Skidmore College High Deductible PPO Medical Plan

Summary of Benefits

Service Category	In-Network Coverage	Out of Network Coverage
Annual Deductible per contract year	$1,750 Individual / $3,500 Family	$3,500 Individual / $6,600 Family
Co-insurance	10% Coinsurance	30% Coinsurance
Annual Out-of-Pocket Maximum	$3,500 Individual / $6,600 Family	$9,000 Individual / $18,000 Family
Employer HSA Contribution	$875 Individual / $1,750 Family	
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.**	
Physician Office Visits (PCP/Specialist)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Gia® Virtual Care Services	Covered in Full, No Deductible	Not Covered
Diagnostic Lab Services (Office)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Diagnostic X-ray (Office)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Advanced Imaging Services (Office – CT/PET scans, MRIs)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Rehabilitative Services (Office – PT/OT/ST)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Allergy Services	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Chemotherapy	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Scalp Cooling Device for Chemo Patients	Covered in Full After Deductible	30% Coinsurance After Deductible
Medical/Surgical Admissions (Inpatient Hospital)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Surgical Services (Inpatient Hospital)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Inpatient Physical Rehabilitation	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Hospital Rehab Services (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
Diagnostic Laboratory Services** (Outpatient Hospital)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Diagnostic X-ray** (Outpatient)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
OB/GYN – Non-routine visits	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Chemo, Radiation and Infusion Therapy & Dialysis	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Inpatient Surgery Physician & Surgical Assistant	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Anesthesia Services	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Cardiac Rehab	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Advanced Imaging Services** (Outpatient-CT/PET, scans, MRIs)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Ambulatory/Outpatient Surgery**	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Emergency Room (ER) Visit	$150 Copay after in-network deductible	
Urgent Care Centers	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Service Category	In-Network Coverage	Out of Network Coverage

Ambulance (Emergency Medical Transportation)	$150 Copay after in-network deductible	
Mental Health Inpatient Hospital	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Mental Health Outpatient	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Substance Use Disorder Inpatient Hospital	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Substance Use Disorder Outpatient	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Maternity – Prenatal Care	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Maternity – Physician Delivery	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Maternity – Inpatient Hospital Services	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Doula Reimbursements	Reimbursement for Doula Services up to $1500 per year	
Skilled Nursing Facility	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Home Health Care	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Hospice	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Durable Medical Equipment (DME)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Diabetic Supplies & Equipment	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Alternative Health Care *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.	
Infertility Treatments Including IVF Gift and Zift ($10,000 max for all services per family per calendar year)	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Routine Eye Exam	10% Coinsurance After Deductible	30% Coinsurance After Deductible
Frames, Lenses, Contacts (Combined in-network and out of network)	Individuals over 19: 50% up to $150 Maximum every 2 calendar years No dollar limit for children up to age 19	Individuals over 19: 50% up to $150 Maximum every 2 calendar years No dollar limit for children up to age 19

Prescription Drug Coverage (OptumRx)

(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.