Madison-Oneida-Herkimer HealthCare Consortium

2025/2026 Standard Platinum PPO Plan Benefit Change Summary

Plan Benefit and Cost Sharing Highlights		Madison-Oneida-Herkimer HealthCare Consortium Oneida City School District Current PPO Plan ($10/$20/$35 Rx Plan)		Madison-Oneida-Herkimer HealthCare Consortium Platinum PPO Plan		Effective 1/1/2026
Cost Sharing		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**Adopted**
Deductible	Individual	Not Applicable	$100	Not Applicable	$500	$1,000
	Family	Not Applicable	$300	Not Applicable	$1,500	$3,000
Deductible Aggregation Definition		Not Applicable	Each family member is only subject to the single deductible and any combination of family members can satisfy the family deductible. (Individual)	Not Applicable	Each family member is only subject to the single deductible and any combination of family members can satisfy the family deductible. (Individual)	
Out-of-Pocket Maximum **(Medical Plan Coinsurance and Copayments)**	Individual	$1,000 Combined In-Network (Medical) and Out-of Network (Medical)		$2,000 In-Network (Rx and Medical)	$4,000 Out-of-Network (Medical Only)	
	Family	$2,500 Combined In-Network (Medical) and Out-of Network (Medical)		$6,000 In-Network (Rx and Medical)	$12,000 Out-of-Network (Medical Only)	
Out-of-Pocket Maximum **(Rx Plan Copayments)**	Individual	$2,000 In-Network (Rx Copayments)	Not Applicable	Included in Medical Plan Out-of-Pocket Maximum	Not Applicable	
	Family	$6,000 In-Network (Rx Copayments)	Not Applicable	Included in Medical Plan Out-of-Pocket Maximum	Not Applicable	
Out-of-Pocket Maximum Aggregation Definition		Each family member is only subject to the single Out-of-Pocket Maximum and any combination of family members can satisfy the family Out-of-Pocket Maximum. (Individual)	Each family member is only subject to the single Out-of-Pocket Maximum and any combination of family members can satisfy the family Out-of-Pocket Maximum. (Individual)	Each family member is only subject to the single Out-of-Pocket Maximum and any combination of family members can satisfy the family Out-of-Pocket Maximum. (Individual)	Each family member is only subject to the single Out-of-Pocket Maximum and any combination of family members can satisfy the family Out-of-Pocket Maximum. (Individual)	
Annual Maximum		Unlimited	Unlimited	Unlimited	Unlimited	
Lifetime Maximum		Unlimited	Unlimited	Unlimited	Unlimited	

Madison-Oneida-Herkimer HealthCare Consortium

2025/2026 Standard Platinum PPO Plan Benefit Change Summary

Effective 1/1/2026

Plan Benefit and Cost Sharing Highlights	Madison-Oneida-Herkimer HealthCare Consortium Oneida City School District Current PPO Plan ($10/$20/$35 Rx Plan)		Madison-Oneida-Herkimer HealthCare Consortium Platinum PPO Plan	
Allowable Expense	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Facility In Excellus Service Area	Negotiated Amount (Member's cost share is based on lesser of charges or negotiated rate)	Excellus allows the lesser of 80% of the Medicare Prospective Payment System or 100% of Charge. If the service is not listed on the Medicare Prospective Payment System, Excellus allows 75% of Charge.	Negotiated Amount (Member's cost share is based on lesser of charges or negotiated rate)	Excellus allows the lesser of 80% of the Medicare Prospective Payment System or 100% of Charge. If the service is not listed on the Medicare Prospective Payment System, Excellus allows 75% of Charge.
Facility Outside Excellus Service Area	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows the lesser of 150% of the Medicare Prospective Payment System, 100% of the Blue Card Allowance, or 100% of the Charge. If the service is not listed on the Medicare Prospective Payment System, Excellus allows 75% of the Charge.	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows the lesser of 150% of the Medicare Prospective Payment System, 100% of the Blue Card Allowance, or 100% of the Charge. If the service is not listed on the Medicare Prospective Payment System, Excellus allows 75% of the Charge.
Professional Healthcare Provider In Excellus Service Area	Lower of Negotiated Amount or Charge	Excellus allows the lesser of 80% of the Medicare Provider Fee Schedule or 100% of Charge. If the service is not listed on the Medicare Provider Fee Schedule, Excellus allows 75% of Charge.	Lower of Negotiated Amount or Charge	Excellus allows the lesser of 80% of the Medicare Provider Fee Schedule or 100% of Charge. If the service is not listed on the Medicare Provider Fee Schedule, Excellus allows 75% of Charge.
Professional Healthcare Provider Outside Excellus Service Area	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows the lesser of 150% of the Medicare Provider Fee Schedule, 100% of the Blue Card Allowance, or 100% of Charge. If the service is not listed on the Medicare Provider Fee Schedule, Excellus allows 75% of Charge.	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows the lesser of 150% of the Medicare Provider Fee Schedule, 100% of the Blue Card Allowance, or 100% of Charge. If the service is not listed on the Medicare Provider Fee Schedule, Excellus allows 75% of Charge.
Emergency Facility In Excellus Service Area	Negotiated Amount (Member's cost share is based on lesser of charges or negotiated rate)	Excellus allows 100% of the Charge.	Negotiated Amount (Member's cost share is based on lesser of charges or negotiated rate)	Excellus allows 100% of the Charge.

Madison-Oneida-Herkimer HealthCare Consortium

2025/2026 Standard Platinum PPO Plan Benefit Change Summary

Plan Benefit and Cost Sharing Highlights	Madison-Oneida-Herkimer HealthCare Consortium Oneida City School District Current PPO Plan ($10/$20/$35 Rx Plan)		Madison-Oneida-Herkimer HealthCare Consortium Platinum PPO Plan		Effective 1/1/2026
Emergency Facility Outside Excellus Service Area	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows 100% of the Charge.	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows 100% of the Charge.	
Emergency Professional Healthcare Provider In Excellus Service Area	Lower of Negotiated Amount or Charge	Excellus allows 100% of the Charge.	Lower of Negotiated Amount or Charge	Excellus allows 100% of the Charge.	
Emergency Professional Healthcare Provider Outside Excellus Service Area	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows 100% of the Charge.	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows 100% of the Charge.	
Dialysis Facility In Excellus Service Area	Negotiated Amount (Member's cost share is based on lesser of charges or negotiated rate)	Excellus allows the lesser of 80% of the Medicare Prospective Payment System or 100% of Charge. If the service is not listed on the Medicare Prospective Payment System, Excellus allows 75% of Charge.	Negotiated Amount (Member's cost share is based on lesser of charges or negotiated rate)	Excellus allows the lesser of 80% of the Medicare Prospective Payment System or 100% of Charge. If the service is not listed on the Medicare Prospective Payment System, Excellus allows 75% of Charge.	
Dialysis Facility Outside Excellus Service Area	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows the lesser of 150% of the Medicare Prospective Payment System, 100% of the Blue Card Allowance, or 100% of the Charge. If the service is not listed on the Medicare Prospective Payment System, Excellus allows 75% of the Charge.	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows the lesser of 150% of the Medicare Prospective Payment System, 100% of the Blue Card Allowance, or 100% of the Charge. If the service is not listed on the Medicare Prospective Payment System, Excellus allows 75% of the Charge.	

Madison-Oneida-Herkimer HealthCare Consortium					
2025/2026 Standard Platinum PPO Plan Benefit Change Summary					
Plan Benefit and Cost Sharing Highlights	**Madison-Oneida-Herkimer HealthCare Consortium Oneida City School District Current PPO Plan ($10/$20/$35 Rx Plan)**		**Madison-Oneida-Herkimer HealthCare Consortium Platinum PPO Plan**		**Effective 1/1/2026**
Dialysis Professional Healthcare Provider In Excellus Service Area	Lower of Negotiated Amount or Charge	Excellus allows the lesser of 80% of the Medicare Provider Fee Schedule or 100% of Charge. If the service is not listed on the Medicare Provider Fee Schedule, Excellus allows 75% of Charge.	Lower of Negotiated Amount or Charge	Excellus allows the lesser of 80% of the Medicare Provider Fee Schedule or 100% of Charge. If the service is not listed on the Medicare Provider Fee Schedule, Excellus allows 75% of Charge.	
Dialysis Professional Healthcare Provider Outside Excellus Service Area	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows the lesser of 150% of the Medicare Provider Fee Schedule, 100% of the Blue Card Allowance, or 100% of Charge. If the service is not listed on the Medicare Provider Fee Schedule, Excellus allows 75% of Charge.	Lower of Negotiated Amount, Blue Card Allowance, or Charge	Excellus allows the lesser of 150% of the Medicare Provider Fee Schedule, 100% of the Blue Card Allowance, or 100% of Charge. If the service is not listed on the Medicare Provider Fee Schedule, Excellus allows 75% of Charge.	

Madison-Oneida-Herkimer HealthCare Consortium

2025/2026 Standard Platinum PPO Plan Benefit Change Summary

Plan Benefit and Cost Sharing Highlights		Madison-Oneida-Herkimer HealthCare Consortium Oneida City School District Current PPO Plan ($10/$20/$35 Rx Plan)		Madison-Oneida-Herkimer HealthCare Consortium Platinum PPO Plan		Effective 1/1/2026
Preventive Health Care Services		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Well Child Visits and Immunizations		Covered In Full	Covered In Full	Covered In Full	Covered In Full	
Adult Routine Physical Exams (1 Per Year)		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Adult Immunizations		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Routine Gynecological Exams		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Cervical Cytology Preventive		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Prostrate Cancer Screenings		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Mammography Preventive Facility and Professional		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Bone Density Testing Facility and Professional		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Colonoscopy Screening Facility and Professional		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Family Planning Services		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Pre/Post Natal Care		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Inpatient Facility Benefits		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Hospital Benefits	Unlimited Days	Covered In Full	20% After Deductible	$250 Copay	20% After Deductible	$500
Mental Health Care		Covered In Full	20% After Deductible	$250 Copay	20% After Deductible	$500
Mental Health Residential Care		Covered In Full	20% After Deductible	$250 Copay	20% After Deductible	$500
Substance Use Detoxification		Covered In Full	20% After Deductible	$250 Copay	20% After Deductible	$500
Substance Use Rehabilitation		Covered In Full	20% After Deductible	$250 Copay	20% After Deductible	$500
Substance Use Residential Care		Covered In Full	20% After Deductible	$250 Copay	20% After Deductible	$500
Skilled Nursing Facility	Limited to 45 Days Per Year In and Out-of Network Combined	Covered In Full	20% After Deductible	$250 Copay	20% After Deductible	$500
Inpatient Physical Rehabilitation	Limited to 60 Days Per Year In and Out-of Network Combined	Covered In Full	20% After Deductible	$250 Copay	20% After Deductible	$500

Madison-Oneida-Herkimer HealthCare Consortium					
2025/2026 Standard Platinum PPO Plan Benefit Change Summary					
Plan Benefit and Cost Sharing Highlights	**Madison-Oneida-Herkimer HealthCare Consortium Oneida City School District Current PPO Plan ($10/$20/$35 Rx Plan)**		**Madison-Oneida-Herkimer HealthCare Consortium Platinum PPO Plan**		**Effective 1/1/2026**
Maternity Care	Covered In Full	20% After Deductible	$250 Copay	20% After Deductible	$500
Routine Newborn Nursery Care	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Prosthetics - Implanted Devices	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Mastectomy	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Observation Stay	Covered In Full	20% After Deductible	$150 Copay	20% After Deductible	$300
Inpatient Professional Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Inpatient Hospital Surgery	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Anesthesia	Covered In Full	Covered In Full Up to Excellus Allowed Amount	Covered In Full	Covered In Full Up to Excellus Allowed Amount	
In-Hospital Physician Visits and Consults	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Outpatient Facility Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Surgical Centers and Free Standing Ambulatory Centers Surgical Care	Covered In Full	20% After Deductible	$150 Copay	20% After Deductible	$300
Colonoscopy Facility Diagnostic	Covered In Full	20% After Deductible	$150 Copay	20% After Deductible	$300
Pre-Admission / Pre-Operative Testing	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Diagnostic X-Rays	Covered In Full	20% After Deductible	$40 Copay	20% After Deductible	
Routine X-Rays	Covered In Full	20% After Deductible	$40 Copay	20% After Deductible	
Advanced Imaging Services	Covered In Full	20% After Deductible	$40 Copay	20% After Deductible	$100
Diagnostic Laboratory and Pathology	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	$25

Madison-Oneida-Herkimer HealthCare Consortium

2025/2026 Standard Platinum PPO Plan Benefit Change Summary

Plan Benefit and Cost Sharing Highlights		Madison-Oneida-Herkimer HealthCare Consortium Oneida City School District Current PPO Plan ($10/$20/$35 Rx Plan)		Madison-Oneida-Herkimer HealthCare Consortium Platinum PPO Plan	
Routine Laboratory and Pathology		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible
Diagnostic Testing		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible
Radiation Therapy		Covered In Full	20% After Deductible	$40 Copay	20% After Deductible
Chemotherapy		Covered In Full	20% After Deductible	$25 Copay	20% After Deductible
Infusion Therapy		Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service
Dialysis		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible
Injectable Drugs		Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service
Mental Health Care		$10 Copay	20% After Deductible	$25 Copay	20% After Deductible
Substance Use Care		Covered In Full	20% After Deductible	$25 Copay	20% After Deductible
Substance Use Family Counseling		Covered In Full	20% After Deductible	$25 Copay	20% After Deductible
Autism Applied Behavior Analysis		$10 Copay	20% After Deductible	$25 Copay	20% After Deductible
Pulmonary Rehabilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible
Cardiac Rehabilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible
Home Care and Hospice Care		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Home Care	Unlimited Medical Necessary Visits	Covered In Full	20% After $50 Deductible	Covered In Full	20% After $50 Deductible
Hospice Care Inpatient		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible
Hospice Care Outpatient		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible
Family Bereavement	Limited to 5 Visits Per Year	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible
Outpatient and Office Professional Services		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient Hospital and Ambulatory Surgery		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible
Office Surgery		$10 Copay	20% After Deductible	$25 PCP / $40 Spec Copay	20% After Deductible
Diagnostic X-Ray		Covered In Full	20% After Deductible	$40 Copay	20% After Deductible

Effective 1/1/2026

Madison-Oneida-Herkimer HealthCare Consortium					
2025/2026 Standard Platinum PPO Plan Benefit Change Summary					
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Routine X-Ray	Covered In Full	20% After Deductible	$40 Copay	20% After Deductible	
Advanced Imaging Services	Covered In Full	20% After Deductible	$40 Copay	20% After Deductible	
Diagnostic Laboratory and Pathology	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Routine Laboratory and Pathology	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Radiation Therapy	Covered In Full	20% After Deductible	$40 Copay	20% After Deductible	
Chemotherapy	Covered In Full	20% After Deductible	$25 Copay	20% After Deductible	
Infusion Therapy	Covered In Full	20% After Deductible	Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Injectable Drugs	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	
Mental Health Care	$10 Copay	20% After Deductible	$25 Copay	20% After Deductible	
Substance Use Treatment	Covered In Full	20% After Deductible	$25 Spec Copay	20% After Deductible	
Maternity Care	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Autism Applied Behavior Analysis	$10 Copay	20% After Deductible	$25 Copay	20% After Deductible	
Additional (Second) Surgical Opinion	$10 Copay	20% After Deductible	$25 PCP / $40 Spec Copay	20% After Deductible	
Second Medical Opinion for Cancer	$10 Copay	20% After Deductible	$25 PCP / $40 Spec Copay	20% After Deductible	
Pulmonary Rehabilitation	$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Office Visits - Diagnostic	$10 Copay	20% After Deductible	$25 PCP / $40 Spec Copay	20% After Deductible	
Medications Administration in Office	$10 Copay	20% After Deductible	Inclusive of Primary Service	Inclusive of Primary Service	
Eye Exams Diagnostic	$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Hearing Evaluation Diagnostic	$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Chiropractic Care	$10 Copay	20% After Deductible	$25 Copay	20% After Deductible	
Allergy Testing	$10 Copay	20% After Deductible	$25 PCP / $40 Spec Copay	20% After Deductible	

Madison-Oneida-Herkimer HealthCare Consortium						
2025/2026 Standard Platinum PPO Plan Benefit Change Summary						
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Allergy Treatment including Serum		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Hearing Evaluation Routine		Not Covered	Not Covered	$40 Copay	20% After Deductible	
Adult Hearing Aids		Not Covered	Not Covered	Not Covered	Not Covered	
Pediatric Hearing Aid Age Limit		Not Applicable	Not Applicable	Not Applicable	Not Applicable	
Pediatric Hearing Aid		Not Covered	Not Covered	Not Covered	Not Covered	
Cochlear Implants		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Rehab and Habilitation Services - Outpatient Facility		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Physical Rehabilitation	(45 / 60 Visits Per Year Rehab and Habilitation Services Combined)	$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Occupational Rehabilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Speech Rehabilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Physical Habilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Occupational Habilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Speech Habilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Rehab and Habilitation Services - Professional Services		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Physical Rehabilitation	(45 / 60 Visits Per Year Rehab and Habilitation Services Combined)	$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Occupational Rehabilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Speech Rehabilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Physical Habilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	

Madison-Oneida-Herkimer HealthCare Consortium						
2025/2026 Standard Platinum PPO Plan Benefit Change Summary						
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Occupational Habilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Speech Habilitation		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Other Benefits		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Treatment of Diabetes Insulin and Supplies **(INSULIN COVERED IN FULL)**		$10 Copay **(Insulin Covered in Full)**	20% After Deductible	$25 Copay **(Insulin Covered in Full)**	20% After Deductible	
Diabetic Education		$10 Copay	20% After Deductible	$25 Copay	20% After Deductible	
Diabetic Equipment		$10 Copay	20% After Deductible	$25 Copay	20% After Deductible	
Diabetic Retail Pharmacy	30 Day Supply Max	$30 Copay	20% After Deductible	$25 Copay	Not Covered	
Diabetic Mail-Order Pharmacy	90 Day Supply Max	$30 Copay	Not Covered	$50 Copay	Not Covered	
Autism Assistive Communication Device		$10 Copay	20% After Deductible	$25 Copay	20% After Deductible	
Autologous Blood Banking		Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	
Durable Medical Equipment (DME)		Covered In Full	20% After Deductible	20% Coinsurance	20% After Deductible	
Mastectomy Prosthesis		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Orthotics		Covered In Full	20% After Deductible	20% Coinsurance	20% After Deductible	
Foot Orthotics		Covered In Full	20% After Deductible	20% Coinsurance	20% After Deductible	
Prosthetic - External Benefit		Covered In Full	20% After Deductible	20% Coinsurance	20% After Deductible	
Prosthetic - Wigs External Benefit		Not Covered	Not Covered	Not Covered	Not Covered	
Breast Pump Purchase or Rental	1 Purchase Per Pregnancy	Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Medical Supplies		Covered In Full	20% After Deductible	20% Coinsurance	20% After Deductible	
Acupuncture	Limit of 10 Visits Per Year	Not Covered	Not Covered	$40 Copay	50% After Deductible	
Reproductive Services		Not Covered	Not Covered	Not Covered	Not Covered	
Private Duty Nursing		Not Covered	Not Covered	Not Covered	Not Covered	

Madison-Oneida-Herkimer HealthCare Consortium

2025/2026 Standard Platinum PPO Plan Benefit Change Summary

Plan Benefit and Cost Sharing Highlights		Madison-Oneida-Herkimer HealthCare Consortium Oneida City School District Current PPO Plan ($10/$20/$35 Rx Plan)		Madison-Oneida-Herkimer HealthCare Consortium Platinum PPO Plan		Effective 1/1/2026
PUVA Treatment		$10 Copay	20% After Deductible	Not Covered	Not Covered	
Nutritional Therapy		Not Covered	Not Covered	Not Covered	Not Covered	
Biofeedback		$10 Copay	20% After Deductible	Not Covered	Not Covered	
Emergency Services		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Emergency Room Care - Facility	waived if admitted to hospital	$35 Copayment	$35 Copayment	$150 Copayment	$150 Copayment	$300
Emergency Room Care - Professional		Covered In Full	Covered In Full	Covered In Full	Covered In Full	
Ambulance - Pre-Hospital Emergency Services Transportation (Ground)		Covered In Full	Covered in Full	$150 Copayment	$150 Copayment	$300
Air Ambulance		Covered In Full	Covered In Full	$150 Copayment	20% After Deductible	$300
Water Ambulance		Covered In Full	Covered In Full	$150 Copayment	$150 Copayment	$300
Urgent Care Center - Facility		$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Urgent Care Center - Professional Services		Covered In Full	20% After Deductible	Covered In Full	20% After Deductible	
Urgent Care Office Visit		$10 Copay	20% After Deductible	$25 PCP / $40 Spec Copay	20% After Deductible	
Vision Benefits		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Adult Routine Vision Exam	1 Per Year	$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Adult Eyewear		Not Covered	Not Covered	Not Covered	Not Covered	
Pediatric Routine Vision Exam	1 Per Year Children < age 19	$10 Copay	20% After Deductible	$40 Copay	20% After Deductible	
Pediatric Eyewear		Not Covered	Not Covered	Not Covered	Not Covered	
Total Health Management Programs		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Case Management Program		Applicable	Applicable	Applicable	Applicable	
Case Management Behavioral Health Program		Applicable	Applicable	Applicable	Applicable	
Disease Management Program		Applicable	Applicable	Applicable	Applicable	
Health Promotion		Applicable	Applicable	Applicable	Applicable	

Madison-Oneida-Herkimer HealthCare Consortium					
2025/2026 Standard Platinum PPO Plan Benefit Change Summary					
Plan Benefit and Cost Sharing Highlights	**Madison-Oneida-Herkimer HealthCare Consortium Oneida City School District Current PPO Plan ($10/$20/$35 Rx Plan)**		**Madison-Oneida-Herkimer HealthCare Consortium Platinum PPO Plan**		**Effective 1/1/2026**
Prescription Drug Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Retail Pharmacy (limited to a 30-day supply)	Tier 1 $10	Not Covered	Tier 1 $5	Not Covered	$10
	Tier 2 $20	Not Covered	Tier 2 $35	Not Covered	
	Tier 3 $35	Not Covered	Tier 3 $70	Not Covered	
Mail-Order Pharmacy (limited to a 90-day supply)	Tier 1 $20	Not Covered	Tier 1 $10	Not Covered	$20
	Tier 2 $40	Not Covered	Tier 2 $70	Not Covered	
	Tier 3 $70	Not Covered	Tier 3 $140	Not Covered	
$0 Generics for Children Less Than 19 Years of Age	Applicable	Not Covered	Applicable	Not Covered	
MAC Penalty (Mandatory Generic Substitution)	Applicable	Not Covered	Applicable	Not Covered	
Step Therapy	Applicable	Not Covered	Applicable	Not Covered	
Prior Authorization	Applicable	Not Covered	Applicable	Not Covered	
Generic Oral Contraceptives - Covered In Full	Applicable	Not Covered	Applicable	Not Covered	
Mandatory Mail-Order for Maintenance Medications	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
Monthly Premium Rates	**Individual**	**Family**	**Individual**	**Family**	
2025/2026 Fiscal Year	***$921.00***	***$2,296.00***	***$794.00***	***$1,982.00***	
Wellness Plan Included	***NO***		***YES***		
Health Savings Account Eligible	***NO***		***NO***		

*** The benefits outlined above are a summary of the benefits for the 2025/2026 Fiscal Year and are subject to change to keep the overall benefit equal to an ACA Platinum Level each year.**

*** Please refer to the actual insurance certificate or plan document for a detailed description of what is covered under this health insurance plan.**