

# Skidmore College High Deductible PPO Medical Plan



## Summary of Benefits

Service Category	In-Network Coverage	Out of Network Coverage
<b>Annual Deductible per contract year</b>	\$1,650 Individual / \$3,300 Family	\$3,200 Individual / \$6,400 Family
<b>Co-insurance</b>	10% Coinsurance	30% Coinsurance
<b>Annual Out-of-Pocket Maximum</b>	\$4,500 Individual / \$9,000 Family	\$9,000 Individual / \$18,000 Family
<b>Employer HSA Contribution</b>	\$825 Individual / \$1,650 Family	
<b>Preventive &amp; Well Care Services</b> Well Child Care & Immunizations Adult Physical (One Routine Physical/Contract Year) Mammography Annual Pap Test & Ob/Gyn Exam Immunizations for Adults Colonoscopy & Sigmoidoscopy Screening (For Adults) Bone Density Tests	<b>Preventive &amp; Well Care Services are covered in full.</b>	
<b>Physician Office Visits</b> (PCP/Specialist)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Gia® Virtual Care Services</b>	Covered in Full After Deductible	Not Covered
<b>Diagnostic Lab Services</b> (Office)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Diagnostic X-ray</b> (Office)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Advanced Imaging Services</b> (Office – CT/PET scans, MRIs)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Rehabilitative Services</b> (Office – PT/OT/ST)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Allergy Services</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Chemotherapy</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Medical/Surgical Admissions</b> (Inpatient Hospital)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Surgical Services</b> (Inpatient Hospital)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Inpatient Physical Rehabilitation</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Hospital Rehab Services</b> (Outpatient – PT)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
(Outpatient – OT)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
(Outpatient – ST)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Diagnostic Laboratory Services**</b> (Outpatient Hospital)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Diagnostic X-ray**</b> (Outpatient)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>OB/GYN – Non-routine visits</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Chemo, Radiation and Infusion Therapy &amp; Dialysis</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Inpatient Surgery Physician &amp; Surgical Assistant</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Anesthesia Services</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Cardiac Rehab</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Advanced Imaging Services**</b> (Outpatient-CT/PET, scans, MRIs)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Ambulatory/Outpatient Surgery**</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Emergency Room (ER) Visit</b>	\$150 Copay after in-network deductible	
<b>Urgent Care Centers</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible

Service Category	In-Network Coverage	Out of Network Coverage
<b>Ambulance</b> (Emergency Medical Transportation)	\$150 Copay after in-network deductible	
<b>Mental Health Inpatient Hospital</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Mental Health Outpatient</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Substance Use Disorder Inpatient Hospital</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Substance Use Disorder Outpatient</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Maternity – Prenatal Care</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Maternity – Physician Delivery</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Maternity – Inpatient Hospital Services</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Skilled Nursing Facility</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Home Health Care</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Hospice</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Durable Medical Equipment (DME)</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Diabetic Supplies &amp; Equipment</b>	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Alternative Health Care</b> *Acupuncture *Child Birth Classes *Fitness Center Membership *Fitness Classes *Fitness Training Sessions with a Training Coach *Homeopathic *Hypnotherapy (Weight Control and Smoking Cessation) *Massage Therapy *Nutritional Counseling *Weight Control Programs	100% Coverage up to \$300 per year per covered employee/contract  (\$300 limit is the maximum benefit per contract per calendar year regardless of family size)  Products purchased through these Programs are not covered.	
<b>Infertility Treatments Including IVF Gift and Zift</b> (\$10,000 max for all services per family per calendar year)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
<b>Prescription Drug Coverage (OptumRx)</b>		
(Covers up to a 30-day supply (retail); 31-90 day supply (mail order prescription). Pre auth required for certain drugs or no coverage. No charge for certain preventative drugs)		
Generic Drugs	Retail: 10% Coinsurance After Deductible Mail Order: 10% Coinsurance After Deductible	Retail: 30% Coinsurance After Deductible Mail Order: 30% Coinsurance After Deductible
Preferred Brand Drugs	Retail: 10% Coinsurance After Deductible Mail Order: 10% Coinsurance After Deductible	Retail: 30% Coinsurance After Deductible Mail Order: 30% Coinsurance After Deductible
Non-preferred Brand Drugs	Retail: 10% Coinsurance After Deductible Mail Order: 10% Coinsurance After Deductible	Retail: 30% Coinsurance After Deductible Mail Order: 30% Coinsurance After Deductible
Specialty Drugs	As Applicable	As Applicable

\*Deductible applies to this benefit. Some services are subject to notification or prior authorization requirements. See your Summary Plan Description for details.

Virtual care services from MVP Health Care are provided by UCM Digital Health, Amwell and Galileo. (Plan exceptions may apply.) Members' direct or digital provider visits may be subject to co-pay/cost-share per plan. This plan overview is intended to provide a general outline of coverage. In the event of any conflict between this document and your SPD, the SPD will be controlling. Health benefit plans are issued or administered by MVP Health Plan, Inc.; MVP Health Insurance Company; MVP Select Care, Inc.; and MVP Health Services Corp., operating subsidiaries of MVP Health Care, Inc. Not all plans available in all states and counties.