



## Daemen College

### General Information

#### Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	\$0	\$1,000	
Deductible - Family	\$0	\$2,000	Each individual does not exceed the single deductible.
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	\$6,350	\$5,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	\$12,700	\$10,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

#### Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	\$25 Copayment	20% Coinsurance Subject to Deductible	



Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	\$25 Copayment	20% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).
Home Infusion Therapy	\$25 Copayment	20% Coinsurance Subject to Deductible	

## Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	\$25 Copayment	20% Coinsurance Subject to Deductible	

## Outpatient and Office Professional Services

### Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - \$25 Copayment \$0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	

Diagnostic X-ray

## Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	\$25 Copayment	20% Coinsurance Subject to Deductible	30 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	\$25 Copayment	20% Coinsurance Subject to Deductible	30 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	\$25 Copayment	20% Coinsurance Subject to Deductible	30 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

## Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	30 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	30 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	30 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

## Preventive Services

### Preventive Professional Services Meeting Federal Guidelines\*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

### Preventive Facility Services Meeting Federal Guidelines\*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	\$25 Copayment	20% Coinsurance Subject to Deductible	

## Other Benefits

### Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - Covered in Full	50% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

## Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Covered	Covered	\$4,000 Reimbursement Per Plan Year Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available

## Emergency Services

### ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	\$50 Copayment	\$50 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

### Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	\$50 Copayment	\$50 Copayment	

### Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	\$35 Copayment	\$35 Copayment	

## Ancillary Benefits

### Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Covered in Full	25% Coinsurance Subject to Deductible	1 Exam per contract year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Covered in Full	25% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

## Rx Benefits

### Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			\$10/\$50/\$100, \$0 Gen for Kids

### Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		

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This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

\* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.