Excellus

Simply Blue Copay
Contraceptives Only
Benefit Time Period: 01/01/2016 - 12/31/2016

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	$0	$500	
Deductible - Family	$0	$1,500	Each individual does not exceed the single deductible.
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	$2,000	$2,000	Out-of-pocket maximums accumulate the coinsurance amount and include the deductible , copay and Rx Copay ,including carry over deductible if applicable.
Annual Out of Pocket Maximum - Family	$6,000	$6,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$15 Copayment	20% Coinsurance Subject to Deductible	$0 copayment for dependents to age 19 on all In-Network PCP office visits.
Cost Share - Specialist	$25 Copayment	20% Coinsurance Subject to Deductible	

Plan Limits

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

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	$250 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	$250 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	$250 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$250 Copayment	20% Coinsurance Subject to Deductible	45 Days per year Limits are combined INN and OON.
Physical Rehabilitation	$250 Copayment	20% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	Covered in Full	20% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	Covered in Full	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	$150 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$25 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	Injectable drug copay applies
Mental Health Care	$25 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$25 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	20% Coinsurance Subject to $50 Deductible	40 Visits per year Limits are combined INN and OON.

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	20% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP - $15 Copayment Specialist - $25 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Injectable drug copay applies
Mental Health Care	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Chiropractic Care	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP - $15 Copayment Specialist - $25 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP - $15 Copayment Specialist - $25 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	1 Exam Per 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	$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per 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	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per 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	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

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	20% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	

Preventive Professional Services Not Meeting Federal Guidelines

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	

Preventive Facility Services Not Meeting Federal Guidelines

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$25 Copayment	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - $25 Copayment	20% Coinsurance Subject to Deductible	10 Visits per year Limits combined INN and OON.
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
OP Facility Emergency Room Visit	$150 Copayment	$150 Copayment	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	$150 Copayment	$150 Copayment	

Urgent Care Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$25 Copayment	20% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Eye Exams - Routine	$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eye Exams - Routine	$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per year Limits are combined INN and OON.
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			Contraceptives Only

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	NA		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by theterms 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 list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.