



# Platinum vs. Silver Excellus BluePPO In-Network Plan Comparison Chart

GREATER TOMPKINS CO. MUNICIPAL HLTH INS CONS

\$10/\$35/\$70  
Benefit Time Period: 01/01/2026 - 12/31/2026

## General Information

Cost Sharing Expenses	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name			
Deductible - Single	\$0	\$3,200*	*Silver In-Network Individual and Family Deductibles covered by County-funded HRA.
Deductible - Family	\$0	\$6,400*	Silver Family: The entire family deductible must be met before copay/coinsurance applies to any individual family member.
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	\$3,000	\$8,000	Platinum and Silver: Out-of-pocket max accumulates coinsurance, copays and the deductible. Excludes balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	\$9,000	\$16,000	Platinum and Silver: Out-of-pocket max accumulates coinsurance, copays and the deductible. Excludes balances over allowable expense and non-covered services.

## Office Visit Cost Shares

Office Visit Cost Shares	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name			
Cost Share - Primary Care	\$15 Copayment	Deductible, then 20% Coinsurance	
Cost Share - Specialist	\$25 Copayment	Deductible, then 20% Coinsurance	

## Plan Limits

Plan Limits	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name			
Plan/Calendar Year			Platinum and Silver: Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			Platinum and Silver: Applies

## Who is Covered

Who is Covered	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name			
Domestic Partner Coverage			Platinum and Silver: Covered

## Inpatient Services

### Inpatient Facility

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Inpatient Hospital Services	\$350 Copayment	Deductible, then 20% Coinsurance	
Mental Health Care	\$350 Copayment	Deductible, then 20% Coinsurance	
Substance Use Detoxification	\$350 Copayment	Deductible, then 20% Coinsurance	
Skilled Nursing Facility	\$350 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: 200 Days per year. Limits are combined INN and OON.
Physical Rehabilitation	\$350 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: 60 Days per year. Limits are combined INN and OON.
Maternity Care	\$350 Copayment	Deductible, then 20% Coinsurance	

Inpatient Professional Services	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	Deductible, then 20% Coinsurance	
Anesthesia	PCP/Specialist - Covered in Full	Deductible, then 20% Coinsurance	Platinum and Silver: Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauthorization or referral.

## Outpatient Facility Services

Outpatient Facility Services	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	\$150 Copayment	Deductible, then 20% Coinsurance	
Diagnostic X-ray	\$30 Copayment	Deductible, then 20% Coinsurance	
Diagnostic Laboratory and Pathology	Covered in Full	Deductible, then 20% Coinsurance	
Radiation Therapy	\$25 Copayment	Deductible, then 20% Coinsurance	
Chemotherapy	\$15 Copayment	Deductible, then 20% Coinsurance	
Infusion Therapy Outpatient	Covered in Full	Deductible, then 20% Coinsurance	
Dialysis	Covered in Full	Deductible, then 20% Coinsurance	
Mental Health Care	\$15 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: Includes Partial Hospitalization
Substance Use Care	\$15 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: Includes Partial Hospitalization

## Home and Hospice Care

Home Care	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Home Care	Covered in Full	Deductible, then 20% Coinsurance	
Home Infusion Therapy	Covered in Full	Deductible, then 20% Coinsurance	

## Hospice Care

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	Deductible, then 20% Coinsurance	

## Outpatient and Office Professional Services

Professional Services	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Office Surgery	PCP - \$15 Copayment Specialist - \$25 Copayment	Deductible, then 20% Coinsurance	
Diagnostic X-ray	PCP/Specialist - \$30 Copayment	Deductible, then 20% Coinsurance	
Diagnostic Laboratory and Pathology	PCP/Specialist - \$30 Copayment	Deductible, then 20% Coinsurance	
Radiation Therapy	PCP/Specialist - \$25 Copayment	Deductible, then 20% Coinsurance	
Chemotherapy	PCP/Specialist - \$15 Copayment	Deductible, then 20% Coinsurance	
Infusion Therapy Services	PCP/Specialist - Covered in Full	Deductible, then 20% Coinsurance	
Dialysis	PCP/Specialist - Covered in Full	Deductible, then 20% Coinsurance	
Mental Health Care	PCP/Specialist - \$15 Copayment	Deductible, then 20% Coinsurance	
Maternity Care	PCP/Specialist - Covered in Full	Deductible, then 20% Coinsurance	
Telehealth	PCP - \$15 Copayment Specialist - \$25 Copayment	Deductible, then 20% Coinsurance	
TeleMedicine Program	PCP/Specialist - Covered in Full	Deductible, then Covered in Full	Platinum and Silver: Covers online consultations between the member and providers who participate in our MDLive TeleMedicine Program for medical and behavioral health conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - \$15 Copayment	Deductible, then 20% Coinsurance	
Allergy Testing	PCP - \$15 Copayment Specialist - \$25 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	Deductible, then 20% Coinsurance	Platinum and Silver: Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - \$25 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: 1 Exam per contract year Limits are combined INN and OON.

## Rehab and Habilitation

Outpatient Facility	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Physical Rehabilitation	\$25 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: 60 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	Deductible, then 20% Coinsurance	Platinum and Silver: 60 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	Deductible, then 20% Coinsurance	Platinum and Silver: 60 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	Platinum In Network	Silver In Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - \$25 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: 60 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	Deductible, then 20% Coinsurance	Platinum and Silver: 60 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	Deductible, then 20% Coinsurance	Platinum and Silver: 60 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	Platinum In Network	Silver In Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Platinum and Silver: 1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	

### Preventive Facility Services Meeting Federal Guidelines\*

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	
Mammography Screening Facility	Covered in Full	Covered in Full	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	
Bone Density Screening Facility	Covered in Full	Covered in Full	

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

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	
Bone Density Screening Professional	PCP/Specialist - \$25 Copayment	Deductible, then 20% Coinsurance	

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

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	Covered in Full	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	
Bone Density Screening Facility	\$25 Copayment	Deductible, then 20% Coinsurance	

## Other Benefits

Additional Benefits	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - \$15 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: Limited to a 30 day supply retail or a 90 day supply mail order.
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Platinum and Silver: Limited to a 30 day supply retail or a 90 day supply mail order.
Diabetic Equipment	PCP/Specialist - \$15 Copayment	Deductible, then 20% Coinsurance	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	Deductible, then 20% Coinsurance	
Medical Supplies	PCP/Specialist - 20% Coinsurance	Deductible, then 20% Coinsurance	
Acupuncture	PCP/Specialist - \$25 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: 10 Visits per contract year
Private Duty Nursing	Not Covered	Not Covered	

## Diagnoses

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	Not Covered	Not Covered	

## Emergency Services

ER Facility	Platinum In Network	Silver In Network	Limits and Additional Information
Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Facility Emergency Room Visit	\$250 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

## Transportation

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	\$150 Copayment	Deductible, then 20% Coinsurance	

## Urgent Care

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Urgent Care Center Facility Visit	\$40 Copayment	Deductible, then 20% Coinsurance	

## Ancillary Benefits

**Vision**

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Pediatric Eye Exams - Routine	\$25 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: 1 Exam per contract year Limits are combined INN and OON.
Pediatric Eyewear - Routine	20% Coinsurance	Deductible, then 20% Coinsurance	Platinum and Silver: 1 Pair per contract year Limits are combined INN and OON.
Adult Eye Exams - Routine	\$25 Copayment	Deductible, then 20% Coinsurance	Platinum and Silver: 1 Exam per contract year Limits are combined INN and OON.
Adult Eyewear - Routine	Covered	Covered	Platinum and Silver: \$100 Reimbursement per year Includes Frames/Lenses or Contact Lenses. Limits are combined INN and OON.

**Rx Benefits**

Rx Plan	Platinum In Network	Silver In Network	Limits and Additional Information
Rx Plan			Platinum and Silver: \$10/\$35/\$70 Silver: Deductible first, then co-pays above.

**Rx Benefits**

Benefit Name	Platinum In Network	Silver In Network	Limits and Additional Information
Days Supply Per Retail Order	30	30	
Days Supply Per Mail Order	90	90	
Copays Per Mail Order Supply	2	2	

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.