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
2014 Deductibles	Medicare A = $1,216 per benefit period Medicare B = $147 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

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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	<u>Medicare A (per benefit period)</u> $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)	<u>Covers Medicare Part A:</u> 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

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Benefits	Medicare Parts 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 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) $1,216 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.
Part A & B Blood Deductible	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible & Coinsurance
HOSPITAL OUTPATIENT SERVICES		
Observation Stay	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Surgical Care including "Surgicenters" and Freestanding	Medicare B $147 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 $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Diagnostic Imaging, X-ray, CAT, MRI	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

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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 $147 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 $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Chemotherapy (excludes drugs dispensed by a pharmacy)	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Hemodialysis	Medicare B $147 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 $147 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 $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

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 $147 Deductible & 20% to 40% Coinsurance for Professional Services	Covers Medicare B Deductible and Coinsurance
Covered Therapies Includes Physical, Speech, and Occupational Therapy	Medicare B $147 Deductible & 20% Coinsurance Annual Limit may apply	Covers Medicare B Deductible and Coinsurance
Pulmonary Rehabilitation	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Cardiac Rehabilitation	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Injectable Drugs Excludes vaccines, allergy injections & treatment of diabetes.	Medicare B $147 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.

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 $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Outpatient Hospital & Ambulatory Surgery	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Office Surgery	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Covered Therapies Includes Physical, Speech, and Occupational Therapy	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Anesthesia (includes IP, OP, OV and delivery)	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

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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 $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Second Medical Opinion State Mandated for cancer; cover equivalent to office visit.	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Maternity Care: Normal, Complications & Termination.	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Prenatal and Postpartum Care	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Delivery Anesthesia Must cover equivalent to surgical Anesthesia	Medicare B $147 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 $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

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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 $147 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 $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Diagnostic Office Visits	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Diagnostic Laboratory and Pathology	Medicare B $147 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 $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Hearing Evaluations Diagnostic	Medicare B $147 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 $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Radiation Therapy (excludes drugs dispensed by a pharmacy)	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Chemotherapy (excludes drugs dispensed by a pharmacy)	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Hemodialysis	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Mammogram - Diagnostic	Medicare B $147 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 $147 Deductible & 20% to 40% Coinsurance	Covers Medicare B Deductible and Coinsurance
Chemical Dependency	Medicare B $147 Deductible & 20% to 40% Coinsurance	Covers Medicare B Deductible and Coinsurance

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Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Chiropractic Care	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Injectable Drugs (excludes vaccines, allergy injections & treatment of diabetes)	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
ADDITIONAL BENEFITS		
Treatment of Diabetes (Insulin & Supplies)	Medicare B $147 Deductible & 20% Coinsurance Insulin Not Covered by Medicare B	Covers Medicare B Deductible and Coinsurance Insulin Covered Under Rx Plan
Diabetic Education	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Diabetic Equipment	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Mastectomy Prosthesis	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Durable Medical Equipment (DME)	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
External Prosthetics/Orthotics (including Foot Orthotics)	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Medical Supplies	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Nutritional Therapy	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Pre-hospital Emergency Services and/or Transportation Services (includes all ground transportation)	Medicare B $147 Deductible & 20% Coinsurance	Covers Medicare B Deductible and Coinsurance
Air Ambulance Service	Medicare B $147 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 $147 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 $147 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

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 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
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.

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
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
Free Care	Not Covered	Not Covered
Government Hospitals	Not Covered	Not Covered
Government Programs	Not Covered	Not Covered

Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
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

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Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
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

2014 MONTHLY PREMIUM RATES		
Medicare Part A and B GTCMHIC Medicare Supplement Plan No Rx Coverage	Medicare Part A = $0.00 Medicare Part B = $104.90 Premium Could be Higher if Your Adjusted Gross Income is Above $85,000 for an Individual or $170,000 for a Couple	GTCMHIC Medicare Supplement = $215.00
Medicare Part A and B GTCMHIC Medicare Supplement Plan GTCMHIC Rx Plan Option 1: Rx copayments: Retail = Tier1 $5/Tier2 $15/Tier3 $30 Mail = Tier1 $10/Tier2 $30/ Tier3 $60	Medicare Part A = $0.00 Medicare Part B = $104.90 Premium Could be Higher if Your Adjusted Gross Income is Above $85,000 for an Individual or $170,000 for a Couple	GTCMHIC Medicare Supplement = $710.96

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Benefits	Medicare Parts A & B	GTCMHIC Medicare Supplement Plan
Medicare Part A and B GTCMHIC Medicare Supplement Plan GTCMHIC Rx Plan Option 2: Rx copayments: Retail = Tier1 $10/Tier2 $25/Tier3 $40 Mail = Tier1 $20/Tier2 $50/ Tier3 $80	Medicare Part A = $0.00 Medicare Part B = $104.90 Premium Could be Higher if Your Adjusted Gross Income is Above $85,000 for an Individual or $170,000 for a Couple	GTCMHIC Medicare Supplement = $548.06
Medicare Part A and B GTCMHIC Medicare Supplement Plan GTCMHIC Rx Plan Option 3: Rx copayments: Retail = Tier1 $15/Tier2 $30/Tier3 $45 Mail = Tier1 $30/Tier2 $60/ Tier3 $90	Medicare Part A = $0.00 Medicare Part B = $104.90 Premium Could be Higher if Your Adjusted Gross Income is Above $85,000 for an Individual or $170,000 for a Couple	GTCMHIC Medicare Supplement = $442.40
Medicare Part A and B GTCMHIC Medicare Supplement Plan GTCMHIC Rx Plan Option 4: Rx copayments: Retail = Tier1 20%/Tier2 20%/Tier3 40% Mail = Tier1 15%/Tier2 15%/ Tier3 40%	Medicare Part A = $0.00 Medicare Part B = $104.90 Premium Could be Higher if Your Adjusted Gross Income is Above $85,000 for an Individual or $170,000 for a Couple	GTCMHIC Medicare Supplement = $463.44
Medicare Part A and B GTCMHIC Medicare Supplement Plan GTCMHIC Rx Plan Option 5: Rx copayments: Retail = Tier1 20%/Tier2 30%/Tier3 50% Mail = Tier1 20%/Tier2 30%/ Tier3 50%	Medicare Part A = $0.00 Medicare Part B = $104.90 Premium Could be Higher if Your Adjusted Gross Income is Above $85,000 for an Individual or $170,000 for a Couple	GTCMHIC Medicare Supplement = $440.51

- ***Please note that this overview provides a summary of the Plan Benefits. Please be sure to refer to the Plan Document for a complete description of the benefits provided by the Plan, including, any benefit conditions, limitations, or exclusions.***