Summary of Material Modifications to the DC 37 Local 95 Head Start Employee's Welfare Fund

This Summary of Material Modification ("SMM") modifies some of the information contained in the Summary Plan Description ("SPD") for the DC 37 Local 95 Head Start Employees Welfare Fund (the "Plan") that describes the Plan as of August1,2023.

Note: In the event of any discrepancy between this SMM and the SPD, the provisions of this SMM will govern.

Modification(s)

Important changes to certain benefits under the Plan will go into effect on August 1, 2023. Coverage for Medical, Dental and Prescription Drug Coverage shall be amended as follows:

1.Effective August 1, 2023, the Fund will remove from eligibility all legally married spouses and Domestic Partners for all benefits.

2.The Fund will change from the current Empire Blue Connection EPO ASO Agreement to the fully insured Empire Blue Connection EPO network benefit with the following changes to current benefits:

- Primary Care / Specialist Visit Copay $30.
- Annual deductible $1,000 individual/ $2,000 Member & Child.
- Coinsurance 80%/20%.
- Emergency Room Copay Visit Copay $300 (waived if admitted).

If you have questions about these changes in benefits, please contact your Plan Administrator at (212) 343 1660.

Frequently Asked Questions

Why is the Plan making these changes?

The Plan has been running at a deficit due to the volume of medical claims that are paid annually, and the costs associated with certain medical procedures that are covered by the Plan. To continue providing coverage to participants, the Trustees review many factors, such as the number of members enrolled that are contributing to the Plan, the Claim utilization spending, and the projected future cost of providing benefits (medical inflation).

Based on these factors, there are limited options available:

Plan savings by cutting costs through increased cost sharing and behavior modification. The Summary of Material Modifications included with this FAQ provides all the benefit modifications effective **August 1, 2023,** the new benefit period options.

When will the changes become effective?

The changes for services will begin **on August 1, 2023**.

Why is the Plan eliminating Spousal coverage.

The elimination of Spouse coverage, is necessary because the Fund does not receive enough funding to support the cost of providing benefits. In prior years the Fund spent money held in reserves, however the reserves have been depleted. It's a difficult decision, hopefully a temporary one, but necessary to stabilize the Plan.

Where will my spouse receive their benefits after August 1,2023?

If eligible, Medicare as the Primary insurer, through their employer's insurance, or through the New York State Health Exchange.

Where can I obtain information on health insurance that is available on the marketplace?

In New York, you can log onto: https://nystateofhealth.ny.gov/ to find a health plan that best suits your needs. Bronze plans are the least expensive. Even within "bronze plans" the cost varies considerably. Not only should you check the premium, but you should also examine what co-pays you would be charged as well as what hospitals are in the carrier's network.

How do I know if I'm eligible for free Medicaid coverage?

Eligibility for Medicaid depends upon your annual family income as determined by the Federal Poverty Level. In 2023 these limits are: $14,580 for a single adult person, $30,000 for a family of four and $50,560 for a family of eight. To calculate for larger households, you need to add $5,140 for each additional person in families with nine or more members. You can apply for NY Medicaid online by logging on to: https://www.health.ny.gov/health_care/medicaid/ or, you can contact the NYC Human Resources Administration by calling 718-557-1399.

What happens if they are in the Hospital on August 1, 2023?

The Fund will continue coverage if they are in treatment on August 1st until they are discharged, **however do not wait to find alternative coverage that's why we are providing this notice**.

What about my other dependents?

The Fund will continue to cover your eligible dependents until they age out of the Plan, age 26.

How can you minimize your out-of-pocket costs?

The Plan is designed to provide the best medical services using a Primary Care Physician ("PCP") to manage your treatment. As previously communicated, you can select your PCP. If you do not choose a PCP, one is assigned to you when you enroll in the Plan based on your residence.

Suppose you become ill or need a referral to a specialist. In that case, it is your PCP who will guide you to all medical services in the most appropriate setting, and your PCP will manage the most efficient care needed. Utilizing alternative settings to the hospital emergency rooms and Outpatient facilities is highly recommended. The hospital is the costliest setting to receive care for those services. Alternative settings, for Laboratory tests and X-rays, can be obtained through independent offices.

For example, in the new benefit period Outpatient Services from a participating hospital facility will incur a $200 co-pay for each service you receive. The same services obtained at an independent office will be subject to the $30 co-pay office visit. Additionally, the hospital emergency room should only be used for emergency conditions.

The Blue Connect network.

The Plan network will remain the same Empire BlueCross Blue Connect EPO for your healthcare needs. However we are changing the funding to a fully insured model. Information about the Blue Connect network is available on the Funds website at https:/dc1707l95wf.net or through the Empire website at www.empireblue.com.

To search for a network provider or to confirm if your physician participates in the Anthem network, call Empire's member services at telephone 1-844-241-7089 or search their website at www.empireblue.com

How can I find who my Primary Care Physician is or a list of alternative labs to the hospital outpatient facility?

You may find an alternative facility or choose a PCP through the Anthem website empireblue.com and select the option ***Find care>Updated Primary Care Physician*****,** then follow the steps. You can also find network Labs and Imaging providers thru this site. You may also contact Empire member service by calling 844-241-7089.

Prescription Benefits

What is Navitus? What is a Pharmacy Benefit Manager?

Navitus Health Solutions is your Pharmacy Benefits Manager (PBM). A PBM directs prescription drug programs and processes prescription claims by negotiating drug costs with manufacturers, contracting with pharmacies, and building and maintaining drug formularies. These cost-saving strategies will lower drug costs and promote good member health. **Remember: Using generic alternative drugs will save you and the Plan money.**

Whom do I contact with questions about my pharmacy benefit (such as preferred drug list, claims, participating pharmacies, etc.)?

You can find your preferred drug list, list of participating pharmacies, and other information about your pharmacy benefit at **www.navitus.com** ***>Members > Member Login.***

You can also call Navitus 24-hour Customer Care toll-free at 866-333-2757 with questions about your pharmacy benefit.

How do I find information about my prescription benefit online?

Your health comes first, and **Navi-Gate** can help you with your pharmacy benefit questions and more. Navi-Gate for Members provides information to help you understand your prescription drug benefits, add convenience to your life, and offer cost-saving options. By helping you find a local pharmacy or reviewing your medication profile, Navi-Gate can provide you with the information to take control of your health. You can sign up for Navi-Gate for Members by visiting ***www.navitus.com>Members>Member Login. This service is free.***

Where can I find my formulary?

The list of drugs covered by your benefit is available on the Navitus website:
www.navitus.com > Members > Member Login.

Can I use my health plan card to fill prescriptions at my pharmacy?

No, you must present a **Navitus** ID card to the pharmacy when you fill a prescription. You can request replacement cards from Navitus by calling Customer Care toll-free at 866-333-2757.

Whom do I call to request additional cards?

Please call Navitus Customer Care toll-free at 866-333-2757. Navitus will mail you a new ID card, and you should receive it within 7-10 calendar days from the date of your request.

When can I refill my prescription?

You can refill your prescription at a retail pharmacy after using approximately three-quarters or 85% of the medication.

How do I use the Navitus SpecialtyRx program?

Navitus SpecialtyRx works with our specialty partner to offer services with the highest standard of care. You will get one-on-one assistance from skilled pharmacists, and they can answer questions about side effects and give advice to help you stay on course with your treatment.

With Navitus SpecialtyRx, delivery of your specialty medications is free to your home or prescriber's office via FedEx. Local courier service is available for emergency, same-day medication needs. To start using Navitus SpecialtyRx, please call toll-free at **855-847-3553**. We will work with your prescriber for current or new specialty prescriptions. The Plan works with the Copay Max Plus Program to obtain copay assistance on your behalf. This program applies to certain drugs that have manufacturer-funded copay assistance programs available.

Are there any changes to my Prescription Benefits?

Beginning August 1, 2022, the Fund started to participate with Navitus to minimize your out-of-pocket cost for certain drugs that have available manufacturer funded copay assistance.

Under the Copay Max Plus Program, if the drugs have copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, you will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including co-pay assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons)

will not count toward your annual out-of-pocket maximum or deductible. Instead, only those payments made directly by you will count toward your out-of-pocket maximum or deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design. Your copay will default to the formulary's current tiered coinsurance/copay if a drug does not qualify to be in the Copay Max Plus Program or is removed from the program.

How do I make a complaint or file an appeal?

When you are concerned about a benefit, claim, or other services, please call Navitus Customer Care toll-free at 866-333-2757. Our Customer Care Specialists will answer your questions and resolve your concerns quickly. If Customer Care does not resolve your issue, you have the right to file a written appeal with Navitus. Send your appeal, along with related information from your doctor, to:

MAIL: Navitus Health Solutions
Attn: Appeals Department
P. O. Box 999, Appleton, WI 54912-0999

FAX: 855-673-6507
Attn: Appeals Dept.

You may also appeal to the Board of Trustees by requesting a review after the appeal with Navitus has been denied. Appeal's must be received by the Plan not more than 180 days after receipt of written notice of denial of the claim.