Madison-Oneida-Herkimer HealthCare Consortium
Standard Platinum Plan Benefit Plan 2020

Plan Benefit and Cost Sharing Highlights		**Madison-Oneida-Herkimer HealthCare Consortium Standard Platinum Plan (2020)**	
Cost Sharing		**In-Network**	**Out-of-Network**
Deductible	Individual	Not Applicable	$500
	Family	Not Applicable	$1500
Out-of-Pocket Maximum **(Medical and Rx Plan Coinsurance and/or Copayments)**	Individual	$2,000 In-Network (Rx and Medical)	$4,000 Out-of Network (Medical Only)
	Family	$6,000 In-Network (Rx and Medical)	$12,000 Out-of Network (Medical Only)
Annual Maximum		Unlimited	Unlimited
Lifetime Maximum		Unlimited	Unlimited
Preventive Health Care Services		**In-Network**	**Out-of-Network**
Well Child Visits		Covered In Full	Covered in Full
Adult Routine Physical Exams (1 exam/year)		Covered In Full	20% After Deductible
Adult Immunizations		Covered In Full	20% After Deductible
Mammography		Covered In Full	20% After Deductible
Pap Smears		Covered In Full	20% After Deductible
Routine Gynecological Exams		Covered In Full	20% After Deductible
Prostrate Cancer Screenings		Covered In Full	20% After Deductible
Colonoscopies		Preventive Screenings Covered in Full	20% After Deductible
Family Planning Services		Covered In Full	20% After Deductible
Physician Office Services		**In-Network**	**Out-of-Network**
Diagnostic Office Visits		$25 PCP / $40 Spec Copay	20% After Deductible
Diagnostic X-Rays		$40 Copay	20% After Deductible

Madison-Oneida-Herkimer HealthCare Consortium **Standard Platinum Plan Benefit Plan 2020**		
Plan Benefit and Cost Sharing Highlights	**Madison-Oneida-Herkimer HealthCare Consortium Standard Platinum Plan (2020)**	
Diagnostic Laboratory and Pathology	Covered In Full	20% After Deductible
Allergy Tests	$25 PCP / $40 Spec Copay	20% After Deductible
Allergy Injections	Covered In Full	20% After Deductible
Chemotherapy	$25 Copay	20% After Deductible
Radiation Therapy	$40 Copay	20% After Deductible
Maternity Services	**In-Network**	**Out-of-Network**
Prenatal Services	Covered In Full	20% After Deductible
Postnatal Services	Covered In Full	20% After Deductible
Newborn Nursery Care	Covered In Full	20% After Deductible

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Plan Benefit and Cost Sharing Highlights	**Madison-Oneida-Herkimer HealthCare Consortium Standard Platinum Plan (2020)**	
Prescription Drug Benefits	**In-Network**	**Out-of-Network**
Retail Pharmacy (limited to a 30-day supply)	Tier 1 $5	Not Covered
	Tier 2 $35	Not Covered
	Tier 3 $70	Not Covered
Mail-Order Pharmacy (limited to a 90-day supply)	Tier 1 $10	Not Covered
	Tier 2 $70	Not Covered
	Tier 3 $140	Not Covered
$0 Copay for Pediatric (Age 0-19) Generic Medications	Covered In Full	Not Covered
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Hospital Benefits (unlimited days)	$250 Copay	20% After Deductible
Physician Visits in the Hospital	Covered In Full	20% After Deductible
Inpatient Physical Rehabilitation (60-day limit)	$250 Copay	20% After Deductible
Surgery	Covered In Full	20% After Deductible
Anesthesia	Covered In Full	Covered in Full
Emergency Care	**In-Network**	**Out-of-Network**
Emergency Room Care (waived if admitted to hospital)	$150 Copay	$150 Copay
Freestanding Urgent Care Center	$40 Copay	20% After Deductible
Ambulance	$150 Copay	$150 Copay
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**
Diagnostic X-Rays	$40 Copay	20% After Deductible
Diagnostic Laboratory and Pathology	Covered In Full	20% After Deductible
Surgical Care Facility Fee	$150 Copay	20% After Deductible

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Chemotherapy	$25 Copay	20% After Deductible
Radiation Therapy	$40 Copay	20% After Deductible
Mental Health and Chemical Dependence	**In-Network**	**Out-of-Network**
Inpatient Mental Health Care (unlimited days)	$250 Copay	20% After Deductible
Outpatient Mental Health Care (unlimited visits)	$40 Copay	20% After Deductible
Inpatient Chemical Dependence	$250 Copay	20% After Deductible
Outpatient Chemical Dependence	$40 Copay	20% After Deductible

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Plan Benefit and Cost Sharing Highlights	**Madison-Oneida-Herkimer HealthCare Consortium Standard Platinum Plan (2020)**	
Other Services	**In-Network**	**Out-of-Network**
Diabetic Insulin and Supplies	$25 Copay	20% After Deductible
Skilled Nursing Facility	$250 Copay (limited to 45 days/year)	20% After Deductible
Home Care	Covered In Full (unlimited medically necessary visits)	20% After Deductible
Hospice Care	Covered In Full	20% After Deductible
Outpatient Therapy (45 visits per condition/lifetime) (physical, speech, and occupational)	$40 Copay	20% After Deductible
Durable Medical Equipment	20% Coinsurance	20% After Deductible
External Prosthetics	20% Coinsurance	20% After Deductible
Chiropractic Care	$25 Copay	20% After Deductible
Acupuncture (10 Visits Per Calender Year Combined In/Out Network)	$40 Copay	50% After Deductible
Pediatric Hearing Aids	Not Covered	Not Covered
Vision Benefits	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam (one per year)	$40 Copay	20% After Deductible
Adult Diagnostic Vision Exam	$40 Copay	20% After Deductible
Adult Eyewear	Not Covered	Not Covered
Pediatric Routine Vision Exam (one per year children < age 19)	$40 Copay	20% After Deductible
Pediatric Eyewear	Not Covered	Not Covered
Dental Benefits	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered
Pediatric Dental: Preventive and Routine	Not Covered	Not Covered

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Plan Benefit and Cost Sharing Highlights	**Madison-Oneida-Herkimer HealthCare Consortium Standard Platinum Plan (2020)**	
Pediatric Major Dental Care and Medical Ortho	Not Covered	Not Covered
Accidental Dental	Covered	Covered, subject to deductible
Wellness Plan		
Wellness Plan Included	***YES***	
Health Savings Account Eligible	***NO***	

*** The benefits summarized above are a summary of the benefits for 2020 and are subject to change to keep the overall benefit equal to an ACA Platinum Level each year.**

*** Please refer to the actual insurance certificate or plan document for a detailed description of what is covered under this health insurance plan.**