	Municipal Health Insurance Consortium 2026 Platinum PPO Plan		Town of Mendon Current Plan Excellus SimplyBlue Plus Platinum 2	
Plan Overview				
Plan ID	Not Applicable		78124NY0980025-00 (TIX6)	
Plan Name	MHIC 2026 Platinum PPO Plan		SimplyBlue Plus Platinum 2	
Plan Highlights	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. Consortium Wellness Program.		Predictable out-of-pocket costs without a deductible, includes ThriveWell.	
Plan Type	Copay		Copay	
HSA Eligible	No		No	
Quote Effective	01/01/2026 - 12/31/2026		01/01/2026 - 03/31/2026	
Rate ($)				
Single	$1,127.82		$1,421.46	
Subscriber and Spouse	$2,932.39		$2,842.92	
Subscriber and Child(ren)	$2,932.39		$2,416.49	
Family	$2,932.39		$4,051.16	
Plan Features				
Primary Care Physician (PCP)	Not Required		Not Required	
Referrals	Not Required		Not Required	
Out-of-Network Benefits	80% Coverage of Excellus Allowable Expense After Deductible **Patient may be Responsible for Balance Billed Charges.**		80% Coverage of Excellus Allowable Expense After Deductible **Patient may be Responsible for Balance Billed Charges.**	
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	Covered		Covered	
Wellness Incentives	Excellus Blue4U Wellness Program Consortium Wellness Program		ThriveWell, a digital home base dedicated to engaging in health and wellbeing. This digital hub will include rewards of up to $200 per subscriber and $200 per spouse, or domestic parner, for a total rewards payout of $400 per plan year.	
Plan Cost-Sharing Highlights				
Plan Cost-Sharing Highlights	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Primary Care Office Visit	$15 Copay	80% Coverage After Deductible	$15 Copay	80% Coverage After Deductible
Specialist Office Visit	$25 Copay	80% Coverage After Deductible	$40 Copay	80% Coverage After Deductible
Coinsurance	None	20%	None	20%
Deductible	None	$1,000 Individual $3,000 Family	None	$5,000 Individual $10,000 Family
Out-of-Pocket Maximum	$3,000 Individual $6,000 Two- Person $9,000 Family	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 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	Covered In Full	Covered In Full	Covered In Full	80% Coverage After Deductible

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Adult Routine Physical Exams Limit 1 per year	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
+Adult Immunizations	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
+Mammography	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
+Pap Smear	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
Routine GYN Exam	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
+Prostate Cancer Screening	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
+Colonoscopy	Covered In Full Preventive Screenings	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
+Family Planning Services	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
Physician Office Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits - Diagnostic	$15 PCP / $25 Copay	80% Coverage After Deductible	$15 PCP / $40 Copay	80% Coverage After Deductible
TeleMedicine Program MD Live	Covered In Full	Not Covered	Covered In Full	Not Covered
Telederm MD Live	$25 Copay	Not Covered	$40 Copay	Not Covered
Diagnostic X-Ray	$30 Copay	80% Coverage After Deductible	$40 Copay	80% Coverage After Deductible
Advanced Imaging Services	$30 Copay	80% Coverage After Deductible	$100 Copay	80% Coverage After Deductible
Diagnostic Laboratory and Pathology	$30 Copay	80% Coverage After Deductible	$15 Copay	80% Coverage After Deductible
Allergy Testing	$15 PCP / $25 Copay	80% Coverage After Deductible	$15 PCP / $40 Copay	80% Coverage After Deductible
Allergy Treatment including Serum	Covered In Full	80% Coverage After Deductible	$15 PCP / $40 Copay	80% Coverage After Deductible
Chemotherapy	$15 Copay	80% Coverage After Deductible	$15 Copay	80% Coverage After Deductible
Radiation Therapy	$25 Copay	80% Coverage After Deductible	$40 Copay	80% Coverage After Deductible
Maternity Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Pre/Post Natal Care	Covered In Full	80% Coverage After Deductible	Covered In Full (Cost share may apply to ultrasounds, lab work and sick visits)	80% Coverage After Deductible
Maternity Care	$350 Copay	80% Coverage After Deductible	$500 Copay	80% Coverage After Deductible
Routine Newborn Nursery Care	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible

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Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital Benefits — Unlimited Days	$350 Copay	80% Coverage After Deductible	$500 Copay	80% Coverage After Deductible
In-Hospital Physician Visits and Consults	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
Inpatient Physical Rehabilitation	$350 Copay 60 Days Per Year	80% Coverage After Deductible 60 Days Per Year	$500 Copay 60 Days Per Year	80% Coverage After Deductible 60 Days Per Year
Inpatient Hospital Surgery	Covered In Full	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
Anesthesia	Covered In Full	Covered In Full Up to Excellus Allowed Amount	Covered In Full	80% Coverage After Deductible
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency Room Care	$250 Copay	$250 Copay	$300 Copay	$300 Copay
Ambulance	$250 Copay	$250 Copay	$300 Copay	$300 Copay
Urgent Care	$40 Copay	80% Coverage After Deductible	$40 Copay	80% Coverage After Deductible
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic X-Rays	$30 Copay	80% Coverage After Deductible	$40 Copay	80% Coverage After Deductible
Advanced Imaging Services	$30 Copay	80% Coverage After Deductible	$100 Copay	80% Coverage After Deductible
Diagnostic Laboratory and Pathology	$30 Copay	80% Coverage After Deductible	$15 Copay	80% Coverage After Deductible
Surgical Centers and Free Standing Ambulatory Centers Surgical Care	$150 Copay	80% Coverage After Deductible	$300 Copay	80% Coverage After Deductible
Chemotherapy	$15 Copay	80% Coverage After Deductible	$15 Copay	80% Coverage After Deductible
Radiation Therapy	$25 Copay	80% Coverage After Deductible	$40 Copay	80% Coverage After Deductible
Mental Health and Substance Use	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient Mental Health Care	$350 Copay	80% Coverage After Deductible	$500 Copay	80% Coverage After Deductible
Outpatient Mental Health Care	$15 Copay	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
Inpatient Substance Use Care	$350 Copay	80% Coverage After Deductible	$500 Copay	80% Coverage After Deductible
Outpatient Substance Use	$15 Copay	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Skilled Nursing Facility	$350 Copay 200 Days Per Year	80% Coverage After Deductible 200 Days Per Year	$500 Copay 200 Days Per Year	80% Coverage After Deductible 200 Days Per Year

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Home Care	Covered In Full Unlimited Visits	80% Coverage After $50 Deductible	$15 Copay 40 Visits Per Year	80% Coverage 40 Visits Per Year
Hospice	Covered In Full	80% Coverage After Deductible	$500 Copay 210 Visits Per Year	80% Coverage 210 Visits Per Year
Physical Rehabilitation	$25 Copay 60 Visits Per Year	80% Coverage After Deductible 60 Visits Per Year	$15 Copay 60 Visits Per Year	80% Coverage After Deductible 60 Visits Per Year
Occupational Rehabilitation	$25 Copay 60 Visits Per Year	80% Coverage After Deductible 60 Visits Per Year	$15 Copay 60 Visits Per Year	80% Coverage After Deductible 60 Visits Per Year
Speech Rehabilitation	$25 Copay 60 Visits Per Year	80% Coverage After Deductible 60 Visits Per Year	$15 Copay 60 Visits Per Year	80% Coverage After Deductible 60 Visits Per Year
Durable Medical Equipment (DME)	80% Coverage	80% Coverage After Deductible	50% Coverage	50% Coverage After Deductible
Prosthetic - External Benefit	80% Coverage	80% Coverage After Deductible	50% Coverage	50% Coverage After Deductible
Chiropractic Care	$15 Copay	80% Coverage After Deductible	$15 Copay	80% Coverage After Deductible
Acupuncture	$25 Copay 10 Visits Per Year	Covered at 50% After Deductible	$15 Copay 10 Visits Per Year	80% Coverage After Deductible
Hearing Evaluation Routine	$25 Copay	80% Coverage After Deductible		
Hearing Aids	50% Coverage		50% Coverage	
Vision Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam (Annual)	$25 Copay	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
Adult Eyewear	$100 Allowance Per Year (includes frames, lenses, and contact lenses)		$100 Allowance Per Year (includes frames, lenses, and contact lenses)	
Pediatric Routine Vision Exam (Annual)	$25 Copay	80% Coverage After Deductible	Covered In Full	80% Coverage After Deductible
Pediatric Eyewear (1 Paid Per Contract Year, Including Frames/Lenses or Contacts)	80% Coverage	80% Coverage After Deductible	50% Coverage	50% Coverage After Deductible
Dental Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	Not Covered	Not Covered	Preventive 100% Coverage Routine 80% Coverage	Preventive 100% Coverage Routine 80% Coverage After Deductible Subject to Balance Billing
Pediatric Major Dental Care & Medical Ortho	Not Covered	Not Covered	50% Coverage	50% Coverage After Deductible Subject to Balance Billing

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Accidental Dental - Outpatient Surgical	PCP/Specialist- Included	Not Covered	$300 Copay	80% Coverage
Prescription Drug	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Retail Pharmacy (limited to a 30-day supply)	Tier 1 $10	Not Covered	Tier 1 $10	Not Covered
	Tier 2 $35	Not Covered	Tier 2 $35	Not Covered
	Tier 3 $70	Not Covered	Tier 3 $70	Not Covered
Mail-Order Pharmacy (limited to a 90-day supply)	Tier 1 $20	Not Covered	Tier 1 $20	Not Covered
	Tier 2 $70	Not Covered	Tier 2 $70	Not Covered
	Tier 3 $140	Not Covered	Tier 3 $140	Not Covered
$0 Generics for Children Less Than 19 Years of Age	Not Applicable	Not Covered	Applicable	Not Covered
MAC Penalty (Mandatory Generic Substitution)	Not Applicable	Not Covered		Not Covered
Step Therapy	Applicable	Not Covered		Not Covered
Prior Authorization	Applicable	Not Covered		Not Covered
Generic Oral Contraceptives - Covered In Full	Applicable	Not Covered		Not Covered
Mandatory Mail-Order for Maintenance Medications	Not Applicable	Not Applicable		Not Applicable
Diabetic Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Treatment of Diabetes: Supplies	$15 Copay	80% Coverage After Deductible	$15 Copay	80% Coverage After Deductible
$0 Copay for Insulin	Applicable	Not Applicable	Applicable	Not Applicable

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.