Excellus

Silver Excellus BluePPO Signature Deduct 3

$10/$35/$70 Integrated Rx

Benefit Time Period: 01/01/2026 - 12/31/2026

GREATER TOMPKINS CO. MUNICIPAL HLTH INS CONS

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$3,200	$5,000	
Deductible - Family	$6,400	$10,000	Deductible Single & Family Aggregation: Family - The entire family annual deductible must be met before copay or coinsurance is applied for any individual family member. If the family deductible amount exceeds the out of pocket maximum per person cap, the individual cannot contribute more than the out of pocket maximum per person cap amount for the plan year.
Coinsurance	20%	40%	
Annual Out of Pocket Maximum - Single	$8,000	$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.
Annual Out of Pocket Maximum - Family	$16,000	$20,000	Annual OOP Max Single & Family Aggregation: Individual - Each family member is only subject to the single Annual Out of Pocket Maximum any combination of family members can satisfy the family Annual Out of Pocket Maximum.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Cost Share - Specialist	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Mental Health Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Substance Use Detoxification	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Skilled Nursing Facility	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	200 Days per contract year Limits are combined INN and OON.
Physical Rehabilitation	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	60 Days per plan year Limits are combined INN and OON.
Maternity Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Anesthesia	Deductible, then 20% Coinsurance	$3,200 Deductible, then 40% Coinsurance	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Diagnostic X-ray	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Diagnostic Laboratory and Pathology	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Radiation Therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Chemotherapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Infusion Therapy Outpatient	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Dialysis	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Mental Health Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	Includes Partial Hospitalization
Substance Use Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Home Infusion Therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	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).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Diagnostic X-ray	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Diagnostic Laboratory and Pathology	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Radiation Therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Chemotherapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Infusion Therapy Services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Dialysis	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Mental Health Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Maternity Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Telehealth	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
MD Live TeleMedicine Program	Deductible, then Covered in Full	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Chiropractic Care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	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	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	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	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	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	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	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	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	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	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	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	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	Deductible, then 40% Coinsurance	1 Exam per plan year
Adult Immunizations	PCP/Specialist - Covered in Full	Deductible, then 40% Coinsurance	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	Deductible, then 40% Coinsurance	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	Deductible, then 40% Coinsurance	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	Deductible, then 40% Coinsurance	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	Deductible, then 40% Coinsurance	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	Deductible, then 40% Coinsurance	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Deductible, then 40% Coinsurance	
Mammography Screening Facility	Covered in Full	Deductible, then 40% Coinsurance	
Colonoscopy Screening Facility	Covered in Full	Deductible, then 40% Coinsurance	
Bone Density Screening Facility	Covered in Full	Deductible, then 40% Coinsurance	

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	Deductible, then 40% Coinsurance	
Mammography Screening Professional	PCP/Specialist - Covered in Full	Deductible, then 40% Coinsurance	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	Deductible, then 40% Coinsurance	
Bone Density Screening Professional	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	

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	Deductible, then 40% Coinsurance	
Colonoscopy Screening Facility	Covered in Full	Deductible, then 40% Coinsurance	
Bone Density Screening Facility	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Preventive	N/A	N/A	
Treatment of Diabetes - Non-Insulin Drugs and Supplies	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	Covered in Full	Deductible, then 40% Coinsurance	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Durable Medical Equipment (DME)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Medical Supplies	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	
Acupuncture	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	10 Visits per contract year
Private Duty Nursing	Not Covered	Not Covered	

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	Not Covered	Not Covered	

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	Deductible, then 20% Coinsurance	$3,200 Deductible, then 20% Coinsurance	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	Deductible, then 20% Coinsurance	$3,200 Deductible, then 20% Coinsurance	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	1 Exam per contract year Limits are combined INN and OON.
Pediatric Eyewear - Routine	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	1 Pair per contract year Limits are combined INN and OON.
Adult Eye Exams - Routine	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance	1 Exam per contract year Limits are combined INN and OON.
Adult Eyewear - Routine	Covered	Covered	$100 Reimbursement per contract year Includes Frames/Lenses or Contact Lenses. Limits are combined INN and OON.

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			Deductible, then $10/$35/$70

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	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.