

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 | \$0 | \$500 | |
| Deductible - Family | \$0 | \$1,500 | Each individual does not exceed the single deductible. |
| Coinsurance | 0% | 20% | |
| Annual Out of Pocket Maximum - Single | \$1,500 | \$1,500 | 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 | \$4,500 | \$4,500 | 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 | \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| Cost Share - Specialist | \$15 Copayment | 20% Coinsurance Subject to Deductible | |

Plan Limits

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

Who is Covered

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---------------------------|------------|----------------|-----------------------------------|
| Domestic Partner Coverage | | | Covered |

Inpatient Services
Inpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|------------------------------|-----------------|--|---|
| Inpatient Hospital Services | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Mental Health Care | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Substance Use Detoxification | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Skilled Nursing Facility | Covered in Full | 20% Coinsurance Subject to Deductible | 120 Days per year Limits are combined INN and OON. |
| Physical Rehabilitation | Covered in Full | 20% Coinsurance Subject to Deductible | 60 Days per year Limits are combined INN and OON. |
| Maternity Care | Covered in Full | 20% Coinsurance Subject to Deductible | |

Inpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|----------------------------|----------------------------------|--|--|
| Inpatient Hospital Surgery | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Anesthesia | PCP/Specialist - Covered in Full | 20% Coinsurance 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 | \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| Diagnostic X-ray | \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| Diagnostic Laboratory and Pathology | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Radiation Therapy | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Chemotherapy | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Infusion Therapy | Inclusive of Primary Service | Inclusive of Primary Service | Is inclusive in the Home Care benefit and not covered as a separate benefit |
| Dialysis | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Mental Health Care | \$15 Copayment | 20% Coinsurance Subject to Deductible | Includes Partial Hospitalization |
| Substance Use Care | \$15 Copayment | 20% Coinsurance 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 | 20% Coinsurance Subject to \$50 Deductible | |
| Home Infusion Therapy | Covered in Full | 20% Coinsurance Subject to \$50 Deductible | |

Hospice Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|------------------------|-----------------|--|-----------------------------------|
| Hospice Care Inpatient | Covered in Full | 20% Coinsurance Subject to Deductible | |

Outpatient and Office Professional Services

Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------------|---|--|--|
| Office Surgery | PCP/Specialist - \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| Diagnostic X-ray | PCP/Specialist - \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| Diagnostic Laboratory and Pathology | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Radiation Therapy | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Chemotherapy | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Infusion Therapy | PCP/Specialist - Inclusive of Primary Service | Inclusive of Primary Service | Is inclusive in the Home Care benefit and not covered as a separate benefit |
| Dialysis | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Mental Health Care | PCP/Specialist - \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| Maternity Care | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Telehealth | PCP/Specialist - \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| TeleMedicine Program | PCP/Specialist - \$15 Copayment | Not Covered | Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions. |
| Chiropractic Care | PCP/Specialist - \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| Allergy Testing | PCP/Specialist - \$15 Copayment | 20% Coinsurance Subject to Deductible | Allergy Testing includes injections and scratch and prick tests. |
| Allergy Treatment Including Serum | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | Includes desensitization treatments (injections & serums). |
| Hearing Evaluations Routine | PCP/Specialist - Not Covered | Not Covered | Not Covered |

Rehab and Habilitation

Outpatient Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-----------------------------|----------------|--|---|
| Physical Rehabilitation | \$15 Copayment | 20% Coinsurance Subject to Deductible | 45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | \$15 Copayment | 20% Coinsurance Subject to Deductible | 45 Visits per year |
| Speech Rehabilitation | \$15 Copayment | 20% Coinsurance 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 - \$15 Copayment | 20% Coinsurance Subject to Deductible | 45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy. |
| Occupational Rehabilitation | PCP/Specialist - \$15 Copayment | 20% Coinsurance Subject to Deductible | 45 Visits per year |
| Speech Rehabilitation | PCP/Specialist - \$15 Copayment | 20% Coinsurance 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 | 20% Coinsurance Subject to Deductible | 1 Exam per year |
| Adult Immunizations | PCP/Specialist - Covered in Full | Not Covered | |
| Well Child Visits and Immunizations | PCP/Specialist - Covered in Full | Covered in Full | |
| Routine GYN Visit | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Pre/Post-Natal Care | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance 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 | 20% Coinsurance Subject to Deductible | |
| Mammography Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | |

Preventive services in addition to those required under Federal Guidelines - Professional

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------------|----------------------------------|--|--|
| Prostate Cancer Screening | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | NYS Prostate Cancer Testing Mandate applies. |
| Mammography Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |
| Bone Density Screening Professional | PCP/Specialist - Covered in Full | 20% Coinsurance Subject to Deductible | |

Preventive services in addition to those required under Federal Guidelines - Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---------------------------------|-----------------|--|-----------------------------------|
| Mammography Screening Facility | Covered in Full | 20% Coinsurance Subject to Deductible | |
| Colonoscopy Screening Facility | \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| Bone Density Screening Facility | Covered in Full | 20% Coinsurance 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 - \$15 Copayment | 20% Coinsurance Subject to Deductible | Limited to a 30 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. For Diabetic purchased at a Pharmacy: Diabetic oral medication \$10/\$25/\$40 and Insulin and Supplies \$15 per 30 day supply. |
| Diabetic Equipment | PCP/Specialist - \$15 Copayment | 20% Coinsurance Subject to Deductible | |
| Durable Medical Equipment (DME) | PCP/Specialist - 20% Coinsurance | 20% Coinsurance Subject to Deductible | |
| Medical Supplies | PCP/Specialist - 20% Coinsurance | 20% Coinsurance Subject to Deductible | |
| Acupuncture | PCP/Specialist - 50% Coinsurance | 50% Coinsurance Subject to Deductible | 10 Visits per year Limits combined INN and OON. |
| Private Duty Nursing | PCP/Specialist - Not Covered | Not Covered | Not Covered |

Diagnoses

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|---|------------------------------|----------------|-----------------------------------|
| Reimbursement for Travel and Lodging Expenses | PCP/Specialist - Not Covered | Not Covered | Not Covered |

Emergency Services

ER Facility

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------|----------------|----------------|--|
| Facility Emergency Room Visit | \$35 Copayment | \$35 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 | \$15 Copayment | \$15 Copayment | |

Urgent Care

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-----------------------------------|----------------|--|-----------------------------------|
| Urgent Care Center Facility Visit | \$25 Copayment | 20% Coinsurance Subject to Deductible | |

Ancillary Benefits

Vision

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|-------------------------------|-----------------|--|---|
| Pediatric Eye Exams - Routine | \$15 Copayment | 20% Coinsurance Subject to Deductible | 1 Exam every year Limits are combined INN and OON. |
| Pediatric Eyewear - Routine | 20% Coinsurance | 20% Coinsurance Subject to Deductible | 1 Pair every year Includes Frames/Lenses or Contact Lenses |
| Adult Eye Exams - Routine | \$15 Copayment | 20% Coinsurance Subject to Deductible | 1 Exam every year Limits are combined INN and OON. |
| Adult Eyewear - Routine | Covered | Covered | \$60 Reimbursement every year Includes Frames/Lenses or Contact Lenses |

Rx Benefits

Rx Plan

| Benefit Name | In Network | Out of Network | Limits and Additional Information |
|--------------|------------|----------------|-----------------------------------|
| Rx Plan | | | \$10/\$25/\$40 |

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 | 2 | | |

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 (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.