GREATER
TOMPKINS COUNTY MUNICIPAL
HEALTH INSURANCE CONSORTIUM

Municipalities building a
stable insurance future.

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MOTION NO. 005-2014 – Approval of Medicare Supplement Plan Rate as Described in attached spreadsheet

MOVED BY: Judy Drake

SECONDED BY: Mack Cook

VOTE: Unanimous

* * * * * * * * *

STATE OF NEW YORK)
) ss:
COUNTY OF TOMPKINS)

I hereby certify that the foregoing is a true and correct transcript of a motion adopted by the Greater Tompkins County Municipal Health Insurance Consortium on June 26, 2014.

Michelle Pottorff, Administrative Clerk

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Requires both Medicare A & B enrollment.		
WHO IS COVERED		
Type of Coverage Offered	Single only	Single only
MEDICAL NECESSITY		
Pre-Certification Requirement	None	None
Medical Benefit Management Program	Not Applicable	Not Applicable
COST SHARING EXPENSES		
Contract Year	Calendar year	Calendar year
2014 Deductibles	Medicare A = $1,216 per benefit period Medicare B = $147 per year	None
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	None

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare 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) $1,216 Deductible $0 for the first 60 days $304 per day for days 61–90 $608 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 A & B deductible & copays.	Covers Medicare deductible & 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 A & B	GTCMHIC Medicare Supplement Plan
Detoxification	Medicare A (per benefit period) $1,216 Deductible $0 for the first 60 days $304 per day for days 61–90 $608 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 $152 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) $1,216 Deductible $0 for the first 60 days $304 per day for days 61–90 $608 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) $1,216 Deductible $0 for the first 60 days $304 per day for days 61–90 $608 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.

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Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Maternity Care (Federal Mandate, 48 hrs regular delivery, 96 for c-section; one home care visit covered in full, not subject to any other home care visit limitations)	Medicare A (per benefit period) $1,216 Deductible $0 for the first 60 days $304 per day for days 61–90 $608 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.
Maternity Care – Routine Newborn Nursery (Federal Mandate - must be covered equivalent to Maternity care, no limits).	Medicare A (per benefit period) $1,216 Deductible $0 for the first 60 days $304 per day for days 61–90 $608 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.
Observation Stay	Medicare A (per benefit period) $1,216 Deductible $0 for the first 60 days $304 per day for days 61–90 $608 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.

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Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Part A & B Blood Deductible	Medicare B deductible and copayment	Covers Medicare B deductible & copayment
HOSPITAL OUTPATIENT SERVICES		
Surgical Care including "Surgicenters" and Freestanding	Medicare B copayment	Covers Medicare B copayment
Pre-admission/Pre-Operative Testing (State Mandated if inpatient hospital, medical/surgery covered, cover equivalent to medical/surgery)	Medicare B copayment	Covers Medicare B copayment
Diagnostic Imaging, X-ray, CAT, MRI	Medicare B copayment	Covers Medicare B copayment
Diagnostic Laboratory and Pathology	Medicare B copayment	Covers Medicare B copayment
Routine Laboratory and Pathology (Benefit must be equal to Diagnostic)	Medicare B - Some preventive labs CIF (e.g. Cholesterol, lipid, and triglyceride levels every five years)	Not Covered
Radiation Therapy (excludes drugs dispensed by a pharmacy)	Medicare B copayment	Covers Medicare B copayment
Chemotherapy (excludes drugs dispensed by a pharmacy)	Medicare B copayment	Covers Medicare B copayment
Hemodialysis	Medicare B copayment	Covers Medicare B copayment

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Mammogram State Mandated if inpatient hospital, medical/surgery covered	Medicare B Covered in Full	Not covered unless Medicare deductible, coinsurance or copay applies.
Cervical Cytology Pap Smear, doesn't include breast exam State Mandated if inpatient hospital, medical/surgery covered	Medicare B Covered in Full	Not covered unless Medicare deductible, coinsurance or copay applies.
Mental Health Care Federal Mandate - Unique financial limits not imposed on other benefits prohibited. NYS Mandate: 20 visits per calendar year combined with physician, coverage equal to diagnostic office visit, if OV not covered coverage equal to CD	Medicare B deductible & copayment. 50% coinsurance for professional.	Medicare B Deduct, Copay or Coinsurance
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

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Chemical Dependency State Mandated 60 visits (includes 20 family visits); cover equivalent to inpatient surgical benefit	Medicare B deductible & copayment. 50% coinsurance for professional.	Equivalent to Medicare Supplemental Coverage
Covered Therapies Includes Physical, Speech, and Occupational Therapy	Medicare B deductible & coinsurance.	Covers Medicare B deductible and coinsurance
Pulmonary Rehabilitation	Medicare B copayment	Covers Medicare B copayment
Cardiac Rehabilitation	Medicare B deductible & coinsurance.	Covers Medicare B deductible and coinsurance
Injectable Drugs Excludes vaccines, allergy injections & treatment of diabetes.	Medicare B copayment	Covers Medicare B copayment
HOME CARE		
Home Care Services State Mandated; benefits of not less than 40 4 hour visits per 12 month period, no less than 75% coinsurance & no more than $50 deductible	Medicare 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.

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Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
HOSPICE CARE		
Hospice Care New York State Mandated must include 5 bereavement counseling visits.	Medicare A – Covered In Full • A Hospice benefit will be added to all Med Supp plans which covers for all Part A eligible hospice and respite care expenses. • 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 A Copay for outpatient prescription drugs. Medicare A Coinsurance for respite care.
PHYSICIAN SERVICES		
Inpatient Hospital Surgery	Medicare A or B deductible & coinsurance	Covers Medicare A or B deductible & coinsurance
Outpatient Hospital & Ambulatory Surgery	Medicare B deductible & coinsurance	Covers Medicare B deductible and coinsurance
Office Surgery	Medicare B deductible & coinsurance	Covers Medicare B deductible and coinsurance
Covered Therapies Includes Physical, Speech, and Occupational Therapy	Medicare B deductible & coinsurance	Covers Medicare B deductible and coinsurance

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Anesthesia (includes IP, OP, OV and delivery)	Medicare A or B deductible & coinsurance depending on site of service	Covers Medicare A or B deductible & coinsurance depending on site of service
Additional Surgical Opinion State Mandated if inpatient hospital, medical/surgery covered. Coverage equivalent to inpatient medical/surgery.	Medicare B deductible & coinsurance	Covers Medicare B deductible and coinsurance
Second Medical Opinion State Mandated for cancer; cover equivalent to office visit.	Medicare B deductible & coinsurance	Covers Medicare B deductible and coinsurance
Maternity Care: Normal, Complications & Termination. Federal Mandated coverage. Global fee includes prenatal and postpartum care.	Medicare A or B deductible & coinsurance depending on site of service	Not unless Medicare covers.
Prenatal and Postpartum Care	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Delivery Anesthesia Must cover equivalent to surgical Anesthesia	Medicare A or B deductible & coinsurance depending on site of service	Covers Medicare A or B deductible & coinsurance depending on site of service

Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
In-Hospital Physician Visits Federal Mandate - IHM for mastectomy must be covered for as long as attending physician deems medically necessary	Medicare A deductible & coinsurance	Covers Medicare B deductible & coinsurance
PHYSICIAN'S OFFICE SERVICES – PREVENTIVE SERVICES		
Well Child Visits and Immunizations State mandated benefit - must be covered in full for in-network or participating providers. Apply benefit equivalent deductible, copayment, or coinsurance to out-of-network or non-participating providers.	Not Applicable	Not Applicable
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.
PHYSICIAN'S OFFICE SERVICES – OTHER SERVICES		
Diagnostic Laboratory and Pathology	Medicare B deductible & coinsurance	Not covered unless Medicare deductible, coinsurance or copay applies.

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Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Routine Laboratory and Pathology (Benefit must be equal to Diagnostic)	Medicare B deductible & coinsurance some preventive labs are covered in full (e.g. Cholesterol, lipid, and triglyceride levels every five years)	Not covered unless Medicare deductible, coinsurance or copay applies.
Eye Exams – Diagnostic	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Eye Exams Routine	Not covered	Not Covered
Eyewear (Frames, Lenses, and/or Contact lenses)	Not Covered	Not Covered
Hearing Evaluations Diagnostic	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Hearing Evaluations Routine	Not Covered	Not Covered
Hearing Aids	Not Covered	Not Covered
Diagnostic Office Visits Includes all diagnostic physician visits e.g. GYN, cardiac, orthopedists, etc.	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Office/Outpatient Consultations	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance

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Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Diagnostic Imaging Services X-ray, CAT, MRI, etc.	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Radiation Therapy (excludes drugs dispensed by a pharmacy)	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Chemotherapy (excludes drugs dispensed by a pharmacy)	Medicare B deductible & coinsurance	Covers Medicare A or B deductible & coinsurance.
Hemodialysis	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Mammogram State Mandated if inpatient hospital, medical/surgery covered.	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Routine GYN Visits including Cervical Cytology mandate State Mandated if inpatient hospital, medical/surgery covered.	Medicare B deductible & coinsurance for office exam. Pap Medicare B CIF.	Covers Medicare B deductible & coinsurance for office exam. Pap not covered.

Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Prostate Cancer Screenings State Mandated if physician office visit covered; must be covered equal to office visit.	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Allergy Testing and Treatment (Includes Serum and Injections)	Not Covered	Not Covered
Mental Health Care Federal Mandate - Unique financial limits not imposed on other benefits prohibited. NYS Mandate: 20 visits per calendar year combined with outpatient facility, coverage equal to diagnostic office visit, if OV not covered coverage equal inpatient surgery	Medicare B deductible & 50% coinsurance.	Equivalent to Medicare Supplemental Coverage
Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Not Applicable	Not Applicable

Greater Tompkins County Municipal Health Insurance Consortium

Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Chiropractic Care State Mandated if physician office visit covered; must be covered equal to office visit.	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Inpatient Consultations	Medicare A deductible & coinsurance	Covers Medicare B deductible & coinsurance
Infertility Care State Mandated if inpatient hospital, medical/surgery covered	Covered same as similar services under benefit plan for medically necessary services	Covers Medicare B deductible & coinsurance
Bone Density Testing State Mandated if physician office visit covered; must be covered equal to office visit	Medicare B deductible & coinsurance. Outpt facility Medicare B Copayment	Covers Medicare B deductible & coinsurance
Injectable Drugs (excludes vaccines, allergy injections & treatment of diabetes)	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance

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Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
ADDITIONAL BENEFITS		
Treatment of Diabetes (Insulin & Supplies) State Mandated if physician office visit covered; must be covered equal to or better than office visit for a 30 day supply	Medicare B deductible & coinsurance for supplies. Insulin not covered by Medicare B.	Covers Medicare B deductible & coinsurance for supplies. Insulin not covered.
Diabetic Education State Mandated if physician office visit covered; must be covered equal to or better than office visit	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Diabetic Equipment State Mandated if physician office visit covered; must be covered equal to or better than office visit	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Mastectomy Prosthesis Federal Mandate benefit – if inpatient hospital, medical/surgery covered must cover equivalent to inpatient surgery or DME whichever is the better benefit.	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance

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Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Durable Medical Equipment (DME)	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
External Prosthetics/Orthotics (foot orthotics excluded)	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Foot Orthotics (coverage must be equal to external prosthetic benefit)	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Medical Supplies	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Air Ambulance Service	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Pre-hospital Emergency Services and/or Transportation Services (includes all ground transportation) Mandated, coverage must be equal to or better than emergency benefit. Includes all ground transport	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Acupuncture	Not Covered	Not Covered
Oral Surgery	Not Covered	Not Covered

Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Prescription Drugs If Rx covered, enteral nutrition, cancer, bone density, infertility drugs and oral contraceptive drugs & devices mandated; coverage must be equal to all other drugs; certain formulas capped at $2,500 annually.	Not Covered	Covered By: ProAct Option 1: $5/$15/$30 Retail $10/$30/$60 Mail Option 2: $10/$25/$40 Retail $20/$50/$80 Mail Option 3: $15/$30/$45 Retail $30/$60/$90 Mail Option 4: 20%/20%/40% Retail 15%/15%/40% Mail Option 5: 20%/30%/50% Retail 20%/30%/50% Mail
Nutritional Therapy	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Private Duty Nursing	Not Covered	Not Covered
Non-assigned Provider	Not Covered	Not Covered
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
EMERGENCY SERVICES **(Emergency Condition Mandated if inpatient hospital, medical/surgery; O/N benefit for Emergency Condition must be equal to I/N)**		
Facility – Emergency Room	Medicare B copayment	Covers Medicare B copayment

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Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Physician's Emergency Room Visit	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
Freestanding Urgent Care Center (emergency & non-emergency services)	Medicare B copayment	Covers Medicare B copayment
Physician's Freestanding Urgent Care Center Visit (emergency & non-emergency services)	Medicare B deductible & coinsurance	Covers Medicare B deductible & coinsurance
WAITING PERIODS		
Pre-Existing Conditions	Not Applicable	Not Applicable
COORDINATION OF BENEFITS		
COORDINATION OF BENEFITS (includes Medicare eligibles)	Not Applicable	Make Whole
EXCLUSIONS: The following are common exclusions that will apply.		
Acupuncture	Not Covered	Not Covered
Blood products	Not Covered	Not Covered
Certification Examinations	Not Covered	Not Covered
Cosmetic Services	Not Covered	Not Covered
Court Ordered Services	Not Covered	Not Covered
Criminal Behaviors	Not Covered	Not Covered
Custodial Care	Not Covered	Not Covered
Dental (non-accidental services)	Not Covered	Not Covered
Developmental Delay	Not Covered	Not Covered
Disposable Supplies	Not Covered	Not Covered
Experimental and Investigational Services	Not Covered	Not Covered

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Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan
Free Care	Not Covered	Not Covered
Government Hospitals	Not Covered	Not Covered
Government Programs	Not Covered	Not Covered
Hair Prosthetics	Not Covered	Not Covered
Household Fixtures	Not Covered	Not Covered
Hypnosis/Biofeedback	Not Covered	Not Covered
Military Service-Connected Conditions	Not Covered	Not Covered
No-Fault Automobile Insurance	Not Covered	Not Covered
Non-covered Services	Not Covered	Not Covered
Personal Comfort Services	Not Covered	Not Covered
Prohibited Referrals	Not Covered	Not Covered
Reproductive Procedures	Not Covered	Not Covered
Reversal of elective sterilization	Not Covered	Not Covered
Routine Care of the Feet	Not Covered	Not Covered
Self-Help Diagnosis, Training, and Treatment	Not Covered	Not Covered
Services covered under Hospice	Not Covered	Not Covered
Services before Coverage begins	Not Covered	Not Covered
Smoking Cessation Programs	Not Covered	Not Covered
Social Counseling & Therapy	Not Covered	Not Covered
Special Charges	Not Covered	Not Covered
Transsexual Surgery and Related Services	Not Covered	Not Covered
Unlicensed Provider	Not Covered	Not Covered
Vision & Hearing Therapy & Supplies	Not Covered	Not Covered
Weight Loss Services	Not Covered	Not Covered
Workers Compensation	Not Covered	Not Covered

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

Benefits	Medicare A & B	GTCMHIC Medicare Supplement Plan

RIDERS:

Optional Benefits

Private Duty Nursing

☒ Coverage for up to 30 days per Member per Calendar
Services of Participating and Non-Participating Providers will both be counted toward this maximum.
Services of Participating and Non-Participating Providers are covered at 80% of the charge up to a maximum of $100 per day.

Non-assigned Provider

☒ The balance will be covered when Medicare pays a percentage of the Medicare approved amount for a covered Part B service.

Medically Necessary Emergency Care in a Foreign Country

☒ 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

2014 Fiscal Year Premium Equivalent Rates - Medicare Supplement Rx Plan Rates

Prescription Drug Plan Rates (Three-Tier Co-Payment Structure									
Plan Code	**Retail Pharmacy**			**Mail-Order Pharmacy**			**2014 Premium Rates**		
	Tier 1	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**			
	Generic	**Preferred Brand**	**Non-Preferred Brand**	**Generic**	**Preferred Brand**	**Non-Preferred Brand**	**Medical Rate**	**Rx Rate**	**Total Premium**
3T6	$5.00	$15.00	$30.00	$10.00	$30.00	$60.00	$215.00	$495.96	$710.96
3T9	$10.00	$25.00	$40.00	$20.00	$50.00	$80.00	$215.00	$333.06	$548.06
3T10	$15.00	$30.00	$45.00	$30.00	$60.00	$90.00	$215.00	$227.40	$442.40
3T11	20%	20%	40%	15%	15%	40%	$215.00	$248.44	$463.44
3T13	20%	30%	50%	20%	30%	50%	$215.00	$225.51	$440.51

All of the three-tier plan options available for negotiations as listed above include the following elements:

1. Retail purchases limited to a 30 day supply.
2. Mail-order purchases limited to a 90 day supply.
3. Standard edits, exclusions, management protocols apply as follows:
   a. Standard Excellus contract exclusions apply
   b. No coverage for prescriptions filled at non-participating pharmacies
   c. Generic Advantage Program (GAP) for Maximum Allowable Cost applies.
   d. Standard use management protocols apply (including Excellus standard prior authorization list, step therapy programs, dose efficiency edits, quantity limits, and new drug management).
   e. All federal & state mandates that apply to pharmacy benefits are included
   f. Diabetic prescriptions, supplies and equipment follow the NYS mandate and are processed in accordance with the office visit benefit.
   g. Mandatory Specialty Pharmacy Program applies at retail benefit.
   h. Generic Trial Program applies

Premium Factor	***2.624***