

Summary of Benefits

(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 maximum	None	\$1,000 Individual; \$2,000 Family copayment 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 UCR	No cost	Paid at 70% of UCR
	Well-woman visits	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Immunizations	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR

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Maternity Care	Obstetrical, prenatal care, delivery, and postnatal care for mother	\$10 copayment for initial visit only	Paid at 100% of UCR	\$10 copayment for initial visit only	Paid at 100% of UCR
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 UCR	No cost	Paid at 70% of UCR
	Surgery (Physician's services)	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR
	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	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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Outpatient Care	Office visits	\$10 copay/visit PCP; \$25 copay/visit specialist	Paid at 70% of UCR	\$10 copay/visit PCP; \$30 copay/visit specialist	Paid at 70% of UCR
	Chiropractic care*	\$10 copayment per visit	Paid at 70% of UCR	\$30 copayment per visit	Paid at 70% of UCR
	Acupuncture*	\$25 copayment per visit	Paid at 70% of UCR	\$30 copayment per visit	Paid at 70% of UCR
	Allergy treatment*	\$25 copayment per visit	Paid at 70% of UCR	\$30 copayment per visit	Paid at 70% of UCR
	Restorative physical and occupational therapy*	\$10 copayment per visit	Paid at 70% of UCR	\$30 copayment per visit	Paid at 70% of UCR
	Cardiac rehabilitation*	\$25 copayment per visit	Paid at 70% of UCR	\$30 copayment per visit	Paid at 70% of UCR
	Radiology/imaging	No cost	Paid at 70% of UCR	\$25 copayment	Paid at 70% of UCR
	Laboratory tests	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Restorative speech therapy for up to 60 consecutive days*	\$10 copayment per visit	Paid at 70% of UCR	\$30 copayment per visit	Paid at 70% of UCR
	Surgery (physician's services)	No cost	Paid at 100% of UCR	No cost	Paid at 100% of UCR
	Surgery (facility charges)	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR

* If services are provided by a PCP (family/general practitioner, internist, OB/GYN, or pediatrician) \$10 copay (Plans A and Plan B) applies.

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Other Services	Physician house calls	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
	Skilled home health care services	No cost	Paid at 75%	No cost	Paid at 75%
	Home hospice care (up to 210 days)	No cost	Paid at 75%	No cost	Paid at 75%
	Inpatient hospice care (up to 210 days)	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	Paid at 80% of cost of covered items to an unlimited maximum per participant or dependent per calendar year	Paid at 70% of cost of covered items to an unlimited maximum/ participant or dependent per calendar year	Paid at 80% of cost of covered items to an unlimited maximum/ participant or dependent per calendar year	Paid at 70% of cost of covered items to an unlimited maximum/ participant or dependent per calendar year
	In vitro fertilization services and covered fertility drugs ⁺ (up to a \$5,000 lifetime maximum benefit. May elect to use the \$5,000 max for prescriptions, if desired.)	No cost	Paid at 70% of UCR	No cost	Paid at 70% of UCR
ER	At hospital emergency room (waived if admitted)	\$75 copayment per visit		\$100 copayment per visit	

⁺ RNs at St. Joseph Hospital do not have coverage for infertility, including in vitro fertilization services and infertility drugs



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Mental Health	Outpatient mental health	\$25 copayment per visit	Paid at 70% of UCR	\$30 copayment per visit	Paid at 70% of UCR
	Inpatient mental health 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%
Substance Abuse	Outpatient medical rehabilitative care for substance abuse/ alcohol addiction	\$25 copayment per visit	Paid at 70% of UCR	\$30 copayment per visit	Paid at 70% of UCR
	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%