and Complex Condition means one of the following:

1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent; or

2. In the case of a chronic illness or condition, a condition that is the following:

   a. Life-threatening, degenerative, potentially disabling, or congenital; and

   b. Requires specialized medical care over a prolonged period of time.

Please keep this important notice with your Plan Document/SPD for easy reference to all Plan provisions. If you have any questions, you may also call the Benefits Office at 212-356-8180.

Sincerely,

This summary of material modifications ("SMM") is intended to provide you with an easy-to-understand description of certain changes to the Plan's benefits.

The Board of Trustees (or its duly authorized designee), reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters, legal and/or factual, arising under the Plan.