The Greater Tompkins County Municipal Health Insurance Consortium
Indemnity Benefit Plan

Draft 5/3/09

Benefit Type	Benefit Description	
WHO IS COVERED		
Type of Premium Tiers • individual • family	**2-Tier (Individual and Family)**	
Dependent Coverage • Age to which dependents covered • Age to which students covered	**Dependent to 19th Birthday** **Student to 25th Birthday**	
Domestic Partner	**Covered**	
WAITING PERIODS Pre-Existing Condition Waiting Period	**No – waived**	
Pre-Certification	**Not Required**	
COST SHARING EXPENSES		
Deductible Individual / Family	**Group Specific**	**When services are rendered by an Out of Network Provider, member is responsible for difference between in-network Allowed Amount and the Out of Network provider charge.**
Deductible Carry-Over Y/N	**Yes**	
Coinsurance	**20% of Allowed Amount**	
Annual Out-of-Pocket Maximum (excludes deductible, and co-payments)	**Group Specific**	
Lifetime Benefit Maximum	**Group Specific**	
Benefit Type	**Benefit Description**	
BASIC COVERAGE	***In Network***	***Out of Network***
Inpatient Hospital Services • Inpt. Adm. for mastectomy must be covered for as long as attending physician deems medically necessary) (365 days per Calendar Year)	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Acute Mental Health Care Includes Partial Hospital 3:1 days. (Mandate: 30 days per calendar year, coverage equal to Inpatient Hospital Services)	**Mandatory Rider** **Covered in Full – 30 Inpatient Days**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 30 Days**
Acute Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	**Coverage is inclusive with Inpatient Hospital Services.**	

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BASIC COVERAGE (Con't)	***In Network***	***Out of Network***
Residential Treatment	**Not Covered**	**Not Covered**
Inpatient Detoxification (7 days per Calendar Year)	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Skilled Nursing Facility	**Covered in Full 365 days per calendar year**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount** – 365 Days
Inpatient Physical Rehabilitation	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Inpatient Chemical Dependence and Abuse Rehabilitation (49 days per Calendar Year)	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Inpatient Maternity Care (Mandated, 48 hrs regular delivery, 96 for c-section; one home care visit covered in full, not subject to any other home care visit limitations)	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Newborn Nursery Care	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Internal Prosthetics	**Included in inpatient services**	
MEDICAL/SURGICAL COVERAGE	***In Network***	***Out of Network***
Surgical Care including Surgicenters/Freestanding	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Pre-admission/Pre-Operative Testing (Mandated benefit; same as inpatient)	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Diagnostic Imaging, Diagnostic Testing, X-ray, CAT, MRI	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Diagnostic Laboratory and Pathology	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Radiation Therapy and Chemotherapy	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Hemodialysis	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Routine Mammogram	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Cervical Cytology (Pap Smear, does not include exam)	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Chemical Dependency (Mandated 60 visits, includes 20 family visits; should be on par with inpatient)	**Covered in Full 60 Visits**	**Covered in full – 60 Visits Member responsible for difference between Provider Charge and Allowed Amount**
Physical Therapy/Respiratory Therapy	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Surgery/Assistant Surgeon	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**

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MEDICAL/SURGICAL COVERAGE (Con't)	***In Network***	***Out of Network***
Cardiac Rehabilitation	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Home Health Care	**Covered in Full – 40 Visits**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 40 Visits**
Hospice Care (Includes 5 bereavement counseling visits) (210 visits per Calendar Year)	**Covered in Full**	**80% – Member responsible for difference between Provider Charge and Allowed Amount**
Emergency Room	**Covered in Full**	**Covered in Full**
Ambulance	**Deductible/80%**	**Deductible/80%**
Urgent Care	**Covered in Full**	**Covered in Full**
MAJOR MEDICAL COVEAGE	***In Network***	***Out of Network***
Inpatient Hospital – Additional Days	**Covered in Full**	**Coinsurance**
Skilled Nursing – Additional Days	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Elective Sterilization	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Surgery – IP Physician	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Surgery – OP Physician	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Consultation - Inpatient	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Anesthesia	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Additional Surgical Opinion (mandate)	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
In Hospital Medical Care	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Emergency Care	**Covered in Full**	**Covered in Full**
Adult Routine Physical 1 Per Calendar Year	**Covered in Full**	**Not Covered**
X-rays	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Lab Tests	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Maternity	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
In-Hospital Physician Visits (IHM for mastectomy must be covered for as long as attending physician deems medically necessary)	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Skilled Nursing Care	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**

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Benefit Type	Benefit Description	
MAJOR MEDICAL COVERAGE (Con't)	***In Network***	***Out of Network***
Well Child Visits and Immunizations (mandated visits/immunizations full coverage)	**Covered in full**	**Covered in full**
Adult Immunizations	**Not Covered**	**Not Covered**
Cervical Cancer Screen	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Chemotherapy	**Covered in Full**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Office Visits	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Chiropractic Visits	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Eye Exams - Diagnostic	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Hearing Evaluations Routine	**Not Covered**	**Not Covered**
Hearing Aids	**Not Covered**	**Not Covered**
Durable Medical Equipment	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Prosthetics	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Medical Supplies – including Diabetic Equipment and Supplies	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Office Consultations	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Home Care 325 Visit Max	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Prostate Cancer Screenings (Mandated if office visits covered; coverage must be equal to office visits)	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Routine GYN Visits including Pap Smear (Mandated; same as other basic physician services; co-payment allowed on PPO)	**Covered In Full, including Lab**	**Covered in full – Member responsible for difference between Provider Charge and Allowed Amount**
Diagnostic GYN Visits	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**

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MAJOR MEDICAL COVERAGE (Con't)	***In Network***	***Out of Network***
Speech Therapy	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Allergy Testing and Treatment (Injections are inclusive)	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Mental Health Care (Federal Mandate – Unique financial limits not imposed on other benefits prohibited. NYS Mandate – 20 visits per calendar year combined with physician, coverage equal to diagnostic office visit,)	**Deductible/Coinsurance**	**Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount**
Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	**Coverage is equivalent to Diagnostic Office visits.**	
Prescription Drugs (If Rx covered, enteral nutrition mandated; coverage must be equal to all other drugs; certain formulas capped at $2,500 annually.)	**Covered – see RX options**	**Not covered**
CLUSIONS:		
Acupuncture	**Excluded**	
Blood products	**Excluded**	
Certification Examinations	**Excluded**	
Cosmetic Services	**Excluded**	
Custodial Care	**Excluded**	
Dental (non-accidental services)	**Excluded**	
Developmental Delay	**Excluded**	
Experimental and Investigational Services	**Excluded**	
Free Care	**Excluded**	
Hypnosis/Biofeedback	**Excluded**	
Military Service-Connected Conditions	**Excluded**	
No-Fault Automobile Insurance	**Excluded**	
Nutritional Therapy	**Excluded**	
Private Duty Nursing	**Excluded**	
Reproductive Procedures	**Excluded**	
Reversal of elective sterilization	**Excluded**	
Routine Care of the Feet	**Excluded**	
Self-Help Diagnosis, Training, and Treatment	**Excluded**	
Smoking Cessation Programs	**Excluded**	
Transsexual Surgery and Related Services	**Excluded**	
Weight Loss Services	**Excluded**	

Note: This benefit grid provides a summary of benefits only and does not, nor is it intended to, replace the legal contract.

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*Payments for all out-of-network benefits are based on participating provider allowances. Any difference between the allowance and the out-of-network provider's actual charge is the responsibility of the member, in addition to any applicable deductible, copayment or coinsurance amounts.

Consortium Options Available

	Major Medical Deductibles	
Consortium Plan Options	**Individual**	**Family**
Deductible Plan 1 (Current Plan)	$50.00	$150.00
Deductible Plan 2 (Current Plan)	$100.00	$200.00
Deductible Plan 3 (Current Plan)	$100.00	$250.00
Deductible Plan 4 (Current Plan)	$100.00	$300.00
Deductible Plan 5	$150.00	$450.00
Deductible Plan 6	$250.00	$750.00

	Out of Pocket Maximums	
Consortium Plan Options	**Individual**	**Family**
Out –of-Pocket Plan 1 (Current Plan)	$ 400.00	$1,200.00
Out –of-Pocket Plan 2 (Current Plan)	$ 750.00	$3,750.00
Out –of-Pocket Plan 3	$1,000.00	$3,000.00
Out –of-Pocket Plan 4	$1,500.00	$4,500.00

Consortium Plan Options	**Lifetime Maximums**
Lifetime Maximum Plan 1 (Current Plan)	$1,000,000
Lifetime Maximum Plan 2 (Current Plan)	$2,000,000
Lifetime Maximum Plan 3	Unlimited

	Retail Pharmacy Benefit			**Mail-Order Benefit**		
Possible Consortium Plan Options	**Tier I**	**Tier II**	**Tier III**	**Tier I**	**Tier II**	**Tier III**
2-Tier Plan 1 (Current Plan)	$1.00	$1.00	$1.00	$0.00	$0.00	$0.00
2-Tier Plan 2 (Current Plan)	$2.00	$5.00	$5.00	$0.00	$0.00	$0.00
2-Tier Plan 3 (Current Plan)	$2.00	$10.00	$10.00	$0.00	$0.00	$0.00
2-Tier Plan 4	$0.00	$15.00	$15.00	$0.00	$30.00	$30.00
2-Tier Plan 5	$5.00	$15.00	$15.00	$10.00	$30.00	$30.00
2-Tier Plan 6	$5.00	$20.00	$20.00	$10.00	$40.00	$40.00
3-Tier Plan 1 (Current Plan)	$5.00	$10.00	$25.00	$10.00	$20.00	$50.00
3-Tier Plan 2 (Current Plan)	$5.00	$10.00	$25.00	$15.00	$30.00	$75.00
3-Tier Plan 3 (Current Plan)	$5.00	$15.00	$30.00	$10.00	$30.00	$60.00
3-Tier Plan 4 (Current Plan)	20%	30%	50%	20%	30%	50%
3-Tier Plan 5	$0.00	$5.00	$20.00	$0.00	$10.00	$40.00
3-Tier Plan 6	$5.00	$20.00	$35.00	$10.00	$40.00	$70.00
3-Tier Plan 7	$10.00	$20.00	$35.00	$20.00	$40.00	$70.00
3-Tier Plan 8	$15.00	$30.00	$45.00	$30.00	$60.00	$90.00