HOUSE STAFF BENEFITS PLAN

SUMMARY OF MATERIAL MODIFICATION #1
HOUSE STAFF BENEFITS PLAN 2024 SPD
PLEASE READ NOW!

May 29th 2026

This notice contains important information regarding changes to the 2024 House Staff Benefits Plan (the "Plan" or "HSBP") Summary Plan Description ("SPD"). **This Summary of Material Modifications ("SMM") is issued to notify you of changes and improvements to your vision benefits effective July 1, 2026.**

The Plan has improved the level of benefits provided by Davis Vision, added coverage for contact lens exams, and has expanded the list of in-network providers to include Warby Parker, Target, and Walmart.

Please take the time to read this notice carefully and share it with your covered family members. Keep this notice with your Plan documents.

1. **The Plan's in-network provider list for Vision benefits has been expanded to include Warby Parker, Target, and Walmart.**

2. **The "In-Network Benefit" subsection under *Vision Benefit*, on page 23 of the SPD, and the charts, on pages 25-26 of the SPD, are deleted in their entirety and replaced as follows:**

   <u>In-Network Benefit</u>

   The Plan offers a comprehensive vision benefit through Davis Vision. When you and your eligible dependent(s) use your benefit In-Network you will be entitled to the following benefits:

   - Free eye exam every Plan Year (July 1 to June 30) (includes dilation when professionally indicated);
   - Spectacle Lenses every Plan Year (see chart below for lens options and co-pay amounts);
   - Frames every Plan Year as follows:
     - Any frame from the Davis Vision Fashion, Designer, or Premier Collection will be covered in full (retail value, up to $225) with no copayment; OR

    - If you choose a frame that is NOT in the Davis Vision Collection, you will receive a $130 allowance toward any frame from the participating provider plus 20% off any balance with no copayment.*
- Contact Lenses every Plan Year (in lieu of eyeglasses):
    - Any contact lenses from the Davis Vision Collection are covered in full, including up to two boxes/multipacks for planned replacement contact lenses or four boxes/multipacks for disposable contact lenses; OR
    - If you choose contact lenses that are NOT in the Davis Vision Collection, you will receive a $130 allowance plus 15% off any balance with no copayment*; OR
    - If you choose visually required contacts, they will be covered up to $210 with prior approval.

  *Some limitations apply to additional discounts; discounts not applicable at all in-network providers

Contact Lenses

If you require a contact lens evaluation, fitting, and follow up care, it will be covered in full with no copayment. This includes Davis Vision Collection contacts, non-Collection standard contacts, and non-Collection specialty contacts**.

**Including, but not limited to toric, multifocal, and gas permeable contact lenses.

Copayments

Lens Types and Coatings	Copay
Clear Plastic Lenses (single, bifocal, trifocal, or lenticular)	$0
Scratch Resistant Coating	$0
Premium Scratch Resistant Coating	$30
Tinting of Plastic Lenses	$0
Polycarbonate Lenses	$0
Ultraviolet Coating	$0
Standard Progressives	$0
Premium Progressives	$40
Ultra Progressives	$90
Ultimate Progressives	$125
Plastic Photosensitive Lenses	$65
Digital Single Vision Lenses	$0
Polarized Lenses	$75
Standard Anti-Reflective (AR) Coating	$35
Premium AR Coating	$48
Ultra AR Coating	$60
Ultimate AR Coating	$85
High-Index Lenses 1.67	$55

High-Index Lenses 1.74	$120
Scratch Protection Plan Single Vision	$20
Scratch Protection Plan Multifocal Lenses	$40
Trivex Lenses	$50
Blue Light Filtering	$15

3. **The "Out-of-Network Benefit" subsection under *Vision Benefit* on page 24 of the SPD is amended to update the claims mailing address as follows:**

   Mail claims to:

   Vision Care Processing Unit
   P.O. Box 479
   Troy, NY 12181

4. **The "Other Vision Benefits" subsection under *Vision Benefit* on page 23 of the SPD is deleted and replaced with the following:**

   Mail Order Contacts: You can purchase contact lenses online through available in-network or out-of-network providers. Please refer to the "In-Network Benefit" and "Out-of-Network Benefit" subsections for applicable cost-sharing.

   One Year Breakage: Warranty Repair or replacement of your plan-covered spectacle lenses, collection frame or frame from an In-Network retail location where the Collection is still available. If your selected lenses, Collection frame, or frame is not available, Davis Vision will replace with another item from the same tier.

   Additional Savings: Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount (some limitations apply to additional discounts; discounts not applicable at all in-network providers).

   Laser Vision correction: Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisionvision.com.

   Low Vision Services: Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

5. **The "Appealing Vision Coverage" subsection under *Vision Benefit* on page 26 of the SPD is amended to update the contact information and claims filing address:**

   Call Davis Vision, (800) 999-5431 for more information. Email your complaint, grievance or appeal to RTQA@versanthealth.com, or address it to:

   Davis Vision Inc.
   Attention: Quality Assurance/Patient Advocate Department
   PO Box 547
   Troy, NY 12181

6. **The following subsections under the *Claims Review and Appeals Procedure* section on pages 44-45 of the SPD are deleted and replaced as follows:**

   Requests for Review of Davis Vision Claims (Client Code 3614)

   Appeals for vision benefits must be directed to Davis Vision. Your request for review must be made in writing **within 180 days** after you receive notice of denial. Call Davis Vision at (800) 999-5431 for more information.

   Email your complaint, grievance or appeal to RTQA@versanthealth.com, or mail it to:

   Davis Vision Inc.
   Attention: Quality Assurance/Patient Advocate Department
   PO Box 547
   Troy, NY 12181

   In all communications about a claim, be sure to include your identification number and group number.

7. **A new section, *Coordination of Benefits*, shall be added before the *Notice of Electronic Disclosure* section on page 47 of the SPD that states as follows:**

COORDINATION OF BENEFITS

Purpose

When a covered person has health care coverage under more than one plan, this section allows HSBP to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than they incur in charges.

Definitions

Allowable Expense

This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense

and a benefit paid. An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

- If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim
This term means a request that benefits of a plan be provided or paid.

Claim Determination Period
This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Coordination of Benefits
This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent
This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan
This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group or group remittance subscriber contracts; (2) uninsured arrangements of group coverage; (3) group coverage through health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice plans; (4) blanket contracts, except as shown below; (5) medical benefits under group or individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts; and (6) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) direct payment subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice, and individual practice plans. This term also does not include: (i) blanket school

accident type coverage or such coverage issued to a substantially similar group; or (ii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description. Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan
This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan
This term means a plan that is not a primary plan.

This Plan
This term means the benefits provided under the HSBP.

Order of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the following rules that applies is the rule to use.

Order in which HSBP will Coordinate:
The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

The plan that covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan that covers the person as a dependent of a person whose birthday comes later in that calendar year.

If items 1 and 2 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed primary and will pay its benefits first, except that the benefits of a plan which covers the person as a retired employee or the dependent of such person shall be determined after the benefits (that is, as a secondary plan) of any other plan which covers such person as an employee who is not retired or a dependent of such person. If either plan does not have a provision regarding retired employees and as a result each plan determines its benefits after the other, then the preceding sentence will not apply.

Coordination of Benefits with Medicare
If you or your spouse is age 65 or older, you are eligible for Medicare even if you are not retired. Medicare includes hospital insurance benefits (Part A), other medical insurance (Part B), and prescription drug benefits (Part D).

As stated above, the plan that covers the person other than as a dependent (for example, as an employee or member) is primary and the plan that covers the person as a dependent is secondary. However, if a person is a Medicare beneficiary, and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent and primary to the plan that covers the person other than as a dependent (for example, a retiree), then the order of payment between the two plans is reversed so that the plan that covers the person as an employee or member, etc., is secondary and the other plan covering the person as a dependent is primary. Note that special rules apply if you or your dependent are entitled to Medicare because of End Stage Renal Disease or disability. Contact the Benefits Office at (212) 356-8180 for more information.

Child Covered under more than One Plan
The order of benefit determination when a child is covered by more than one plan is:

If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

Active or Inactive Employee
The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage
The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length of Coverage
The plan that covered the person longer is primary.

Other
If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But this plan will not pay more than it would have had it been the primary plan.

Effect on the Benefits of this Plan

When This Plan Is Primary
When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

8. A new section, *Third Party Liability*, shall be added before the *Notice of Electronic Disclosure* section on page 47 of the SPD that states as follows:

THIRD PARTY LIABILITY

Subrogation

If you or any person covered by HSBP as your beneficiary (hereinafter "You" or "covered individual") should suffer an illness or injury, or require medical treatment through the act or omission of someone else or for which a third party may be legally responsible, for which benefits under HSBP's coverage is payable, the following subrogation provisions will apply. If this illness or injury is the result of an accident for which payment may be available from another source, a claim may be submitted for these expenses and payment considered by the Trustees. It is possible that HSBP may advance benefit payment in order to assist you in your time of need. HSBP will have the right to recover any paid benefits from the responsible party. You are required to notify HSBP promptly of any third-party claim you may have for an injury or illness for which HSBP has paid or may pay benefits and any demand made or suit filed against any third party.

In addition, HSBP will have the right to recover any payments which were made to a covered individual and which caused a duplicate payment for the same expenses. The covered individual will cooperate with and assist HSBP in recovering any benefits for which other payment is available and to notify HSBP promptly of any third-party recovery, whether in or out of court, that you, your dependent, or your parents or any agent, representative or trustee or any of them obtains.

The covered individual must reimburse HSBP promptly out of any recovery from any source, including the third party or the third party's insurer, for the benefits paid to the covered individual. HSBP's right to subrogation and reimbursement applies to all rights of recovery of the covered individual and the covered individual's dependents, parents, representative, guardian or trustee, regardless of whether the recovery fully compensates the covered individual for the loss. Acceptance of benefits from HSBP automatically assigns to HSBP any rights to recovery of duplicate payments. HSBP has a constructive trust and an equitable right to and lien with regard to any monies received by an employee or dependent and/or his or her attorney or representative from a third party to the extent of benefits as described above. You must forward any recovery to HSBP within ten (10) days of receipt or notify HSBP why you are unable to do so.

HSBP must be reimbursed in full up to the total amount of all benefits paid by HSBP in connection with the injury or illness from any recovery you receive from a third party, as well any first-party coverage, including, but not limited to, any payments you receive from your own personal injury protection (PIP), med-pay, uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, school insurance or workers' compensation insurance, even if the recovery is not specifically identified as a reimbursement of medical expenses. All recoveries from a third party or first-party coverage (whether by lawsuit, settlement, insurance or otherwise) must be used to reimburse HSBP for benefits paid. In the event you receive an award for future medical expenses, HSBP will not pay any benefits until you demonstrate that the full award of future medical benefits has been used to treat the injury or illness. HSBP has the right of first reimbursement on a priority first-dollar basis out of any recovery obtained,

even if you are not fully compensated (or "made whole") for your loss, and HSBP's claim has first priority over all other claims and rights.

Neither you nor your dependent is compelled to pursue any right of recovery from a third party whose conduct caused the injuries for which benefits were paid by HSBP. The Trustees strongly recommend, however, that if you are injured as a result of the negligence or wrongful act of a third party, you should contact an attorney for advice and counsel. HSBP cannot and does not pay for the legal fees your attorney may charge.

HSBP's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise. Any reduction of HSBP's claim is subject to prior written approval by the Trustees in their sole discretion.

If you choose not to pursue the liability of a third party, HSBP will be subrogated to your right of recovery and may pursue your claims against the third party. You agree to cooperate with HSBP with respect to any attempt to recover HSBP benefits payable to you or your eligible dependent related to an injury or illness caused by the act or omission of a third party.

Note that other provisions of HSBP may exclude or limit coverage under certain circumstances where the injury or illness may have been the result of the act or omission of a third party (e.g., Workers' Compensation cases, certain automobile accidents, etc.). Please review carefully the specific limitations and exclusions in this SPD.

Please contact us if you have questions.

Sincerely,

CIR BENEFIT FUNDS