Greater Tompkins County Municipal Health Insurance Consortium

2017 Standard Platinum vs. NYS Teamsters

Plan Benefit and Cost Sharing Highlights		Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan		Greater Tompkins County Municipal Health Insurance Consortium $10 PPO Plan	
Cost Sharing		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	Individual	$0	$500	$0	$250
	Family	$0	$1,500	$0	$750
Out-of-Pocket Maximum **(Medical Plan Coinsurance and Copayments)**	Individual	$2,000 In-Network (Rx and Medical)	$4,000 Out-of-Network (Medical Only)	$1,000 In and Out of Network (Medical Only)	
	Family	$6,000 In-Network (Rx and Medical)	$12,000 Out-of-Network (Medical Only)	$3,000 In and Out of Network (Medical Only)	
Coinsurance		N/A	20%	0%	20%
Out-of-Pocket Maximum **(Rx Plan Copayments)**	Individual	Combined with Medical - See Note	Not Applicable	Not Applicable	Not Applicable
	Family	Combined with Medical - See Note	Not Applicable	Not Applicable	Not Applicable
Annual Maximum		Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum		Unlimited	Unlimited	Unlimited	Unlimited
Preventive Health Care 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 (1 Per Year)		Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Adult Immunizations		Covered In Full	20% After Deductible	Covered In Full	Not Covered
Routine Gynecological Exams		Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Cervical Cytology Preventive		Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Prostrate Cancer Screenings		Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Mammography Preventive Facility and Professional		Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Bone Density Testing Facility and Professional		Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Colonoscopy Screening Facility and Professional		Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Family Planning Services		Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Pre/Post Natal Care		Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Inpatient Facility Benefits		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital Benefits (unlimited days)**		$250 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Mental Health Care**		$250 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Mental Health Residential Care**		$250 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Substance Use Detoxification**		$250 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount

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Substance Use Residential Care**	$250 Copay	20% After Deductible	Covered in Full	20% of Allowed Amount
Skilled Nursing Facility (Limited to 45 Days Per Year In and Out-of Network)	$250 Copay	20% After Deductible	Covered In Full (120 Days - In & Out of Network combined)	20% of Allowed Amount (120 Days - In & Out of Network combined)
Inpatient Physical Rehabilitation (Limited to 60 Days Per Year In and Out-of-Network)	$250 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Maternity Care	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Routine Newborn Nursery Care	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Prosthetics - Implanted Devices	Covered In Full	20% After Deductible	Included in Inpatient Services	20% of Allowed Amount

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2017 Standard Platinum vs. NYS Teamsters

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan		Greater Tompkins County Municipal Health Insurance Consortium $10 PPO Plan	
Mastectomy	$250 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Observation Stay	$150 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Inpatient Professional Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient Hospital Surgery	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Anesthesia	Covered In Full	Covered In Full	Covered In Full	20% of Allowed Amount
In-Hospital Physician Visits and Consults	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Outpatient Facility Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Surgical Centers and Free Standing Ambulatory Centers Surgical Care	$150 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Pre-Admission / Pre-Operative Testing	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Diagnostic and Routine X-Rays	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Advanced Imaging Services**	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Diagnostic and Routine Laboratory and Pathology	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Diagnostic Testing	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Radiation Therapy	$25 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Chemotherapy	$15 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Infusion Therapy**	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive to primary service	Inclusive to primary service
Dialysis	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Injectable Drugs	Inclusive of Primary Service	20% After Deductible	Inclusive to primary service	Inclusive to primary service
Mental Health Care	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Substance Use Care	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Substance Use Family Counseling	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Autism Applied Behavior Analysis	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Pulmonary Rehabilitation	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Cardiac Rehabilitation	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Home Care and Hospice Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Home Care (Limited to 40 Visits Per Year)**	Covered In Full	20% After $50 Deductible	Covered In Full	20% of Allowed Amount
Hospice Care Inpatient	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Hospice Care Outpatient	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Family Bereavement(Limited to 5 Visits Per Year)	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount

Greater Tompkins County Municipal Health Insurance Consortium **2017 Standard Platinum vs. NYS Teamsters**				
Plan Benefit and Cost Sharing Highlights	**Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan**		**Greater Tompkins County Municipal Health Insurance Consortium $10 PPO Plan**	
Outpatient and Office Professional Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient Hospital and Ambulatory Surgery	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Office Surgery	$15 PCP / $25 Spec Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Diagnostic X-Ray	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Routine X-Ray	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Advanced Imaging Services**	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Diagnostic Laboratory and Pathology	$25 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount

Greater Tompkins County Municipal Health Insurance Consortium

2017 Standard Platinum vs. NYS Teamsters

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan		Greater Tompkins County Municipal Health Insurance Consortium $10 PPO Plan	
Routine Laboratory and Pathology	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Radiation Therapy	$25 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Chemotherapy	$15 Copay	20% After Deductible	Covered In Full	20% of Allowed Amount
Infusion Therapy**	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive to primary service	Inclusive to primary service
Dialysis	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Injectable Drugs	$15 PCP / $25 Spec Copay	20% After Deductible	Inclusive to primary service	Inclusive to primary service
Mental Health Care	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Substance Use Treatment	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Maternity Care	Covered In Full	20% After Deductible	Covered in Full	20% of Allowed Amount
Autism Applied Behavior Analysis	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Additional (Second) Surgical Opinion	$15 PCP / $25 Spec Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Second Medical Opinion for Cancer	$15 PCP / $25 Spec Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Pulmonary Rehabilitation	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
TeleMedicine Program	Not Covered	Not Covered	$10 Copay	20% of Allowed Amount
Office Visits - Diagnostic	$15 PCP / $25 Spec Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Medications Administration in Office	$15 PCP / $25 Spec Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Eye Exams Diagnostic	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Hearing Evaluation Diagnostic	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Chiropractic Care	$15 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Allergy Testing	$15 PCP / $25 Spec Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Allergy Treatment including Serum	Covered In Full	20% After Deductible	Covered in Full	20% of Allowed Amount
Hearing Evaluation Routine	$25 Copay	20% After Deductible	Not Covered	Not Covered
Adult Hearing Aids	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit	Not Applicable	Not Applicable	N/A	N/A
Pediatric Hearing Aid - 1 Hearing Aide Every 3 Years	Not Covered	Not Covered	Not Covered	Not Covered
Cochlear Implants	Covered In Full	20% After Deductible	Covered in Full	20% of Allowed Amount
Rehab and Habilitation Services - Outpatient Facility	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

Greater Tompkins County Municipal Health Insurance Consortium **2017 Standard Platinum vs. NYS Teamsters**				
Plan Benefit and Cost Sharing Highlights	**Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan**		**Greater Tompkins County Municipal Health Insurance Consortium $10 PPO Plan**	
Physical Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Occupational Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Speech Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Physical Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Occupational Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Speech Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount

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2017 Standard Platinum vs. NYS Teamsters

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan		Greater Tompkins County Municipal Health Insurance Consortium $10 PPO Plan	
Rehab and Habilitation Services - Professional Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physical Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Occupational Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Speech Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Physical Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Occupational Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Speech Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Other Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Treatment of Diabetes Insulin and Supplies	$15 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Diabetic Education	$15 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Diabetic Equipment	$15 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Autism Assistive Communication Device	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Autologous Blood Banking	Not Covered	Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% Coinsurance	20% After Deductible	20% Coinsurance	20% of Allowed Amount
Mastectomy Prosthesis	Covered In Full	20% After Deductible	Covered in Full	20% of Allowed Amount
Orthotics	20% Coinsurance	20% After Deductible	20% Coinsurance	20% of Allowed Amount
Foot Orthotics	20% Coinsurance	20% After Deductible	20% Coinsurance	20% of Allowed Amount
Prosthetic - External Benefit	20% Coinsurance	20% After Deductible	20% Coinsurance	20% of Allowed Amount
Prosthetic - Wigs External Benefit	Not Covered	Not Covered	Not Covered	Not Covered
Medical Supplies	20% Coinsurance	20% After Deductible	Deductible/Coinsurance	20% of Allowed Amount
Acupuncture - 10 visits per year	$25 Copay	20% After Deductible	50% Coinsurance	50% of Allowed Amount
Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered
Emergency Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency Room Care - Facility (waived if admitted to hospital)	$150 Copayment	$150 Copayment	$35	$35 Copay
Emergency Room Care - Professional	Covered In Full	Covered In Full	Covered in Full	Covered In Full
Ambulance - Pre-Hospital Emergency Services Transportation (Ground)	$150 Copayment	$150 Copayment	$10 Copay	20% of Allowed Amount

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Air Ambulance	$150 Copayment	$150 Copayment	$10 Copay	20% of Allowed Amount
Water Ambulance	$150 Copayment	$150 Copayment	$10 Copay	20% of Allowed Amount
Urgent Care Center - Facility	$25 Copay	20% After Deductible	$25 Copay	20% of Allowed Amount
Urgent Care Center - Professional Services	Covered In Full	20% After Deductible	Covered In Full	20% of Allowed Amount
Urgent Care Office Visit	$15 PCP / $25 Spec Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Vision Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam (1 Per Year)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Adult Eyewear	Not Covered	Not Covered	$60 Per year - includes Frames/Lenses or Contact Lenses	
Pediatric Routine Vision Exam (1 Per Year Children Less Than 19 Years Old)	$25 Copay	20% After Deductible	$10 Copay	20% of Allowed Amount
Pediatric Eyewear	Not Covered	Not Covered	$60 Per year - includes Frames/Lenses or Contact Lenses	

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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: Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Emergency Care	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Preventive	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Endodontic	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Prosthodontics	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered
Prescription Drug Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Retail Pharmacy (limited to a 30-day supply)	Tier 1 $10	Not Covered		Not Covered
	Tier 2 $30	Not Covered		Not Covered
	Tier 3 $50	Not Covered		Not Covered
Mail-Order Pharmacy (limited to a 90-day supply)	Tier 1 $20	Not Covered		Not Covered
	Tier 2 $60	Not Covered		Not Covered
	Tier 3 $100	Not Covered		Not Covered
$0 Generics for Children Less Than 19 Years of Age	Applicable	Not Covered	Not Applicable	Not Covered
MAC Penalty (Mandatory Generic Substitution)	Applicable	Not Covered	N/A	Not Covered
Step Therapy	Applicable	Not Covered	N/A	Not Covered
Prior Authorization	Applicable	Not Covered	N/A	Not Covered
Generic Oral Contraceptives - Covered In Full	Applicable	Not Covered	Applicable	Not Covered
Mandatory Mail-Order for Maintenance Medications	Not Applicable	Not Applicable	N/A	Not Applicable
Monthly Premium Rates	**Individual**	**Subscriber and Spouse**	**Individual**	**Subscriber and Spouse**
2017 Fiscal Year	***$576.63***	***Not Applicable***		***Not Applicable***
	Subscriber and Children	**Family**	**Subscriber and Children**	**Family**
	Not Applicable	***$1,499.25***	***Not Applicable***	
Wellness Plan Included	***YES***		***YES***	
Health Savings Account Eligible	***NO***		***YES***	

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Plan Benefit and Cost Sharing Highlights	**Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan**	**Greater Tompkins County Municipal Health Insurance Consortium $10 PPO Plan**

***** Prior Authorization applies to all Inpatient Admissions excluding maternity and Emergency Admissions only.Pre-cert is required for home health, infusion therapy, DME > $200, MRI, CAT Scans, PET Scans for the $10 PPO Plan.***

*** The benefits outlined above are a summary of the benefits for the 2017 Fiscal Year and are subject to change to keep the overall benefit equal to an ACA Platinum Level each year.**

*** Please refer to the actual insurance certificate or plan document for a detailed description of what is covered under this health insurance plan.**