## *Madison-Oneida-Herkimer HealthCare Consortium*

***2016-2026 Platinum PPO Plan AV and Benefit Summary***

| Benefit Description | | Platinum Plan | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| **Actuarial Value** | **Initial** | ***92.60%*** | ***94.60%*** | ***89.96%*** | ***90.46%*** | ***90.97%*** | ***91.06%*** | ***90.74%*** | ***91.58%*** | ***92.00%*** | ***92.36%*** | ***92.88%*** |
| | **Final** | ***92.60%*** | ***90.97%*** | ***89.96%*** | ***90.46%*** | ***90.97%*** | ***91.06%*** | ***90.74%*** | ***91.58%*** | ***92.00%*** | ***92.36%*** | ***91.42%*** |
| **In-Network Deductible** | **Individual** | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **Family** | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| **Deductible Aggregation** | | Individual | Individual | Individual | Individual | Individual | Individual | Individual | Individual | Individual | Individual | Individual |
| **Out-of-Network Deductible** | **Individual** | $500.00 | $500.00 | $500.00 | $500.00 | $500.00 | $500.00 | $500.00 | $500.00 | $500.00 | $500.00 | $1,000.00 |
| | **Family** | $1,500.00 | $1,500.00 | $1,500.00 | $1,500.00 | $1,500.00 | $1,500.00 | $1,500.00 | $1,500.00 | $1,500.00 | $1,500.00 | $3,000.00 |
| **Out-of-Pocket Maximum Aggregation** | | Individual | Individual | Individual | Individual | Individual | Individual | Individual | Individual | Individual | Individual | Individual |
| **In-Network Out-of-Pocket Maximum** *Includes Rx Copayments* | **Individual** | $2,000.00 | $2,000.00 | $2,000.00 | $2,000.00 | $2,000.00 | $2,000.00 | $2,000.00 | $2,000.00 | $2,000.00 | $2,000.00 | $2,000.00 |
| | **Family** | $6,000.00 | $6,000.00 | $6,000.00 | $6,000.00 | $6,000.00 | $6,000.00 | $6,000.00 | $6,000.00 | $6,000.00 | $6,000.00 | $6,000.00 |
| **Out-of-Network Out-of Pocket Maximum** | **Individual** | $2,000.00 | $4,000.00 | $4,000.00 | $4,000.00 | $4,000.00 | $4,000.00 | $4,000.00 | $4,000.00 | $4,000.00 | $4,000.00 | $4,000.00 |
| | **Family** | $6,000.00 | $12,000.00 | $12,000.00 | $12,000.00 | $12,000.00 | $12,000.00 | $12,000.00 | $12,000.00 | $12,000.00 | $12,000.00 | $12,000.00 |
| **Primary Care Physician Copay** | | $15.00 | $25.00 | $25.00 | $25.00 | $25.00 | $25.00 | $25.00 | $25.00 | $25.00 | $25.00 | $25.00 |
| **Specialist Copay** | | $25.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 |
| **Inpatient Hospital Copay** | | $250.00 | $250.00 | $250.00 | $250.00 | $250.00 | $250.00 | $250.00 | $250.00 | $250.00 | $250.00 | $500.00 |
| **Emergency Room Copay** | | $150.00 | $150.00 | $150.00 | $150.00 | $150.00 | $150.00 | $150.00 | $150.00 | $150.00 | $150.00 | $300.00 |
| **Chiropractor Copay** | | $25.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $40.00 | $25.00 |
| **Diagnostic Lab Copay** | | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $25.00 |
| **In-Network Coinsurance** | | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| **Out-of-Network Coinsurance** | | 20.00% | 20.00% | 20.00% | 20.00% | 20.00% | 20.00% | 20.00% | 20.00% | 20.00% | 20.00% | 20.00% |
| **Pharmacy Copayments Retail (30 Day Supply)** *Subject to Deductible for all plans except the Platinum Plan* | **Tier 1** | $10.00 | $5.00 | $5.00 | $5.00 | $5.00 | $5.00 | $5.00 | $5.00 | $5.00 | $5.00 | $10.00 |
| | **Tier 2** | $30.00 | $35.00 | $35.00 | $35.00 | $35.00 | $35.00 | $35.00 | $35.00 | $35.00 | $35.00 | $35.00 |
| | **Tier 3** | $50.00 | $70.00 | $70.00 | $70.00 | $70.00 | $70.00 | $70.00 | $70.00 | $70.00 | $70.00 | $70.00 |
| **High Deductible Health Plan** | | No | No | No | No | No | No | No | No | No | No | No |
| **Health Savings Account Eligible.** | | No | No | No | No | No | No | No | No | No | No | No |