SKIDMORE COLLEGE

Traditional Blue
BlueShield of Northeastern New York

Skidmore College PPO Plan

Administered by BlueShield of Northeastern New York

BENEFITS	Traditional Blue PPO 898	
	In-Network	***Out-of-Network***
Copay	$15 co-pay	N/A
Inpatient Hospital Copay	$200 Individual $500 Family aggregate	N/A
Deductible	None	$200 Individual $500 Family aggregate
Coinsurance	None	20% Coinsurance
Out-of-Pocket Maximum	None	$1,500 Individual $3,000 Other than individual (Only Out of Network coinsurance applies)
Dependent Coverage (Includes eligible Domestic Partners and Dependents)	Spouses or Qualified Domestic Partners, and children to age 26 as long as they do not have healthcare benefits available through another employer other than as the dependent of a parent. (covered through end of birthday month)	
Inpatient Hospital - $200 individual/ $500 family aggregate inpatient co-pay		
Hospital Services	100% Coverage after IP co-pay	Deductible & coinsurance
Maternity	100% Coverage after IP co-pay	Deductible & coinsurance
Physical Rehab – 60 Days	100% Coverage after IP co-pay	Deductible & coinsurance
Mental Health and Alcohol & Substance Abuse Detox/Rehab	100% Coverage after IP co-pay	Deductible & coinsurance
Skilled Nursing Facility – 120 Days (after minimum 3-day hospital stay and admitted within 10 days of hospital discharge)	100% Coverage after IP co-pay	Deductible & coinsurance
Prior authorization is required for all Inpatient Hospital Stays		
Outpatient Hospital		
Preadmission Testing – within 7 days of admission	100% Coverage	Deductible & coinsurance
Emergency Room Care	$50 Co-pay (Co-pay waived if admitted)	
Alcohol & Substance Abuse – Outpatient services; includes visits for covered family members	$15 Co-pay	Deductible & coinsurance

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Diagnostic X-Rays, Labs & MRIs (*prior authorization for MRI*)	100% Coverage	Deductible & coinsurance
EEG and EKG/ECG	100% Coverage	Deductible & coinsurance
Chemotherapy	$15 Co-pay	Deductible & coinsurance
Hemodialysis	$15 Co-pay	Deductible & coinsurance
Radiation Therapy	$15 Co-pay	Deductible & coinsurance
Surgery – Outpatient (*prior authorization required for select procedures*)	$15 Co-pay	Deductible & coinsurance
Infertility - $10,000 maximum per family per calendar year	100% Coverage	Deductible & coinsurance
Medical Services		
Well Child Care & Immunizations to 19	100% Coverage	Deductible & coinsurance
Immunizations – Includes foreign travel & school	100% Coverage	Deductible & coinsurance
Doctor's Office Visit	$15 Co-pay	Deductible & coinsurance
Routine Physical 1 per calendar year	$15 Co-pay	Not covered
Routine OB/GYN 2 per calendar year	$15 Co-pay	Deductible & coinsurance
Cervical Cytology Screening	100% Coverage	Deductible & coinsurance
Mammogram – 1 baseline age 35 – 39 Annually 40 and older	100% Coverage	Deductible & coinsurance
Maternity	Covered in full after $15 Co-pay for initial visit	Deductible & coinsurance
Chiropractic Benefits - $1,500 maximum per calendar year	$15 Co-pay	Deductible & coinsurance
Mental Health – Outpatient	$15 Co-pay	Deductible & coinsurance
Alcohol & Substance Abuse – Outpatient services; includes visits for covered family members	$15 Co-pay	Deductible & coinsurance

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Inpatient Surgery – Physician	100% Coverage	Deductible & coinsurance
Surgical Assistant	100% Coverage	Deductible & coinsurance
Anesthesia Service	100% Coverage	Deductible & coinsurance
Oral Surgery	$15 Co-pay	Deductible & coinsurance
Cardiac Rehab 24 Visits in a 12 week period	$15 Co-pay	Deductible & coinsurance
Physical, Occupational & Speech Therapy – 80 visits aggregate	$15 Co-pay	Deductible & coinsurance
Diabetic Supplies & Education	$15 Co-pay	Deductible & coinsurance
Other Services		
Ambulance (Includes Air Ambulance)	$50 Co-pay	
Ambulatory Surgery Center	$15 Co-pay	Deductible & coinsurance
Durable Medical Equipment - $5,000 per calendar year (*prior authorization required on select items*).	100% Coverage	Deductible & coinsurance
Medical Supplies	100% Coverage	Deductible & coinsurance
Home Health Care & Home Infusion Therapy – 200 visits	$15 Co-pay	Deductible & coinsurance
Hospice	100% Coverage	Deductible & coinsurance
Post Mastectomy Prosthetics (1 every year; 2 if bilateral)	100% Coverage	Deductible & coinsurance
Prosthetics / Orthotics (*Prior authorization for select items*)	20%	Deductible & *50% coinsurance*
Urgent Care	$25 Co-pay	
Routine Eye Exam 1 exam every 2 years	$15 Co-pay	Deductible & coinsurance
Frames, Lenses & Contacts – $150 maximum for materials every two years	100% Coverage	100% Coverage

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	In-Network	*Out-of-Network*
Alternative Health Care *Acupuncture *Fitness Center Membership *Fitness Classes *Homeopathic *Hypnotherapy (weight control, 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	

- Out of Network providers are reimbursed up to the Usual and Customary allowance for eligible Hospital and Medical services. For out of network services, in addition to any applicable deductible and coinsurance, the patient is responsible for any amounts that exceed the Usual and Customary allowance.
- Preauthorization is required, but not limited to, all inpatient admissions; select outpatient procedures; home health care; select durable medical equipment; select prosthetics and orthotics; MRIs, MRAs, and Pet Scans.
- If readmitted within 90 days, the inpatient hospital co-pay does not apply.
- Maternity admissions include Nursery care up to 48 hours for normal delivery and 96 hours for C-section without additional inpatient co-pay for the newborn. Preauthorization is not needed for maternity stay unless complications necessitate longer than normal hospital stay noted above.
- For Prosthetics/Orthotics benefits: orthotics will not include footwear; prosthetic coverage includes repairs but not replacement, except for members under the age of 19.

PRESCRIPTION DRUG COVERAGE

Skidmore's prescription plan component for the PPO Plan is administered by informedRx. To view their formulary drug lists or check on any mail order prescriptions you may have ordered, please log on to: http://www.myinformedRx.com. You may call 1-800-880-1188 for information, or 1-800-881-1966 for mail order information. Please remember that any participating pharmacy information listed in BlueShield's literature does not apply to informedRx and Skidmore's PPO prescription plan. Because this is a separate company, you will receive an identification card for prescription coverage directly from informedRx (or SilverScript if you are a Medicare eligible retiree).

BENEFITS	In-Network	Out-Of-Network
Prescription Drugs Automatic Generic Fill Programs	informedRx (not a BlueShield Plan) $5 Employee co-pay for Generic; $20 or $35 employee co-pay for Brand Name; Mail Order Program for 90 day supply at 2x employee co-pay. http://www.myinformedRx.com SilverScript for Medicare eligible retirees https://skidmorecollege.silverscript.com	informedRx (not a BlueShield Plan) Out-Of-Network pharmacy will charge employee full cost of drug; Employee may not be reimbursed full cost of prescription if a participating Pharmacy was available.