NEW YORK STATE NURSES ASSOCIATION BENEFITS FUND SUMMARY OF MATERIAL MODIFICATIONS

All modifications below are effective January 1, 2027

These modifications are intended to serve as a summary of changes recently adopted by the Board of Trustees of the New York State Nurses Association Benefits Fund (the Fund) and as a supplement to the Fund's most recent Summary Plan Description (SPD) effective July 2024. These modifications should be added to the SPD and read together for a complete description of your 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 (SMM) and the SPD, the provisions of this SMM shall govern.

The Fund has a new medical care provider, Aetna, Inc. to replace Anthem BlueCross BlueShield. Therefore, please replace any mention of "Anthem" or "Anthem BlueCross BlueShield" with "Aetna" wherever it is found within the Fund's SPD, including, but not limited to, Chapter 1: Introduction and Administration (Page 6, appeals procedures), Chapter 5: Enrollment (Page 23, identification cards), and Chapter 9: Medical Benefits, pages 32-73. In addition, under the "Fund administration" section on Page 7, the reference to Anthem BlueCross BlueShield should be removed.

Under Aetna, Inc., the following sentence can be removed:

Aetna administers the Fund's self-funded dental benefit.

And replaced with:

Aetna administers the Fund's self-funded medical coverage and dental benefits.

In addition, the following provisions of the SPD describe programs, websites, and tools that are specific to Anthem BlueCross BlueShield and are deleted in their entirety: (i) "G. Inter-Plan Programs," including the BlueCard® Program (Chapter 9, pages 38-39); (ii) "H. Blue Cross Blue Shield Global Core® Program" (Chapter 9, page 39); and (iii) all references to anthem.com, anthem.com/find-care, anthemblue.com, livehealthonline.com, and the Sydney App (Chapter 9, including pages 32-33, 38, 40, 47, and 57).

All claims, preauthorization requests, grievances, utilization review appeals, and external appeal requests described in Chapter 9 that are directed to Anthem should be directed to Aetna at:

Claims:
PO Box 981106
El Paso, TX 79998-1106

Pre-Service Appeals/Grievances:
PO Box 14001
Lexington, KY 40512
Fax (859) 425-3379

Post-Service Appeals/Grievances:
PO Box 14463
Lexington, KY 40512
Fax (859) 425-3379

Precertification: (888) 632-3862 (option 3)

THIS PORTION OF THE SMM REFERS TO CHAPTER 10: PRESCRIPTION DRUG BENEFITS PAGE 75 UNDER COVERED MEDICATIONS

The following sentence should be removed:

• Fertility drugs.* There is a $5,000 lifetime maximum benefit for in vitro fertilization or covered fertility drugs. (If you choose, this means this benefit may be used for in vitro fertilization under your medical coverage with the Benefits Fund.)

And replaced with the following:

• Fertility drugs.* There is a lifetime maximum benefit for covered fertility drugs of three in vitro fertilization cycles.

THIS PORTION OF THE SMM REFERS TO CHAPTER 9: MEDICAL BENEFITS PAGES 44-46

Section J. Infertility Treatment should be removed and replaced with the following:

J. Infertility Services.

Infertility services included under the medical plan

Services to treat the underlying cause of infertility will be provided to eligible Participants using guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine. As with many services under the plan, additional medical necessity criteria may apply to particular fertility procedures.

Covered services include seeing a provider:

• To diagnose and evaluate the underlying medical cause of infertility.

• To do surgery to treat the underlying medical cause of infertility. Examples are endometriosis surgery or, for men,

varicocele surgery.

• For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.

See Chapter 10: Prescription Drug Benefits for information on coverage of infertility prescription drugs.

Advanced reproductive technology (ART)

Advanced reproductive technology is a more advanced type of infertility treatment. The medical necessity criteria in the Advanced Reproductive Technology section below are met for persons who are unable to conceive after an appropriate trial of egg-sperm contact. For women under 35 years of age, an appropriate trial of egg-sperm contact requires 12 months of regular intravaginal inseminations or four cycles of timed intrauterine or intracervical inseminations, documented in the medical record. For women 35 years of age and older, an appropriate trial of egg-sperm contact requires six months of regular intravaginal inseminations or three cycles of timed intrauterine or intracervical insemination, documented in the medical record. This requirement applies to all individuals regardless of sexual orientation or the availability of a reproductive partner. For IVF procedures under the ART benefit, these requirements for a trial of egg-sperm contact are waived for persons for whom intravaginal, intrauterine, or intracervical inseminations would not be expected to be effective and IVF procedures are the only effective treatment.

Covered services include the following services provided by an ART specialist:

• Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests. An ovulation induction cycle is defined as an attempt at ovulation induction while on medication to stimulate the ovaries with or without artificial insemination.

• In vitro fertilization (IVF). There is a lifetime limit of three cycles of IVF.

• Zygote intrafallopian transfer (ZIFT).

• Gamete intrafallopian transfer (GIFT).

• Cryopreserved (frozen) embryo transfers (FET).

• Intracytoplasmic sperm injection (ICSI) and assisted hatching.

• Cryopreservation (freezing) and thawing of eggs, embryos, or sperm.

• Storage of cryopreserved (frozen) eggs, embryos, or sperm.

• Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.

• Charges associated with your care when using a gestational carrier, including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

• Prescription drugs injected by your provider to stimulate the ovaries.

An ART cycle is defined as:

ART service	Procedure	Cycle count
IVF	One complete fresh cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
IVF	One fresh cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One half cycle
IVF	Fertilization of egg and transfer of embryo	One half cycle
IVF	One cryopreserved (frozen) embryo transfer	One half cycle
GIFT	One complete cycle	One full cycle
ZIFT	One complete cycle	One full cycle

Aetna's National Infertility Unit

Aetna's National Infertility Unit (NIU) is staffed by a team of registered nurses and infertility coordinators who can help with determining available benefits and precertification and also provide information about Aetna's infertility Institutes of Excellence™(IOE) facilities. The NIU can be reached by calling (800) 575-5999.

Your network provider will request approval from Aetna in advance for your infertility services. If your provider is not a network provider, you're responsible for requesting approval from Aetna in advance.

Fertility preservation

Fertility preservation involves the retrieval of eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

• You are believed to be fertile

• You have planned medical services that are proven to result in infertility such as:

- Chemotherapy or radiation therapy that is established in medical literature to result in infertility

- Other gonadotoxic therapies removing both ovaries or testicles

• The eggs that will be retrieved for use are likely to result in a pregnancy

Premature ovarian insufficiency

If your infertility has been diagnosed as premature ovarian insufficiency (POI), you are eligible for ART services using donor eggs/embryos.

Infertility services exclusions:

The following are not covered services:

• The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.

• A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman

who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.

• Infertility medication not injected by your provider, including but not limited to menotropins, hCG, and GnRH agonists. See Chapter 10: Prescription Drug Benefits for information on coverage of infertility prescription drugs.

• All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.

• Home ovulation prediction kits or home pregnancy tests.

• The purchase of donor embryos, donor eggs or donor sperm.

• Obtaining sperm from a person not covered under this Plan.

• Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.

• Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.

• Cryopreservation, thawing, and storage of reproductive tissue.

• Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g., perimenopause, menopause).

• Elective cryopreservation, thawing, or storage of eggs, embryos, or sperm that is not part of a covered ART cycle or covered fertility preservation.

• Reversal of voluntary sterilization.

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 Advanced Infertility Services, including in vitro fertilization services and infertility drugs.

THIS PORTION OF THE SMM REFERS TO CHAPTER 9: MEDICAL BENEFITS PAGE 55

Under Exclusions and Limitations, item 11 (Infertility treatments and supplies), including its list of services and supplies that are not covered, should be removed and replaced with the following: "11. Infertility treatments and supplies, except as Covered under Section J. Infertility Services of the Outpatient and Professional Services section of this chapter, and subject to the exclusions listed in that section."

THIS PORTION OF THE SMM REFERS TO CHAPTER 4: SCHEDULE OF BENEFITS

Under Other Services, within the benefit titled "In vitro fertilization services or covered fertility drugs (up to a $5,000 lifetime max benefit)" on Page 17, the language should be removed and replaced with the following for Benefit Plans A and B:

Benefit	Plan A In-Network	Plan A Out-of-Network	Plan B In-Network	Plan B Out-of-Network
Infertility specialist visits	$25 copay/ visit	Paid at 70% of the allowed amount after deductible is met	$30 copay/ visit	Paid at 70% of the allowed amount after deductible is met
Infertility surgical services	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met

Under Dental Care, within the benefit titled "Maximum yearly benefit" on Page 19, the $1,200 should be removed and replaced with $2,000 for in- and out-of-network for Benefit Plans A and B.

THIS PORTION OF THE SMM REFERS TO CHAPTER 11: DENTAL BENEFITS PAGE 80

The following sentence should be removed:

The maximum amount payable for each individual for all covered dental expenses incurred during a calendar year is $1,200.

And replaced with the following:

The maximum amount payable for each individual for all covered dental expenses incurred during a calendar year is $2,000.

New York State Nurses Association
NYSNA Benefits Fund
PO Box 12430 - Albany, NY 12212-2430 - (518) 869-9501

Summary of Material Modifications – 2026

Maximum network pharmacy out-of-pocket cost
January 2026

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 $9,600 for individuals and $19,200 for families for 2026.***

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 2024). 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.

9/2025