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	$2/$10 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