The Greater Tompkins County Municipal Health Insurance Consortium
PPO Benefit Plan

Benefit Type	Benefit Description	
	• PPO In Network	• PPO Out-of-Network
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**	
MEDICAL NECESSITY		
Pre-Certification	**Pre-Certification Applies to:** **All Inpatient admissions, excluding maternity, home health care, infusion therapy, Durable Medical Equipment (DME) over $200, MRI, CAT scans, and PET scans.**	
COST SHARING EXPENSES		
Deductible Individual / Family	**None**	**$250 / $750**
Deductible Carry-Over Y/N	**No**	**No**
Co-Payment	**$10, except where noted**	**None**
Coinsurance	**None**	**20%, except where noted**
Annual Out-of-Pocket Maximum (includes deductible, excludes co-payment)	**None**	**$1,000/$3,000** **Includes deductible and coinsurance, no co-payment. Excludes artificial insemination and prescription drugs.**
Lifetime Benefit Maximum	**None**	**None**
HOSPITAL INPATIENT SERVICES		
Inpatient Hospital Services • Inpt. Adm. for mastectomy must be covered for as long as attending physician deems medically necessary) (Unlimited days per Calendar Year)	**Covered in Full**	**Deductible/Coinsurance**

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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**	**Mandatory Rider** **Deductible/Coinsurance**
Acute Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	**Coverage is inclusive with Inpatient Hospital Services.**	
Residential Treatment	**Not Covered**	**Not Covered**
Detoxification (7 days per Calendar Year)	**Covered in Full**	**Deductible/Coinsurance**
Skilled Nursing Facility	**Covered in Full** **120 days per calendar year**	**Deductible/Coinsurance** **120 days per calendar year**
Physical Rehabilitation (60 days per Calendar Year)	**Not Covered**	**Not Covered**
Chemical Dependence and Abuse Rehabilitation (30 days per Calendar Year) (2 admissions per Life)	**Covered in Full**	**Deductible/Coinsurance**
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**	**Deductible/Coinsurance**
Newborn Nursery Care	**Covered in Full**	**Deductible/Coinsurance**
Internal Prosthetics	**Included in inpatient services**	
HOSPITAL OUTPATIENT SERVICES		
Surgical Care including Surgicenters/Freestanding	**Co-Payment**	**Deductible/Coinsurance**
Pre-admission/Pre-Operative Testing (Mandated benefit; same as inpatient)	**Covered in Full**	**Deductible/Coinsurance**
Diagnostic Imaging, X-ray, CAT, MRI	**Co-Payment**	**Deductible/Coinsurance**
Diagnostic Laboratory and Pathology	**Covered in Full**	**Deductible/Coinsurance**
Radiation Therapy and Chemotherapy	**Covered in Full**	**Deductible/Coinsurance**
Hemodialysis	**Covered in Full**	**Deductible/Coinsurance**
Mammogram	**Covered in Full**	**Deductible/Coinsurance**
Cervical Cytology (Pap Smear, does not include exam)	**Covered in Full**	**Deductible/Coinsurance**
Mental Health Care (Federal Mandate – Unique financial limits no imposed on other benefits prohibited. NYS Mandate – 20 visits per calendar year combined with physician, coverage equal to diagnostic office visit, if OV not covered coverage equal to CD)	**Co-Payment**	**Deductible/Coinsurance**

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Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	**Coverage is equivalent to Diagnostic Office visits.**	
Chemical Dependency (Mandated 60 visits, includes 20 family visits; should be on par with inpatient)	**Co-Payment**	**Deductible/Coinsurance**
Covered Therapies (Includes aggregate of [45] per calendar year of Physical, Speech, Occupational and Respiratory Therapy)	**Co-Payment**	**Deductible/Coinsurance**
Cardiac Rehabilitation	**Co-Payment**	**Deductible/Coinsurance**
HOME CARE (Mandated; benefits of not less than 40 4 hr. visits per 12 month period, no more than 25% coinsurance & no more than $50 deductible) (Unlimited visits per Calendar Year)	**Covered in Full**	**$50 Ded/20% Coins**
HOSPICE CARE (Includes 5 bereavement counseling visits) (Unlimited visits per Calendar Year)	**Covered in Full**	**Deductible/Coinsurance**
PHYSICIAN SERVICES		
Inpatient Hospital Surgery	**Covered in Full**	**Deductible/Coinsurance**
Outpatient Hospital & Ambulatory Surgery	**Covered in Full**	**Deductible/Coinsurance**
Office Surgery	**Co-Payment**	**Deductible/Coinsurance**
Covered Therapies (Includes aggregate of [45] per calendar year of Physical, Speech, Occupational and Respiratory Therapy)	**Co-Payment**	**Deductible/Coinsurance**
Anesthesia	**Covered in Full**	**Deductible/Coinsurance**
Additional Surgical Opinion (mandate)	**Co-Payment**	**Deductible/Coinsurance**
Second Medical Opinion (mandated for cancer; cover same as office visit)	**Co-Payment**	**Deductible/Coinsurance**
Normal Pregnancy	**Covered in Full**	**Deductible/Coinsurance**
Prenatal and Postpartum Care	**Co-Payment for initial visit, then covered in full**	**Deductible/Coinsurance**
Complications of Pregnancy and Termination	**Covered in Full**	**Deductible/Coinsurance**
Delivery Anesthesia	**Covered in Full**	**Deductible/Coinsurance**
In-Hospital Physician Visits (IHM for mastectomy must be covered for as long as attending physician deems medically necessary)	**Covered in Full**	**Deductible/Coinsurance**

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Physician's Office – Preventive Services		
Routine Physical Examinations (1 per Calendar Year)	**Co-Payment**	**Deductible/Coinsurance**
Well Child Visits and Immunizations (mandated visits/immunizations full coverage)	**Covered in full**	**Covered in full**
Adult Immunizations	**Not Covered**	**Not Covered**
Physician's Office - Other Services		
Diagnostic Laboratory and Pathology	**Covered in Full**	**Deductible/Coinsurance**
Eye Exams Routine	**Co-Payment** **1 per Calendar Year**	**Deductible/Coinsurance** **1 per Calendar Year**
Eyewear Routine (must purchase eye exam)	**$60 allowance** **1 per Calendar year**	**$60 allowance** **1 per Calendar year**
Eye Exams - Diagnostic	**Co-Payment**	**Deductible/Coinsurance**
Hearing Evaluations Routine	**Not Covered**	**Not Covered**
Hearing Evaluations Diagnostic	**Co-Payment**	**Deductible/Coinsurance**
Hearing Aids (Children to age 19)	**$600 allowance every 3 years**	**Not Covered**
Diagnostic Office Visits	**Co-Payment**	**Deductible/Coinsurance**
Office Consultations	**Co-Payment**	**Deductible/Coinsurance**
Diagnostic Imaging Services, X-ray, CAT, MRI, etc.	**Co-Payment**	**Deductible/Coinsurance**
Radiation Therapy and Chemotherapy	**Covered in Full**	**Deductible/Coinsurance**
Hemodialysis	**Covered in Full**	**Deductible/Coinsurance**
Mammogram (Mandated; should be on par with other basic physician services; co-payment allowed on PPO)	**Covered in Full**	**Deductible/Coinsurance**
Routine GYN Visits including Pap Smear (Mandated; same as other basic physician services; co-payment allowed on PPO)	**Covered In Full, including Lab**	**Deductible/Coinsurance**
Diagnostic GYN Visits	**Co-Payment**	**Deductible/Coinsurance**
Prostate Cancer Screenings (Mandated if office visits covered; coverage must be equal to office visits)	**Co-Payment**	**Deductible/Coinsurance**
Allergy Testing and Treatment (Injections are inclusive)	**Co-Payment – Testing** **Covered In Full – Treatment**	**Deductible/Coinsurance**

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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,)	**Co-Payment**	**Deductible/Coinsurance**
Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	**Coverage is equivalent to Diagnostic Office visits.**	
Chiropractic Care (Mandated if office visits covered; coverage must be equal to office visits)	**Co-Payment**	**Deductible/Coinsurance**
Inpatient Consultations	**Covered in Full**	**Deductible/Coinsurance**
Infertility Care (Mandated if inpatient hospital, medical/surgery covered)	**Covered same as similar services under benefit plan – i.e. labs see Diagnostic Laboratory and Pathology benefit, office visit see Diagnostic Office visit benefit.**	
Bone Density Testing (Mandated if x-ray covered; coverage must be equal office visit or x-ray benefit, whichever is better benefit)	**Co-Payment**	**Deductible/Coinsurance**
ADDITIONAL BENEFITS		
Treatment of Diabetes (Insulin & Supplies) Education and DME (Mandated if physician office visits covered; must be covered equal to office visits for a 30 day supply)	**Co-Payment**	**Deductible/Coinsurance**
Durable Medical Equipment (DME)	**20% Coinsurance**	**Deductible/Coinsurance**
External Prosthetics/Orthotics (foot orthotics excluded) ($15,000 max per Calendar Year)	**Included in DME Benefit**	
Medical Supplies	**20% Coinsurance**	**Deductible/Coinsurance**
Foot Orthotics	**Not Covered**	**Not Covered**
Ambulance Service (Includes air)	**Co-Payment**	**Deductible/Coinsurance**
Pre-Hospital Emergency Services/Transportation (Mandated for ambulance, coverage must be equal to or better than emergency benefit. Excludes air.)	**Co-Payment**	
Acupuncture (10 visits per Calendar Year)	**Not Covered**	**Not Covered**
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**
EMERGENCY SERVICES (Emergency Condition Mandated; coverage on par with inpatient; copayment allowed for POS/PPO; O/N benefit for Emergency Condition must be same covered same as I/N)		

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Facility – Emergency Room	**$35 Co-Payment**	
Freestanding Urgent Care Center	**$25 Co-Payment**	**Deductible/Coinsurance**
Physician's Hospital Emergency Room Visit	**Covered in Full**	
WAITING PERIODS		
Pre-Existing Condition Waiting Period	**No – waived**	
EXCLUSIONS: The following are common exclusions that will apply. Indicate if coverage should be provided and the applicable deductible/copayment/coinsurance.		
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**	

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Consortium Options Available

Consortium Plan Options	Co-Payments Per Service "Office"	Emergency Room
Co-Payment Plan 1 (Current Plan)	$10.00	$35.00
Co-Payment Plan 2 (Current Plan)	$15.00	$50.00
Co-Payment Plan 3 (Current Plan)	$20.00	$50.00
Co-Payment Plan 4	$25.00	$50.00

	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

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

*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.