Excellus

Excellus BluePPO

Contraceptives Only

Benefit Time Period: 01/01/2016 - 12/31/2016

GREATER TOMPKINS CO MUNICPAL HLTH INS CONS

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$3,500	$3,500	
Deductible - Family	$7,000	$7,000	
Coinsurance	20%	40%	
Annual Out of Pocket Maximum - Single	$6,350	$6,350	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	$12,700	$12,700	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 - Per Person Cap	$6,550	$6,550	For family coverage, the entire Family Annual Out of Pocket Maximum must be met before family members receive covered services at no charge for the remainder of the year. An individual covered under a family plan will not exceed the Per Person Cap amount for that year, should the family out of pocket maximum level exceed the Per Person Cap.

Office Visit Cost Shares

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

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			No

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	120 Days per year
Physical Rehabilitation	Not Covered	Not Covered	Not Covered
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service Subject to Deductible	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	20% Coinsurance Subject to Deductible	40% 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	20% Coinsurance Subject to $50 Deductible	25% Coinsurance Subject to $50 Deductible	

Hospice Care

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

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP / Specialist - Inclusive of Primary Service Subject to Deductible	Inclusive of Primary Service Subject to Deductible	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chiropractic Care	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Allergy Testing	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% 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 - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% 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	40% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP / Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	40% 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	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% 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 - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Bone Density Screening Professional	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% 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	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	20% Coinsurance Subject to Deductible	40% 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 - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - Not Covered	Not Covered	Not Covered
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	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible	

Urgent Care Facility

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

Vision and Dental

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
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.