TOMPKINS COUNTY

Early Retirement
Health Insurance Incentive

Inclusion through Diversity

Tompkins County Department of Human Resources
125 East Court Street, Ithaca, NY 14850 | P: (607) 274-5526 | F: (607) 274-5401 | www.TompkinsCountyNY.gov
Inclusion through Diversity

June 22, 2020

Greetings:

Congratulations on qualifying for the early retirement health insurance incentive ratified by the Tompkins County Legislature this past Tuesday. Regardless of whether or not the incentive is of interest to you, thank you so much for all your hard work and dedication over more than a decade of service with Tompkins County; we couldn't have made it where we are today without your efforts. Should you choose to retire through the incentive, please know that your presence and expertise will be deeply missed, and you will always be part of the Tompkins County community.

In this packet, you will find details on the retirement incentive health insurance plans, rates, and pharmacy coverage, as well as an overview of the whole retirement process. To start, please see the full text of the early retirement incentive portion of the Legislature's resolution below:

a. The following health insurance incentive will be offered to County employees age 55 and over with 10 or more years of service with Tompkins County who choose to retire before 01/01/2021.
   i. If the employee is not Medicare-eligible, and on an individual plan, they will retire into their current Individual Plan at 20% Retiree Share, 80% County Share.
   ii. If the employee is not Medicare-eligible and has a non-Medicare-eligible spouse, they will retire into their Family Plan at 20% Retiree Share, 80% County Share.
   iii. If the employee is not Medicare-eligible and has a Medicare-eligible spouse, the employee will retire into their Individual Plan at 20% Retiree Share, 80% County Share, and the spouse will go on the Medicare Supplement 4 (MS4) Plan at 20% Retiree Share, 80%County Share.
   iv. If the employee is Medicare-eligible, and on an individual plan, they will retire into the Medicare Supplement 4 (MS4) Plan at 20% Retiree Share, 80% County Share.
   v. If the employee is Medicare-eligible and has a Medicare-eligible spouse, they will both receive Medicare Supplement 4 (MS4) Plans: the County retiree at 20% Retiree Share, 80%County Share; the Spouse at 20% Retiree Share, 80% County Share.
   vi. If the employee is Medicare-eligible and has a non-Medicare-eligible spouse, the employee will retire onto the Medicare Supplement 4 (MS4) Plan at 20% Retiree Share, 80% County Share, and the spouse will go onto an Individual Plan at 20% Retiree Share, 80% County Share.
b. This incentive will be in effect at these cost sharing rates until **12/31/2022**. Effective **01/01/2023**, all retirees and spouses under this incentive will move to the Platinum Plan, if non-Medicare eligible, at a 50/50 cost sharing rate. Those that are Medicare eligible will move to the Medicare Supplement 4 (MS4) Plan at the 50/50 cost sharing rate.
c. Employees must notify their Department Head and Human Resources of their intention to retire in 2020 by submitting an irrevocable letter of resignation by **08/14/2020**. The retirement date must fall between **06/16/2020** and **12/31/2020.** .
d. Employees whose effective retirement date from the County was prior to **06/16/2020** will not be eligible for this incentive.

e. Employees must retire directly into the New York State and Local Retirement System (NYSLRS).

As always, please feel free to reach out to Sarah Thomas, Employee Benefits Administrator, with any questions you may have once you have reviewed the materials contained herein:

Phone: (607)274-5528 / Email: sthomas@tompkins-co.org

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Quick Retirement Checklist

☐ Picking your retirement date:

In order to qualify for the retirement incentive, your retirement date must fall between 06/16/2020-12/31/2020. Per the New York State and Local Retirement System (NYSLRS), your retirement date should be the day after your last day worked/in active status. For example, if you want your official last day to be a Friday, you would pick an official retirement date of the following Saturday.

Per NYSLRS requirements, the earliest you can officially file for retirement is 90 days before your chosen retirement date and the latest you can file is 15 days before your chosen retirement date (though giving them at least one month notice is recommended if possible).

Per County policy, you must give at least 2 weeks' notice to your Department Head and the Commissioner of Human Resources prior to retirement to be eligible for fringe payout. If you give more than 2 weeks' notice, you must work at least 2 weeks between the time you give notice and the time you retire. This requirement doesn't mean you have to work every day of your last 2 weeks; just 2 weeks total after official notice is given and before retirement. The work requirement does not apply to employees out on leave when notice is given; in these cases the 2 weeks' notice is sufficient.

Please check your bargaining unit contract to see which fringes are eligible for payout and in what amounts.

☐ Who to notify:

Once you have chosen your retirement date, fill out the attached Service Retirement Application, have it notarized, then return it to NYSLRS. You also have the option of filing for retirement through your Retirement Online account, if you use one. In addition, submit written notice to your Department Head and the Commissioner of Human Resources. Please note that if you are retiring during the incentive, this notice is irrevocable once given.

Again, make sure to give notice to the County at least 2 weeks before you intend to retire, and make sure to officially file for retirement with NYSLRS no later than 15 days before your desired retirement date.

☐ Signing up for retiree health insurance:

Review the materials in this packet and reach out to Sarah Thomas, Employee Benefits Administrator, with any questions. All paperwork should be submitted prior to your last day in active status and may be turned in via email to sthomas@tompkins-co.org, fax to 607-274-5401, or interoffice mail to Human Resources. Your retiree health insurance will start the first of the month after your retirement (and your active employee health insurance will continue until the end of the month in which you retire).

Office of the New York State Comptroller
NYSLRS
New York State and Local Retirement System
110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Received Date

Application for Service Retirement

RS 6037
(Rev.09/18)

NYSLRS ID

Social Security Number [last 4 digits]
XXX-XX-

Retirement System [check one]
Employees' Retirement System (ERS) ☐
Police and Fire' Retirement System (PFRS) ☐

Proof of your date of birth is require before a benefit can be paid. If it is not immediately available, file this application now and submit proof as soon as possible. The delay in filing this document will delay payment of your allowance.

THIS APPLICATION MUST BE ON FILE WITH THE RETIREMENT SYSTEM FOR AT LEAST 15 DAYS, BUT NO MORE THAN 90 DAYS, BEFORE YOUR RETIREMENT CAN BECOME EFFECTIVE.

Items 1-12 MUST be completed. The application must be signed and notarized on reverse side.

Information About You

1. Name: (First, Middle Initial, Last)	**2. Date of Birth:**
3. Telephone Numbers: HOME ( ) CELL ( )	**4. Effective Retirement Date:****

5. Address: (Including Street, City, State and Zip Code)

6. For United States Tax Withholding and Reporting Purposes: (please check one),
I am currently a: ☐ US Citizen ☐ Resident Alien ☐ Non-resident Alien

If you are a U.S. Citizen or Resident Alien:
This form will be used as a substitute IRS Form W-9. Under penalty or perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am writing for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from back withholdings; or (b) I have not been notified by the Internal Revenue Service (IRS) I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me I am no longer subject to backup withholding I am a U.S. Citizen/Resident Alien (defined in the instructions); and
3. I am a U.S. Citizen or other U.S. person (defined in the instructions) and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (Note: This item does not apply for the Retirement application).

If you are a Non-resident Alien:
You must submit a W-8BEN tax form with your Retirement application. Please refer to the IRS instructions for directions to obtain this form. Retirement applications received without a W-8BEN tax form will be rejected. Federal Taxes must be withheld for Non- Resident Aliens.

* Social Security Number Required (see statement on reverse side)

** The effective retirement date is the first day of your retirement, not the last day worked. If you do not choose an *Effective Retirement Date*, we will, subject to your approval, establish the earliest possible retirement date.

7. Information About Your Public Employment:
To the best of your ability, please complete the following record of ALL PUBLIC EMPLOYMENT, including service in the ARMED FORCES. You may be able to secure credit for MILITARY SERVICE AND PUBLIC EMPLOYMENT, which previously may not have been available. Since you will not be able to claim any such service after your retirement becomes effective, you must provide information at this time.

Employer (Indicate whether State, County, City, Town, Village, etc.)	Department or Agency	Title of Position	Service From	Service To

8. Tier Reinstatement Application:
If you were previously a member of any public Retirement System in New York State you may be eligible to retire based on your previous membership date and tier. To apply for tier reinstatement, please complete this section.

IMPORTANT – You must complete other side

8. Tier Reinstatement Continued:

Former Membership Information: Please check the first Retirement System you were a member of:

- ☐ New York State Teachers' Retirement System
- ☐ New York State and Local Employees' Retirement System
- ☐ New York State and Local Police and Fire Retirement System
- ☐ New York City Employees' Retirement System
- ☐ New York City Board of Education Retirement System
- ☐ New York City Teachers' Retirement System
- ☐ New York Police Pension Fund
- ☐ New York City Fire Pension Fund

PLEASE COMPLETE THE FOLLOWING (if known):

Former Registration Number: _____ Date of Membership:_____

Former Name (if applicable): _____

Have you received credit for this former membership in any other retirement system? Yes ☐ No ☐

If Yes, what Retirement System? _____

Are you receiving or eligible to receive a retirement allowance based on this service? Yes ☐ No ☐

9. Other Public Retirement System Memberships:

- Are you **currently** a member of another public Retirement System in New York State? Yes ☐ No ☐
- Are you receiving or are you about to begin receiving a retirement benefit from any Retirement System on the basis of employment with New York State or any public entity in the State? Yes ☐ No ☐
- If yes, what Retirement System? _____ Registration Number: _____

10. Domestic Relations Order (DRO):

Retirement benefits are considered marital property and can be divided between you and your ex-spouse when the marriage ends in divorce. Any division of your benefits must be stated in the form of a Domestic Relations Order (DRO) – a legal document that gives us specific instructions on how your benefits should be divided.

- Do you have a current or pending legal restriction on the distribution of your pension benefit as a result of a DRO? Yes ☐ No ☐
- Have you ever been divorced? Yes ☐ No ☐

11. Beneficiary/Option Information for Estimate:

This is not the document on which you designate a beneficiary under your retirement option. You are require to make your option beneficiary on a separate form, called a "Retirement Option Election Form". If you have not filed a Retirement Option Election Form, we will be sending you one to complete and return. We are asking the following information about your intended beneficiary for informational purposes. It will ensure that the estimate, upon which you make your options selection, is based on the correct beneficiary. We are not permitted by law to accept untimely option election forms. If your form is not timely filed, the Law requires an option which does not provide benefits to any beneficiary.

Estimate Beneficiary Information:

Beneficiary Name	Date of Birth	Gender (M/F)	Spouse (Y/N)

Item numbers 12 and 13 **MUST** be completed or your application will not be accepted.

12. Please sign your name in full below: Women should sign their own names, e.g. Jane Smith **NOT** Mrs. John Smith

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of the Retirement System constitutes a crime punishable by potential incarceration and other sanctions.

I hereby make application for Service Retirement. I understand that this application may not be withdrawn on or after the effective date of retirement.

Signature:_____

13. Acknowledgement to be Completed by a Notary Public:

State of _____ County of _____ On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

NOTARY PUBLIC (Please sign and affix stamp)

POST RETIREMENT EMPLOYMENT: Your paid **public** employment must cease at the time of your retirement. There are laws governing employment after retirement, and if you plan to be employed by or contract with a **public** employer, it is important for you to know about them. Failure to comply with these laws could result in the suspension or diminishment of your retirement allowance or termination of your retirement and reinstatement in the Retirement System as a new member.

Public employment is employment by, or contract with, the State of New York, one of its political subdivisions (county, city, town village, school district) or some other public agency, such as a public authority. Employment by any other public employer located outside of New York State, employment by the Federal Government, or private employment, does not need any approval and will in no way affect the retirement allowance paid to you by this Retirement System. Any questions concerning this most important matter should be directed to the New York State and Local Retirement System. By signing this application I hereby elect coverage under Section 212 of the Retirement and Social Security Law, which permits me to earn from post-retirement public service annual amounts which do not exceed the limit provided in such section, without a resulting suspension or reduction of my retirement allowance.

HEALTH INSURANCE INFORMATION: The Retirement System does not administer Health Insurance Benefits. Any questions regarding this issue should be directed to your last employer.

***Social Security Disclosure Requirement:** In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11, 34, 311 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Personal Privacy Protection Law: The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with the timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member and Employer Services, NYS and Local Retirement System, Albany, NY 12244; call toll-free at 1-866-805-0990 or 518-474-7736 in the Albany Area.

2020 Retirement Incentive Health Insurance Rates

(Cost-sharing split is 20% Retiree/80% County through 12/31/2022.)

Plan Name/Level	2020 Rates (Full)	County Monthly	**Retiree Monthly**
Classic Blue - Individual	$983.11	$786.49	**$196.62**
Classic Blue - Family	$2,130.88	$1,704.70	**$426.18**
PPO - Individual	$967.47	$773.98	**$193.49**
PPO - Family	$2,094.68	$1,675.74	**$418.94**
Platinum - Individual	$661.16	$528.93	**$132.23**
Platinum - Family	$1,719.04	$1,375.23	**$343.81**
Medicare Supplement (MS4) - Individual Only	$576.01	$460.81	**$115.20**

*Note: Effective 01/01/2023 (or 01/01/2021 if incentive is not elected), all retirees and/or spouses under age 65 will move to the **Platinum plan**, and all retirees and/or spouses over age 65 will move to the **Medicare Supplement (MS4)** at a cost-sharing split of 50% Retiree/50% County. Retirees with a dependent child will remain on the Platinum family plan even if Medicare-eligible for as long as the child remains on coverage.*

2020 ProAct Rx Coverage

Classic Blue and PPO - $5.00/$20.00/$35.00 (90-day mail order - $10.00/$40.00/$70.00)
Platinum - $5.00/$35.00/$70.00 (90-day mail order - $10.00/$70.00/$140.00)
Medicare Supplement (MS4) - $15.00/$30.00/$45.00 (90-day mail order - $30.00/$60.00/$90.00)

All plans are also eligible for participation in the **CanaRx** mail order pharmacy program, which provides 90-day supplies of eligible name-brand medications free of charge to the retiree.

Comparison of Coverage Under the MS4 Medicare Supplement Plan, Platinum Plan, PPO Plan, and Classic Blue Plan with Medicare as Primary Payer

Covered Service	MS4 Medicare Supplement Plan	Platinum	PPO	Classic Blue
Covered Individuals	Individual - Retiree Only/Spouse Only	Individual, or Family (Spouse/DP, eligible Children)	Individual, or Family (Spouse/DP, eligible Children)	Individual, or Family (Spouse/DP, eligible Children)
Annual Out-of-Pocket Maximum	N/A	$2,000 per person/$6,000 maximum combined (In-Network)	$1,000 per person/$3,000 maximum medical (In-Network) $2,000 per person/$6,000 maximum Rx (In-Network)	$200 Individual/$400 Family medical $2,000 per person/$6,000 maximum Rx
Annual Maximum Benefits	Yes on some services; see below.	Yes on some services; see below.	Yes on some services; see below.	No.
Lifetime Maximum Benefits	Yes on some services; see below.	No.	No.	No.
Deductibles	Medicare Part A: $1,408.00/ Medicare Part B: $198.00 (Deductibles are covered in full by the Medicare Supplement Plan)	Medicare Part A: $1,408.00/ Medicare Part B: $198.00 (Platinum Deductible: $0.00, services just run through Platinum Plan until Medicare Deductibles are met.)	Medicare Part A: $1,408.00/ Medicare Part B: $198.00 (PPO Deductible: $0.00, services just run through PPO Plan until Medicare Deductibles are met.)	Medicare Part A: $1,408.00/ Medicare Part B: $198.00 (Classic Blue Deductible: $100.00 Individual/ $200.00 Family, services run through Medicare Deductibles and then apply to Classic Blue Deductibles until met.)
Inpatient Hospital	$0.00 - max 90 days/year, then standard Medicare **60-day "Lifetime Reserve"**, then additional **365 days lifetime allotment** under Medicare Supplement Plan.	$250.00 per hospitalization, unlimited days/year, unlimited lifetime max. (Once Part A deductible is met, $0.00 for first 60 days, then $250.00 for the duration of hospitalization.)	$0.00 - Unlimited	$0.00 - Unlimited
Inpatient Hospital - Mental Health	$0.00 - max 90 days/year, then standard Medicare **60-day "Lifetime Reserve"** (**190 Day Lifetime Maximum**)	$250.00 per hospitalization, unlimited days/year, unlimited lifetime max. (Once Part A deductible is met, $0.00 for first 60 days, then $250.00 for the duration of hospitalization.)	$0.00 - Unlimited	$0.00 - Unlimited
Inpatient Skilled Nursing Facility	$0.00 - max 100 days/year	$250.00 per inpatient admittance up to 45 days/year, unlimited lifetime max. (Once Part A deductible is met, $0.00 days 1-20, $250.00 up to 45 days. Additional days up to 100 days fall under Medicare Part A rate of $176.00/day.)	$0.00 - max 120 days/year (inpatient and outpatient)	$0.00 - Unlimited
Inpatient Physical Rehabilitation	$0.00 - max 90 days/year, then standard Medicare **60-day "Lifetime Reserve"**, then additional **365 days lifetime allotment** under Medicare Supplement Plan.	$250.00 per inpatient admittance up to 60 days/year, unlimited lifetime max. (Once Part A deductible is met, $0.00 up to 60 days/year. Additional days up to 90 total days fall under Medicare Part A rate of $341.00/day. "Lifetime Reserve" days up to 60 additional days per lifetime at $682.00/day.)	$0.00 - Up to 60 days/year, unlimited lifetime max. Additional days up to 90 total days fall under Medicare Part A rate of $341.00/day. "Lifetime Reserve" days up to 60 additional days per lifetime at $682.00/day.)	$0.00 - Up to 60 days/year, unlimited lifetime max. Additional days up to 90 total days fall under Medicare Part A rate of $341.00/day. "Lifetime Reserve" days up to 60 additional days per lifetime at $682.00/day.)
Inpatient Chemical Dependency/Abuse Rehab	$0.00 - max 90 days/year, then standard Medicare **60-day "Lifetime Reserve"**, then additional **365 days lifetime allotment** under Medicare Supplement Plan.	$250.00 per hospitalization, unlimited days/year, unlimited lifetime max. (Once Part A deductible is met, $0.00 for first 60 days, then $250.00 for the duration of hospitalization.)	$0.00 - Unlimited	$0.00 - Unlimited
Hospice	$0.00 - unlimited as long as provider certifies the member as terminally ill.	$0.00 - unlimited as long as provider certifies the member as terminally ill.	$0.00 - unlimited as long as provider certifies the member as terminally ill.	$0.00 - unlimited as long as provider certifies the member as terminally ill.
Ambulance (Air or Ground)	$0.00	The lesser of 20% Medicare Co-insurance/ $150.00 Platinum Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	$0.00

Covered Service	MS4 Medicare Supplement Plan	Platinum	PPO	Classic Blue
ER Visit	$0.00	The lesser of 20% Medicare Co-insurance/ $150.00 Platinum Co-pay (Co-pay waived if admitted)	The lesser of 20% Medicare Co-insurance/ $35.00 PPO Co-pay (Co-pay waived if admitted)	$0.00
Urgent Care - Facility	$0.00	The lesser of 20% Medicare Co-insurance/ $40.00 Platinum Co-pay	The lesser of 20% Medicare Co-insurance/ $25.00 PPO Co-pay	$0.00
Urgent Care - Physician Office	$0.00	The lesser of 20% Medicare Co-insurance/ $15.00 Platinum Primary/$25.00 Specialist Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	$0.00
Outpatient Primary Care Doctor	$0.00	The lesser of 20% Medicare Co-insurance/ $15.00 Platinum Primary Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	20% Co-insurance after Classic Blue deductible is met, then $0.00 after OOP max is hit.
Outpatient Specialist	$0.00	The lesser of 20% Medicare Co-insurance/ $25.00 Platinum Specialist Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	20% Co-insurance after Classic Blue deductible is met, then $0.00 after OOP max is hit.
Outpatient Mental Health	$0.00	The lesser of 20% Medicare Co-insurance/ $15.00 Platinum Primary Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	$0.00
Outpatient Chemical Dependency	$0.00	The lesser of 20% Medicare Co-insurance/ $15.00 Platinum Primary Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	$0.00
Outpatient Diagnostic Imaging (X-ray, CAT, MRI)	$0.00	The lesser of 20% Medicare Co-insurance/ $25.00 Platinum Specialist Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	$0.00
Outpatient Diagnostic Lab/Pathology	$0.00	$0.00	$0.00	$0.00
Outpatient Rehabilitation (Physical, Speech, Occupational, Pulmonary, Cardiac, etc.)	$0.00	The lesser of 20% Medicare Co-insurance/ $25.00 Platinum Specialist Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	$0.00
Treatment of Diabetes	$0.00 (Insulin covered under Rx plan)	The lesser of 20% Medicare Co-insurance/ $15.00 Platinum Primary Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	20% Co-insurance after Classic Blue deductible is met, then $0.00 after OOP max is hit.
Radiation Therapy	$0.00	The lesser of 20% Medicare Co-insurance/ $25.00 Platinum Specialist Co-pay	$0.00	$0.00
Chemotherapy	$0.00	The lesser of 20% Medicare Co-insurance/ $15.00 Platinum Primary Co-pay	$0.00	$0.00
Dialysis	$0.00	$0.00	$0.00	$0.00
Durable Medical Equipment (DME)	$0.00	20% Co-insurance	20% Co-insurance	20% Co-insurance after Classic Blue deductible is met, then $0.00 after OOP max is hit.
Eye Exams - Diagnostic	$0.00	The lesser of 20% Medicare Co-insurance/ $25.00 Platinum Specialist Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	20% Co-insurance after Classic Blue deductible is met, then $0.00 after OOP max is hit.
Routine Vision Exams	Not Covered	$25.00 Platinum Specialist Co-pay	$10.00 PPO Co-pay	Not Covered
Eyewear	Not Covered	Not Covered	$60.00 Allowance	Not Covered
Hearing Evaluations - Diagnostic	$0.00	The lesser of 20% Medicare Co-insurance/ $25.00 Platinum Specialist Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	20% Co-insurance after Classic Blue deductible is met, then $0.00 after OOP max is hit.
Routing Hearing Evaluations	Not Covered	$25.00 Platinum Specialist Co-pay	Not Covered	Not Covered
Hearing Aids	Not Covered	Coverage starting in 2021	Not Covered	Not Covered
Allergy Testing and Treatment	Not Covered	$15.00 Platinum Primary/$25.00 Specialist Co-pay	$10.00 PPO Co-pay	20% Co-insurance after Classic Blue deductible is met, then $0.00 after OOP max is hit.

Covered Service	MS4 Medicare Supplement Plan	Platinum	PPO	Classic Blue
Chiropractic Care	$0.00	The lesser of 20% Medicare Co-insurance/ $15.00 Platinum Primary Co-pay	The lesser of 20% Medicare Co-insurance/ $10.00 PPO Co-pay	20% Co-insurance after Classic Blue deductible is met, then $0.00 after OOP max is hit.
Acupuncture	Not Covered	$25.00 Platinum Specialist Co-pay	50% Co-insurance	Not Covered
Orthotics	$0.00	20% Co-insurance	20% Co-insurance	20% Co-insurance after Classic Blue deductible is met, then $0.00 after OOP max is hit.

Rx Co-pays	$15.00/$30.00/$45.00 or $30.00/$60.00/$90.00 (90 Day Mail Order)	$5.00/$35.00/$70.00 or $10.00/$70.00/$140.00 (90 Day Mail Order)	$5.00/$20.00/$35.00 or $10.00/$40.00/$70.00 (90 Day Mail Order)	$5.00/$20.00/$35.00 or $10.00/$40.00/$70.00 (90 Day Mail Order)

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.excellusbcbs.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?	$300 Individual/$300 Two Person/$600 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.excellusbcbs.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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	20% Coinsurance	None
	Specialist visit	20% Coinsurance	20% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No Charge X-Ray: Deductible does not apply Blood Work: No Charge Blood Work: Deductible does not apply	X-Ray: No Charge X-Ray: Deductible does not apply Blood Work: No Charge Blood Work: Deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com/rxlist	Tier 1 (Generic drugs)	Deductible does not apply	Not Covered	Preauthorization required for certain prescription drugs. If you don't get a preauthorization, you must pay the entire cost of the drug.
	Tier 2 (Preferred brand drugs)	Deductible does not apply	Not Covered	
	Tier 3 (Non-preferred brand drugs)	Deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need immediate medical attention	Emergency room care	No Charge Deductible does not apply	No Charge Deductible does not apply	None

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.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)	
	Emergency medical transportation	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Urgent care	No Charge Deductible does not apply	No Charge Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge Deductible does not apply	No Charge Deductible does not apply	None N/A None limit
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Inpatient services	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you are pregnant	Office visits	No Charge Deductible does not apply	No Charge Deductible does not apply	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Childbirth/delivery facility services	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No Charge Deductible does not apply	No Charge Deductible does not apply	60 Visits per year limit
	Rehabilitation services	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Habilitation services	No Charge Deductible does not apply	No Charge Deductible does not apply	
	Skilled nursing care	No Charge Deductible does not apply	No Charge Deductible does not apply	45 Days Per Year limit

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.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)	
	Durable medical equipment	20% Coinsurance	20% Coinsurance	None
	Hospice services	No Charge Deductible does not apply	No Charge Deductible 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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- Weight loss programs

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

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

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. 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 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.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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. 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 or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

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

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

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.––––––––––––––––––

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

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 plan's overall deductible	**$100**
Coinsurance	**20%**
Hospital (facility) copayment	**$0**
Other coinsurance	**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*)

Total Example Cost	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	**$80**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$100**
Coinsurance	**20%**
Hospital (facility) copayment	**$0**
Other coinsurance	**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*)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$120
What isn't covered	
Limits or exclusions	$370
The total Joe would pay is	**$590**

Mia's Simple Fracture

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

The plan's overall deductible	**$100**
Coinsurance	**20%**
Hospital (facility) copayment	**$0**
Other coinsurance	**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*)

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$170**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

B-5495

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.

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	$4,000	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	$12,000	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			Yes

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	
TeleMedicine Program	PCP/Specialist - $15 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 - $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
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	Not Covered	Not Covered	Not Covered
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

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		

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Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Requires Covered Member to be Enrolled in Both Medicare Parts A & B		
WHO IS COVERED		
Type of Coverage Offered	Single only	Single only
MEDICAL NECESSITY		
Pre-Certification Requirement	Not Applicable	Not Applicable
Medical Benefit Management Program	Not Applicable	Not Applicable
COST SHARING EXPENSES		
Contract Year	Calendar year	Calendar year
2020 Deductibles	Medicare A = $1,408 per benefit period Medicare B = $198 per year	Not Applicable
4th Quarter Deductible Carry-Over Y/N	Not Applicable	Not Applicable
Copayment	See specific benefit type	None
Coinsurance	Medicare Part B = 20%	None
Annual Out-of-Pocket Maximum	Not Applicable	Not Applicable

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Lifetime Benefit Maximum	Not Applicable	Not Applicable
HOSPITAL INPATIENT SERVICES		
Inpatient Hospital Services • Federal Mandate - Inpatient Admission for mastectomy must be covered for as long as attending physician deems medically necessary, includes mastectomy prosthesis	Medicare A (per benefit period) $1,408 Deductible $0 for the first 60 days $341 per day for days 61–90 $682 per "Lifetime Reserve Day" days 91-150 (up to a lifetime maximum of 60)	Covers Medicare Part A: Deductible Daily Copayment Amounts (days 61-90) Lifetime Reserve Copayments (days 91-150) When Medicare exhausts 100% of the Medicare allowed amount (not charges) for covered services up to 365 days per lifetime.
Mental Health Care Includes Partial Hospital State & Federal Mandate	Medicare Parts A & B Deductibles & Copays.	Covers Medicare Parts A & B Deductibles & Copays that may Apply
Mental Health Care State Mandate for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Does not apply	Inclusive in Mental Health or Inpatient benefit as determined by Medicare
Residential Treatment	Not Covered	Not Covered

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Detoxification	Medicare A (per benefit period) $1,408 Deductible $0 for the first 60 days $341 per day for days 61–90 $682 per "Lifetime Reserve Day" days 91-150 (up to a lifetime maximum of 60)	Covers Medicare Part A: Deductible Daily Copayment Amounts (days 61-90) Lifetime Reserve Copayments (days 91-150)
Skilled Nursing Facility	Medicare A (per benefit period) $0 for Days 1 – 20 $176 per day for days 21 – 100 Limited to 100 days per benefit period	Covers Medicare A: Deductible Daily copay
Physical Rehabilitation	Medicare A (per benefit period) $1,408 Deductible $0 for the first 60 days $341 per day for days 61–90 $682 per "Lifetime Reserve Day" days 91-150 (up to a lifetime maximum of 60)	Covers Medicare Part A: Deductible Daily Copayment Amounts (days 61-90) Lifetime Reserve Copayments (days 91-150) When Medicare exhausts 100% of the Medicare allowed amount (not charges) for covered services up to 365 days per lifetime.
Chemical Dependence and Abuse Rehabilitation	Medicare A (per benefit period) $1,408 Deductible $0 for the first 60 days $341 per day for days 61–90 $682 per "Lifetime Reserve Day" days 91-150 (up to a lifetime maximum of 60)	Covers Medicare Part A: Deductible Daily Copayment Amounts (days 61-90) Lifetime Reserve Copayments (days 91-150) When Medicare exhausts 100% of the Medicare allowed amount (not charges) for covered services up to 365 days per lifetime.

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Maternity Care (Federal Mandate, 48 hours for regular delivery, 96 hours for caesarean-section delivery; one home care visit covered in full, not subject to any other home care visit limitations)	Medicare A (per benefit period) $1,408 Deductible $0 for the first 60 days $341 per day for days 61–90 $682 per "Lifetime Reserve Day" days 91-150 (up to a lifetime maximum of 60)	Covers Medicare Part A: Deductible Daily Copayment Amounts (days 61-90) Lifetime Reserve Copayments (days 91-150) When Medicare exhausts 100% of the Medicare allowed amount (not charges) for covered services up to 365 days per lifetime.
Internal Prosthetics	Medicare A deductible & copay	Covers Medicare A deductible & copays.
Part A & B Blood Deductible	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible & Coinsurance
HOSPITAL OUTPATIENT SERVICES		
Observation Stay	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Surgical Care including "Surgicenters" and Freestanding	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Pre-admission/Pre-Operative Testing (State Mandated if inpatient hospital, medical/surgery covered, cover equivalent to medical/surgery)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Diagnostic Imaging, X-ray, CAT, MRI	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Routine Imaging, X-ray, CAT, MRI	Not Covered	Not Covered
Diagnostic Laboratory and Pathology	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Routine Laboratory and Pathology (Benefit must be equal to Diagnostic)	Medicare B - Some Preventive Labs Covered in Full as Determined by Medicare (e.g. Cholesterol, lipid, and triglyceride levels every five years)	Not Covered
Radiation Therapy (excludes drugs dispensed by a pharmacy)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Chemotherapy (excludes drugs dispensed by a pharmacy)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Hemodialysis	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Screening Mammogram	Medicare B Covered in Full once every 12 months for patients age 40 and above	Not covered unless Medicare deductible, coinsurance or copay applies.
Diagnostic Mammogram	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Cervical Cytology	Medicare B Covered in Full	Not covered unless Medicare deductible, coinsurance or copay applies.
Mental Health Care	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Not applicable	Inclusive in Mental Health or Office Visit as Determined by Medicare
Chemical Dependency	Medicare B $198 Deductible & 20% to 40% Coinsurance for Professional Services	Covers Medicare B Deductible and Coinsurance
Covered Therapies Includes Physical, Speech, and Occupational Therapy	Medicare B $198 Deductible & 20% Coinsurance Annual Limit may apply	Covers Medicare B Deductible and Coinsurance
Pulmonary Rehabilitation	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Cardiac Rehabilitation	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Injectable Drugs Excludes vaccines, allergy injections & treatment of diabetes.	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
HOME CARE		
Home Care Services	Medicare Parts A & B Covered in Full	Not covered unless Medicare deductible, coinsurance or copay applies. DME as part of Home Care Medicare A or B Coinsurance.

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
HOSPICE CARE		
Hospice Care	Medicare Part A – Covered In Full • Medicare pays all but very limited coinsurance for outpatient drugs and inpatient respite care • Available as long as the provider certifies the member is terminally ill and the member elects to receive these services.	Medicare Part A Copay for Outpatient Prescription Drugs. Medicare Part A Coinsurance for Respite Care.
PHYSICIAN SERVICES		
Inpatient Hospital Surgery	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Outpatient Hospital & Ambulatory Surgery	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Office Surgery	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Covered Therapies Includes Physical, Speech, and Occupational Therapy	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Anesthesia (includes IP, OP, OV and delivery)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Additional Surgical Opinion State Mandated if inpatient hospital, medical/surgery covered. Coverage equivalent to inpatient medical/surgery.	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Second Medical Opinion State Mandated for cancer; cover equivalent to office visit.	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Maternity Care: Normal, Complications & Termination.	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Prenatal and Postpartum Care	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Delivery Anesthesia Must cover equivalent to surgical Anesthesia	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
In-Hospital Physician Visits Federal Mandate - IHM for mastectomy must be covered for as long as attending physician deems medically necessary	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
PHYSICIAN'S OFFICE SERVICES – PREVENTIVE SERVICES		
Routine Physical Exam – including routine labs done in conjunction with physical.	Initial Welcome to Medicare Visit Covered in Full within first 12 Months of Enrollment. Yearly Wellness Exams – Covered in Full	Not Covered
Adult Immunizations	Medicare B Flu Shot, including H1N1 covered in full Hepatitis shot subject to deductible & coinsurance	Not covered unless Medicare Deductible, Coinsurance or Copay Applies.
Eye Exams Routine	Not covered	Not Covered
Eyewear (Frames, Lenses, and/or Contact lenses)	Not Covered	Not Covered
Hearing Evaluations Routine	Not Covered	Not Covered
Routine GYN Visits including Cervical Cytology mandate	Covered in Full – Once Every 24 Months	Not Covered
Prostate Cancer Screenings	Exam Covered Every 12 Months Subject to Medicare B $198 Deductible & 20% Coinsurance Lab Test Covered in Full	Covers Medicare B Deductible and Coinsurance

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Bone Density Testing	Covered in Full Every 24 Months Provided Medicare Criteria is Satisfied	Covers Medicare B Deductible and Coinsurance, if applicable
PHYSICIAN'S OFFICE SERVICES		
Office/Outpatient Consultations	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Diagnostic Office Visits	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Diagnostic Laboratory and Pathology	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Routine Laboratory and Pathology (Benefit must be equal to Diagnostic)	Medicare B - Some Preventive Labs Covered in Full as Determined by Medicare (e.g. Cholesterol, lipid, and triglyceride levels every five years)	Not Covered
Eye Exams – Diagnostic	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Hearing Evaluations Diagnostic	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Diagnostic Imaging Services X-ray, CAT, MRI, etc.	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Radiation Therapy (excludes drugs dispensed by a pharmacy)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Chemotherapy (excludes drugs dispensed by a pharmacy)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Hemodialysis	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Mammogram - Diagnostic	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Routine GYN Visits including Cervical Cytology mandate State Mandated if inpatient hospital, medical/surgery covered.	Covered in Full – Every 24 Months Pap Smear Covered in Full	Not Covered
Allergy Testing and Treatment (Includes Serum and Injections)	Not Covered	Not Covered
Mental Health Care	Medicare B $198 Deductible & 20% to 40% Coinsurance	Covers Medicare B Deductible and Coinsurance
Chemical Dependency	Medicare B $198 Deductible & 20% to 40% Coinsurance	Covers Medicare B Deductible and Coinsurance

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Chiropractic Care	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Injectable Drugs (excludes vaccines, allergy injections & treatment of diabetes)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
ADDITIONAL BENEFITS		
Treatment of Diabetes (Insulin & Supplies)	Medicare B $198 Deductible & 20% Coinsurance Insulin Not Covered by Medicare B	Covers Medicare B Deductible and Coinsurance Insulin Covered Under Rx Plan
Diabetic Education	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Diabetic Equipment	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Mastectomy Prosthesis	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Durable Medical Equipment (DME)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
External Prosthetics/Orthotics (including Foot Orthotics)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Medical Supplies	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Nutritional Therapy	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Pre-hospital Emergency Services and/or Transportation Services (includes all ground transportation)	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Air Ambulance Service	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Facility Emergency Room	Medicare Part B Copayment	Covers Medicare Part B Copayment
Emergency Room Physician Visit	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Freestanding Urgent Care Center	Medicare Part B Copayment	Covers Medicare Part B Copayment
Urgent Care Physician Visit	Medicare B $198 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Medically Necessary Emergency Care in a Foreign Country	Not covered	80% of charges after a $250.00 deductible per calendar year Care must begin during the first 60 consecutive days of each trip outside the United States. Payments for emergency care are subject to a lifetime maximum of $50,000

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
OTHER BENEFITS		
Acupuncture	Not Covered	Not Covered
Oral Surgery	Not Covered	Not Covered
Prescription Drugs	Not Covered	Covered By: ProAct $15/$30/$45 Retail (30 Day Supply) $30/$60/$90 Mail (90 Day Supply)
Private Duty Nursing	Not Covered	Covered at 80% of Billed Amount up to a Maximum of $100 Per Day for up to 30 Days Per Calendar Year
Non-assigned Provider	Not Covered	If the Medical Provider Accepts Medicare's Assignment, the Following will Apply: • The balance will be covered when Medicare pays a percentage of the Medicare approved amount for a covered Part B service.

Exclusions: Excluded services are determined by Medicare and are subject to change. For any services not listed herein, check eligibility with Medicare.

Mail Order Registration -

Receive a 90-day supply for the cost of two 30-day fills at your local pharmacy.

Patient Profile Form

PROACT® PHARMACY SERVICES

Insured Family Member

Last Name:_____ First Name:_____ M.I:___ DOB:_____ Sex: M / F

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile:_____ Work:_____

Drug Allergies:_____ Medical Conditions:_____

Spouse

Last Name:_____ First Name:_____ M.I:___ DOB:_____ Sex: M / F

Home Phone:_____ Mobile:_____ Work:_____

Drug Allergies:_____ Medical Conditions:_____

Dependent

Last Name:_____ First Name:_____ M.I:___ DOB:_____ Sex: M / F

Home Phone:_____ Mobile:_____ Work:_____

Drug Allergies:_____ Medical Conditions:_____

Dependent

Last Name:_____ First Name:_____ M.I:___ DOB:_____ Sex: M / F

Home Phone:_____ Mobile:_____ Work:_____

Drug Allergies:_____ Medical Conditions:_____

Prescriptions Enclosed (New/Refills)

Name:_____ DOB:_____ Refill #'s/New Rx:_____

Name:_____ DOB:_____ Refill #'s/New Rx:_____

Name:_____ DOB:_____ Refill #'s/New Rx:_____

Name:_____ DOB:_____ Refill #'s/New Rx:_____

Total Prescriptions Enclosed: **New:**_____ **Refills:**_____

Please Contact us at 1-866-287-9885 to arrange a form of payment to avoid delays in shipping your prescription orders.

Completed Forms can be returned to: **ProAct Pharmacy Services; 1226 US Hwy 11; Gouverneur, NY 13642**

Receipt of Privacy Practices

I acknowledge the receipt of the ProAct Pharmacy Services Notice of Privacy Practices

_____ _____ _____

Signature of Insured Family Member Printed Name of Insured Date

CRXMeds

Receive a 90-day supply of an approved name-brand Rx via mail order free of charge.
Check if your medication is eligible at www.CRXmeds.com or by calling 1-866-893-6337.

MEMBER ID #:

FAX DIRECTLY **FROM YOUR DOCTOR'S OFFICE WITH YOUR PRESCRIPTION(S) TOLL-FREE TO: 1-866-715-(MEDS) 6337**
OR
MAIL **TO:** *CRXMeds*, **235 EUGENIE ST. WEST, SUITE 105D, WINDSOR, ON, CANADA, N8X 2X7 PHONE TOLL-FREE: 1-866-893-(MEDS) 6337**
-CONTACT US ABOUT EXPEDITING COMMUNICATIONS CROSSING THE BORDER

PATIENT INFORMATION: **Birthdate** _____ MM/DD/YYYY ☐ **SUBSCRIBER** ☐ **SPOUSE** ☐ **DEPENDENT**

Phone (Home) **Phone (Work or Cell)**

First Name (please print) **Initial** **Last Name**

Street Address

City/State **Zip Code**

NOTE:
Please request a **3-month** supply of medication with **3 refills.**

New-to-you medications must be domestically prescribed, filled and taken for a period of no less than 30 days.

List all prescription, non-prescription, over-the-counter medications, herbal, nutritional and vitamin supplements and their strengths. *(THIS IS NOT A PRESCRIPTION.)*

Name of Medicine	Dosage	Time(s) to Take	Date Started	Reason for Taking
Ex. Januvia	*Ex. 50mg*	*Ex. Twice Daily*	*Ex. 8/20/2017*	*Ex. Diabetes*

MEDICAL HISTORY ***(If you require more space, please attach a separate piece of paper.)*** ☐ **Male** ☐ **Female**

(i) Operations: e.g., Hysterectomy, Gall bladder, Heart operations, etc. _____

(ii) Hospitalizations: (stays in hospital during the past 5 years) _____

(iii) Present illness: (ongoing) e.g., Diabetes, Heart disease, Osteoporosis, etc. _____

(iv) Drug allergies: ☐ NO ☐ YES If yes, please specify: _____

AUTHORIZATION **IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18**
I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that he/she has been, and will be, regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided above is accurate and true.

Parent's/Guardian's Signature **Date:** *(MM/DD/YY)*

AUTHORIZATION **IF THE PATIENT IS THE SUBSCRIBER, SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER**
I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided by me is accurate and true.

Patient Signature: **Date:** *(MM/DD/YY)*

Excellus

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Instructions on last page. All Dates = mm/dd/yy

Inclusion through Diversity

TOMPKINS COUNTY

GROUP ENROLLMENT FORM

PLEASE PRINT CLEARLY

1 – Group Employer Information

This section should be completed by the Group Benefits Administrator.
This application cannot be processed without this information and a signature.

Please use blue or black ink, print one character per box

Group # 00036755

Subgroup # ☐☐☐☐

Class# ☐☐☐☐

Employer Name: **Tompkins County**

Association/Chamber Name (if applicable)

Group Administrator Signature/Date: **X**

Subscriber Status:
☐ Active ☐ Retired ☐ COBRA ☐ Cancelled

Please indicate reason for COBRA:
☐ Left Employ/Retirement ☐ Death of Spouse
☐ Divorce/Legal Separation ☐ Dependent Reached Max Age
☐ Other _____

Effective Date ☐☐☐☐☐☐

COBRA Effective Date ☐☐☐☐☐☐

Hire/Rehire Date ☐☐☐☐☐☐

Retired Effective Date ☐☐☐☐☐☐

2 – Subscriber Plan Selection

Department # ☐☐☐☐☐☐☐☐ Employee # ☐☐☐☐☐☐☐☐☐☐

Please use blue or black ink, print one character per box. Check applicable plan(s).

Note on plan eligibility: All participants (aside from retirees age 65+) may elect the Platinum plan, but it is the **sole option** for the following:

> White Collar/Mgmt/Confidential/Elected Officials Hired On/After **08/18/15**
> Corrections Employees Hired On/After **09/05/17**
> Sheriff's Association Employees Hired On/After **02/04/16**
> Blue Collar Employees
> Retirees under age 65 who opted into the Platinum previously

Please check coverage type(s) and circle person(s) to be covered:

☐ Platinum: Self / Spouse(DP) / Family
☐ PPO: Self / Spouse(DP) / Family
☐ Classic Blue: Self / Spouse(DP) / Family
☐ Medicare Supplement (MS4): Self / Spouse(DP) / Family

3 – Reason for Enrollment/Change

Subscriber, please indicate the reason for this enrollment or change.

☐ New Hire ☐ COBRA ☐ Retirement ☐ Loss of Coverage ☐ Domestic Partner
☐ Open Enrollment ☐ Address/Phone Number ☐ Last Name ☐ Age 65+ ☐ Remove Dependent ☐ Change in Student Status
☐ Medicare Eligible / Please indicate reason for Medicare eligibility: ☐ Newborn ☐ Disability ☐ End Stage Renal Disease
☐ Add Dependent / Please indicate reason for adding dependent: ☐ Adoption ☐ Marriage ☐ Marital Status Change

4 – Subscriber Information

Please complete both sides of this application.
The subscriber signature is required in order to process the application.

Subscriber's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Subscriber's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Initial ☐ Title ☐☐☐

E-mail Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Mailing Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Apt or Suite ☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State ☐☐ Zip ☐☐☐☐☐

Work Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Home Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Cell Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Date of Birth ☐☐☐☐☐☐

Gender ☐ M ☐ F

Social Security Number ☐☐☐-☐☐-☐☐☐☐

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced/ Marital Status Event Date ☐☐☐☐☐☐

Medicare Number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐ Part A Effective Date ☐☐☐☐☐☐ Part B Effective Date ☐☐☐☐☐☐

If Medicare eligible due to ESRD please check type of dialysis: ☐ Self administered ☐ Facilitated Date started ☐☐☐☐☐☐

5 – Other Coverage Information

Are you or any member of your family enrolled in any other health [or dental] insurance policy (including Medicare or Medicaid)?Health? ☐ No ☐ Yes

If answering "Yes", are you keeping the additional health coverage? ☐ No ☐ Yes

If you are keeping the other coverage and need to coordinate benefits, please answer the questions below:

Who does the other plan cover? ☐ Self ☐ Spouse ☐ Children

Other insurance carrier name:

Other insurance name of policyholder:

Policy ID Number: ☐☐☐☐☐☐☐☐☐☐ Effective Date ☐☐☐☐☐☐ Termination Date ☐☐☐☐☐☐

6 – Cancellation Information

Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).

Subscriber ☐ Medical /Reason_____ Date ☐☐☐☐☐☐

Dependent (list each dependent in section 7)

☐ Medical / Reason _____ Date ☐☐☐☐☐☐

7 – Dependent Information

***Please attach a sheet for additional dependents if needed.**

Please provide all information for each person to be covered.

Subscriber's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Subscriber's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Spouse[/Domestic Partner] Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Spouse[/Domestic Partner] First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ M.I. ☐

☐ Male ☐ Female Date of Birth ☐☐☐☐☐☐ Social Security Number ☐☐☐-☐☐-☐☐☐☐ Are you enrolling as a Domestic Partner? ☐ Yes ☐ No

Medicare Number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐ Part A Effective Date ☐☐☐☐☐☐ Part B Effective Date ☐☐☐☐☐☐

Subscriber's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Subscriber's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐]

Dependent's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Dependent's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ M.I. ☐

☐ Male ☐ Female Date of Birth ☐☐☐☐☐☐ Social Security Number ☐☐☐-☐☐-☐☐☐☐ Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No

(See last page for additional information)

8 – Release/Signature

Subscriber signature required. You must sign and date this form to be eligible for insurance.

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 on the back.

Subscriber Signature_____**Date**_____

Dependent Eligibility Verification Requirements:

> If you are enrolling a **Spouse** or **Domestic Partner** to coverage, you must attach to your application a copy of your **Marriage Certificate** or **Certificate of Domestic Partnership**.

> 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 to your application copies of **birth certificate(s)** and copies of adoption paperwork or court order of custody (if applicable).

March 26, 2018

Re: Tompkins County Retiree Benefits

Important Information About Your Retiree Coverage

Tompkins County has retained **Benetech, Inc.** to provide all retiree billing services effective April 1, 2018.

As you currently have an active retiree health reimbursement arrangement (Retiree HRA (VEBA)), you may use those funds to pay for your retiree medical premium by opting in to do so.

Should you elect to use your Retiree HRA (VEBA) for your medical premium, your premium payment will be deducted from your Retiree HRA (VEBA) balance monthly on or around the 15th of each month. You will not receive a monthly invoice regarding your premium until such time as your Retiree HRA (VEBA) funds will not cover the monthly premium or a premium rate change is effective. You may review your Retiree HRA (VEBA) balance as desired online or through the mobile app.

To use your Retiree HRA (VEBA) for your medical premium, please complete the following and return to Lisa Millington (contact information below).

Name (print clearly): _____

By signing below, I hereby elect to use my retiree health reimbursement arrangement (Retiree HRA (VEBA)) for my medical premium.

Signature: _____

Should you have any questions about any of the materials included in this mailing, please contact:

Lisa Millington - Benetech's Retiree Billing Representative

Phone:	518.283.8500 ext. 337
Toll Free:	800.698.4753 ext. 337
Direct Fax:	518.880.4029
Email:	lisam@benetechadvantage.com

Benetech
c/o: Lisa Millington
PO Box 348
Wynantskill, NY 12198

Thank you!

Benetech
benefits • payroll • hr

P.O. Box 348
One Dodge Street
North Greenbush, NY 12198
P: (518) 283-8500
Toll Free: 800-698-4753
F: (518) 283-2393
www.benetechadvantage.com

Premium Payment Authorization Form

AUTOMATIC MONTHLY DEDUCTION

PARTICIPANT INFORMATION
Employer (Company/Group) Name: _____
Participant Full Name: _____
(Exactly as it appears on the checking account.)

Participant Social Security Number: _____
Participant Phone Number: _____

ACCOUNT INFORMATION
Bank Name: _____
Branch Location: _____
Branch Full Address: _____

_____

Branch Phone Number: _____
Account Number: _____
Routing Number: _____

AGREEMENT
I hereby authorize Benetech to deduct applicable healthcare premium payments from the bank account listed above on a monthly basis. I understand that I may discontinue this payment service at any time by notifying Benetech at least thirty (30) days prior to the payment due date. I also understand that the amount deducted from my account may change if I add or delete a dependent(s) or in the event of a premium change to my plan. I agree that I am solely responsible to maintain sufficient funds in the account to ensure monthly premiums can be deducted on the 15th of each month (or the first business day thereafter if the 15th is on a weekend or bank holiday).

Further, I understand that if the transfer is returned for any reason, I will be invoiced for the total amount due. If there are two (2) returned transfers on the account I will be billed for the premiums due as well as any banking fees incurred, and thereafter will be required to submit money orders as payment.

Participant Signature: _____ Date: _____
(Must be an authorized signer on the checking account.)

*Participant must include a voided or cancelled check with the account information above to complete this authorization.

Mail the completed form and check to:
Benetech, Inc.
ATTN: Sheila Hand
One Dodge Street
North Greenbush, NY 12198

Call Customer Service at (518) 283-8500 option 4 with any questions or to terminate this authorization.
Once Electronic Transfers start you will no longer receive an invoice each month. Invoices will be generated only for rate changes or returned transfers.