Skidmore College PPO Medical Plan

Summary of Benefits

Service Category	In-Network Coverage	Out of Network Coverage
Annual Deductible per contract year	$200 Individual / $400 Family	$200 Individual / $500 Family
Co-insurance	None unless otherwise noted	20% Coinsurance
Annual Out-of-Pocket Maximum (Medical Only)	$1,500 Individual / $3,000 Family	$3,000 Individual / $6,000 Family
Annual Out-of-Pocket Maximum (Prescription Drug Only)	$7,700 Individual / $15,400 Family	Not Applicable
Preventive & Well Care Services 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	**Preventive & Well Care Services are covered in full.**	20% Coinsurance After Deductible
Physician Office Visits (PCP/Specialist)	$25 PCP / $40 Specialist Copay After Deductible	20% Coinsurance After Deductible
Gia® Virtual Care Services	Covered in Full, No Deductible	Not Covered
Diagnostic Lab Services (Office)	Covered in Full After Deductible	20% Coinsurance After Deductible
Diagnostic X-ray (Office)	Covered in Full After Deductible	20% Coinsurance After Deductible
Advanced Imaging Services (Office – CT/PET scans, MRIs)	Covered in Full After Deductible	20% Coinsurance After Deductible
Rehab Services (Office – PT/OT/ST) - 80 visit limit for ST/OT/PT combined	$40 Copay After Deductible	20% Coinsurance After Deductible
OB/GYN – Non-routine visits	$25 Copay After Deductible	20% Coinsurance After Deductible
Chemo, Radiation and Infusion Therapy & Dialysis (Office)	$25 Copay After Deductible	20% Coinsurance After Deductible
Medical/Surgical Admissions (Inpatient Hospital)	$250 Copay After Deductible	20% Coinsurance After Deductible
Surgical Services (Inpatient Hospital)	Covered in Full After Deductible	20% Coinsurance After Deductible
Inpatient Physical Rehabilitation	$250 Copay After Deductible	20% Coinsurance After Deductible
Hospital Rehab Services (Outpatient – PT) - 80 visit limit for ST/OT/PT combined	$40 Copay After Deductible	20% Coinsurance After Deductible
(Outpatient – OT) - 80 visit limit for ST/OT/PT combined	$40 Copay After Deductible	20% Coinsurance After Deductible
(Outpatient – ST) - 80 visit limit for ST/OT/PT combined	$40 Copay After Deductible	20% Coinsurance After Deductible
Diagnostic Laboratory Services** (Outpatient Hospital)	Covered in Full After Deductible	20% Coinsurance After Deductible
Diagnostic X-ray** (Outpatient)	Covered in Full After Deductible	20% Coinsurance After Deductible
Advanced Imaging Services** (Outpatient-CT/PET, scans, MRIs)	Covered in Full After Deductible	20% Coinsurance After Deductible
Ambulatory/Outpatient Surgery**	$100 Copay After Deductible	20% Coinsurance After Deductible
Inpatient Surgery Physician & Surgical Assistant	Covered in Full After Deductible	20% Coinsurance After Deductible
Anesthesia Services	Covered in Full After Deductible	20% Coinsurance After Deductible
Cardiac Rehab (Outpatient - 36 visits)	$40 Copay After Deductible	20% Coinsurance After Deductible

Service Category	In-Network Coverage	Out of Network Coverage
Preadmission Testing (within 7 days of admission)	Covered in Full After Deductible	20% Coinsurance After Deductible
Emergency Room (ER) Visit	$150 Copay (Waived if admitted) After Deductible	
Urgent Care Centers	$25 Copay After Deductible	20% Coinsurance After Deductible
Ambulance (Emergency Medical Transportation)	$150 Copay After Deductible	
Mental Health Inpatient Hospital	$250 Copay After Deductible	20% Coinsurance After Deductible
Mental Health Outpatient	$25 Copay After Deductible	20% Coinsurance After Deductible
Substance Use Disorder Inpatient Hospital	$250 Copay After Deductible	20% Coinsurance After Deductible
Substance Use Disorder Outpatient	$25 Copay After Deductible	20% Coinsurance After Deductible
Maternity – Prenatal Care	Covered in Full after Initial $25 Copay After Deductible	20% Coinsurance After Deductible
Maternity – Physician Delivery	Covered in Full After Deductible	20% Coinsurance After Deductible
Maternity – Inpatient Hospital Services	$250 Copay After Deductible	20% Coinsurance After Deductible
Skilled Nursing Facility 120 day limit	$250 Copay After Deductible	20% Coinsurance After Deductible
Home Health Care 200 visit limit	$40 Copay After Deductible	20% Coinsurance After Deductible
Hospice	Covered in Full After Deductible	20% Coinsurance After Deductible
Durable Medical Equipment (DME)	Covered in Full After Deductible	20% Coinsurance After Deductible
Diabetic Supplies & Equipment	Covered in Full After Deductible	20% Coinsurance After Deductible
Prescription Drug Coverage (OptumRx)		
(Covers up to a 30-day supply (retail); 31-90 day supply (mail order prescription). Prior auth required for certain drugs or no coverage. No charge for certain preventative drugs)		
Generic Drugs	Retail: $10 Copay Mail Order: $25 Copay	Not Covered
Preferred Brand Drugs	Retail: $30 Copay Mail Order: $75 Copay	Not Covered
Non-preferred Brand Drugs	Retail: $50 Copay Mail Order: $125 Copay	Not Covered
Specialty Drugs	As Applicable	Not Covered
Alternative Health Care		
*Acupuncture *Child Birth Classes *Fitness Center Membership *Fitness Equipment *Fitness Classes and Training Sessions *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	
Routine Eye Exam	$25 Copay After Deductible	20% Coinsurance After Deductible
Frames, Lenses, & Contacts	One (1) pair glasses every two (2) calendar years Up to $150 Maximum Every 2 calendar years for individuals 19 and over; No dollar limit for children up to age 19	
Wigs $300 Max Per Person Per Lifetime (Following Chemo Treatment)	Covered in Full After Deductible	20% Coinsurance After Deductible
Prosthetics / Orthotics	20% Coinsurance After Deductible	20% Coinsurance After Deductible
Post Mastectomy Prosthesis (1 every year; 2 if Bilateral)	Covered in Full After Deductible	20% Coinsurance After Deductible
Infertility Treatments Including IVF Gift and Zift ($10,000 max for all services per family per calendar year)	Covered in Full After Deductible	20% Coinsurance After Deductible

*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 at no cost-share for members. (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.