

**Greater Tompkins County Municipal Health Insurance Consortium**  
**2015 Standard Platinum, Gold, Silver, and Bronze Plan Benefit Options**

Plan Benefit and Cost Sharing Highlights		Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan		Greater Tompkins County Municipal Health Insurance Consortium Standard Gold Plan		Greater Tompkins County Municipal Health Insurance Consortium Standard Silver Plan		Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Cost Sharing		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	Individual	Not Applicable	\$500	\$500 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$1,300 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$3,500 Combined In-Network (Rx and Medical) and Out-of Network (Medical)	
	Family	Not Applicable	\$1,500	\$1,500 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$2,600 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$7,000 Combined In-Network (Rx and Medical) and Out-of Network (Medical)	
Out-of-Pocket Maximum <i>(Medical Plan Coinsurance and Copayments)</i>	Individual	\$2,000 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$3,000 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$3,000 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$6,350 Combined In-Network (Rx and Medical) and Out-of Network (Medical)	
	Family	\$6,000 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$9,000 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$6,000 Combined In-Network (Rx and Medical) and Out-of Network (Medical)		\$12,700 Combined In-Network (Rx and Medical) and Out-of Network (Medical)	
Out-of-Pocket Maximum <i>(Rx Plan Copayments)</i>	Individual	Combined with Medical - See Note	Not Applicable	Combined with Medical - See Note	Not Applicable	Combined with Medical - See Note	Not Applicable	Combined with Medical - See Note	Not Applicable
	Family	Combined with Medical - See Note	Not Applicable	Combined with Medical - See Note	Not Applicable	Combined with Medical - See Note	Not Applicable	Combined with Medical - See Note	Not Applicable
Annual Maximum		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Health Care Services		In-Network	Out-of-Network	In-Network	Out-of-Network	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	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	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Adult Immunizations		Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Routine Gynecological Exams		Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Cervical Cytology Preventive		Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Prostrate Cancer Screenings		Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Mammography Preventive Facility and Professional		Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Bone Density Testing Facility and Professional		\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Colonoscopy Screening Facility and Professional		Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Family Planning Services		Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Pre/Post Natal Care		Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Inpatient Facility Benefits		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital Benefits (unlimited days)		\$250 Copay	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Mental Health Care		\$250 Copay	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Mental Health Residential Care		\$250 Copay	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Substance Use Detoxification		\$250 Copay	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Substance Use Residential Care		\$250 Copay	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Skilled Nursing Facility (Limited to 45 Days Per Year In and Out-of Network)		\$250 Copay	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Inpatient Physical Rehabilitation (Limited to 60 Days Per Year In and Out-of-Network)		\$250 Copay	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Maternity Care		Covered In Full	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Routine Newborn Nursery Care		Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Prosthetics - Implanted Devices		Covered In Full	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible

**Greater Tompkins County Municipal Health Insurance Consortium**

**2015 Standard Platinum, Gold, Silver, and Bronze Plan Benefit Options**

<b>Plan Benefit and Cost Sharing Highlights</b>	<b>Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan</b>		<b>Greater Tompkins County Municipal Health Insurance Consortium Standard Gold Plan</b>		<b>Greater Tompkins County Municipal Health Insurance Consortium Standard Silver Plan</b>		<b>Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan</b>	
Mastectomy	\$250 Copay	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Observation Stay	\$150 Copay	20% After Deductible	\$250 Copay	40% After Deductible	\$250 Copay	40% After Deductible	20% After Deductible	40% After Deductible
<b>Inpatient Professional Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Inpatient Hospital Surgery	Covered In Full	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Anesthesia	Covered In Full	Covered In Full	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
In-Hospital Physician Visits and Consults	Covered In Full	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
<b>Outpatient Facility Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Surgical Centers and Free Standing Ambulatory Centers Surgical Care	\$150 Copay	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Pre-Admission / Pre-Operative Testing	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible
Diagnostic and Routine X-Rays	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Advanced Imaging Services	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Diagnostic and Routine Laboratory and Pathology	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible
Diagnostic Testing	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible
Radiation Therapy	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Chemotherapy	\$15 Copay	20% After Deductible	\$25 Copay	40% After Deductible	\$30 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Infusion Therapy	\$15 Copay	20% After Deductible	\$25 Copay	40% After Deductible	\$30 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Dialysis	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible
Injectable Drugs	\$15 PCP / \$25 Spec Copay	20% After Deductible	\$25 PCP / \$40 Spec Copay	40% After Deductible	\$30 PCP / \$50 Spec Copay	40% After Deductible	20% After Deductible	40% After Deductible
Mental Health Care	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Substance Use Care	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Substance Use Family Counseling	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Autism Applied Behavior Analysis	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Pulmonary Rehabilitation	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Cardiac Rehabilitation	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
<b>Home Care and Hospice Care</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Home Care (Limited to 40 Visits Per Year)	Covered In Full	20% After \$50 Deductible	Covered In Full	25% After \$50 Deductible	Covered In Full	25% After \$50 Deductible	20% After \$50 Deductible	25% After \$50 Deductible
Hospice Care Inpatient	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible
Hospice Care Outpatient	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible
Family Bereavement (Limited to 5 Visits Per Year)	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible
<b>Outpatient and Office Professional Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Outpatient Hospital and Ambulatory Surgery	Covered In Full	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Office Surgery	\$15 PCP / \$25 Spec Copay	20% After Deductible	\$25 PCP / \$40 Spec Copay	40% After Deductible	\$30 PCP / \$50 Spec Copay	40% After Deductible	20% After Deductible	40% After Deductible
Diagnostic X-Ray	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Routine X-Ray	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Advanced Imaging Services	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Diagnostic Laboratory and Pathology	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible

**Greater Tompkins County Municipal Health Insurance Consortium**  
**2015 Standard Platinum, Gold, Silver, and Bronze Plan Benefit Options**

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan		Greater Tompkins County Municipal Health Insurance Consortium Standard Gold Plan		Greater Tompkins County Municipal Health Insurance Consortium Standard Silver Plan		Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
Routine Laboratory and Pathology	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible
Radiation Therapy	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Chemotherapy	\$15 Copay	20% After Deductible	\$25 Copay	40% After Deductible	\$30 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Infusion Therapy	\$15 Copay	20% After Deductible	\$25 Copay	40% After Deductible	\$30 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Dialysis	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	20% After Deductible	40% After Deductible
Injectable Drugs	\$15 PCP / \$25 Spec Copay	20% After Deductible	\$25 PCP / \$40 Spec Copay	40% After Deductible	\$30 PCP / \$50 Spec Copay	40% After Deductible	20% After Deductible	40% After Deductible
Mental Health Care	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Substance Use Treatment	\$0 PCP / \$25 Spec Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Maternity Care	Covered In Full	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Autism Applied Behavior Analysis	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Additional (Second) Surgical Opinion	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Second Medical Opinion for Cancer	\$25 Copay	20% After Deductible	\$25 PCP / \$40 Spec Copay	40% After Deductible	\$30 PCP / \$50 Spec Copay	40% After Deductible	20% After Deductible	40% After Deductible
Pulmonary Rehabilitation	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Office Visits - Diagnostic	\$15 PCP / \$25 Spec Copay	20% After Deductible	\$25 PCP / \$40 Spec Copay	40% After Deductible	\$30 PCP / \$50 Spec Copay	40% After Deductible	20% After Deductible	40% After Deductible
Medications Administration in Office	\$15 PCP / \$25 Spec Copay	20% After Deductible	\$25 PCP / \$40 Spec Copay	40% After Deductible	\$30 PCP / \$50 Spec Copay	40% After Deductible	20% After Deductible	40% After Deductible
Eye Exams Diagnostic	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Hearing Evaluation Diagnostic	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Chiropractic Care	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Allergy Testing	\$15 PCP / \$25 Spec Copay	20% After Deductible	\$25 PCP / \$40 Spec Copay	40% After Deductible	\$30 PCP / \$50 Spec Copay	40% After Deductible	20% After Deductible	40% After Deductible
Allergy Treatment including Serum	\$15 PCP / \$25 Spec Copay	20% After Deductible	\$25 PCP / \$40 Spec Copay	40% After Deductible	\$30 PCP / \$50 Spec Copay	40% After Deductible	Covered In Full	40% After Deductible
Hearing Evaluation Routine	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	Not Covered	40% After Deductible
Adult Hearing Aids	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Hearing Aid Age Limit	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Pediatric Hearing Aid	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Cochlear Implants	Covered In Full	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
<b>Rehab and Habilitation Services - Outpatient Facility</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Physical Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Occupational Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Speech Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Physical Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Occupational Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Speech Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible

**Greater Tompkins County Municipal Health Insurance Consortium**  
**2015 Standard Platinum, Gold, Silver, and Bronze Plan Benefit Options**

<b>Plan Benefit and Cost Sharing Highlights</b>	<b>Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan</b>		<b>Greater Tompkins County Municipal Health Insurance Consortium Standard Gold Plan</b>		<b>Greater Tompkins County Municipal Health Insurance Consortium Standard Silver Plan</b>		<b>Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan</b>	
	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Rehab and Habilitation Services - Professional Services</b>								
Physical Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Occupational Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Speech Rehabilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Physical Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Occupational Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Speech Habilitation (45 Visits Per Year Rehab and Habilitation Services Combined)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
<b>Other Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Treatment of Diabetes Insulin and Supplies	\$15 Copay	20% After Deductible	\$25 Copay	40% After Deductible	\$30 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Diabetic Education	\$15 Copay	20% After Deductible	\$25 Copay	40% After Deductible	\$30 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Diabetic Equipment	\$15 Copay	20% After Deductible	\$25 Copay	40% After Deductible	\$30 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Autism Assistive Communication Device	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Autologous Blood Banking	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% Coinsurance	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Mastectomy Prosthesis	Covered In Full	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Orthotics	20% Coinsurance	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Foot Orthotics	20% Coinsurance	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Prosthetic - External Benefit	20% Coinsurance	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Prosthetic - Wigs External Benefit	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Medical Supplies	20% Coinsurance	20% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible	20% After Deductible	40% After Deductible
Acupuncture	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Private Duty Nursing	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Emergency Services</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Emergency Room Care - Facility (waived if admitted to hospital)	\$150 Copayment	\$150 Copayment	\$250 Copayment	\$250 Copayment	\$350 Copayment	\$350 Copayment	20% After Deductible	20% After Deductible
Emergency Room Care - Professional	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Ambulance - Pre-Hospital Emergency Services Transportation (Ground)	\$150 Copayment	\$150 Copayment	\$250 Copayment	\$250 Copayment	\$350 Copayment	\$350 Copayment	20% After Deductible	20% After Deductible
Air Ambulance	\$150 Copayment	\$150 Copayment	\$250 Copayment	\$250 Copayment	\$350 Copayment	\$350 Copayment	20% After Deductible	20% After Deductible
Water Ambulance	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Urgent Care Center - Facility	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	20% After Deductible	40% After Deductible
Urgent Care Center - Professional Services	Covered In Full	20% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible	Covered In Full	40% After Deductible
Urgent Care Office Visit	\$15 PCP / \$25 Spec Copay	20% After Deductible	\$25 PCP / \$40 Spec Copay	40% After Deductible	\$30 PCP / \$50 Spec Copay	40% After Deductible	20% After Deductible	40% After Deductible
<b>Vision Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Adult Routine Vision Exam (1 Per Year)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	Not Covered	Not Covered
Adult Eyewear	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Routine Vision Exam (1 Per Year Children Less Than 19 Years Old)	\$25 Copay	20% After Deductible	\$40 Copay	40% After Deductible	\$50 Copay	40% After Deductible	Not Covered	Not Covered
Pediatric Eyewear	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

**Greater Tompkins County Municipal Health Insurance Consortium**  
**2015 Standard Platinum, Gold, Silver, and Bronze Plan Benefit Options**

Plan Benefit and Cost Sharing Highlights	Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan		Greater Tompkins County Municipal Health Insurance Consortium Standard Gold Plan		Greater Tompkins County Municipal Health Insurance Consortium Standard Silver Plan		Greater Tompkins County Municipal Health Insurance Consortium Standard Bronze Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Dental Benefits</b>								
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventive and Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Emergency Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Preventive	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Endodontic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Prosthodontics	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental - Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Prescription Drug Benefits</b>								
Retail Pharmacy (limited to a 30-day supply)	Tier 1 \$10	Not Covered	Tier 1 \$5	Not Covered	Tier 1 \$5	Not Covered	Tier 1 \$5	Not Covered
	Tier 2 \$30	Not Covered	Tier 2 \$35	Not Covered	Tier 2 \$45	Not Covered	Tier 2 \$35	Not Covered
	Tier 3 \$50	Not Covered	Tier 3 \$70	Not Covered	Tier 3 \$90	Not Covered	Tier 3 \$70	Not Covered
Mail-Order Pharmacy (limited to a 90-day supply)	Tier 1 \$30	Not Covered	Tier 1 \$10	Not Covered	Tier 1 \$10	Not Covered	Tier 1 \$10	Not Covered
	Tier 2 \$90	Not Covered	Tier 2 \$70	Not Covered	Tier 2 \$90	Not Covered	Tier 2 \$70	Not Covered
	Tier 3 \$150	Not Covered	Tier 3 \$140	Not Covered	Tier 3 \$180	Not Covered	Tier 3 \$140	Not Covered
\$0 Generics for Children Less Than 19 Years of Age	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered
MAC Penalty (Mandatory Generic Substitution)	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered
Step Therapy	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered
Prior Authorization	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered
Generic Oral Contraceptives - Covered In Full	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered	Applicable	Not Covered
Mandatory Mail-Order for Maintenance Medications	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
<b>Monthly Premium Rates</b>	<b>Individual</b>	<b>Subscriber and Spouse</b>	<b>Individual</b>	<b>Subscriber and Spouse</b>	<b>Individual</b>	<b>Subscriber and Spouse</b>	<b>Individual</b>	<b>Subscriber and Spouse</b>
2015 Fiscal Year	\$540.75	Not Applicable	\$486.30	Not Applicable	\$403.56	Not Applicable	\$315.26	Not Applicable
	<b>Subscriber and Children</b>	<b>Family</b>	<b>Subscriber and Children</b>	<b>Family</b>	<b>Subscriber and Children</b>	<b>Family</b>	<b>Subscriber and Children</b>	<b>Family</b>
	Not Applicable	\$1,405.95	Not Applicable	\$1,264.37	Not Applicable	\$1,049.26	Not Applicable	\$819.67
Wellness Plan Included	YES		YES		YES		YES	
Health Savings Account Eligible	NO		NO		YES		YES	

\* The benefits outlined above are a summary of the benefits for the 2015 Fiscal Year and are subject to change to keep the overall benefit equal to an ACA Platinum, Gold, Silver, or Bronze 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.