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

Schedule of Benefits 2027
(Benefit Coverage Plans A and B)

	Benefit	Benefit Coverage Plan A		Benefit Coverage Plan B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Financial	Deductible	None	$250 Individual; $500 Family	None	$300 Individual; $600 Family
	Maximum out-of-pocket cost (does not include charges in excess of allowed amount or noncovered benefits)	$1,000 Individual; $2,000 Family copayment/coinsurance maximum	None	$1,000 Individual; $2,000 Family copayment/coinsurance maximum	None
	Coinsurance	None	70%/30%	None	70%/30%
	Reimbursement rate	None	70th percentile	None	70th percentile
Preventive Care	Well-child and well-adult visits	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
	Well-woman visits	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
	Immunizations	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

The information contained herein should not be viewed as a substitute for the most recent *Summary Plan Description* and any relevant Summary of Material Modifications. In case of discrepancies or contradictions, the language and terms of the SPD and SMMs shall prevail.

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Maternity Care	Routine obstetrical, prenatal care, delivery, and postnatal care for mother*	$10 copayment for initial visit only	Paid at 70% of the allowed amount after deductible is met	$10 copayment for initial visit only	Paid at 70% of the allowed amount after deductible is met
Inpatient Care	Room and board *	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
	Physician's services*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of allowed amount after deductible is met
	Surgery (Physician's 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
	Restorative physical and occupational therapy*	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
	Skilled nursing facility (for up to 60 days per calendar year)*	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%

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		In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Care	Office visits	$10 copay/visit PCP; $25 copay/visit specialist	Paid at 70% of the allowed amount after deductible is met	$10 copay/visit PCP; $30 copay/visit specialist	Paid at 70% of the allowed amount after deductible is met
	Chiropractic care*	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Acupuncture	$25 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Allergy treatment	$25 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Restorative physical and occupational therapy*	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Cardiac rehabilitation*	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Radiology/imaging*	No cost	Paid at 70% of the allowed amount after deductible is met	$25 copayment	Paid at 70% of the allowed amount after deductible is met
	Laboratory tests*	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
	Restorative speech therapy for up to 30 visits per calendar year	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Surgery (physician's 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
	Surgery (facility charges)*	No cost	Paid at 70% after deductible is met	No cost	Paid at 70% after deductible is met

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		In-Network	Out-of-Network	In-Network	Out-of-Network
Other Services	Physician house calls	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
	Home health care services*	No cost	Paid at 70% up to 140 visits per calendar year (deductible does not apply)	No cost	Paid at 70% up to 140 visits per calendar year (deductible does not apply)
	Home hospice care (up to 210 days max combined with inpatient hospice care)*	No cost	Paid at 70% (deductible does not apply)	No cost	Paid at 70% (deductible does not apply)
	Inpatient hospice care (up to 210 days max combined with home hospice care)*	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
	Durable medical equipment and supplies*	Paid at 80% of contracted amount	Paid at 70% of the cost of the covered item (deductible does not apply)	Paid at 80% of contracted amount	Paid at 70% of the cost of the covered item (deductible does not apply)
	Infertility specialist visits	$25 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per 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
ER	At hospital emergency room (waived if admitted)	$75 copayment per visit		$100 copayment per visit	

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		In-Network	Out-of-Network	In-Network	Out-of-Network
Behavioral Health	Outpatient behavioral health	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Inpatient behavioral health*	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
Substance Abuse	Outpatient medical rehabilitative care for substance abuse/alcohol addiction	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Inpatient medical rehabilitative care for substance abuse/alcohol addiction*	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
Applied Behavior Analysis (ABA)	Outpatient ABA office visits*	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Outpatient facility care for ABA*	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

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Prescription Drugs	Yearly deductible	None	None	None	None
	Maximum network out-of-pocket cost (doesn't include clinical pharmacy program penalties)	$11,000 Individual; $22,000 Family	None	$11,000 Individual $22,000 Family	None
	Prescription drugs at retail pharmacy (up to a 34-day supply)	Tier 1: $0 Generic Tier 2: $10 Preferred Tier 3: $20 Non-preferred	Reimbursed at contracted amount minus applicable in-network copayment	Tier 1: $7 Generic Tier 2: $20 Preferred Tier 3: $35 Non-preferred	Reimbursed at contracted amount minus applicable in-network copayment
	Mail-order prescription drug program (mandatory for all maintenance prescription medications for up to a 90-day supply)	Tier 1: $0 Generic Tier 2: $20 Preferred Tier 3: $40 Non-preferred	Not applicable	Tier 1: $15 Generic Tier 2: $40 Preferred Tier 3: $70 Non-preferred	Not applicable
	Routine vaccinations (influenza, pneumococcal disease, zoster/ shingles, and COVID-19) administered at the pharmacy	No cost	Not covered	No cost	Not covered
Dental Care	Yearly deductible	None	$50/individual; $150/family	None	$50/individual; $150/family
	Maximum yearly benefit	$2,000	$2,000	$2,000	$2,000
	Orthodontia maximum	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years
	Diagnostic and preventive services	No cost	Paid at 80% of usual and prevailing fee	No cost	Paid at 80% of usual and prevailing fee
	Basic restorative services, endodontics, periodontics, maintenance of prosthodontics, and oral surgery	Paid at 80% of fee schedule	Paid at 80% of usual and prevailing fee	Paid at 80% of fee schedule	Paid at 80% of usual and prevailing fee
	Major restorative services, installation of prosthodontics, and orthodontics	Paid at 50% of fee schedule	Paid at 50% of usual and prevailing fee	Paid at 50% of fee schedule	Paid at 50% of usual and prevailing fee

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Vision Care	Routine eye exam every two years (every year for children up to age 18)	$10 copayment per visit	Paid at up to $75 for exam and glasses or contact lenses (every two years)
	Eyeglasses or contact lenses every 2 years (through Davis Vision)	$30 copay for lenses and/or frames within the Davis Frame Collection, or $150 credit toward non-plan frames, or $25 copay for disposable/planned replacement lenses	

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Disability	Short-term, nonoccupational disability	Paid at two-thirds of regular, weekly compensation, up to $215 per week for a maximum period of 26 weeks
	Long-term disability that extends beyond the qualifying period of six consecutive months	Paid at 50% of monthly base compensation, up to $350 per month, less other disability payments, to age 65 (age 70 if disabled after age 60)
Other Insurance	Life	Paid at a minimum of $20,000 and a maximum of $50,000, computed by taking 150% of current base compensation, to the maximum allowable. Benefit is reduced 35% at age 65, and 50% at age 70.
	Accidental death and dismemberment and loss of sight	Paid at 100% or 50% of maximum benefit, according to specific loss
Paid Family Leave	Job protected, partial wage replacement to bond with a new child, care for a loved one with a serious health condition, or to help relieve family pressures when someone is called to active military service	Coverage provides up to 12 weeks of leave at 67 percent of your average weekly wage, capped at 67 percent of the Statewide Average Weekly Wage (SAWW), which for 2027 is $1,922.25 (maximum benefit is $1,287.91/week).