VOLUNTARY HOSPITALS HOUSE STAFF BENEFITS PLAN

10-27 46th Avenue, Suite 300-2, Long Island City, NY 11101

Phone: (212) 356-8180 Fax: (212) 356-8181 benefits@cirseiu.org http://www.cirseiu.org

Summary of Material Modification: Important October 1, 2019

Medical Plan Changes—Please Read Now!

The information below is a Summary of Material Modification to the Voluntary Hospitals House Staff Benefits Plan. Be sure to read in full.

Starting October 1, 2019, the cost of receiving care from Out-of-Network providers under the Voluntary Hospital House Staff Benefits Plan (VHHSBP) will increase and an Annual Out-of-Pocket maximum will be added In-Network and increased for Out-of-Network, as summarized below:

Plan Provision	In-Network, Currently	In-Network, Starting October 1, 2019**	Out-of-Network, Currently	Out-of-Network, Starting October 1, 2019
Annual Deductible (amount you pay before the Plan starts paying benefits)	None	None	$100 (individual) $200 (family)	$1,000 (individual) $2,000 (family)
Coinsurance (percentage you pay once you meet the annual deductible)	None	None	20%	30%*
Annual Out-of-Pocket Maximum (the most you pay before the Plan pays 100% of eligible costs: annual deductible + coinsurance)	None	Empire Medical: $1,500 (individual) $3,000 (family); Express Scripts Rx: $2,500 (individual) $5,000 (family) Medical and Rx Combined maximums: $4,000 (individual) $8,000 (family)	$500	$2,000 (individual) $5,000 (family)

Please note that there is no Out-of-Network Prescription plan so the Prescription Out-of-Pocket Maximum under the In-Network column applies to all participants whether or not you obtain medical care In or Out-of-Network.

*In addition to the higher coinsurance you will pay starting October 1, keep in mind that you may be balance billed for higher amounts by your **out-of-network** provider. Balance billing is when an out-of-network provider bills you for the difference between what the Plan pays and the amount of the provider's actual charges. The percentage-of-Medicare-reimbursement on which the plan's out-of-network rates to providers are based will be reduced from 360% to 250% of the Medicare rates starting October 1, 2019. Lower reimbursement by the Plan to out-of-network providers means your provider will likely balance bill you for more.

Your take away? **Use in-network providers whenever you can.** You will save dramatically on your out-of-pocket expenses.

In-network providers discount their fees, based on contractual arrangements with Empire Blue Cross Blue Shield—the Plan's administrator. So, you pay less when you or your enrolled dependents receive care from an in-network provider.

Plan Payment Examples

Expense	Care Received *In-Network* **	Care Received *Out-of-Network* (Starting October 1, 2019)
	What **YOU** Pay	What **YOU** Pay
Individual Coverage		
Member visits physical therapist 25 times, @ $250/visit	**$500** ($20 copayment per visit)	**$2,000** (4 visits paid in full by you, to meet the $1,000 individual deductible; then, you pay 30% ($75) of next 13 visits to get to $975; at this point, you've paid $1,975. You will reach the annual individual out-of-pocket maximum of $2,000 during the 18th visit. Then, all subsequent visits are covered in full)

Family Coverage
The examples below represent the cumulative cost for a hypothetical family all accessing Out-of-Network coverage.

Expense	Care Received *In-Network* **	Care Received *Out-of-Network* (Starting October 1, 2019)
	What **YOU** Pay	What **YOU** Pay
Member visits physical therapist 25 times, @ $250/visit	**$500** ($20 copayment per visit)	**$2,000** (4 visits paid in full by you, to meet the $1,000 individual deductible; then you pay 30% ($75) of next 13 visits to get to $975; at this point, you've paid $1,975. You will reach the annual individual out-of-pocket maximum of $2,000 during the 18th visit. Then, all subsequent visits are covered in full)
	Then	
Member's child receives diagnostic care costing $500	**$0**	**$500** (paid by you to partially meet the annual individual deductible of $1,000 and to partially meet the family annual deductible of $2,000)
	Then	
Member's wife is pregnant; total maternity costs: $12,800	**$20** (copayment for first visit confirming pregnancy. All other visits are free)	**$2,000** ($500 paid by you to meet and to satisfy the annual family deductible of $2,000; then, you pay $1,500 to cover the remaining cost, to reach the annual individual out-of-pocket maximum of $2,000)

**Please keep in mind that because office visit copays are $20/visit and Emergency Room visits are $100 copay/visit, it is unlikely you will reach the Annual Out-of-Pocket Maximum for In-Network services. For example, you will need to incur 75 office visits or 15 Emergency room visits to meet the Annual Out-of-Pocket Maximum.

Empire has contracted with more than **40,000 providers** to be in its network. This makes it likely there are in-network providers near you. To find a local in-network provider, visit www.empireblue.com. Search under the "Empire DirectShare POS" or Empire PPO plan. Or, call Empire: 800-553-9603.

Non-Grandfathered Provisions

As a result of changes made July 1, 2018 the Welfare Fund will no longer be considered a grandfathered plan under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As required, the Plan will implement the following improvements:

Out-of-Pocket Maximum

For In-Network benefits, the Plan will add an Out-of-Pocket maximum. The Out-of-Pocket maximum limits your annual cost-sharing for covered essential health benefits received from In-Network providers and includes all cost-sharing (i.e., copayments) up to the amounts permitted under the Affordable Care Act and implementing regulations. The Out-of-Pocket maximum is the most you pay during the calendar year before the Plan begins to pay 100% for covered expenses for the rest of the year. The Plan will maintain Out-of-Pocket maximums for both In-Network Empire PPO/POS providers and for prescription drug benefits received from participating providers.

- As discussed above, this year the Out-of-Pocket maximum for In-Network PPO/POS medical benefits will be $1,500 per individual and $3,000 per family.
- The Out-of-Pocket maximum for prescription drug benefits received from participating providers will be $2,500 per individual and $5,000 per family.
- The total Out-of-Pocket maximums for In-Network PPO/POS medical and prescription drug benefits will be $4,000 per individual and $8,000 per family.
- For family coverage, each family member must meet his/her own Out-of-Pocket maximum until the overall family Out-of-Pocket maximum has been met. Covered expenses are applied to the Out-of-Pocket maximum in the order in which eligible claims are processed by the Plan. The amount of the Out-of-Pocket maximum may be adjusted annually, in an amount as published by Department of Health and Human Services. This means that your Out-of-Pocket maximum for In-Network PPO/POS medical benefits is subject to change next year.

The Out-of-Network Out-of-Pocket maximum will be increased to $2,000 per individual and $5,000 per family as outlined above.

Expenses for services the Plan does not cover, balance billing, penalties for failure to obtain precertification and expenses for Out-of-Network providers will not count toward the in-network maximum. Out-of-Network expenses may not be used to meet the In-Network Out-of-Pocket maximum and vice versa.

Preventive Services

Virtually all preventive care services are currently already covered under the Plan at no cost to you. The Affordable Care Act requires non-grandfathered plans such as ours to provide preventive services, including preventive prescription drugs, at no cost to you. The Plan will pay 100% of the costs incurred for covered preventive services and preventive prescription drugs when those services and drugs are provided by a participating **In-Network provider.**

Preventive Services that will be Covered at No Cost to You

The required services include services that are highly recommended by the U.S. Preventive Services Task Force (that is, have an "A" or "B" rating), and recommendations of the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), and the federal Centers for Disease Control and Prevention Advisory Committee on Immunization Practice (ACIP). These preventive care services include the following:

- Certain preventive services for adults that cover a set of preventive services such as screening tests for high blood pressure, high cholesterol, Type II diabetes, HIV and breast, cervical and colorectal cancer at specified intervals, based on a person's age and sex; screening and cessation interventions for tobacco use; and screening and counseling for alcohol misuse and obesity.

- Additional covered preventive health services for women including annual well-woman care visits to a gynecologist/obstetrician, routine mammograms, comprehensive lactation support and counseling, and screenings and counseling for gestational diabetes, HPV, STIs, HIV, interpersonal and domestic violence, and FDA-approved contraceptives.

- Certain preventive services for newborns, infants and children to age 21—for example, well-baby and well-child visits at specified intervals.

- Immunizations for infants, children, adolescents and adults as recommended by the federal Centers for Disease Control and Prevention Advisory Committee on Immunization Practice (ACIP.

- Certain preventive prescriptions, including low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) if a person meets certain age and risk factors, and FDA-approved contraceptives methods (including barrier methods, hormonal methods, and implanted devices, sterilization procedures and patient education and counseling for women of reproductive capacity) as prescribed by a health care provider. Most preventive prescriptions will be covered under the Plan's Prescription Drug benefits, but a few (generally, contraceptive methods that include sterilization, implanted devices and barrier methods and patient education and counseling) may be covered under the Plan's medical benefits.

  For preventive prescriptions to be covered, they must be prescribed by a doctor and meet the criteria set out by Express Scripts (or Empire Blue Cross Blue Shield, for those items covered under the Medical PPO/POS). The Plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. If a covered item or drug is available over-the-counter and is covered under this provision, you must present a prescription at the time of purchase in order for it to be covered under the Plan.

  A list of the preventive services covered can be found under healthcare.gov/preventive-care-benefits. Or, you can request that a printed copy be mailed to you by calling Empire's Customer Service number (800) 553-9603, Monday – Friday 8:30 am – 5:00 pm or by looking on your identification on your identification card.

  A list of the preventive services covered can be found under healthcare.gov/preventive-care-benefits. Or, you can request that a printed copy be mailed to you by calling the Express

Scripts' (ESI)'s Customer Service number (866) 439-3658 Monday – Friday 9:00 am – 5:00 pm or by looking on your identification card.

Designation of Primary Care Provider

Under the Plan, you are not required to designate a primary care provider. However, should you wish to choose a primary care provider, you have the right to designate any primary care provider who participates in the Plan's Network and who is available to accept you or your family members. This includes the right to designate a participating pediatrician as your child's primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Empire Blue Cross/Blue Shield at (800) 553-9603, Monday – Friday 8:30 am – 5:00 pm or by looking on your identification on your identification card.

Direct Access to Obstetrical and Gynecological Care

You do not need prior authorization from the Plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Empire network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Empire Blue Cross/Blue Shield at (800) 553-9603, Monday – Friday 8:30 am – 5:00 pm or by looking on your identification on your identification card.

Nondiscrimination in Health Care

In accordance with Section 2706 of the Public Health Service Act, as amended by the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan or issuer. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Routine Patient Costs in Connection with Approved Clinical Trials

If you are eligible to participate in an Approved Clinical Trial with respect to treatment of cancer or another life-threatening disease or condition, the Plan will not deny your participation in the trial; deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items, services or drugs otherwise covered by the Plan that are furnished in connection with participation in the trial; and will not discriminate against you because of your participation in the trial.

The Plan covers the routine patient costs for participation in an approved clinical trial and such coverage will not be subject to utilization review if the covered individual is eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; your health care provider is a participating provider; and that provider has concluded that your participation in the trial would be medically appropriate and referred you to participate. You will be required to provide medical and scientific information establishing that your participation would be medically appropriate.

The Plan does not cover the cost of investigational drugs or devices; non-health services required for you to receive the treatment; or managing the research or costs that would not be covered under this benefit plan for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II, III or IV clinical trial that is a federally funded or approved trial; conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or a drug trial that is exempt from having to make an investigational new drug application.

Emergency Room

As reported to you previously, the Plan covers certain emergency services provided in hospital emergency rooms when you are suffering from an emergency medical condition. You do not have to obtain prior authorization from the Plan before seeking emergency services in a hospital emergency room. The hospital emergency room copayment is $100, which applies to both In-Network and Out-of-Network facilities. If you obtain emergency services from an Out-of-Network emergency room, the emergency room may bill you separately if the charges exceed what the Plan pays that hospital on your behalf.

Internal and External Review of Coverage Determinations

The Plan provides an extensive internal appeals procedure that allows you and your family the opportunity to request review of claims determinations that you think are not correct. Under the Affordable Care Act, if your internal appeal is denied, you have the right to appeal to an independent reviewer (External Review procedures). These procedures are being developed. You will receive a notice of the updated procedures in the near future.