New York State Nurses Association

Benefits Fund

Summary of Benefits and Coverage for Plan Year 2027

Benefit Coverage Plan B

New York State Nurses Association

N Y S N A
Benefits Fund

(518) 869-9501
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NYSNA Benefits Fund

Summary of Benefits and Coverage

The following pages contain a Summary of Benefits and Coverage for participants covered by the NYSNA Benefits Fund's Benefit Coverage Plan B. This summary consists of an easy-to-understand chart outlining the significant health benefits provided by the plan. It provides a simple overview of what's covered, when it's covered, and what your share of the costs might be under various circumstances.

As a requirement of the Patient Protection and Affordable Care Act, health insurance issuers and group health plan administrators must distribute this standardized document annually to all eligible participants of a health plan to help individuals better understand their health insurance coverage. Benefits Fund participants, therefore, will receive this summary each year during the Fund's open enrollment period between Nov. 1 and Dec. 31.

Included in the summary grid is information regarding deductibles, out-of-pocket limits, differences in cost of using in-network versus out-of-network providers, and services excluded by the plan. The summary also includes a tool called "Coverage Examples" that, in general terms, shows what the plan covers for three common medical situations – having a baby, treatment for a simple fracture, and managing type 2 diabetes – and an estimate of the out-of-pocket costs for participants. This section is intended as a guide and costs may vary depending on your particular medical situation. (The terminology and examples used in the Coverage Examples were provided by the U.S. Department of Labor and are uniform for all plan issuers across the country. In addition, the cost of services used in this section are national averages.)

Please note, beginning Jan. 1, 2027 the Benefits Fund has established a maximum network pharmacy out-of-pocket cost of $11,000 for individuals and $22,000 for families. This will exclude any penalties incurred under the Fund's clinical pharmacy programs.

The Summary of Benefits and Coverage is not a substitute for the Summary Plan Description *and shouldn't be relied upon in all situations. We urge you to continue referring to our* Summary Plan Description *for detailed information about the plan. In addition, you may always contact a participant service representative at (518) 869-9501 for assistance. However, the* Summary Plan Description *is the Fund's official plan document and supersedes any information provided in writing or verbally.*

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (518) 869-9501. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/health-care-law-protections/summary-of-benefits-and-coverage/ or call (518) 869-9501 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-network medical deductible: $300 Individual/$600 Family. Doesn't apply to pharmacy benefits. Coinsurance does not count toward deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	This plan covers some out-of-network items and services even if you haven't yet met the deductible; however, a copayment or coinsurance may apply. For example, this plan covers both out-of-network durable medical equipment and home health care before you meet your deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network maximum: Medical coverage $1,000/Individual and $2,000/Family. Rx: $11,000/Individual and $22,000/Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums (if applicable), health care services this plan does not cover, clinical pharmacy program penalties, out-of-network coinsurance, and balance billing charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. For a list of network providers, see anthem.com/find-care.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider may use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10/visit	30% coinsurance	None
	Specialist visit	$30/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% coinsurance	Coverage limits based on age. Some routine vaccinations also covered through pharmacy benefit.
If you have a test	Diagnostic test (radiology, blood work)	Blood work: No charge X-ray: $25 copayment	30% coinsurance	Services may not be paid if prior authorization is not obtained.
	Imaging (CT/PET scans, MRIs)	$25 copayment	30% coinsurance	Services may not be paid if prior authorization is not obtained.
If you need drugs to treat your illness or condition (continued) More information about **prescription drug coverage** is available at rnbenefits.org.	Generic drugs	Retail: $7/Rx Mail order: $15/Rx	Retail: Reimbursed up to contracted amount minus applicable in-network copayment. Mail order: Not covered.	Retail: Limit up to 34-day supply. Maintenance medications: Must be filled by mail order or at a retail pharmacy that participates in the Express Scripts Smart90 program. Limited to 90-day supply.
	Preferred brand drugs	Retail: $20/Rx Mail order: $40/Rx	Retail: Reimbursed up to contracted amount minus applicable in-network copayment Mail order: Not covered	
	Non-preferred brand drugs	Retail: $35/Rx Mail order: $70/Rx	Retail: Reimbursed up to contracted amount minus	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
Continued from Page 2			applicable in-network copayment Mail order: Not covered	(See information from page two)
	Specialty drugs	Generic: $7/Rx Preferred brand: $20/Rx	Not covered	Limited to a 30-day supply per fill. Specialty Mail Pharmacy only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	Services may not be paid if prior authorization is not obtained.
	Physician/surgeon fees	No charge	30% coinsurance	
If you need immediate medical attention	Emergency room care	$100/visit	$100/visit	Copayment waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$30/visit	$30/visit	$10/visit for in-network PCP
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$500 copayment/admission. Plus 30% coinsurance.	Out-of-network copayment limited to $1,500 maximum per individual. Deductible does not apply. Services may not be paid if prior authorization is not obtained.
	Physician/surgeon fees	No charge	30% coinsurance	Services may not be paid if prior authorization is not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10/visit	30% coinsurance	None
	Inpatient services	No charge	$500 copayment/admission. Plus 30% coinsurance.	Out-of-network copayment limited to $1,500 maximum per individual. Deductible does not apply. Services may not be paid if prior authorization is not obtained.
If you are pregnant	Office visits	$10 copay initial visit only	30% coinsurance	None
	Childbirth/delivery professional services	No charge	30% coinsurance	None
	Childbirth/delivery facility services	No charge	$500 copayment/admission. Plus 30% coinsurance.	Out-of-network copayment limited to $1,500 maximum per individual. Deductible does not apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Limited to 140 *visits per calendar year* for out-of-network only. Services may not be paid if prior authorization is not obtained. Deductible does not apply.
	Rehabilitation services	$30/visit	30% coinsurance	Speech therapy limited to 30 visits *per calendar year*. Other types of therapies require prior authorization. Must meet requirements for coverage and be medically necessary.
	Habilitation services	$30/visit	30% coinsurance	Services may not be paid if prior authorization is not obtained.
	Skilled nursing care	No charge	$500 copayment/admission to a max of $1,500/individual plus 30% coinsurance	60-day limit per calendar year in a skilled nursing facility. Services may not be paid if prior authorization is not obtained. Deductible does not apply.
	Durable medical equipment	20% coinsurance	30% coinsurance	Services may not be paid if prior authorization is not obtained. Deductible does not apply
	Hospice services	No charge for home or inpatient care	30% coinsurance for home care $500 copayment/admission to a max of $1,500/per individual plus 30% coinsurance	210-day limit. Deductible does not apply. Services may not be paid if prior authorization is not obtained.
If your child needs eye care	Children's eye exam	$10/visit	Up to $75 for eye exam and glasses every two years.	Limit: One exam/year in-network for children up to age 18
	Children's glasses	$30 for lenses and/or select plan frames; or $150 credit toward non-plan frames		Limit: One pair of eyeglasses every two years
If your child needs dental care	Children's dental check-up	No charge	20% coinsurance	Out-of-network dental deductible: $50 individual/$150 family. Coverage limited to $2,000/individual annual maximum. Limited to two check-ups annually.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Long-term care	• Private-duty nursing
• Hearing aids	• Non-emergency care when traveling outside the United States	• Routine foot care
		• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Infertility treatment
• Bariatric surgery	• Dental care (adult)	• Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration (866) 444-EBSA [3272] or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call (800) 318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Fund at (518) 869-9501. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-EBSA [3272] or www.dol.gov/ebsa/healthreform for information.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (518) 869-9501.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$ 0**
- **Specialist copayment (OB/GYN)** **$10**
- **Pharmacy copayment/90 day-supply** **$15**
- **Hospital (facility) copayment** **$ 0**
- **Other copayment (radiology)** **$ 25**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(radiology and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$ 0
Copayments	$105
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$ 0
The total Peg would pay is	**$105**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$ 0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$ 0**
- **Other copayment** **$ 0**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$ 0
Copayments	$1,200
Coinsurance	$ 0
What isn't covered	
Limits or exclusions	$ 20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$ 0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$100**
- **Other copayment (physical therapy)** **$30**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*radiology*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$ 0
Copayments	$280
Coinsurance	$ 20
What isn't covered	
Limits or exclusions	$ 0
The total Mia would pay is	**$300**

The plan would be responsible for the other costs of these EXAMPLE covered services.