Greater Tompkins County Municipal Health Insurance Consortium

2019 Benefit Comparison Platinum Plan, Classic Blue and PPO

Plan Benefit and Cost Sharing Highlights		Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan	GTCMHIC - County of Tompkins Classic Blue Plan	Greater Tompkins County Municipal Health Insurance Consortium $10 PPO Plan
Cost Sharing		**In-Network**	**In-Network**	**In-Network**
Deductible	Individual	$0	$100	$0
	Family	$0	$200	$0
Out-of-Pocket Maximum **(Medical Plan Coinsurance and Copayments)**	Individual	$2,000 In-Network (Rx and Medical)	$200	$1,000 In and Out of Network (Medical Only)
	Family	$6,000 In-Network (Rx and Medical)	$400	$3,000 In and Out of Network (Medical Only)
Coinsurance		N/A	20%	0%
Out-of-Pocket Maximum **(Rx Plan Copayments)**	Individual	Combined with Medical - See Note	$2,000 Rx copayments	$2,000 Rx copayments
	Family	Combined with Medical - See Note	$6,000 Rx copayments	$6,000 Rx copayments
Annual Maximum		Unlimited	Unlimited	Unlimited
Lifetime Maximum		Unlimited	Unlimited	Unlimited
Preventive Health Care Services		**In-Network**	**In-Network/Out of Network**	**In-Network**
Well Child Visits and Immunizations		Covered In Full	Covered In Full	Covered In Full
Adult Routine Physical Exams (1 Per Year)		Covered In Full	Covered In Full	Covered In Full
Adult Immunizations		Covered In Full	Covered In Full	Covered In Full
Routine Gynecological Exams		Covered In Full	Covered In Full	Covered In Full
Cervical Cytology Preventive		Covered In Full	Covered In Full	Covered In Full
Prostrate Cancer Screenings		Covered In Full	Covered In Full	Covered In Full
Mammography Preventive Facility and Professional		Covered In Full	Covered In Full	Covered In Full
Bone Density Testing Facility and Professional		Covered In Full	Covered In Full	Covered In Full
Colonoscopy Screening Facility and Professional		Covered In Full	Covered In Full	Covered In Full
Family Planning Services		Covered In Full	Covered In Full	Covered In Full
Pre/Post Natal Care		Covered In Full	Covered In Full	Covered In Full
Inpatient Facility Benefits		**In-Network**	**In-Network/Out of Network**	**In-Network**
Hospital Benefits (unlimited days)**		$250 Copay	Covered In Full	Covered In Full
Mental Health Care**		$250 Copay	Covered In Full	Covered In Full
Mental Health Residential Care**		$250 Copay	Covered In Full	Covered In Full
Substance Use Detoxification**		$250 Copay	Covered In Full	Covered In Full
Substance Use Residential Care**		$250 Copay	Covered in Full	Covered in Full
Skilled Nursing Facility (Limited to 45 Days Per Year In and Out-of Network)		$250 Copay	Covered In Full Unlimited Days	Covered In Full (120 Days - In & Out of Network combined)

Inpatient Physical Rehabilitation (Limited to 60 Days Per Year In and Out-of-Network)	$250 Copay	Covered In Full	Covered In Full
Maternity Care	Covered In Full	Covered In Full	Covered In Full
Routine Newborn Nursery Care	Covered In Full	Covered In Full	Covered In Full
Prosthetics - Implanted Devices	Covered In Full	Covered In Full	Included in Inpatient Services
Mastectomy	Covered In Full	Covered In Full	Covered In Full
Observation Stay	$150 Copay	Covered In Full	Covered In Full
Inpatient Professional Services	**In-Network**	**In-Network/Out of Network**	**In-Network**
Inpatient Hospital Surgery	Covered In Full	Covered In Full	Covered In Full
Anesthesia	Covered In Full	Covered In Full	Covered In Full
In-Hospital Physician Visits and Consults	Covered In Full	Covered In Full	Covered In Full
Outpatient Facility Services	**In-Network**	**In-Network/Out of Network**	**In-Network**
Surgical Centers and Free Standing Ambulatory Centers Surgical	$150 Copay	Covered In Full	$10 Copay
Pre-Admission / Pre-Operative Testing	Covered In Full	Covered In Full	Covered In Full
Diagnostic and Routine X-Rays	$25 Copay	Covered In Full	$10 Copay
Advanced Imaging Services**	$25 Copay	Covered In Full	$10 Copay
Diagnostic and Routine Laboratory and Pathology	Covered In Full	Covered In Full	Covered In Full
Diagnostic Testing	Covered In Full	Covered In Full	Covered In Full
Radiation Therapy	$25 Copay	Covered In Full	Covered In Full
Chemotherapy	$15 Copay	Covered In Full	Covered In Full
Infusion Therapy**	Inclusive of Primary Service	Inclusive to primary service	Inclusive to primary service
Dialysis	Covered In Full	Covered In Full	Covered In Full
Injectable Drugs	Inclusive of Primary Service	Inclusive to primary service	Inclusive to primary service
Mental Health Care	$25 Copay	Covered In Full	$10 Copay
Substance Use Care	$25 Copay	Covered In Full	$10 Copay
Substance Use Family Counseling	$25 Copay	Covered In Full	$10 Copay
Autism Applied Behavior Analysis	$25 Copay	Covered In Full	$10 Copay
Pulmonary Rehabilitation	$25 Copay	Covered In Full	$10 Copay
Cardiac Rehabilitation	$25 Copay	Covered In Full	$10 Copay
Home Care and Hospice Care	**In-Network**	**In-Network/Out of Network**	**In-Network**
Home Care (Limited to 40 Visits Per Year)**	Covered In Full	60 Visits per calendar year. *Additional visits subject to Ded/Coins*	Covered In Full
Hospice Care Inpatient	Covered In Full	Covered In Full	Covered In Full
Hospice Care Outpatient	Covered In Full	Covered In Full	Covered In Full
Family Bereavement (Limited to 5 Visits Per Year)	Covered In Full	Covered In Full	Covered In Full
Outpatient and Office Professional Services	**In-Network**	**In-Network/Out of Network**	**In-Network**
Outpatient Hospital and Ambulatory Surgery	Covered In Full	Covered In Full	Covered In Full
Office Surgery	$15 PCP / $25 Spec Copay	Covered In Full	$10 Copay
Diagnostic X-Ray	$25 Copay	Covered In Full	$10 Copay
Routine X-Ray	$25 Copay	Covered In Full	$10 Copay

Advanced Imaging Services**	$25 Copay	Covered In Full	$10 Copay
Diagnostic Laboratory and Pathology	$25 Copay	Covered In Full	Covered In Full
Routine Laboratory and Pathology	Covered In Full	Covered In Full	Covered In Full
Radiation Therapy	$25 Copay	Covered In Full	Covered In Full
Chemotherapy	$15 Copay	Covered In Full	Covered In Full
Infusion Therapy**	Inclusive of Primary Service	Inclusive to primary service	Inclusive to primary service
Dialysis	Covered In Full	Covered In Full	Covered In Full
Injectable Drugs	Inclusive of Primary Service	Inclusive to primary service	Inclusive to primary service
Mental Health Care	$25 Copay	Covered In Full	$10 Copay
Substance Use Treatment	$25 Copay	Covered In Full	$10 Copay
Maternity Care	Covered In Full	Covered in Full	Covered in Full
Autism Applied Behavior Analysis	$25 Copay	Covered In Full	$10 Copay
Additional (Second) Surgical Opinion	$15 PCP / $25 Spec Copay	Covered in Full	$10 Copay
Second Medical Opinion for Cancer	$15 PCP / $25 Spec Copay	Covered in Full	$10 Copay
Pulmonary Rehabilitation	$25 Copay	Deductible/Coinsurance	$10 Copay
TeleMedicine Program	Not Covered	Not Covered	Not Covered
Office Visits - Diagnostic	$15 PCP / $25 Spec Copay	Deductible/Coinsurance	$10 Copay
Medications Administration in Office	$15 PCP / $25 Spec Copay	Inclusive to primary service	$10 Copay
Eye Exams Diagnostic	$25 Copay	Deductible/Coinsurance	$10 Copay
Hearing Evaluation Diagnostic	$25 Copay	Deductible/Coinsurance	$10 Copay
Chiropractic Care	$15 Copay	Deductible/Coinsurance	$10 Copay
Allergy Testing	$15 PCP / $25 Spec Copay	Deductible/Coinsurance	$10 Copay
Allergy Treatment including Serum	Covered In Full	Deductible/Coinsurance	Covered in Full
Hearing Evaluation Routine	$25 Copay	Not Covered	Not Covered
Adult Hearing Aids	Not Covered	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit	Not Applicable	Not Applicable	Not Applicable
Pediatric Hearing Aid - 1 Hearing Aide Every 3 Years	Not Covered	Not Covered	Not Covered
Cochlear Implants	Covered In Full	Covered in Full	Covered in Full
Rehab and Habilitation Services - Outpatient Facility	**In-Network**	**In-Network/Out of Network**	**In-Network**
Physical Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Occupational Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Speech Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Physical Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Occupational Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay

Speech Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Rehab and Habilitation Services - Professional Services	**In-Network**	**In-Network/Out of Network**	**In-Network**
Physical Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Occupational Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Speech Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Physical Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Occupational Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Speech Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	$25 Copay	Deductible/Coinsurance Unlimited visits	$10 Copay
Other Benefits	**In-Network**	**In-Network**	**In-Network**
Treatment of Diabetes Insulin and Supplies	$15 Copay	Deductible/Coinsurance	$10 Copay
Diabetic Education	$15 Copay	Deductible/Coinsurance	$10 Copay
Diabetic Equipment	$15 Copay	Deductible/Coinsurance	$10 Copay
Autism Assistive Communication Device	$25 Copay	Covered in Full	$10 Copay
Autologous Blood Banking	Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% Coinsurance	Deductible/Coinsurance	20% Coinsurance
Mastectomy Prosthesis	Covered In Full	Covered in Full	Covered in Full
Orthotics	20% Coinsurance	Deductible/Coinsurance	20% Coinsurance
Foot Orthotics	20% Coinsurance	Deductible/Coinsurance	20% Coinsurance
Prosthetic - External Benefit	20% Coinsurance	Deductible/Coinsurance	20% Coinsurance
Prosthetic - Wigs External Benefit	Not Covered	Not Covered	Not Covered
Medical Supplies	20% Coinsurance	Deductible/Coinsurance	20% Coinsurance
Acupuncture - 10 visits per year	$25 Copay	Not Covered	50% Coinsurance
Private Duty Nursing	Not Covered	Deductible/Coinsurance	Not Covered
Emergency Services	**In-Network**	**In-Network/Out of Network**	**In-Network**
Emergency Room Care - Facility (waived if admitted to hospital)	$150 Copayment	Covered in Full	$35 Capay
Emergency Room Care - Professional	Covered In Full	Covered in Full	Covered in Full
Ambulance - Pre-Hospital Emergency Services Transportation ((	$150 Copayment	Covered in Full	$10 Copay
Air Ambulance	$150 Copayment	Covered in Full	$10 Copay
Water Ambulance	$150 Copayment	Covered in Full	$10 Copay
Urgent Care Center - Facility	$25 Copay	Covered in Full	$25 Copay
Urgent Care Center - Professional Services	Covered In Full	Covered In Full	Covered In Full

Urgent Care Office Visit	$15 PCP / $25 Spec Copay	Covered In Full	$10 Copay
Vision Benefits	**In-Network**	**In-Network/Out of Network**	**In-Network**
Adult Routine Vision Exam (1 Per Year)	$25 Copay	Not Covered	$10 Copay
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	Not Covered	$10 Copay
Pediatric Eyewear	Not Covered	Not Covered	$60 Per year - includes Frames/Lenses or Contact Lenses
Dental Benefits	**In-Network**	**In-Network/Out of Network**	**In-Network**
Adult Dental Care	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventive and Routine	Not Covered	Not Covered	Not Covered
Pediatric Dental - Emergency Care	Not Covered	Not Covered	Not Covered
Pediatric Dental - Preventive	Not Covered	Not Covered	Not Covered
Pediatric Dental - Routine	Not Covered	Not Covered	Not Covered
Pediatric Dental - Endodontic	Not Covered	Not Covered	Not Covered
Pediatric Dental - Prosthodontics	Not Covered	Not Covered	Not Covered
Pediatric Dental - Orthodontics	Not Covered	Not Covered	Not Covered
Prescription Drug Benefits	**In-Network**	**In-Network/Out of Network**	**In-Network**
Retail Pharmacy (limited to a 30-day supply)	Tier 1 $5	Tier 1 $5	Tier 1 $5
	Tier 2 $35	Tier 2 $20	Tier 2 $20
	Tier 3 $70	Tier 3 $35	Tier 3 $35
Mail-Order Pharmacy (limited to a 90-day supply)	Tier 1 $10	Tier 1 $10	Tier 1 $10
	Tier 2 $70	Tier 2 $40	Tier 2 $40
	Tier 3 $140	Tier 3 $70	Tier 3 $70
$0 Generics for Children Less Than 19 Years of Age	Applicable	Not Applicable	Not Applicable
MAC Penalty (Mandatory Generic Substitution)	Applicable	N/A	N/A
Step Therapy	Applicable	N/A	N/A
Prior Authorization	Applicable	N/A	N/A
Generic Oral Contraceptives - Covered In Full	Applicable	Applicable	Applicable
Mandatory Mail-Order for Maintenance Medications	Not Applicable	Not Applicable	Not Applicable
Wellness Blood Screening Plan Included	YES	NO	NO
Blue 365 Discount Programs	YES	YES	YES

***** 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 above illustration reflects in-network benefits only. Please refer to individual benefit summary for both in and out of network benefits. Provider listings can be found at www.excellusbcbs.com**

*** The benefits outlined above are a summary of the benefits for the 2018 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.**