

# TOMPKINS COUNTY EMPLOYEE BENEFITS

# 2021



**Benefits  
Confirmation**



**Open  
Enrollment**

*Inclusion through Diversity*







## Guide to 2021 Benefits

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Please reach out with any questions to Sarah Thomas, Employee Benefits Administrator, at 607-274-5528 or by email at [stthomas@tompkins-co.org](mailto:stthomas@tompkins-co.org).



# TOMPKINS COUNTY 2021 HEALTH INSURANCE RATES

## Platinum Excellus BCBS; Prescription Benefits from ProAct

<b>Open to all, but SOLE OPTION for:</b>		<b>2021 RATES</b>		
<b>Blue Collar</b> (All Dates of Hire)	\$15 PCP/\$25 Specialist/\$150 ER Co-Pay (ER Co-Pay waived if admitted.)	<b>County share per month</b>	<b>Employee share per month</b>	<b>Employee per pay period</b>
<b>White Collar/Confidential/Mgmt/ Elected Officials</b> (Hired After 08/17/15)	Max OOP (Med and Rx) \$2,000/\$6,000 In Network Healthcare Reform - dependents to age 26			
<b>Corrections</b> (Hired After 09/04/17)	Rx co-pay: \$5/\$35/\$70, 2x @ Mail 80/20 employer/employee percent share	Individual	\$555.37	\$138.84
		Family	\$1,443.99	\$361.00
				\$69.42
				\$180.50
<b>Open to all, but SOLE OPTION for:</b>	\$15 PCP/\$25 Urgent or Specialist/\$150 ER Co-Pay (ER Co-Pay waived if admitted.)	<b>County share per month</b>	<b>Employee share per month</b>	<b>Employee per pay period</b>
<b>Deputy Sheriff's Association</b> (Hired After 02/03/16)	Max OOP (Med and Rx) \$2,000/\$6,000 In Network Healthcare Reform - dependents to age 26			
	Rx co-pay: \$5/\$35/\$70, 2x @ Mail 85/15 employer/employee percent share	Individual	\$590.09	\$104.13
		Family	\$1,534.24	\$270.75
				\$52.07
				\$135.37

## PPO Excellus BCBS; Prescription Benefits from ProAct

<b>Plan Available To:</b>		<b>2021 RATES</b>		
<b>White Collar/Confidential/Mgmt/ Elected Officials</b> (Hired Before 08/18/15)	\$10 PCP/\$25 Urgent Care/\$35 ER Co-Pay Max Med OOP \$1,000/\$3,000 Max Rx OOP \$2,000/\$6,000 Healthcare Reform - Dependents to Age 26	<b>County share per month</b>	<b>Employee share per month</b>	<b>Employee per pay period</b>
<b>Corrections</b> (Hired Before 09/05/17)	Rx co-pay: \$5/\$20/\$35, 2x @ Mail 80/20 employer/employee percent share	Individual	\$812.67	\$203.17
		Family	\$1,759.53	\$439.88
				\$101.58
				\$219.94
<b>Plan Available To:</b>	\$10 Office/\$25 Urgent Care/\$35 ER Co-Pay	<b>County share per month</b>	<b>Employee share per month</b>	<b>Employee per pay period</b>
<b>Deputy Sheriff's Association</b> (Hired Before 02/04/16)	Max Med OOP \$1,000/\$3,000 Max Rx OOP \$2,000/\$6,000 Healthcare Reform - Dependents to Age 26			
	Rx co-pay: \$5/\$20/\$35, 2x @ Mail 85/15 employer/employee percent share	Individual	\$863.47	\$152.38
		Family	\$1,869.50	\$329.91
				\$76.19
				\$164.96

## Classic Blue Excellus BCBS; Prescription Benefits from ProAct

<b>Plan Available To:</b>		<b>2021 RATES</b>		
<b>White Collar/Confidential/Mgmt/ Elected Officials</b> (Hired Before 08/18/15)	Annual Deductible: \$100 Individual \$200 Family Max Med OOP \$200/\$400 Max Rx OOP \$2,000/\$6,000 Healthcare Reform - Dependents to Age 26	<b>County share per month</b>	<b>Employee share per month</b>	<b>Employee per pay period</b>
<b>Corrections</b> (Hired Before 09/05/17)	Rx co-pay: \$5/\$20/\$35, 2x @ Mail 80/20 employer/employee percent share	Individual	\$825.81	\$206.45
		Family	\$1,789.94	\$447.48
				\$103.23
				\$223.74
<b>Plan Available To:</b>	Annual Deductible: \$100 Individual \$200 Family	<b>County share per month</b>	<b>Employee share per month</b>	<b>Employee per pay period</b>
<b>Deputy Sheriff's Association</b> (Hired Before 02/04/16)	Max Med OOP \$200/\$400 Max Rx OOP \$2,000/\$6,000 Healthcare Reform - dependents to age 26			
	Rx co-pay: \$5/\$20/\$35, 2x @ Mail 85/15 employer/employee percent share	Individual	\$877.43	\$154.84
		Family	\$1,901.81	\$335.61
				\$77.42
				\$167.81





# Tompkins County Department of Human Resources

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*Inclusion through Diversity*

## 2021 Tompkins County Health Insurance and Rx Plan Comparison Chart

Please note: The following charts are summaries of common expenses. Please contact Excellus BCBS (medical), or ProAct/CanaRx (pharmacy) to inquire about specifics not listed on these charts.

### Excellus BCBS Medical Coverage

Service	Platinum	PPO	Classic Blue
<b>Preventative Care</b> <i>(Adult Annual Exams, Well Child Visits, Immunizations, Cancer Screenings, Pre/Post Natal Care, etc.)</i>	Covered in Full	Covered in Full	Covered in Full
<b>Office Visit – Primary Care (Including Telemedicine)</b> <i>(Including routine lab and pathology)</i>	\$15.00 Co-pay	\$10.00 Co-pay	20% Coinsurance/ Deductible
<b>Office Visit – Specialist (Including Telemedicine)</b> <i>(ex/ Cardiology, Pulmonology, Neurology, Dermatology)</i>	\$25.00 Co-pay	\$10.00 Co-pay	20% Coinsurance/ Deductible
<b>Office Visit – Mental Health/Substance Abuse</b>	\$25.00 Co-pay	\$10.00 Co-pay	Covered in Full
<b>Urgent Care</b> Please note: Some urgent care centers bill the same as a visit to your primary care doctor, whereas others charge as an “urgent care facility”. Any urgent care center should be able to let you know if you provide your insurance details. Locally, Wellnow charges as a PCP visit and CMA Urgent Care charges as an urgent care facility.	\$15.00 Co-pay <i>(if charged as primary care visit)</i> \$40.00 Co-pay <i>(if charged as Urgent Care facility fee)</i>	\$10.00 Co-pay <i>(if charged as primary care visit)</i> \$25.00 Co-pay <i>(if charged as Urgent Care facility fee)</i>	Covered in Full
<b>Diagnostic and Routine X-Rays</b>	\$25.00 Co-pay	\$10.00 Co-pay	Covered in Full
<b>Advanced Imaging Services (MRI, etc.)</b>	\$25.00 Co-pay	\$10.00 Co-pay	Covered in Full
<b>Ambulance</b>	\$150.00 Co-pay	\$10.00 Co-Pay	Covered in Full
<b>Emergency Room (Fee Waived if Admitted)</b>	\$150.00 Co-pay	\$35.00 Co-pay	Covered in Full
<b>Inpatient Hospitalization – Including Surgery, Anesthesiology, Physician Visits, X-Rays, MRIs, Medications, etc.</b> <i>(Surgery, Injury, Physical/Mental Illness, Substance Abuse)</i>	\$250.00 Co-pay	Covered in Full	Covered in Full
<b>Maternity/Routine Newborn Nursery Care</b>	Covered in Full	Covered in Full	Covered in Full
<b>Skilled Nursing Facility</b>	\$250.00 Co-pay (45 Days)	Covered in Full (120 Days)	Covered in Full (unlimited)

<b>Inpatient Physical Rehabilitation (60 Days per Year)</b>	\$250.00 Co-pay	Covered in Full	Covered in Full
<b>Outpatient Physical Rehabilitation (45 Visits per Year)</b>	\$25.00 Co-pay	\$10.00 Co-pay	20% Coinsurance/ Deductible
<b>Chemotherapy</b>	\$15.00 Co-pay	Covered in Full	Covered in Full
<b>Radiation Therapy</b>	\$25.00 Co-pay	Covered in Full	Covered in Full
<b>Dialysis</b>	Covered in Full	Covered in Full	Covered in Full
<b>Chiropractic</b>	\$15.00 Co-pay	\$10.00 Co-pay	20% Coinsurance/ Deductible
<b>Acupuncture (10 Visits per Year)</b>	\$25.00 Co-pay	50% Coinsurance	Not Covered
<b>Orthotics</b>	20% Coinsurance	20% Coinsurance	20% Coinsurance/ Deductible
<b>Routine Vision Exam</b>	\$25.00 Co-pay	\$10.00 Co-pay	Not Covered
<b>Routine Hearing Exam</b>	\$25.00 Co-pay	Not Covered	Not Covered
<b>Adult Eyewear</b>	\$60.00 Reimbursement per year	\$60.00 Reimbursement per year	Not Covered
<b>Hearing Aids</b>	50% Coinsurance (Limit of \$3,500 for one pair every 3 years.)	Not Covered	Not Covered
<b>Allergy Testing</b>	\$15.00 PCP/ \$25.00 Spec.	\$10.00 Co-Pay	20% Coinsurance/ Deductible
<b>Allergy Treatment</b>	Covered in Full	Covered in Full	20% Coinsurance/ Deductible
<b>Blue 365 Discount Programs</b>	Included	Included	Included
<b>Blue 4 U Wellness Program (Including Labs)</b>	Included	Not Included	Not Included

### ProAct/CanaRx Pharmacy Coverage

<b>Prescription Co-pay</b>	<b>Platinum</b>	<b>PPO</b>	<b>Classic Blue</b>
<b>Retail Pharmacy (30 Day Supply)</b>	Tier 1: \$5.00 Co-pay	Tier 1: \$5.00 Co-pay	Tier 1: \$5.00 Co-pay
	Tier 2: \$35.00 Co-pay	Tier 2: \$20.00 Co-pay	Tier 2: \$20.00 Co-pay
	Tier 3: \$70.00 Co-pay	Tier 3: \$35.00 Co-pay	Tier 3: \$35.00 Co-pay
<b>Mail-Order Pharmacy (90 Day Supply)</b>	Tier 1: \$10.00 Co-pay	Tier 1: \$10.00 Co-pay	Tier 1: \$10.00 Co-pay
	Tier 2: \$70.00 Co-pay	Tier 2: \$40.00 Co-pay	Tier 2: \$40.00 Co-pay
	Tier 3: \$140.00 Co-pay	Tier 3: \$70.00 Co-pay	Tier 3: \$70.00 Co-pay
<b>CanaRx Mail-Order Rx (90 Day Supply)</b> (Select name brand medications.)	Covered in Full	Covered in Full	Covered in Full

**GREATER TOMPKINS CO. MUNICIPAL HLTH INS CONS**

**General Information**

**Cost Sharing Expenses**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	\$0	\$500	
Deductible - Family	\$0	\$1,500	Each individual does not exceed the single deductible.
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	\$2,000	\$3,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	\$6,000	\$9,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

**Office Visit Cost Shares**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	\$15 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	\$25 Copayment	20% Coinsurance Subject to Deductible	

**Plan Limits**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

**Who is Covered**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

**Inpatient Services**

**Inpatient Facility**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	\$250 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	\$250 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	\$250 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	\$250 Copayment	20% Coinsurance Subject to Deductible	45 Days per contract year Limits are combined INN and OON.
Physical Rehabilitation	\$250 Copayment	20% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	\$250 Copayment	20% Coinsurance Subject to Deductible	

## Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	Covered in Full	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

## Outpatient Facility Services

### Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	\$150 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	\$25 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	\$25 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	\$15 Copayment	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	\$15 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	\$15 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization

## Home and Hospice Care

### Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	20% Coinsurance Subject to \$50 Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to \$50 Deductible	

### Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	20% Coinsurance Subject to Deductible	

## Outpatient and Office Professional Services

### Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP - \$15 Copayment Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - \$15 Copayment	20% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - \$15 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Telehealth	PCP - \$15 Copayment Specialist - \$25 Copayment \$0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - \$15 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - \$15 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP - \$15 Copayment Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per contract year Limits are combined INN and OON.

## Rehab and Habilitation

### Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	\$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	\$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	\$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per contract year

### Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per contract year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per contract year
Speech Rehabilitation	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	45 Visits per contract year

## Preventive Services

### Preventive Professional Services Meeting Federal Guidelines\*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

### Preventive Facility Services Meeting Federal Guidelines\*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - \$25 Copayment	20% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	\$25 Copayment	20% Coinsurance Subject to Deductible	

## Other Benefits

### Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - \$15 Copayment	20% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - \$15 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - \$25 Copayment	50% Coinsurance Subject to Deductible	10 Visits per contract year
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

## Emergency Services

### ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	\$150 Copayment	\$150 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

### Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	\$150 Copayment	\$150 Copayment	

### Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	\$40 Copayment	20% Coinsurance Subject to Deductible	

## Ancillary Benefits

### Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	\$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per contract year Limits are combined INN and OON.
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	\$25 Copayment	20% Coinsurance Subject to Deductible	1 Exam per contract year Limits are combined INN and OON.
Adult Eyewear - Routine	Covered	Covered	\$60 Reimbursement per year Includes Frames/Lenses or Contact Lenses. Limits are combined INN and OON.

## Rx Benefits

### Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			Contraceptives Only

### Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	N/A		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

\* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

**GREATER TOMPKINS CO. MUNICIPAL HLTH INS CONS - TOMPKINS COUNTY**

**General Information**

**Cost Sharing Expenses**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	\$0	\$250	
Deductible - Family	\$0	\$750	Each individual does not exceed the single deductible.
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	\$1,000	\$1,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	\$3,000	\$3,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

**Office Visit Cost Shares**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	\$10 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	\$10 Copayment	20% Coinsurance Subject to Deductible	

**Plan Limits**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Calendar Year Benefits
Diabetic Preauthorization and Step Therapy			No

**Who is Covered**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

**Inpatient Services**

**Inpatient Facility**

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	Covered in Full	20% Coinsurance Subject to Deductible	120 Days per year Limits are combined INN and OON.
Physical Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	60 Days per year Limits are combined INN and OON.
Maternity Care	Covered in Full	20% Coinsurance Subject to Deductible	

## Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

## Outpatient Facility Services

### Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	\$10 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	\$10 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	20% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive to primary service	Inclusive to primary service	Is inclusive in the Home Care benefit and not covered as a separate benefit
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	\$10 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	\$10 Copayment	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization

## Home and Hospice Care

### Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	20% Coinsurance Subject to \$50 Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to \$50 Deductible	

### Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	20% Coinsurance Subject to Deductible	

## Outpatient and Office Professional Services

### Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive to primary service	Inclusive to primary service	Is inclusive in the Home Care benefit and not covered as a separate benefit
Dialysis	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - \$10 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate in our telemedicine program for medical conditions that are not an emergency condition.
Chiropractic Care	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - Not Covered	Not Covered	Not Covered

## Rehab and Habilitation

### Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	\$10 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	\$10 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	\$10 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

### Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	45 Visits per year

## Preventive Services

### Preventive Professional Services Meeting Federal Guidelines\*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

### Preventive Facility Services Meeting Federal Guidelines\*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

### Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	

## Other Benefits

### Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - \$10 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year Limits combined INN and OON.
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

## Emergency Services

### ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	\$35 Copayment	\$35 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

### Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	\$10 Copayment	\$10 Copayment	

### Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	\$25 Copayment	20% Coinsurance Subject to Deductible	

## Ancillary Benefits

### Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Eye Exams - Routine	\$10 Copayment	20% Coinsurance Subject to Deductible	1 Exam every year Limits are combined INN and OON.
Adult Eyewear - Routine	Covered	Covered	\$60 Reimbursement every year Includes Frames/Lenses or Contact Lenses
Pediatric Eye Exams - Routine	\$10 Copayment	20% Coinsurance Subject to Deductible	1 Exam every year Limits are combined INN and OON.
Pediatric Eyewear - Routine	20% Coinsurance	20% Coinsurance Subject to Deductible	1 Pair every year Includes Frames/Lenses or Contact Lenses

## Rx Benefits

### Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			

### Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	N/A		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

\* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

Excellus BCBS: Classic Blue

TC3, Tompkins County Classic Blue

Coverage Period: 01/01/2021 - 12/31/2021

A nonprofit independent licensee of the BlueCross BlueShield Association

Coverage for: Family | Plan Type: Traditional



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit Our website at www.excellusbcs.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$100 Individual/\$200 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$200 Individual/\$400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Costs for penalties for failure to obtain preauthorization for services, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge <a href="#">Deductible</a> does not apply	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge <a href="#">Deductible</a> does not apply	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. 1 Exam per year
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-Ray: No Charge X-Ray: <a href="#">Deductible</a> does not apply Blood Work: No Charge Blood Work: <a href="#">Deductible</a> does not apply	X-Ray: No Charge X-Ray: <a href="#">Deductible</a> does not apply Blood Work: No Charge Blood Work: <a href="#">Deductible</a> does not apply	None
	Imaging (CT/PET scans, MRIs)	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.excellusbcs.com/rxlist">www.excellusbcs.com/rxlist</a>	Tier 1 (Generic drugs)	<a href="#">Deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> required for certain <a href="#">prescription drugs</a> . If you don't get a <a href="#">preauthorization</a> , you must pay the entire cost of the drug.
	Tier 2 (Preferred brand drugs)	<a href="#">Deductible</a> does not apply	Not Covered	
	Tier 3 (Non-preferred brand drugs)	<a href="#">Deductible</a> does not apply	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	None
	Physician/surgeon fees	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	None

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.excellusbcs.com](http://www.excellusbcs.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Emergency medical transportation</a>	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	None
	<a href="#">Urgent care</a>	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	None N/A None limit
	Physician/surgeon fees	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	None
	Inpatient services	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	
<b>If you are pregnant</b>	Office visits	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery professional services	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	None
	Childbirth/delivery facility services	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	60 Visits per year limit
	<a href="#">Rehabilitation services</a>	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	None
	<a href="#">Habilitation services</a>	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	
	<a href="#">Skilled nursing care</a>	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	45 Days Per Year limit

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.excellusbcb.com](http://www.excellusbcb.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	None
	<a href="#">Hospice services</a>	No Charge <a href="#">Deductible</a> does not apply	No Charge <a href="#">Deductible</a> does not apply	Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

### Excluded Services & Other Covered Services:

#### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Dental care (Child)
- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Hearing aids
- Routine eye care (Adult)
- Dental care (Adult)
- Long-term care
- Routine eye care (Child)

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Chiropractic care
- Routine foot care
- Infertility treatment

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or [www.excellusbcs.com](http://www.excellusbcs.com); Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or [www.dfs.ny.gov](http://www.dfs.ny.gov). Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail [cha@cssny.org](mailto:cha@cssny.org) or [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org). A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and [www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants](http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants).

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Coinsurance</a>	20%
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">coinsurance</a>	20%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,820</b>
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**In this example, Peg would pay:**

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$80
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<b>The total Peg would pay is</b>	<b>\$80</b>
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### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Coinsurance</a>	20%
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">coinsurance</a>	20%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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**In this example, Joe would pay:**

*Cost Sharing*

<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$120

*What isn't covered*

Limits or exclusions	\$370
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<b>The total Joe would pay is</b>	<b>\$590</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Coinsurance</a>	20%
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">coinsurance</a>	20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,970</b>
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**In this example, Mia would pay:**

*Cost Sharing*

<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$70

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$170</b>
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## Dutchess Dental Rate Schedule

Available to: White Collar, Mgmt, Confidential, Elected Officials, Corrections, Sheriff's Assn.

Composite (Rates for Individual and Family are the same.)

7/1/18-6/30/19	\$138.75 month	\$69.38 per pay period
7/1/19-6/30/20	\$141.53 month	\$70.77 per pay period
7/1/20-6/30/21	\$145.78 month	\$72.89 per pay period

### Dutchess Dental Plan

- \$3,210 annual cap per person.
- No waiting period. No deductibles. No co-pays.
- Includes 3 exams and 3 cleanings per year per person.<sup>(1)</sup>
- Orthodontia coverage for dependents and adults.<sup>(2)</sup>
- \$1,000 dental implant coverage available for up to 2 implants per calendar year.<sup>(3)</sup> Additional allowances are provided for procedures related to implants like abutments and bone grafting.
- Participating dentists accept fee schedule for all covered services as payment in full.
- Member can also use their own dentist and submit claims for processing. The balances over fee schedule are responsibility of member.
- A full list of covered services, plan allowances and limitations can be found in the summary plan description booklet (available from HR) or online at [www.cseaebf.com](http://www.cseaebf.com).

*<sup>(1)</sup>Exams and cleanings do not contribute to the annual max. <sup>(2)</sup>Allowances towards orthodontic procedures do not contribute towards the annual max. <sup>(3)</sup>The \$1,000 lump sum allowance towards each implant does not contribute towards the annual max.*

## Sunrise Dental Rate Schedule

Available to Blue Collar Unit Employees ONLY  
**FULLY EMPLOYER PAID FOR THOSE HIRED BEFORE 01/01/2019;**  
 rates below apply for those hired on or after 01/01/2019.

**Composite (Rates for Individual and Family are the same.)**

7/1/19-6/30/20	\$93.12 month	\$46.56 per pay period
7/1/20-6/30/21	\$97.78 month	\$48.89 per pay period
7/1/21-6/30/22	\$105.60 month	\$52.80 per pay period

### Sunrise Dental Plan

- \$2,850 annual cap per person.
- No waiting period. No deductibles. No co-pays.
- Includes 3 exams and 3 cleanings per year per person.<sup>(1)</sup>
- Orthodontia coverage for dependents.<sup>(2)</sup>
- \$1,000 dental implant coverage available for up to 2 implants per calendar year.<sup>(3)</sup> Additional allowances are provided for procedures related to implants like abutments and bone grafting.
- Participating dentists accept fee schedule for all covered services as payment in full.
- Member can also use their own dentist and submit claims for processing. The balances over fee schedule are responsibility of member.
- A full list of covered services, plan allowances and limitations can be found in the summary plan description booklet (available from HR) or online at [www.cseaebf.com](http://www.cseaebf.com).

*<sup>(1)</sup>Exams and cleanings do not contribute to the annual max. <sup>(2)</sup>Allowances towards orthodontic procedures do not contribute towards the annual max. <sup>(3)</sup>The \$1,000 lump sum allowance towards each implant does not contribute towards the annual max.*



**Platinum 12 Vision Rate Schedule**  
Available to all benefits-eligible employees.

**Composite (Rates for Individual and Family are the same.)**

7/1/18-6/30/19	\$24.34 month	\$12.17 per pay period
7/1/19-6/30/20	\$24.34 month	\$12.17 per pay period
7/1/20-6/30/21	\$24.34 month	\$12.17 per pay period

In-Network Benefits	
Eye Exam	Every 12 months, Covered in full
Eyeglasses	
Lenses	Every 12 months, Covered in full for standard glass, plastic or polycarbonate, single-vision, lined bifocal or trifocal lenses, standard progressive (no-line bifocal), scratch resistance, tinting
Frames	Every 12 months, plan frames covered in full (value up to \$149) OR \$149 retail allowance at Vision Works stores \$30 retail allowance toward any frame at other providers
Contact Lenses	
Evaluation, fitting and follow up care	Every 12 months for collection contacts, covered in full
Contact Lenses (in lieu of eyeglasses)	Plan contact lenses consist of soft planned replacement or disposables. A formulary is used which allows for an initial supply of many of the most commonly prescribed brands. Initial supply may vary depending on lens type, wearing habits and replacement schedule OR \$125 retail allowance toward provider supplied contact lenses

**Out of Network Benefits**

You may choose to receive services from an out of network provider. Substantial out of pocket expenses can be avoided by selecting a provider who participates in our network. If an out of network provider is selected, the member must pay the provider directly and then submit for reimbursement. CSEA EBF providers can be located at [cseaebf.com](http://cseaebf.com). Out of network benefits include a reimbursement of up to \$16 for the exam and \$35 for materials.

Additional Discounted Lens Options and Coatings (member pays the indicated \$)	
Standard Anti-Reflective	\$35
Premium Anti-Reflective	\$48
Ultra Anti-Reflective	\$55
Ultraviolet (UV) Coating	\$12
Plastic Photosensitive (Transitions®, etc.)	\$65
High Index Lenses	\$55
Polarized Lenses	\$75
Ultra Progressive Lenses	\$50



Please note: This plan is currently available only to Management, Confidential, and Elected Officials.



## Dental Blue Options Summary of Benefits

Employer Group name: Tompkins County High Option Plan with Ortho

Plan Type: Voluntary

Product Type: Passive PPO (same coinsurance in & out-of-network)

2021 Rates: Individual: \$38.97/month Family: \$102.35/month

### Plan Features

Network: BlueShield local network	Dependent / student age limit: 19/25
Reimbursement In network: Fee Schedule	Reimbursement Out-of-network: Average Market Rate (UCR90)
Annual Plan Deductible: \$50 Ind / \$150 Fam	Annual Plan Maximum per member: \$1,250 per member
Deductible applies to: Classes II, IIA and III services	Annual Max applies to: Classes II, IIA and III services
Ortho Age Limit: Children to age 19	
Lifetime Orthodontia Maximum: \$1,000 per member (does not apply toward annual plan maximum)	

### Plan Benefits

Type of Care	Benefits Included	Excellus BCBS Pays:	
		In-Network	Out-of-Network
<b>Class I Preventive &amp; Diagnostic</b>	<ul style="list-style-type: none"> <li>Cleanings &amp; exams - twice per cal year</li> <li>Fluoride treatments – twice per cal year to age 16</li> <li>Sealants – unrestored 1<sup>st</sup> and 2<sup>nd</sup> permanent molars, once every 36 months</li> <li>Bitewing x-rays – up to 4 every cal year</li> <li>Full mouth / panorex x-rays – once every 36 months</li> <li>Space maintainers – up to age 16</li> <li>Emergency palliative treatment</li> </ul>	100%	100%
<b>Class II Basic Restorative</b>	<ul style="list-style-type: none"> <li>Fillings – amalgam &amp; composite; each surface covered once every 12 months</li> <li>Oral surgery – simple extractions</li> </ul>	80%	80%
<b>Class IIA Basic Restorative</b> (12 month waiting period applies for voluntary plans)	<ul style="list-style-type: none"> <li>Oral surgery – surgical extractions</li> <li>Endodontics – root canal treatment</li> <li>Periodontal surgery – osseous surgery, gingivectomy, gingival flap procedure – covered once per quadrant every 36 months</li> <li>Periodontal scaling &amp; root planing – once per quadrant every 24 months</li> <li>Periodontal maintenance following surgery – twice per cal year</li> </ul>	80%	80%

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract.

Type of Care	Benefits Included	Excellus BCBS Pays:	
		In-Network	Out-of-Network
<b>Class III Major Restorative</b> (12 month waiting period applies for voluntary plans)	<ul style="list-style-type: none"> <li>Fixed prosthetics – bridgework, abutments, pontics</li> <li>Removable prosthetics – partial / complete dentures</li> <li>Inlays / onlays / crowns – includes coverage for re-cementation</li> <li>Relines / rebases – once every 36 months and at least 6 months following initial placement</li> <li>Above services eligible for replacement every 5 years</li> <li>Implants – eligible for replacement every 10 years, and subject to alternate benefits provision</li> </ul>	50%	50%
<b>Class IV Orthodontia</b> (12 month waiting period applies for voluntary plans)	<ul style="list-style-type: none"> <li>Initial banding &amp; monthly follow-up treatment</li> </ul>	50%	50%

## How to Get The Most From Your Plan

### Pre-determination of Benefits

Pre-determination of benefits is recommended for any extensive treatment such as periodontics, orthodontics or prosthetics. A description of planned treatment and expected charges should be sent to the Plan before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be included as Covered Expenses will be determined by your Plan and are subject to the Alternate Benefit provision. When there has not been a predetermination of benefits, your Plan will determine the expenses that will be included as Covered Expenses at the time the claim is received. Predetermination of Benefits does not guarantee payment and expires one year from date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

### Alternate Benefits Provision

All covered procedures are subject to an alternate benefit allowance. When there is more than one technology or material type for a dental procedure, the dental plan will reimburse for the procedure which has the lesser allowance. When alternate benefit is enforced, your benefits are not intended to interfere with the treatment plan recommended by the dentist. You and your dentist should discuss which treatment is best suited for you, and may proceed with the original treatment plan regardless of benefit determination. If the more expensive treatment is chosen, you are liable for the balance up to the billed amount.

### Participating Dentists

Excellus BlueCross BlueShield offers a broad participating dental network in the Rochester, Syracuse, Utica and surrounding areas.

You have the option of receiving care from a dentist of your choice. However, choosing a participating dentist may result in savings for you because participating dentists agree to accept our Schedule of Allowances as payment in full for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist – that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

### Non-participating Dentists

You have the freedom to see any dentist. Non-participating dentists are not obligated to accept our Schedule of Allowances. You will be responsible for balances of non-participating dentists' charges.

### Dental Customer Service – for members and dentists

1-800-724-1675

**Hours:** Monday – Thursday 8:00 am – 5:00 pm

### Mailing address for claims

Excellus BCBS

P.O. Box 22999

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract.

Please note: This plan is currently available only to Management, Confidential, and Elected Officials.



## Dental Blue Options Summary of Benefits

Employer Group name: Tompkins County Low Option Plan, no ortho

Plan Type: Voluntary

Product Type: Passive PPO (same coinsurance in & out-of-network)

### Plan Features

2021 Rates: Individual: \$31.14/month Family: \$81.79/month

Network: BlueShield local network	Dependent / student age limit: 19/25
Reimbursement In network: Fee Schedule Reimbursement Out-of-network: Fee schedule	
Annual Plan Deductible: \$50 Ind / \$150 Fam Deductible applies to: Classes II, IIA and III services	Annual Plan Maximum per member: \$1,000 per member Annual Max applies to: Classes II, IIA and III services
Ortho Age Limit: Not Applicable	
Lifetime Orthodontia Maximum: Not Applicable (does not apply toward annual plan maximum)	

### Plan Benefits

Type of Care	Benefits Included	Excellus BCBS Pays:	
		In-Network	Out-of-Network
<b>Class I Preventive &amp; Diagnostic</b>	<ul style="list-style-type: none"> <li>Cleanings &amp; exams - twice per cal year</li> <li>Fluoride treatments – twice per cal year to age 16</li> <li>Sealants – unrestored 1<sup>st</sup> and 2<sup>nd</sup> permanent molars, once every 36 months</li> <li>Bitewing x-rays – up to 4 every cal year</li> <li>Full mouth / panorex x-rays – once every 36 months</li> <li>Space maintainers – up to age 16</li> <li>Emergency palliative treatment</li> </ul>	100%	100%
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<b>Class IIA Basic Restorative</b> (12 month waiting period applies for voluntary plans)	<ul style="list-style-type: none"> <li>Oral surgery – surgical extractions</li> <li>Endodontics – root canal treatment</li> <li>Periodontal surgery – osseous surgery, gingivectomy, gingival flap procedure – covered once per quadrant every 36 months</li> <li>Periodontal scaling &amp; root planing – once per quadrant every 24 months</li> <li>Periodontal maintenance following surgery – twice per cal year</li> </ul>	50%	50%

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Type of Care	Benefits Included	Excellus BCBS Pays:	
		In-Network	Out-of-Network
<b>Class III Major Restorative</b> (12 month waiting period applies for voluntary plans)	<ul style="list-style-type: none"> <li>Fixed prosthetics – bridgework, abutments, pontics</li> <li>Removable prosthetics – partial / complete dentures</li> <li>Inlays / onlays / crowns – includes coverage for re-cementation</li> <li>Relines / rebases – once every 36 months and at least 6 months following initial placement</li> <li>Above services eligible for replacement every 5 years</li> <li>Implants – eligible for replacement every 10 years, and subject to alternate benefits provision</li> </ul>	50%	50%
<b>Class IV Orthodontia</b> (12 month waiting period applies for voluntary plans)	<ul style="list-style-type: none"> <li>Initial banding &amp; monthly follow-up treatment</li> </ul>	Not Covered	Not Covered

## How to Get The Most From Your Plan

### Pre-determination of Benefits

Pre-determination of benefits is recommended for any extensive treatment such as periodontics, orthodontics or prosthetics. A description of planned treatment and expected charges should be sent to the Plan before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be included as Covered Expenses will be determined by your Plan and are subject to the Alternate Benefit provision. When there has not been a predetermination of benefits, your Plan will determine the expenses that will be included as Covered Expenses at the time the claim is received. Predetermination of Benefits does not guarantee payment and expires one year from date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

### Alternate Benefits Provision

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### Dental Customer Service – for members and dentists

1-800-724-1675

**Hours:** Monday – Thursday 8:00 am – 5:00 pm

### Mailing address for claims

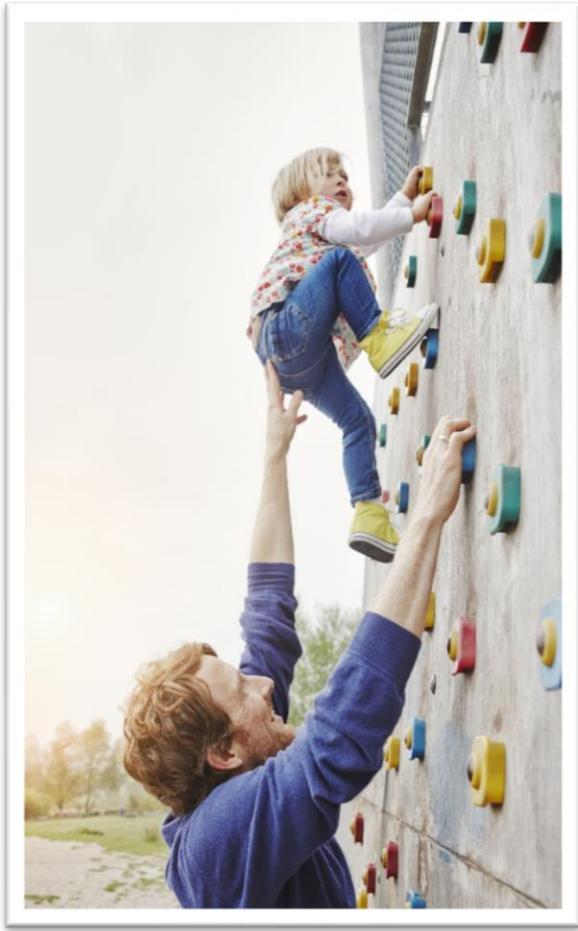
Excellus BCBS

P.O. Box 22999

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract.

# TOMPKINS COUNTY FSA OVERVIEW

Presented by: Benetech, Inc.



## IS A FLEXIBLE SPENDING ACCOUNT (FSA) RIGHT FOR YOU?

- It **saves you money**. An FSA is an employer-sponsored savings account that allows you to put aside money tax-free that can be used to pay for qualified medical and daycare expenses.
- It is a **tax-saver**. Contributions to your FSA are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you pay less in taxes.
- It is **flexible**. You can withdraw **health FSA funds** at any time during the plan year for **qualified medical expenses**, even if it's only the beginning of the year and you haven't contributed the entire yearly amount yet.

## WHAT ARE THE DIFFERENT PLANS?

- Health FSAs offer an option for setting aside money to use for qualified medical expenses. These accounts offer a convenient way to prepare for out-of-pocket medical expenses while saving on taxes. In addition, you can use your health FSA to pay not only for your medical expenses, but also for the medical expenses of your spouse and dependents. The minimum amount you must contribute to your health FSA is \$260/year while the maximum is set each year by the IRS.
- Dependent Care FSAs allow you to contribute pre-tax dollars to pay for qualified dependent care. The maximum amount you may contribute each year is **\$5,000** (or **\$2,500** if married and filing separately).

## WHAT YOU NEED TO KNOW

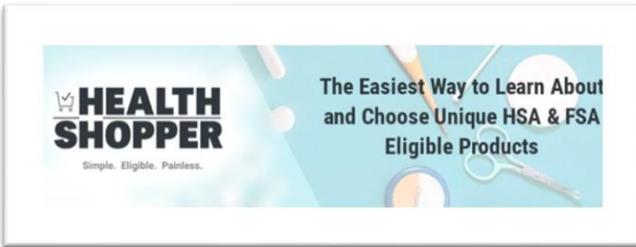
- You can enroll in either or both plans, Healthcare and Dependent Care, but they must be kept separate (funds from one account cannot be used to reimburse expenses that are eligible under the other account).
- It requires **careful planning**. FSAs operate under a use-or-lose rule, meaning that if you don't use the money in your FSA by the end of the plan year, you lose it. The Tompkins County plan however allows you to roll over funds under the HealthCare FSA if you continue to elect the plan in the following year. The maximum amount you can rollover is also set by the IRS each year.
- It requires **proof**. Even if paying for items via the FSA Debit Card, you must maintain all receipts as additional claim substantiation will be required in certain cases (e.g. most dental and vision claims are substantiated to confirm the procedure is medical and not cosmetic).
- If the debit card is used for a nonmedical expense, or you cannot provide documentation when requested, the claim will be denied, and you will have to pay the amount out of your own pocket.

For additional FSA information, visit:

<https://support.benetechadvantage.com/portal/en/kb/fsa-hra-hsa-administration/general>

# TOMPKINS COUNTY FSA OVERVIEW

Presented by: Benetech, Inc.



## LEARN ABOUT AND SHOP FOR FSA ELIGIBLE ITEMS

Benetech introduces [Health Shopper](#)! Health Shopper provides a custom curated product list. Find the products you need with the convenience you love. Visit Health Shopper to use your FSA/HRA dollars. Resupply your

emergency preparedness kit or just explore all the items that are eligible for your plan. Powered by Amazon's convenient shopping experience - search for a wide array of eligible items.

<https://my-healthshopper.com/?id=10456>

## USE THE FSA ACCESS ON THE GO!

### Provides Additional Time-Saving Options

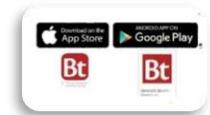
- View claims requiring receipts; we encourage you to actively manage your account using the Consumer Portal at <https://benetech.lh1ondemand.com/> or the Mobile App
- Submit medical FSA claims
- Take a picture of a receipt and submit for a new or existing claim

### Easy, Convenient & Secure

- Simply login to the app using the same health benefits website username and password (or follow alternative instructions if provided)

### Connects You with the Details

- Check available balances 24/7
- View account details
- Click to call or email Customer Service



Learn more, click to the link: [Benetech FSA/HRA/HSA Mobile App - Install and Log In](#)

## HOW DO I ENROLL?

- Even if you signed up last year, you must re-enroll for 2021.
- You must complete and return a Tompkins County Employee Benefit Change form during this years Open Enrollment which will run from October 5, 2020 – October 30, 2020. That form will have to include your FSA elections for the 2021 plan year.

## QUESTIONS?

Please contact Benetech toll free at 800-698-4753

For additional FSA information, visit:

<https://support.benetechadvantage.com/portal/en/kb/fsa-hra-hsa-administration/general>



An FSA or HRA can be used for healthcare costs, such as doctor co-pays, LASIK surgery, eyeglasses, contact lenses, orthodontics, certain over-the-counter medicines, prescriptions, and much more.

## Put the power of healthcare savings into your own hands

Flexible Spending Accounts (FSAs) or Health Reimbursement Arrangements (HRAs), are great ways for you to take advantage of a pre-tax benefit account offered through your employer. These accounts are a simple way for you to save on out-of-pocket healthcare costs not covered by your insurance plan. With healthcare costs continuing to rise, why wouldn't you participate in an FSA or HRA?



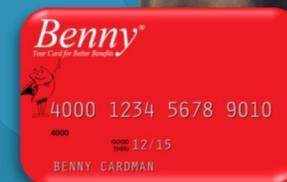
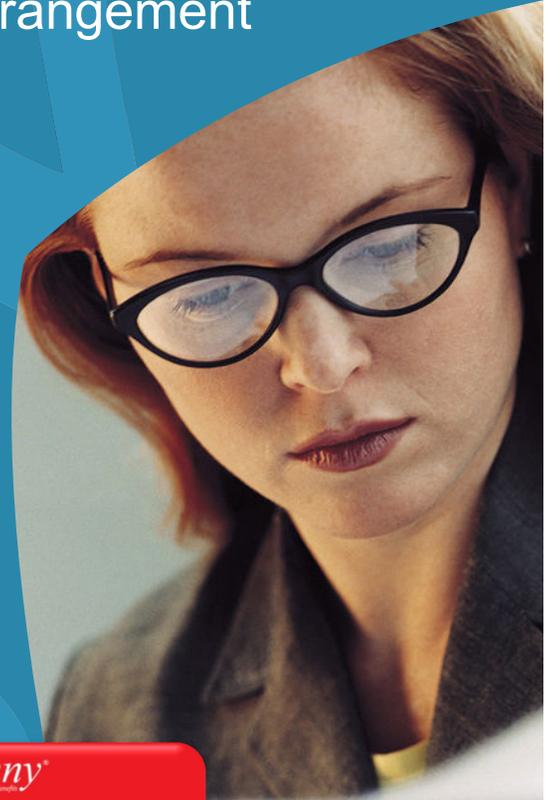
## Save your card and card materials!

One Dodge Street  
Wynantskill, NY 12198  
(518) 283-8500 (800) 698-4753  
(518) 880-4143 fax  
[www.benetechadvantage.com](http://www.benetechadvantage.com)



Important Information About Your Prepaid Benefits Card

## Enrolling in a Flexible Spending Account or Health Reimbursement Arrangement



When you enroll in an **FSA** or **HRA** plan, every dollar you set aside in your plan saves you on taxes and increases your spendable income! You'll then enjoy the benefits of using these pre-tax funds for health-related, out-of-pocket costs not covered by your insurance.

Your Prepaid Benefits Card is loaded with the value of your annual **FSA** or **HRA** election amount (less any amounts you have already spent in this plan year)\*. Using your Card helps you keep cash in your wallet and makes accessing your **FSA/HRA** funds easy. The Card can be used, instead of cash, to pay for qualified health care expenses.

## The Benefits of your Benefits Card

You'll simply swipe your Card each time you incur a qualified health care expense and the amount of your purchase will be deducted from your FSA/HRA – automatically. You can also fill in your Card number on bills you receive from providers to pay the amount you owe for service dates within the plan year. You'll have no claim forms to complete and you won't have to wait to get a check in the mail.

You can check balances or account details anytime – online or with a quick phone call. It's that easy!



**Remember, the card will not work at gas stations or restaurants – only at health care related providers.**

### IT'S IMPORTANT TO SAVE YOUR RECEIPTS!

Your Prepaid Benefits Card will definitely improve your cash flow. However, be aware that the IRS requires the Card be used only for eligible expenses. Most of the time, we can verify the eligibility of the expense automatically. **Yet, there are instances when you'll receive a letter/notification asking you to furnish an itemized receipt to verify the expense.** When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your Card suspended until receipts have been submitted and approved.

### WHAT IS AN ITEMIZED STATEMENT

An itemized statement must include: merchant or provider name, services received or item purchased, date of service, and amount of the expense. Cancelled checks, handwritten receipts, card transaction receipts or previous balance receipts cannot be used to verify an expense.

## Dependent Care FSA

You can use your dependent care FSA to cover the same types of expenses that the IRS recognizes through dependent care tax credits. \*Annual election amounts are NOT pre-loaded under Dependent Care, but are rather only available once funded via payroll contributions. Typical covered expenses include the following:

- Day care for child under the age of 13
- After-school caregivers
- Care for a disabled spouse or a dependent incapable of caring for self
- Care-related services (such as a visiting nurse)
- Summer day camps

### QUALIFIED HEALTH CARE EXPENSE ARE:

- Prescription and health plan copayments, deductibles and coinsurance
- "Amount Due" on medical and dental statements
- Orthodontics
- Mail-order or online prescription invoices
- Vision services and eyeglasses
- LASIK surgery
- Eligible over-the-counter (OTC) items



Know Your Benefits

## Know Your Health Care FSA/HRA Eligible and Ineligible Expenses

**Maximize the Value of Your Reimbursement Account** - Your Health Care Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) dollars can be used for a variety of out-of-pocket health care expenses that qualify as federal income tax deductions under Section 213(d) of the Internal Revenue Code ("IRC").

- Health Care FSA dollars can be used to reimburse you for medical and dental expenses incurred by you, your spouse or eligible dependents (children, siblings, parents and other dependents which are defined in your Plan Documents).
- HRA dollars can only be used to pay for eligible medical expenses incurred by employees and their dependents enrolled in the HRA.

**IMPORTANT:** The IRS defines which medical expenses are eligible under a tax-deferred account. Not all expenses are eligible under all plans. An employer may limit which expenses are allowable under their Health Care FSA or HRA plan. If you are unsure of what your Health Care FSA and/or HRA dollars may be used for, please contact your Plan Administrator.

Here is a sample list of expenses currently eligible and not eligible by the Internal Revenue Service ("IRS") as deductible medical expenses. This list is not necessarily inclusive or exclusive, and may be subject to change based on regulations, IRS revenue rulings and case law. It is solely based on our current interpretation of IRC Section 213(d) and is not intended to be legal advice.

For a complete up-to-date list of FSA Eligible Products & Services please reference the [FSASore.com](http://FSASore.com) [Eligibility Checker Tool](#).

### Sample List of Eligible Expenses

#### BABY/CHILD TO AGE 13

- Lactation Consultant\*
- Lead-Based Paint Removal
- Special Formula\*
- Tuition: Special School/Teacher for Disability or Learning Disability\*
- Well Baby /Well Child Care

#### DENTAL

- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

#### EYES

- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

#### MEDICAL EQUIPMENT/SUPPLIES

- Air Purification Equipment\*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment\*
- Hospital Beds\*
- Mattresses\*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes\*
- Oxygen\*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs\*

#### MEDICATIONS

- Insulin
- Prescription Drugs

#### OBSTETRICS

- Breast Pumps and Lactation Supplies
- Doulas\*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

#### PRACTITIONERS

- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath\*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

## Sample List of Eligible Expenses

### HEARING

- Hearing Aids and Batteries
- Hearing Exams

### LAB EXAMS/TESTS

- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

### MEDICAL PROCEDURES/SERVICES

- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment\*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation\*

### THERAPY

- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs\*
- Hypnosis
- Massage\*
- Occupational
- Physical
- Smoking Cessation Programs\*
- Speech
- Weight Loss Programs\*

**Note:** This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (\*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact your Plan Administrator.

**Please Note:** Currently, the IRS does NOT allow the following expenses to be reimbursed under Health Care FSAs or HRAs, as they are not prescribed by a physician for a specific ailment.

## Sample List of Ineligible Expenses

- Contact Lens or Eyeglass Insurance
- Cosmetic Surgery/Procedures
- Electrolysis
- Marriage or Career Counseling
- Swimming Lessons
- Personal Trainers
- Sunscreen (spf less than 30)

*Note: This list is not meant to be all-inclusive.*

**Please Note:** Currently, the IRS does not allow Over-the-Counter (OTC) medicines or drugs to be purchased with Health Care FSA or HRA funds unless accompanied by a prescription and the prescription is filled by a pharmacist. If you have an OTC prescription, you can use your benefits card for these purchases.

### Sample List of Ineligible Over-the-Counter Medicines and Drugs (unless prescribed in accordance with state laws)

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>■ Acid controllers</li> <li>■ Acne medications</li> <li>■ Allergy &amp; sinus</li> <li>■ Antibiotic products</li> <li>■ Antifungal (Foot)</li> <li>■ Antiphrastic treatments</li> <li>■ Antiseptics &amp; wound cleansers</li> <li>■ Anti-diarrhea's</li> <li>■ Anti-gas</li> <li>■ Anti-itch &amp; insect bite</li> <li>■ Baby rash ointments &amp; creams</li> <li>■ Baby teething pain</li> <li>■ Cold sore remedies</li> <li>■ Contraceptives</li> </ul> | <ul style="list-style-type: none"> <li>■ Cough, cold &amp; flu</li> <li>■ Denture pain relief</li> <li>■ Digestive aids</li> <li>■ Ear care</li> <li>■ Eye care</li> <li>■ Feminine antifungal &amp; anti-itch</li> <li>■ Fiber laxatives (bulk forming)</li> <li>■ First aid burn remedies</li> <li>■ Foot care treatment</li> <li>■ Hemorrhoidal preps</li> <li>■ Homeopathic remedies</li> <li>■ Incontinence protection &amp; treatment products</li> </ul> | <ul style="list-style-type: none"> <li>■ Laxatives (non-fiber)</li> <li>■ Medicated nasal sprays, drops, &amp; inhalers</li> <li>■ Medicated respiratory treatments &amp; vapor products</li> <li>■ Motion sickness</li> <li>■ Oral remedies or treatments</li> <li>■ Pain relief (includes aspirin)</li> <li>■ Skin treatments</li> <li>■ Sleep aids &amp; sedatives</li> <li>■ Smoking deterrents</li> <li>■ Stomach remedies</li> <li>■ Unmedicated vapor products</li> </ul> |
|---|---|--|

- As of January 1, 2011 eligible over-the-counter (OTC) products that are medicines or drugs (e.g., acne treatments, allergy and cold medicines, antacids, etc.) will **only** be eligible for reimbursement from your Health Care FSA with a physician's prescription that includes his or her address and license number, as stated in [IRS Notice 2010-59](#). The only exception is insulin - which will not require a prescription.

OTC items that are not medicines or drugs remain eligible for purchase with FSAs and HRAs. You can use your benefits card for these items.

### Sample List of Eligible Over-the-Counter Items (Product categories are listed in bold face; common examples are listed in regular face.)

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>■ <b>Baby Electrolytes and Dehydration</b><br/>Pedialyte, Enfalyte</li> <li>■ <b>Contraceptives</b><br/>Unmedicated condoms</li> <li>■ <b>Denture Adhesives, Repair, and Cleansers</b><br/>PoliGrip, Benzodent, Plate Weld, Efferdent</li> <li>■ <b>Diabetes Testing and Aids</b><br/>Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products</li> <li>■ <b>Diagnostic Products</b><br/>Thermometers, blood pressure monitors, cholesterol testing</li> <li>■ <b>Ear Care</b><br/>Unmedicated ear drops, syringes, ear wax removal</li> </ul> | <ul style="list-style-type: none"> <li>■ <b>Elastics/Athletic Treatments</b><br/>ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts</li> <li>■ <b>Eye Care</b><br/>Contact lens care</li> <li>■ <b>Family Planning</b><br/>Pregnancy and ovulation kits</li> <li>■ <b>First Aid Dressings and Supplies</b><br/>Band Aid, 3M Nexcare, non-sport tapes</li> <li>■ <b>Foot Care Treatment</b><br/>Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles</li> <li>■ <b>Glucosamine &amp;/or Chondroitin</b><br/>Osteo-Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements</li> <li>■ <b>Hearing Aid/Medical Batteries</b></li> </ul> | <ul style="list-style-type: none"> <li>■ <b>Home Health Care (limited segments)</b><br/>Ostomy, walking aids, decubitis/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints &amp; casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedicated wound care, wheel chairs</li> <li>■ <b>Incontinence Products</b><br/>Attends, Depend, GoodNites for juvenile incontinence, Prevail</li> <li>■ <b>Nasal Care</b><br/>Saline Nasal Spray</li> <li>■ <b>Prenatal Vitamins</b><br/>Stuart Prenatal, Nature's Bounty Prenatal Vitamins</li> <li>■ <b>Reading Glasses and Maintenance Accessories</b></li> </ul> |
|---|---|---|

For a complete up-to-date list of FSA Eligible Products & Services please reference the [FSASore.com Eligibility Checker Tool](#).





# Tompkins County

## Employee Benefits Change Form

**For HR Use Only:**  
 HI Enrollment Code: 000367-\_\_\_\_ - \_\_\_\_  
 Enrolled with Vendors Date: \_\_\_\_\_  Entered in HRIS Date: \_\_\_\_\_  
 Signature: \_\_\_\_\_

**➤ Part 1: Employee Information**

Employee Name:	Employee ID #:	Reason for Change:
Street Address:	Hire Date:	<input type="checkbox"/> Open Enrollment
City/State/Zip:	Effective Date:	<input type="checkbox"/> New Hire
Email:	Phone:	<input type="checkbox"/> Qualifying Life Event

**➤ Part 2: Health / Dental / Vision / FSA Options**

Health Plan	Dental Plan	Vision Plan	Flex Spending	HEALTH ELIGIBILITY:
<input type="checkbox"/> Platinum <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> PPO <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Classic Blue <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> CANCEL/WAIVE	<input type="checkbox"/> Dutchess Dental <input type="checkbox"/> Sunrise Dental <input type="checkbox"/> BCBS High <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> BCBS Low <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> CANCEL/WAIVE	<input type="checkbox"/> Platinum Vision <input type="checkbox"/> CANCEL/WAIVE	<input type="checkbox"/> Healthcare FSA <input type="checkbox"/> Dep. Care FSA <input type="checkbox"/> CANCEL/WAIVE	The Platinum plan is the sole option for Blue Collar, White Collar/Mgmt/Conf/Elected Officials hired after <b>08/17/15</b> , Sheriff Assn. hired after <b>02/03/16</b> , and Corrections hired after <b>09/04/17</b> . <b>DENTAL ELIGIBILITY:</b> Dutchess Dental is available to all employees aside from Blue Collar, Sunrise Dental is only available to Blue Collar, and BCBS Dental is only available to Mgmt/Conf/Elected Officials.

**➤ Part 3: Flexible Spending Account Election Amount(s)** Full Year of Pay Periods = 26 (bi-weekly employees) /12 (monthly employees)

Account	Min. Election	Max. Election	Annual Election	# of Pay Periods	\$ per Period	Note on Healthcare FSA:
Healthcare FSA	\$10.00 per Pay Period	\$2,750.00 Annual				Funds may be used for eligible expenses for all tax dependents. Up to \$550 in unused funds will roll over yearly if you are still enrolled in a Healthcare FSA.
Dependent Care FSA	\$10.00 per Pay Period	\$5,000.00 Annual				This type of FSA is for day care expenses for dependents up to age 13.

**➤ Part 4: Employee/Dependent Enrollment/Cancellation Information**

Please select Spouse or DP (Domestic Partner) if applicable. In the Health, Dental, Vision, and FSA columns, select Y to enroll in coverage or N to cancel or waive coverage.

Participant	Name (Last, First)	Gender	DOB	SSN	Health	Dental	Vision	FSA
Employee					Y <input type="checkbox"/> N <input type="checkbox"/>			
Spouse <input type="checkbox"/> DP <input type="checkbox"/>					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 1					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 2					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 3					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 4					Y <input type="checkbox"/> N <input type="checkbox"/>			
Dependent 5					Y <input type="checkbox"/> N <input type="checkbox"/>			

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Excellus BCBS Release (Classic Blue, PPO, Platinum Health Insurance Plans; BCBS High/Low Dental Plans):**

- I am applying to enroll myself and my eligible dependents, if any, under the medical contract.
  - In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
  - If this application is made on behalf of a minor, the responsible party must complete the application.
  - By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
  - I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
  - PREFERRED PROVIDER ORGANIZATION (PPO) - I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
  - I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release.**

**CSEA Release (Dutchess and Sunrise Dental; Platinum Vision):**

- Not all employers allow domestic partner coverage. For New York State Employees; before enrollment of a domestic partner can be completed, the CSEA EBF must receive eligibility confirmation from The NYS Department of Civil Service. For Local Government employees, the confirmation must come from your employer. For purposes of IRS reporting, it is necessary that you provide your domestic partner's social security number on this form.
  - When enrolling dependent children, it may be necessary for the CSEA EBF to require and/or request additional information which may include verification of eligibility by "Proof of Dependency" form, copy of Birth Certificate and/or "Certification of Disability" form.
  - In certain instances, a copy of a Marriage Certificate may be requested for proof of eligibility.
  - An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are EBF members, coverage may not be claimed under both plans.
  - For a detailed outline of eligibility rules, please refer to your Summary Plan Description or visit our website at [www.cseaebf.com](http://www.cseaebf.com).
- I certify that the information provided on my enrollment form is correct.**

**Benetech Release (Health and Dependent Care Flexible Spending Accounts):**

- I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year starting \_\_\_/\_\_\_/\_\_\_ and ending \_\_\_/\_\_\_/\_\_\_ Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked and I understand that election is required annually to participate. As a participant, I understand that:
- I cannot change or revoke this agreement during the above Plan Year, unless I have a change in my family status as set forth in the Summary Plan Description.
  - My pay will be reduced each pay period by the amount of my election(s) shown on page 1, continuing for each succeeding pay period until this agreement is amended or terminated.
  - The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my payroll reduction will automatically be adjusted to reflect that change.
  - My employer may change the amount of my reduction or otherwise modify this agreement, if it believes that the change is required to satisfy provisions of the Internal Revenue Code.
  - The amount of my compensation reduction will be credited to the appropriate reimbursement account for payment of eligible expenses incurred within the plan year.
  - Reimbursement will be available only for qualifying expenses as described in the attached form. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer, on demand, for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense that I receive.
  - Upon request, I will provide the Claims Administrator with the information (e.g., detailed receipts, itemized statements, etc.) needed to substantiate the expenses submitted for reimbursement, if needed by the Claims Administrator to satisfy the relevant IRS regulations, and that my failure to provide the required documentation will result in the deactivation of my debit card and a repayment request.
  - If there is a remaining balance in my account(s) at the end of the Plan Year (i.e., after all eligible claims have been reimbursed), I may forfeit that excess amount, based on the provisions of the Plan as detailed in the Summary Plan Description.
- By my signature, I hereby certify that any amounts reimbursed to me under this Plan will not be claimed as a deduction on my personal income tax return and will not be reimbursed to me by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA) plan.**

**Dependent Eligibility Verification Requirements:**

- > If you are enrolling a **Spouse** or **Domestic Partner**, you must attach a copy of your **Marriage Certificate**, **Certificate of Domestic Partnership**, or **Affidavit of Domestic Partnership** (contact HR for Affidavit).
- > If you are enrolling any **Dependent Children** (including step children, children of a domestic partner or any children over whom you have custody), you must attach copies of **birth certificate(s)** and copies of adoption paperwork or court order of custody (if applicable).