Classic Blue benefits - $50/$150 Deductible
Greater Tompkins County Municipal Health Insurance Consortium

Excellus

Type of Care/Plan Benefits	Coverage
Plan features	
• **Primary Care Physician (PCP)**	• No copay, office visit covered subject to deductible and coinsurance
• **Referrals**	• Not required
• **Out of Network Benefits**	• Covered
• **Out of Area Benefits**	• Coverage provided worldwide through BlueCross BlueShield Global Core
• **Student/Dependent Coverage**	• Qualified dependents and students are covered to age 26
• **Domestic Partner**	• Covered
Plan cost-sharing highlights	
• **Office Visit Copay (Primary Care Physician)**	• No copay, office visit covered subject to deductible and coinsurance
• **Office Visit Copay (Specialist)**	• No copay, office visit covered subject to deductible and coinsurance
• **Coinsurance**	• 20%
• **Deductible**	• $50 individual / $150 family, enhanced benefits only
• **Coinsurance Out of Pocket Maximum**	• $400 Individual / $1,200 Family

Type of care/plan benefits	Coverage
Wellness Incentive	
• **Stay healthy with great programs and incentives!**	• Blue365 - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids.
Preventive Services	
• **Well Child Visits and Immunizations**	• Covered in full
• **Routine Physical Examinations**	• Covered in full, 1 exam per calendar year
• **Adult Immunizations**	• Covered in full
• **Routine Mammogram**	• Covered in full
• **Prostate Cancer Screening**	• Covered in full
• **Routine GYN & Cervical Screening**	• Covered in full
• **Bone Density Testing**	• Covered in full
• **Colonoscopy**	• Covered in full
Physician Office Services	
• **Diagnostic Office Visits & Diagnostic GYN Visits**	• Subject to deductible and coinsurance
• **Diagnostic Imaging, X-Rays, CAT, MRI**	• Covered in full
• **Diagnostic Laboratory and Pathology**	• Covered in full
• **Allergy Tests and Treatment**	• Subject to deductible and coinsurance
• **Allergy Injections**	• Subject to the deductible and coinsurance
• **Chemotherapy**	• Covered in full
• **Radiation Therapy**	• Covered in full
• **Chiropractic Care**	• Subject to the deductible and coinsurance
Maternity Services	
• **Prenatal Care**	• Covered in full
• **Maternity Care**	• Covered in full
• **Newborn Care**	• Covered in full
Prescription Drug	• $5/$15/$30 OOP Max $1,000/$3,000

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Type of Care/Plan Benefits	Coverage
Hospital Inpatient Services	
• **Hospital Benefits**	• Covered in full, unlimited days
• **Physician Visits in the Hospital**	• Covered in full
• **Inpatient Physical Rehabilitation**	• Covered in full, 30 days. (After basic benefit is exhausted, additional coverage will be payable at 100% of allowance not subject to Deductible)
• **Surgery**	• Covered in full
• **Anesthesia**	• Covered in full
Emergency Services	
• **Facility Emergency Room**	• Covered in full
• **Freestanding Urgent Care Center**	• Covered in full
• **Prehospital Emergency Services/Transportation**	• Covered in full
Hospital Outpatient Services	
• **Pre-admission/Pre-operative Testing**	• Covered in full
• **Diagnostic Imaging, X-Ray, CAT, MRI**	• Covered in full
• **Diagnostic Laboratory and Pathology**	• Covered in full
• **Surgical Care including Surgicenters & Freestanding Facilities**	• Covered in full
• **Chemotherapy**	• Covered in full
• **Radiation therapy**	• Covered in full
• **Dialysis**	• Covered in full
Mental Health Care and Substance Use	
• **Inpatient Mental Health Care**	• Covered in full, unlimited days
• **Outpatient Mental Health Care**	• Covered in full
• **Inpatient Substance Use, Detox, Rehab & Residential Care**	• Covered in full, unlimited days
• **Outpatient Substance Use Treatment**	• Covered in full
Other Services	
• **Treatment of Diabetes & Supplies *(insulin covered under ProAct)***	• Subject to deductible and coinsurance
• **Skilled Nursing Facility**	• Covered in full
• **Home Care**	• Covered in full, 60 visits per calendar year. (After basic benefit is exhausted, additional coverage subject to $50 deductible and 20% coinsurance up to 325 visits)
• **Hospice**	• Covered in full, (includes 5 bereavement counseling visits)
• **Covered Therapies (Physical, Speech and Occupational)**	• Subject to deductible and coinsurance, unlimited
• **Cardiac Rehabilitation & Pulmonary Rehabilitation Therapy**	• Covered in full,
• **Durable Medical Equipment (DME)**	• Subject to deductible and coinsurance
• **External Prosthetics/Orthotics**	• Subject to deductible and coinsurance
• **Medical Supplies**	• Subject to deductible and coinsurance
• **Diagnostic Hearing Exam**	• Subject to deductible and coinsurance, routine not covered
• **Diagnostic Eye Exam**	• Subject to deductible and coinsurance, routine not covered
• **Acupuncture**	• Not covered