SKIDMORE COLLEGE PPO MEDICAL PLAN

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017
Coverage For: Single + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.skidmore.edu/hr/benefits/benefitsprogramінfo.php or by contacting this Plan Sponsor at 518-580-5800

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In Network: **$0** individual/**$0** family; Out of Network: **$200** individual/**$500** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other Deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on Page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Medical: In-network: **$1,500** individual/**$3,000** family Out-of-network: **$3,000** individual/**$6,000** family. Prescription drug: **$5,650** individual/**$11,300** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balanced-billed charges, excluded charges and penalties for failure to obtain preauthorization.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers see: www.mvphealthcare.com **or call 1-800-229-5851**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-229-5851 or visit us at www.mvphealthcare.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-229-5851 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	20% coinsurance after deductible	--None--
	Specialist visit	$40 copay per visit	20% coinsurance after deductible	--None--
	Other practitioner office visit (Chiro)	$40 copay per visit for chiropractic services	20% coinsurance after deductible	--None--
	Preventive care/screening/immunization	No charge	20% coinsurance after deductible	Age and frequency limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance after deductible	--None--
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance after deductible	--None--
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com, or **1-855-505-8107**	Generic drugs	$10 copay retail $25 copay mail order	Not covered	Retail limited to up to a 30-day supply for retail; mail order limited to up to a 90-day supply. Preauthorization required for certain drugs or no coverage. No charge for certain preventive drugs.
	Preferred brand drugs	$25 copay retail $62.50 copay mail order	Not covered	
	Non-preferred brand drugs	$40 copay retail $100 copay mail order	Not covered	
	Specialty drugs	Retail covered as noted generic, preferred, and non-preferred	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	20% coinsurance after deductible	Preauthorization required.
	Physician/surgeon fees	No charge	20% coinsurance after deductible	--None--
If you need immediate medical attention	Emergency room services	$100 copay	$100 copay	Copay waived if admitted.
	Emergency medical transportation	$100 copay	20% coinsurance after deductible	Certain limitations in the use of air ambulance services
	Urgent care	$25 copay	20% coinsurance after deductible	The $25 copay applies to the visit only. If additional services are provided, additional out-of-pocket costs apply based on services received.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay	20% coinsurance after deductible	--None--
	Physician/surgeon fee	No charge after deductible	20% coinsurance after deductible	--None--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay	20% coinsurance after deductible	--None--
	Mental/Behavioral health inpatient services	$250 copay	20% Coinsurance after deductible	--None--
	Substance use disorder outpatient services	$20 copay	20% Coinsurance after deductible	--None--
	Substance use disorder inpatient services and Residential Treatment	$250 copay	20% Coinsurance after deductible	--None--
If you are pregnant	Prenatal and postnatal care	No charge after $20 copay	20% Coinsurance after deductible	Covered in full after initial $20 copay.
	Delivery and all inpatient services	$250 copay	20% Coinsurance after deductible	--None--

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$40 copay per visit	20% coinsurance after deductible	Limited to up to 200 visits per year.
	Rehabilitation services (PT/ST/OT)	$40 copay per visit	20% coinsurance after deductible	Limited to up to 80 visits per year. (Office visits PT/OT/ST combined)
	Habilitation services	Not covered	Not covered	--None--
	Skilled nursing care	$250 copay	20% coinsurance after deductible	Limited to up to 120 visits per year.
	Durable medical equipment	No charge	20% coinsurance after deductible	Preauthorization required.
	Hospice service (inpatient and outpatient)	No charge	20% coinsurance after deductible	Limited to lifetime maximum of 210 days
If your child needs dental or eye care	Eye exam	$20 copay	20% coinsurance after deductible	One (1) exam every 24 months
	Glasses	100% coinsurance up to $150 maximum every 24 months	100% coinsurance up to $150 maximum every 24 months	This maximum is applied over two coverage periods (24 months)
	Dental check-up	Not Covered	Not Covered	--None--

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Prescription Drugs
- Routine eye care (Adult)
- Some coverage provided outside the United States. See www.mvphealthcare.com

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan sponsor at (518) 580-5800. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: MVP Health Care, PO Box 2207, Schenectady, NY 12305 or 1-800-229-5851.

Additionally, a consumer assistance program can help you file your appeal. Contact Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010, (888) 614-5400 directly or www.communityhealthadvocates.org.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,850
- **Patient pays** $ 690

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$540
Coinsurance	$0
Limits or exclusions	$150
Total	**$690**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4650
- **Patient pays** $ 750

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$670
Coinsurance	$0
Limits or exclusions	$80
Total	**$750**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.