	Lansing CSD 2026/2027 Indemnity Plan ($150 Ded / $0/$10/$25 Rx Plan 3T2a)		Tompkins-Seneca-Tioga Schools Health Insurance Cooperative 2026/2027 Platinum PPO Plan	
Plan Overview				
Plan ID	Not Applicable		Not Applicable	
Plan Name	T-S-T Schools Health Ins. Cooperative Indemnity Plan (BDW)		T-S-T Schools Health Ins Cooperative 2026/2027 Platinum PPO Plan	
Plan Highlights	A deductible is applied only to all enhanced benefits. Preventative services are Covered in Full.		Deductible only applies to out-of-network covered medical and prescription drug benefits. Preventive services are Covered In Full. Plan includes the Blue4U Wellness Program.	
Plan Type	Indemnity		PPO	
HSA Eligible	No		No	
Quote Effective	07/01/2026 - 06/30/2027		07/01/2026 - 06/30/2027	
Rate ($)				
Single	$1,448.60		$1,077.64	
Family	$3,375.29		$2,510.84	
Total Cost	**$0.00**		**$0.00**	
Plan Features				
Primary Care Physician (PCP)	Not Required		Not Required	
Referrals	Not Required		Not Required	
Out-of-Network Benefits	Covered, as noted Patient may be responsible for Balance Billed Charges		Covered at 80% After Deductible	
Out-of-Area Benefits	Coverage provided worldwide through BlueCard® Network		Coverage provided worldwide through BlueCard® Network	
Student/Dependent coverage	Qualified dependents are covered to age 26		Qualified dependents are covered to age 26	
Domestic Partner	Not Covered		Not Covered	
Prior Authorization	None		Applies	
Wellness Incentives	None		Excellus Blue4U Program	
Plan Cost-Sharing Highlights				
Plan Cost-Sharing Highlights	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Primary Care Office Visit	Covered at 80% After Deductible	Covered at 80% After Deductible	$15 Copay Per Visit	Covered at 80% After Deductible
Specialist Office Visit	Covered at 80% After Deductible	Covered at 80% After Deductible	$40 Copay Per Visit	Covered at 80% After Deductible
Coinsurance	Covered at 80%	Covered at 80%	None	Covered at 80%
Deductible	In-Network and Out-of-Network Combined: $150 Individual / $450 Family		None	Out-of-Network: $1,000 Individual / $3,000 Family

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Out-of-Pocket Maximum	In-Network and Out-of-Network Combined: Medical Coinsurance = $400 Individual / $1,200 Family Rx Copayments = $1,000 Individual / $3,000 Family		In-Network: (Medical and Rx) $2,000 Individual / $6,000 Family	Out-of-Network: $4,000 Individual / $12,000 Family
Lifetime Maximum	None	None	None	None
Plan Benefits				
Preventive Healthcare Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Well Child Visits and Immunizations	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Adult Routine Physical Exams	Covered In Full (1 exam per plan year)	Covered In Full (1 exam per plan year)	Covered In Full (1 exam per plan year)	Covered at 80% After Deductible (1 exam per plan year)
+Adult Immunizations	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
+Mammography	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
+Pap Smear	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
Routine GYN Exam	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
+Prostate Cancer Screening	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
+Colonoscopy	Preventive Screenings Covered In Full	Preventive Screenings Covered In Full	Preventive Screenings Covered In Full	Covered at 80% After Deductible
+Family Planning Services	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
Physician Office Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits	Covered at 80% After Deductible	Covered at 80% After Deductible	$15 PCP Copay Per Visit; $40 Specialist Copay Per Visit	Covered at 80% After Deductible
Telemedicine Visits	Covered at 80% After Deductible	Not Covered	$10 Copay	Not Covered
Advanced Imaging Services (CT, PET Scans, MRI's)	Covered In Full	Covered In Full	$40 Copay Per Visit	Covered at 80% After Deductible
Diagnostic X-Rays	Covered In Full	Covered In Full	$40 Copay Per Visit	Covered at 80% After Deductible
Diagnostic Laboratory and Pathology	Covered In Full	Covered In Full	$15 Copay	Covered at 80% After Deductible
Allergy Tests	Covered at 80% After Deductible	Covered at 80% After Deductible	$15 PCP Copay Per Visit; $40 Specialist Copay Per Visit	Covered at 80% After Deductible

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Allergy Injections	Covered at 80% After Deductible	Covered at 80% After Deductible	Covered in Full	Covered at 80% After Deductible
Chemotherapy	Covered In Full	Covered In Full	$15 Copay Per Visit	Covered at 80% After Deductible
Radiation Therapy	Covered In Full	Covered In Full	$40 Copay Per Visit	Covered at 80% After Deductible
Maternity Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prenatal Care	Covered In Full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered In Full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered In Full (Cost share may apply to ultrasounds, lab work and sick visits)	Covered at 80% After Deductible
Hospital Care for Mom (including delivery)	Covered In Full	Covered In Full	$500 Copay Per Admission	Covered at 80% After Deductible
Newborn Nursery Care	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
Prescription Drug	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	Retail: $0/$10/$25 (90-days) Mail-Order: $0/$10/$25 (90-days) No Rx Edits	Not Covered	Retail: $10/$35/$70 (30-days) Mail-Order: $20/$70/$140 (90-days) Rx Edits	Not Covered
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital Benefits	Covered In Full	Covered In Full	$500 Copay Per Admission	Covered at 80% After Deductible
Physician Visits in the Hospital	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
Inpatient Physical Rehabilitation	Covered In Full	Covered In Full	$500 Copay Per Admission (Limited to 60-Days Per Cal. Yr.) (Combined In & OON)	Covered at 80% After Deductible (Limited to 60-Days Per Cal. Yr.) (Combined In & OON)
Surgery	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
Anesthesia	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency Room Care	Covered In Full	Covered In Full	$300 Copay Per Visit	$300 Copay Per Visit
Freestanding Urgent Care Center	Covered In Full	Covered In Full	$40 Copay Per Visit	Covered at 80% After Deductible
Ambulance	Covered In Full	Covered In Full	$300 copay	$300 copay

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Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic X-Rays	Covered In Full	Covered In Full	$40 Copay Per Visit	Covered at 80% After Deductible
Advanced Imaging Services (CT, PET Scans, MRI's)	Covered In Full	Covered In Full	$40 Copay Per Visit	Covered at 80% After Deductible
Diagnostic Laboratory and Pathology	Covered In Full	Covered In Full	$15 Copay	Covered at 80% After Deductible
Surgical Care Facility Fee	Covered In Full	Covered In Full	$150 Copay Per Visit	Covered at 80% After Deductible
Chemotherapy	Covered In Full	Covered In Full	$15 Copay Per Visit	Covered at 80% After Deductible
Radiation Therapy	Covered In Full	Covered In Full	$40 Copay Per Visit	Covered at 80% After Deductible
Mental Health and Substance Use	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient Mental Health Care	Covered In Full	Covered In Full	$500 Copay Per Admission	Covered at 80% After Deductible
Outpatient Mental Health Care	Covered In Full	Covered In Full	$15 Copay Per Visit	Covered at 80% After Deductible
Inpatient Substance Use	Covered In Full	Covered In Full	$500 Copay Per Admission	Covered at 80% After Deductible
Outpatient Substance Use	Covered In Full	Covered In Full	$15 Copay Per Visit	Covered at 80% After Deductible
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diabetic Drugs, Insulin, and Supplies (Insulin Covered In Full)	Covered In Full	Covered In Full	$15 Copay	Covered at 80% After Deductible
Skilled Nursing Facility	Covered In Full (Limited to 100-Days Per Cal. Yr.)	Covered In Full (Limited to 100-Days Per Cal. Yr.)	$500 Copay Per Admission (Limited to 45-Days Per Cal. Yr.) (Combined In & OON)	Covered at 80% After Deductible (Limited to 45-Days Per Cal. Yr. combined In & OON)
Home Care	Covered In Full (Limited to 60-Visits Per Cal. Yr.) After benefit is exhausted additional 325 days Covered at 80% After Deductible	Covered In Full (Limited to 60-Visits Per Cal. Yr.) After benefit is exhausted additional 325 days Covered at 80% After Deductible	Covered In Full	Covered at 80% After $50 Deductible
Hospice	Covered In Full	Covered In Full	Covered In Full	Covered at 80% After Deductible
Outpatient Therapy (Physical, Occupational, and Speech Therapy)	Covered at 80% After Deductible	Covered at 80% After Deductible	$40 Copay Per Visit (Limited to 45-Visits Per Cal. Yr.) (Combined In & OON)	Covered at 80% After Deductible (Limited to 45-Visits Per Cal. Yr.) (Combined In & OON)

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Durable Medical Equipment	Covered at 80% After Deductible	Covered at 80% After Deductible	Covered at 80%	Covered at 80% After Deductible
External Prosthetics	Covered at 80% After Deductible	Covered at 80% After Deductible	Covered at 80%	Covered at 80% After Deductible
Chiropractic	Covered at 80% After Deductible	Covered at 80% After Deductible	$15 Copay Per Visit	Covered at 80% After Deductible
Acupuncture	Not Covered	Not Covered	$40 Copay Per Visit (Limited to 10-Visits Per Cal. Yr.)	Covered at 50% After Deductible (Limited to 10-Visits Per Cal. Yr.)
Adult Hearing Aids	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Hearing Aids	Not Covered	Not Covered	Not Covered	Not Covered
Vision Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam (Annual)	Not Covered	Not Covered	$40 Copay Per Visit	Covered at 80% After Deductible
Adult Diagnostic Eye Exam	Covered at 80% After Deductible	Covered at 80% After Deductible	$40 Copay Per Visit	Covered at 80% After Deductible
Adult Eyewear	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Routine Vision Exam (Annual)	Not Covered	Not Covered	$40 Copay Per Visit	Covered at 80% After Deductible
Pediatric Eyewear	Not Covered	Not Covered	Not Covered	Not Covered
Dental Benefits				
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Major Dental Care & Medical Ortho	Not Covered	Not Covered	Not Covered	Not Covered
Accidental Dental - Outpatient Surgical	Covered. Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services	Covered. Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services	Covered. Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services	Covered. Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the

Federal 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 Federal Patient Protection and Affordable Care Act requirements.