GREATER
TOMPKINS COUNTY MUNICIPAL
HEALTH INSURANCE CONSORTIUM
Municipalities building a stable insurance future.

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RESOLUTION NO. 016-2014 - RESOLUTION TO ADOPT THE "PLATINUM PLAN"

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

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

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

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

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

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

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

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

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

Greater Tompkins County Municipal Health Insurance Consortium

2014 Standard Platinum Plan Benefit Option

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

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

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

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Plan Benefit and Cost Sharing Highlights		**GTCMHIC Standard Platinum Plan**		**Current Tompkins County Plan (County CSEA PPO Plan)**		**Current Tompkins County Plan (County CSEA Indemnity Plan)**	
Dental Benefits		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Dental Care		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventive and Routine		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Major Dental Care and Medical Ortho		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Accidental Dental - Outpatient Surgery (accidental injury to sound, natural teeth and for care due to congenital disease or anomaly,)		$150 Copay	80% After Deductible	Not Covered	Not Covered	Not Covered	Not Covered
Monthly Premium Rates		**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**
2014 Fiscal Year - Tompkins County		***$515.00***	***$1,339.00***	***$734.04***	***$1,608.75***	***$744.09***	***$1,612.67***
Wellness Plan Included		***YES***		***NO***		***NO***	
Health Savings Account Eligible		***NO***		***NO***		***NO***	
Employer Annual Contribution (Assumes 80%)	***Individual***	***$4,944.00***		***$7,046.78***		***$7,143.26***	
	Family	***$12,854.40***		***$15,444.00***		***$15,481.63***	
Employee Annual Contribution (Assumes 20%)	***Individual***	***$1,236.00***		***$1,761.70***		***$1,785.82***	
	Family	***$3,213.60***		***$3,861.00***		***$3,870.41***	

manner that provides a close approximation to the actual average spending by a wide range of consumers in a standard population and that said Actuarial Value will be equal to or greater than 90% within an acceptable deviation of + or – 2%,

RESOLVED, further, That the Greater Tompkins County Municipal Health Insurance Consortium Board of Directors directs the Executive Director to coordinate the development of procedures necessary to coordinate the logistics of making changes to the "Greater Tompkins County Municipal Health Insurance Consortium Standard Platinum Plan" which will occur no more frequently than once annually on January 1st of the year in question and that those procedures will become effective when approved by the Consortium Board of Directors.

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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 August 28, 2014.

Michelle Pottorff, Administrative Clerk