



Municipalities building a  
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## RESOLUTION NO. 016-2014 - RESOLUTION TO ADOPT THE "PLATINUM PLAN"

WHEREAS, the Greater Tompkins County Municipal Health Insurance Consortium (Consortium) is a self-insured municipal cooperative health benefit plan operating pursuant to a Certificate of Authority issued on October 1, 2010 in accordance with the provisions of Article 47 of the New York State Health Insurance Law, and

WHEREAS, the Consortium's consultant, Locey and Cahill, LLC and medical claims administrator, Excellus BlueCross BlueShield, have collaboratively developed the "Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan" which is consistent with and meets the standards for Platinum level benefit plans as defined by the Patient Protection and Affordable Care Act, and

WHEREAS the "Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan" will have an Actuarial Value as defined by the Patient Protection and Affordable Care Act equal to an overall plan benefit for the average participant of 90%, and

WHEREAS, the Joint Committee on Plan Structure and Design has reviewed the details of the "GTCMHIC Standard Platinum Plan" and was not able to reach a consensus to approve or disapprove recommending this plan for adoption by the Board of Directors, and

WHEREAS, the addition of this Plan or other metal level Plans of coverage will not diminish, alter, or eliminate any current medical or prescription drug plans offered by the Consortium, and

WHEREAS, comparable benefit plans are available to the Consortium's Participating Municipalities either through the Patient Protection and Affordable Care Act Health Insurance Exchange or on the private health insurance marketplace, and

WHEREAS, several Participating Municipalities in the Consortium are seeking plan designs consistent with the metal levels of coverage as defined by the Patient Protection and Affordable Care Act, now therefore be it

RESOLVED, That the Greater Tompkins County Municipal Health Insurance Consortium Board of Directors adopts the "Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan" for inclusion in the Greater Tompkins County Municipal Health Insurance Consortium's available benefit plan menu to be effective as soon as practicable,

RESOLVED, further, the Consortium Board of Directors requires that Said Actuarial Value be calculated annually by the rating and underwriting department at Excellus BlueCross BlueShield or an independent actuarial firm using the Actuarial Value Calculator developed by the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) which was implemented in accordance with the Patient Protection and Affordable Care Act. If such calculator is no longer available or in use, the Consortium will have an independent Actuary develop the Actuarial Value of the health insurance plan on an annual basis. In either case, it is the intent that the result will represent an empirical estimate of the Actuarial Value calculated in a



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**2014 Standard Platinum Plan Benefit Option**

| Plan Benefit and Cost Sharing Highlights                                  |            | GTCMHIC Standard Platinum Plan                 |                      | Current Tompkins County Plan<br>(County CSEA PPO Plan) |                      | Current Tompkins County Plan<br>(County CSEA Indemnity Plan) |                        |
|---|------------|--|----------------------|--|----------------------|--|------------------------|
| Cost Sharing  |            | In-Network                                     | Out-of-Network       | In-Network   | Out-of-Network       | In-Network   | Out-of-Network         |
| Deductible  | Individual | Not Applicable                                 | \$500                | n/a  | \$250                | \$100  | \$250                  |
|   | Family     | Not Applicable                                 | \$1,500              | n/a  | \$750                | \$200  | \$750                  |
| Out-of-Pocket Maximum<br><i>(Medical Plan Coinsurance and Copayments)</i> | Individual | \$2,000 Combined In-Network and Out-of-Network |                      | \$1,000  | \$1,000              | \$400  | \$400                  |
|   | Family     | \$6,000 Combined In-Network and Out-of-Network |                      | \$3,000  | \$3,000              | \$800  | \$800                  |
| Out-of-Pocket Maximum<br><i>(Rx Plan Copayments)</i>                      | Individual | \$2,000  | Not Applicable       | \$1,000  | Not Applicable       | \$1,000  | Not Applicable         |
|   | Family     | \$6,000  | Not Applicable       | \$3,000  | Not Applicable       | \$3,000  | Not Applicable         |
| Annual Maximum  |            | Unlimited                                      | Unlimited            | Unlimited  | Unlimited            | Unlimited  | Unlimited              |
| Lifetime Maximum  |            | 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         |
| Well Child Visits   |            | Covered In Full                                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Adult Routine Physical Exams  |            | Covered In Full                                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Adult Immunizations   |            | Covered In Full                                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Mammography   |            | Covered In Full                                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Pap Smears  |            | Covered In Full                                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Routine Gynecological Exams   |            | Covered In Full                                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Prostrate Cancer Screenings   |            | Covered In Full                                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Colonoscopies   |            | Preventive Screenings Covered in Full          | 80% After Deductible | Preventive Screenings Covered in Full                  | 80% After Deductible | Preventive Screenings Covered in Full                        | 100% of Allowed Amount |
| Family Planning Services  |            | Covered In Full                                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Physician Office Services   |            | In-Network                                     | Out-of-Network       | In-Network   | Out-of-Network       | In-Network   | Out-of-Network         |
| Diagnostic Office Visits  |            | \$15 PCP / \$25 Spec Copay                     | 80% After Deductible | \$10 PCP / \$10 Spec Copay                             | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| Diagnostic X-Rays   |            | \$15 PCP / \$25 Spec Copay                     | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Diagnostic Laboratory and Pathology                                       |            | \$15 PCP / \$25 Spec Copay                     | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Allergy Tests   |            | \$15 PCP / \$25 Spec Copay                     | 80% After Deductible | \$10 PCP / \$10 Spec Copay                             | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| Allergy Injections  |            | \$15 PCP / \$25 Spec Copay                     | 80% After Deductible | \$10 PCP / \$10 Spec Copay                             | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| Chemotherapy  |            | \$15 Copay                                     | 80% After Deductible | \$15 Copay   | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Radiation Therapy   |            | \$15 Copay                                     | 80% After Deductible | \$15 Copay   | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |

*Greater Tompkins County Municipal Health Insurance Consortium*

2014 Standard Platinum Plan Benefit Option

| Plan Benefit and Cost Sharing Highlights         | GTCMHIC Standard Platinum Plan |                       | Current Tompkins County Plan<br>(County CSEA PPO Plan) |                       | Current Tompkins County Plan<br>(County CSEA Indemnity Plan) |                        |
|--|--------------------------------|-----------------------|--|-----------------------|--|------------------------|
|  | In-Network                     | Out-of-Network        | In-Network   | Out-of-Network        | In-Network   | Out-of-Network         |
| <b>Maternity 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>  |
| Prenatal Services                                | Covered In Full                | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Hospital Care for Mother (includes delivery)     | \$250 Copay                    | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Newborn Nursery Care                             | Covered In Full                | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| <b>Prescription Drug 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>  |
| Retail Pharmacy (limited to a 30-day supply)     | Tier 1 \$10                    | Not Covered           | Tier 1 \$5   | Not Covered           | Tier 1 \$5   | Not Covered            |
|  | Tier 2 \$30                    | Not Covered           | Tier 2 \$20  | Not Covered           | Tier 2 \$20  | Not Covered            |
|  | Tier 3 \$50                    | Not Covered           | Tier 3 \$35  | Not Covered           | Tier 3 \$35  | 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 2 \$90                    | Not Covered           | Tier 2 \$40  | Not Covered           | Tier 2 \$40  | Not Covered            |
|  | Tier 3 \$150                   | Not Covered           | Tier 3 \$70  | Not Covered           | Tier 3 \$70  | Not Covered            |
| <b>Inpatient Hospital 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>  |
| Hospital Benefits (unlimited days)               | \$250 Copay                    | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Physician Visits in the Hospital                 | Covered In Full                | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Inpatient Physical Rehabilitation (60-day limit) | \$250 Copay                    | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Surgery  | \$150 Copay                    | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Anesthesia                                       | Covered In Full                | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| <b>Emergency 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>  |
| Emergency Room Care                              | \$150 Copay                    | \$150 Copay           | \$35 Copay   | \$35 Copay            | Covered In Full  | 100% of Allowed Amount |
| Freestanding Urgent Care Center                  | \$25 Copay                     | 80% After Deductible  | \$25 Copay   | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Ambulance  | \$150 Copay                    | \$150 Copay           | \$10 Copay   | \$100 Copay           | Covered In Full  | 100% of Allowed Amount |
| <b>Outpatient Hospital 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>  |
| Diagnostic X-Rays                                | \$25 Copay                     | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Diagnostic Laboratory and Pathology              | \$25 Copay                     | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Surgical Care Facility Fee                       | \$150 Copay                    | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Chemotherapy                                     | \$15 Copay                     | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |
| Radiation Therapy                                | \$15 Copay                     | 80% After Deductible  | Covered In Full  | 80% After Deductible  | Covered In Full  | 100% of Allowed Amount |

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|---|--------------------------------|----------------------|--|----------------------|--|------------------------|
|   | In-Network                     | Out-of-Network       | In-Network   | Out-of-Network       | In-Network   | Out-of-Network         |
| <b>Mental Health and Chemical Dependence</b>  |                                |                      |  |                      |  |                        |
| Inpatient Mental Health Care (unlimited days)   | \$250 Copay                    | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Outpatient Mental Health Care (unlimited visits)  | \$15 Copay Per Visit           | 80% After Deductible | \$10 Copay Per Visit                                   | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| Inpatient Chemical Dependence   | \$250 Copay                    | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Outpatient Chemical Dependence  | \$15 Copay Per Visit           | 80% After Deductible | \$10 Copay Per Visit                                   | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| <b>Other Services</b>   |                                |                      |  |                      |  |                        |
| Diabetic Insulin and Supplies   | \$15 Copay                     | 80% After Deductible | \$10 Copay   | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| Skilled Nursing Facility (limited to 200 days/year)   | \$250 Copay                    | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Home Care (limited to 40 visits per year)   | Covered In Full                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Hospice Care  | Covered In Full                | 80% After Deductible | Covered In Full  | 80% After Deductible | Covered In Full  | 100% of Allowed Amount |
| Outpatient Therapy (60 visits per condition/lifetime)<br>(physical, speech, and occupational) | \$25 Copay                     | 80% After Deductible | \$10 Copay   | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| Durable Medical Equipment   | 80% Coinsurance                | 80% After Deductible | Covered In Full  | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| External Prosthetics  | 80% Coinsurance                | 80% After Deductible | Covered In Full  | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| Chiropractic Care   | \$25 Copay                     | 80% After Deductible | \$10 Copay   | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| Acupuncture (10 Visits Per Calender Year Combined In/Out Network)                             | \$25 Copay                     | Not Covered          | Not Covered  | Not Covered          | Not Covered  | Not Covered            |
| Hearing Aids (Age <19 single purchase once every 3 years)                                     | Covered In Full                | 80% After Deductible | Not Covered  | Not Covered          | Not Covered  | Not Covered            |
| <b>Vision Benefits</b>  |                                |                      |  |                      |  |                        |
| Adult Routine Vision Exam (one per year)  | Not Covered                    | Not Covered          | Not Covered  | Not Covered          | Not Covered  | Not Covered            |
| Adult Diagnostic Vision Exam  | \$15 PCP / \$25 Spec Copay     | 80% After Deductible | \$10 PCP / \$10 Spec Copay                             | 80% After Deductible | 80% After Deductible   | 80% After Deductible   |
| Adult Eyewear   | Not Covered                    | Not Covered          | \$60 Annual Allowance                                  | Not Covered          | Not Covered  | Not Covered            |
| Pediatric Routine Vision Exam (one per year)  | \$15 PCP / \$25 Spec Copay     | 80% After Deductible | \$10 PCP / \$10 Spec Copay                             | 80% After Deductible | Not Covered  | Not Covered            |
| Pediatric Eyewear   | Not Covered                    | Not Covered          | \$60 Annual Allowance                                  | Not Covered          | Not Covered  | Not Covered            |

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|--|--------------------------------|----------------------|--|-------------------|--|-------------------|
|  | 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       |
| Pediatric Dental: Preventive and Routine   | Not Covered                    | Not Covered          | Not Covered  | Not Covered       | Not Covered  | Not Covered       |
| Pediatric Major Dental Care and Medical Ortho  | Not Covered                    | Not Covered          | Not Covered  | Not Covered       | Not Covered  | Not Covered       |
| Accidental Dental - Outpatient Surgery<br>(accidental injury to sound, natural teeth and for care due to congenital disease or anomaly,) | \$150 Copay                    | 80% After Deductible | Not Covered  | Not Covered       | Not Covered  | Not Covered       |
| <b>Monthly Premium Rates</b>   | <b>Individual</b>              | <b>Family</b>        | <b>Individual</b>                                      | <b>Family</b>     | <b>Individual</b>  | <b>Family</b>     |
| <i>2014 Fiscal Year - Tompkins County</i>  | <i>\$515.00</i>                | <i>\$1,339.00</i>    | <i>\$734.04</i>  | <i>\$1,608.75</i> | <i>\$744.09</i>  | <i>\$1,612.67</i> |
| <i>Wellness Plan Included</i>  | <i>YES</i>                     |                      | <i>NO</i>  |                   | <i>NO</i>  |                   |
| <i>Health Savings Account Eligible</i>   | <i>NO</i>                      |                      | <i>NO</i>  |                   | <i>NO</i>  |                   |
| <i>Employer Annual Contribution (Assumes 80%)</i>  | <i>Individual</i>              | <i>\$4,944.00</i>    | <i>\$7,046.78</i>                                      |                   | <i>\$7,143.26</i>  |                   |
|  | <i>Family</i>                  | <i>\$12,854.40</i>   | <i>\$15,444.00</i>                                     |                   | <i>\$15,481.63</i>   |                   |
| <i>Employee Annual Contribution (Assumes 20%)</i>  | <i>Individual</i>              | <i>\$1,236.00</i>    | <i>\$1,761.70</i>                                      |                   | <i>\$1,785.82</i>  |                   |
|  | <i>Family</i>                  | <i>\$3,213.60</i>    | <i>\$3,861.00</i>                                      |                   | <i>\$3,870.41</i>  |                   |