

**GREATER TOMPKINS CO MUNICIPAL HLTH INS CONS**

**General Information**

**Cost Sharing Expenses**

| Benefit Name                          | In Network | Out of Network | Limits and Additional Information  |
|---------------------------------------|------------|----------------|--|
| Deductible - Single                   | \$500      | \$500          | One deductible for in and out of network combined.   |
| Deductible - Family                   | \$1,500    | \$1,500        | Each individual does not exceed the single deductible.   |
| Coinsurance                           | 20%        | 40%            |  |
| Annual Out of Pocket Maximum - Single | \$3,000    | \$3,000        | Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services. |
| Annual Out of Pocket Maximum - Family | \$9,000    | \$9,000        | Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services. |

**Office Visit Cost Shares**

| Benefit Name              | In Network     | Out of Network                           | Limits and Additional Information   |
|---------------------------|----------------|--|---|
| Cost Share - Primary Care | \$25 Copayment | 40% Coinsurance<br>Subject to Deductible | \$0 copayment for dependents to age 19 on all In-Network PCP office visits. |
| Cost Share - Specialist   | \$40 Copayment | 40% Coinsurance<br>Subject to Deductible |   |

**Plan Limits**

| Benefit Name                               | In Network | Out of Network | Limits and Additional Information |
|--|------------|----------------|-----------------------------------|
| Plan/Calendar Year                         |            |                | Plan Year Benefits                |
| Diabetic Preauthorization and Step Therapy |            |                | Yes                               |

**Who is Covered**

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|--------------|------------|----------------|-----------------------------------|
|--------------|------------|----------------|-----------------------------------|

**Inpatient Services**

**Inpatient Facility**

| Benefit Name                 | In Network                               | Out of Network                           | Limits and Additional Information |
|------------------------------|--|--|-----------------------------------|
| Inpatient Hospital Services  | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |
| Mental Health Care           | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |
| Substance Use Detoxification | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |                                   |

| Benefit Name             | In Network                               | Out of Network                           | Limits and Additional Information                    |
|--------------------------|--|--|--|
| Skilled Nursing Facility | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 45 Days per year<br>Limits are combined INN and OON. |
| Physical Rehabilitation  | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible | 60 Days per year<br>Limits are combined INN and OON. |
| Maternity Care           | 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |  |

## Inpatient Professional Services

| Benefit Name               | In Network   | Out of Network                           | Limits and Additional Information  |
|----------------------------|--|--|--|
| Inpatient Hospital Surgery | PCP / Specialist - 20%<br>Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |  |
| Anesthesia                 | PCP / Specialist - 20%<br>Coinsurance<br>Subject to Deductible | 20% Coinsurance<br>Subject to Deductible | Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral. |

## Outpatient Facility Services

### Outpatient Facility Services

| Benefit Name   | In Network  | Out of Network  | Limits and Additional Information  |
|--|---|---|--|
| SurgiCenters and Freestanding Ambulatory Centers Surgical Care | 20% Coinsurance<br>Subject to Deductible              | 40% Coinsurance<br>Subject to Deductible              |  |
| Diagnostic X-ray   | \$40 Copayment  | 40% Coinsurance<br>Subject to Deductible              |  |
| Diagnostic Laboratory and Pathology                            | Covered in Full                                       | 40% Coinsurance<br>Subject to Deductible              |  |
| Infusion Therapy   | Inclusive of Primary Service<br>Subject to Deductible | Inclusive of Primary Service<br>Subject to Deductible | Is inclusive in the Home Care benefit and not covered as a separate benefit. |
| Dialysis   | Covered in Full                                       | 40% Coinsurance<br>Subject to Deductible              |  |
| Mental Health Care   | \$40 Copayment  | 40% Coinsurance<br>Subject to Deductible              | Includes Partial Hospitalization   |
| Substance Use Care   | \$40 Copayment  | 40% Coinsurance<br>Subject to Deductible              | Includes Partial Hospitalization   |

## Home and Hospice Care

### Home Care

| Benefit Name | In Network      | Out of Network                                | Limits and Additional Information                      |
|--------------|-----------------|---|--|
| Home Care    | Covered in Full | 25% Coinsurance<br>Subject to \$50 Deductible | 40 Visits per year<br>Limits are combined INN and OON. |

### Hospice Care

| Benefit Name           | In Network      | Out of Network                           | Limits and Additional Information |
|------------------------|-----------------|--|-----------------------------------|
| Hospice Care Inpatient | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |

## Outpatient and Office Professional Services

### Professional Services

| Benefit Name                        | In Network  | Out of Network  | Limits and Additional Information  |
|-------------------------------------|---|---|--|
| Office Surgery                      | PCP - \$25 Copayment<br>Specialist - \$40 Copayment<br>\$0 PCP Copay for members to age 19. | 40% Coinsurance<br>Subject to Deductible              |  |
| Diagnostic X-ray                    | PCP / Specialist - \$40 Copayment   | 40% Coinsurance<br>Subject to Deductible              |  |
| Diagnostic Laboratory and Pathology | PCP / Specialist - Covered in Full  | 40% Coinsurance<br>Subject to Deductible              |  |
| Infusion Therapy                    | PCP / Specialist - Inclusive of Primary Service<br>Subject to Deductible                    | Inclusive of Primary Service<br>Subject to Deductible | Is inclusive in the Home Care benefit and not covered as a separate benefit. |
| Dialysis                            | PCP / Specialist - Covered in Full  | 40% Coinsurance<br>Subject to Deductible              |  |
| Mental Health Care                  | PCP / Specialist - \$40 Copayment   | 40% Coinsurance<br>Subject to Deductible              |  |
| Maternity Care                      | PCP / Specialist - 20% Coinsurance<br>Subject to Deductible                                 | 40% Coinsurance<br>Subject to Deductible              |  |
| Chiropractic Care                   | PCP / Specialist - \$40 Copayment   | 40% Coinsurance<br>Subject to Deductible              |  |
| Allergy Testing                     | PCP - \$25 Copayment<br>Specialist - \$40 Copayment<br>\$0 PCP Copay for members to age 19. | 40% Coinsurance<br>Subject to Deductible              | Allergy Testing includes injections and scratch and prick tests.             |
| Allergy Treatment Including Serum   | PCP - \$25 Copayment<br>Specialist - \$40 Copayment<br>\$0 PCP Copay for members to age 19. | 40% Coinsurance<br>Subject to Deductible              | Includes desensitization treatments (injections & serums).                   |
| Hearing Evaluations Routine         | PCP / Specialist - \$40 Copayment   | 40% Coinsurance<br>Subject to Deductible              | 1 Exam Per Year<br>Limits are combined INN and OON.                          |

## Rehab and Habilitation

### Outpatient Facility

| Benefit Name                | In Network     | Out of Network                           | Limits and Additional Information   |
|-----------------------------|----------------|--|---|
| Physical Rehabilitation     | \$40 Copayment | 40% Coinsurance<br>Subject to Deductible | 45 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | \$40 Copayment | 40% Coinsurance<br>Subject to Deductible | 45 Visits per year  |
| Speech Rehabilitation       | \$40 Copayment | 40% Coinsurance<br>Subject to Deductible | 45 Visits per year  |

### Outpatient Professional Services

| Benefit Name                | In Network                        | Out of Network                           | Limits and Additional Information   |
|-----------------------------|-----------------------------------|--|---|
| Physical Rehabilitation     | PCP / Specialist - \$40 Copayment | 40% Coinsurance<br>Subject to Deductible | 45 Visits per year<br>Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | PCP / Specialist - \$40 Copayment | 40% Coinsurance<br>Subject to Deductible | 45 Visits per year  |
| Speech Rehabilitation       | PCP / Specialist - \$40 Copayment | 40% Coinsurance<br>Subject to Deductible | 45 Visits per year  |

## Preventive Services

### Preventive Professional Services Meeting Federal Guidelines\*

| Benefit Name                        | In Network                         | Out of Network                           | Limits and Additional Information |
|-------------------------------------|------------------------------------|--|-----------------------------------|
| Adult Physical Examination          | PCP / Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible | 1 Exam per year                   |
| Adult Immunizations                 | PCP / Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Well Child Visits and Immunizations | PCP / Specialist - Covered in Full | Covered in Full                          |                                   |
| Routine GYN Visit                   | PCP / Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Pre/Post-Natal Care                 | PCP / Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Mammography Screening Professional  | PCP / Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Colonoscopy Screening Professional  | PCP / Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Bone Density Screening Professional | PCP / Specialist - Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |

### Preventive Facility Services Meeting Federal Guidelines\*

| Benefit Name                    | In Network      | Out of Network                           | Limits and Additional Information |
|---------------------------------|-----------------|--|-----------------------------------|
| Cervical Cytology Preventative  | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Mammography Screening Facility  | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Colonoscopy Screening Facility  | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Bone Density Screening Facility | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |

### Preventive Professional Services Not Meeting Federal Guidelines

| Benefit Name                        | In Network  | Out of Network                           | Limits and Additional Information |
|-------------------------------------|---|--|-----------------------------------|
| Prostate Cancer Screening           | PCP - \$25 Copayment<br>Specialist - \$40 Copayment | 40% Coinsurance<br>Subject to Deductible |                                   |
| Mammography Screening Professional  | PCP / Specialist - \$40 Copayment                   | 40% Coinsurance<br>Subject to Deductible |                                   |
| Colonoscopy Screening Professional  | PCP / Specialist - Covered in Full                  | 40% Coinsurance<br>Subject to Deductible |                                   |
| Bone Density Screening Professional | PCP / Specialist - \$40 Copayment                   | 40% Coinsurance<br>Subject to Deductible |                                   |

### Preventive Facility Services Not Meeting Federal Guidelines

| Benefit Name                    | In Network      | Out of Network                           | Limits and Additional Information |
|---------------------------------|-----------------|--|-----------------------------------|
| Mammography Screening Facility  | \$40 Copayment  | 40% Coinsurance<br>Subject to Deductible |                                   |
| Colonoscopy Screening Facility  | Covered in Full | 40% Coinsurance<br>Subject to Deductible |                                   |
| Bone Density Screening Facility | \$40 Copayment  | 40% Coinsurance<br>Subject to Deductible |                                   |

## Other Benefits

### Additional Benefits

| Benefit Name                               | In Network  | Out of Network                           | Limits and Additional Information  |
|--|---|--|--|
| Treatment of Diabetes Insulin and Supplies | PCP / Specialist - \$25 Copayment                           | 40% Coinsurance<br>Subject to Deductible | Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. |
| Diabetic Equipment                         | PCP / Specialist - \$25 Copayment                           | 40% Coinsurance<br>Subject to Deductible |  |
| Durable Medical Equipment (DME)            | PCP / Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |  |
| Medical Supplies                           | PCP / Specialist - 20% Coinsurance<br>Subject to Deductible | 40% Coinsurance<br>Subject to Deductible |  |
| Acupuncture                                | PCP / Specialist - \$40 Copayment                           | 40% Coinsurance<br>Subject to Deductible | 10 Visits per year<br>Limits combined INN and OON.   |
| Private Duty Nursing                       | PCP / Specialist - Not Covered                              | Not Covered                              | Not Covered  |

## Emergency Services

### ER Facility

| Benefit Name                     | In Network      | Out of Network  | Limits and Additional Information  |
|----------------------------------|-----------------|-----------------|--|
| OP Facility Emergency Room Visit | \$250 Copayment | \$250 Copayment | Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility. |

### Transportation

| Benefit Name   | In Network      | Out of Network  | Limits and Additional Information |
|--|-----------------|-----------------|-----------------------------------|
| Prehospital Emergency and Transportation - Ground or Water | \$250 Copayment | \$250 Copayment |                                   |

### Urgent Care Facility

| Benefit Name                      | In Network     | Out of Network                           | Limits and Additional Information |
|-----------------------------------|----------------|--|-----------------------------------|
| Urgent Care Center Facility Visit | \$40 Copayment | 40% Coinsurance<br>Subject to Deductible |                                   |

## Vision and Dental

### Vision

| Benefit Name                  | In Network     | Out of Network                           | Limits and Additional Information                   |
|-------------------------------|----------------|--|---|
| Adult Eye Exams - Routine     | \$40 Copayment | 40% Coinsurance<br>Subject to Deductible | 1 Exam per year<br>Limits are combined INN and OON. |
| Adult Eyewear - Routine       | Not Covered    | Not Covered                              | Not Covered   |
| Pediatric Eye Exams - Routine | \$40 Copayment | 40% Coinsurance<br>Subject to Deductible | 1 Exam per year<br>Limits are combined INN and OON. |
| Pediatric Eyewear - Routine   | Not Covered    | Not Covered                              | Not Covered   |

## Rx Benefits

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### Rx Plan

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|--------------|------------|----------------|-----------------------------------|
| Rx Plan      |            |                | Contraceptives Only               |

### Rx Benefits

| Benefit Name                 | In Network | Out of Network | Limits and Additional Information |
|------------------------------|------------|----------------|-----------------------------------|
| Days Supply Per Retail Order | 30         |                |                                   |
| Days Supply Per Mail Order   | 90         |                |                                   |
| Copays Per Mail Order Supply | NA         |                |                                   |

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This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

\* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.