# SECTION XV

# IND4 - $100/$200

## SCHEDULE of BENEFITS

## The Greater Tompkins County Municipal Health Insurance Consortium

| COST-SHARING | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | |
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| **Medical Deductible**<br>• Individual<br>• Family | $ 100<br>$ 200 | $ 100<br>$ 200 | |
| **Prescription Drug Deductible**<br>• Individual<br>• Family | None<br>None | Not Applicable<br>Not Applicable | |
| **Out-of-Pocket Limit (Medical)**<br>• Individual<br>• Family | $ 200 – Medical Only<br>$ 400 – Medical Only | $ 200 – Medical Only<br>$ 400 – Medical Only | |
| Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year. | | See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount. | |

| OFFICE VISITS | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| Primary Care Office Visits (or Home Visits) | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | See benefit for description |
| Specialist Office Visits (or Home Visits) | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | See benefit for description |
| **PREVENTIVE CARE** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| • Well Child Visits and Immunizations* | Covered in full | Covered in full | See benefit for description |
| • Adult Annual Physical Examinations* | Covered in full | Covered in full | |
| • Adult Immunizations* | Covered in full | Covered in full | |
| • Routine Gynecological Services/Well Woman Exams* | Covered in full | Covered in full | |
| • Mammography Screenings* | Covered in full | Covered in full | |
| • Sterilization Procedures for Women | Covered in full | Covered in full | |
| • Vasectomy | Covered in full | Covered in full | |
| • Bone Density Testing* | Covered in full | Covered in full | |
| • Screening for Prostate Cancer | | | |
|   • Performed in PCP Office | Covered in full | Covered in full | |
|   • Performed in Specialist Office | Covered in full | Covered in full | |
| • Colonoscopy | Covered in full | Covered in full | |

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| • All other preventive services required by USPSTF and HRSA<br><br>• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | Covered in full<br><br>Use Cost-Sharing for appropriate service (Primary Care/Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Covered in full<br><br>Use Cost-Sharing for appropriate service (Primary Care/Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | |
| **EMERGENCY CARE** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Pre-Hospital Emergency Medical Services (Ground or Water Ambulance Services) | Covered in Full | Covered in Full | See benefit for description |
| Air Ambulance | Covered in Full | Covered in Full | |
| Non-Emergency Ambulance Services (Intra Hospital) | Covered in Full | Covered in Full | See benefit for description |
| Emergency Department<br><br>Copayment waived if Hospital admission | Covered in Full | Covered in Full | See benefit for description |
| Urgent Care Center | Covered in Full | Covered in Full | See benefit for description |
| **PROFESSIONAL SERVICES and OUTPATIENT CARE** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Acupuncture | Not Covered | Not Covered | See benefit for description |
| Advanced Imaging Services **(MRI, CAT, PET, nuclear medicine)**<br><br>• Performed in a Freestanding Radiology Facility or Office Setting<br><br>• Performed as Outpatient | <br><br><br>Covered in Full<br><br>Covered in Full | <br><br><br>Covered in Full<br><br>Covered in Full | See benefit for description |

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| Hospital Service | | | |
| Allergy Testing and Treatment<br>• Performed in a PCP Office<br>• Performed in a Specialist Office | <br>20% Coinsurance after Deductible<br>20% Coinsurance after Deductible | <br>20% Coinsurance after Deductible<br>20% Coinsurance after Deductible | See benefit for description |
| Ambulatory Surgical Center Facility Fee | Covered in Full | Covered in Full | See benefit for description |
| Anesthesia Services (all settings) | Covered in full | Covered in Full | See benefit for description |
| Autologous Blood Banking | Not Covered | Not Covered | Not Covered |
| Cardiac and Pulmonary Rehabilitation<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services<br>• Performed as Inpatient Hospital Services | <br>Covered in Full<br>Covered in Full<br>Included as part of inpatient hospital service Cost-Sharing | <br>Covered in Full<br>Covered in Full<br>Included as part of inpatient hospital service Cost-Sharing | See benefits for description |
| Chemotherapy<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services | <br>Covered in full<br>Covered in full<br>Covered in full | <br>Covered in Full<br>Covered in Full<br>Covered in Full | See benefit for description |
| Chiropractic Services | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | See benefit for description |
| Clinical Trials | Use Cost-Sharing for appropriate service | Use Cost-Sharing for appropriate service | See benefit for description |

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| Diagnostic Testing<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services | <br>Covered in full<br>Covered in full<br>Covered in full | <br>Covered in full<br>Covered in full<br>Covered in full | See benefit for description |
| Dialysis<br>• Performed in a PCP Office<br>• Performed in a Freestanding Center or Specialist Office Setting<br>• Performed as Outpatient Hospital Services | <br>Covered in full<br>Covered in full<br>Covered in full | <br>Covered in full<br>Covered in full<br>Covered in full | See benefit for description |
| Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | Covered in full | Covered in full | Unlimited medically necessary visits. Maximum also includes Rehabilitation Services |
| Home Health Care | 60 visits - Covered in full<br><br>Up to 325 additional visits subject to Deductible/ Coinsurance | 60 visits - Covered in full<br><br>Up to 325 additional visits subject to Deductible/ Coinsurance | See benefit for description |
| Infertility Services | Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)<br>Deductible/Coinsurance Invitro, GIFT, ZIFT | Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)<br>Deductible/Coinsurance Invitro, GIFT, ZIFT | See benefit for description |

| | **Prior Approval Required for Non-mandated services.** | **Prior Approval Required for Non-mandated services** | |
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| Infusion Therapy<br><br>• Performed in a PCP Office<br><br>• Performed in Specialist Office<br><br>• Performed as Outpatient Hospital Services<br><br>• Home Infusion Therapy | <br><br>Inclusive to primary service<br><br>Inclusive to primary service<br><br>Inclusive to primary service<br><br>Inclusive of primary service | <br><br>Inclusive to primary service<br><br>Inclusive to primary service<br><br>Inclusive to primary service<br><br>Inclusive to primary service | <br><br><br><br><br><br><br><br>Is inclusive in the Home Care benefit and not covered as a separate benefit |
| Inpatient Medical Visits | Covered in full | Covered in full | See benefit for description |
| Laboratory Procedures<br>• Performed in a PCP Office<br><br>• Performed in a Freestanding Laboratory Facility or Specialist Office<br><br>• Performed as Outpatient Hospital Services | <br>Covered in full<br><br>Covered in full<br><br>Covered in full | <br>Covered in full<br><br>Covered in full<br><br>Covered in full | See benefit for description |
| Maternity and Newborn Care<br><br>• Prenatal Care<br>• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | <br><br>Covered in full | <br><br>Covered in full | See benefit for description |

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| • Inpatient Hospital Services and Birthing Center<br><br>• Physician and Midwife Services for Delivery<br><br>• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps<br><br>• Postnatal Care | Covered in full<br><br>Covered in full<br><br>Covered in full<br><br>Covered in full | Covered in full<br><br>Covered in full<br><br>Covered in full<br><br>Covered in full | Covered for duration of breast feeding |
| Outpatient Hospital Surgery Facility Charge | Covered in full | Covered in full | See benefit for description |
| Preadmission Testing | Covered in full | Covered in full | See benefit for description |
| Prescription Drugs Administered in Office<br><br>• Performed in a PCP Office<br><br>• Performed in Specialist Office | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | See benefit for description |
| Diagnostic Radiology Services<br>• Performed in a PCP Office<br><br>• Performed in a Freestanding Radiology Facility or Specialist Office<br><br>• Performed as Outpatient Hospital Services | Covered in Full<br><br>Covered in Full<br><br>Covered in Full | Covered in Full<br><br>Covered in Full<br><br>Covered in Full | See benefit for description |

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| Therapeutic Radiology Services<br>• Performed in a Freestanding Radiology Facility or Specialist Office<br><br>• Performed as Outpatient Hospital Services | <br><br>Covered in Full<br><br><br><br>Covered in Full | <br><br>Covered in Full<br><br><br><br>Covered in Full | See benefit for description |
| Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | Covered in Full | Covered in Full | Unlimited Medically Necessary visits per Plan year. Maximum also includes Habilitation Services. |
| Second Opinions on the Diagnosis of Cancer, Surgery and Other Conditions | Covered in Full | Covered in Full | See benefit for description |
| Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)<br><br>• Inpatient Hospital Surgery<br><br>• Outpatient Hospital Surgery<br><br>• Surgery Performed at an Ambulatory Surgical Center<br><br>• Office Surgery | <br><br><br><br><br><br><br><br>Covered in full<br><br><br>Covered in full<br><br><br>Covered in full<br><br><br><br>Covered in full | <br><br><br><br><br><br><br><br>Covered in full<br><br><br>Covered in full<br><br><br>Covered in full<br><br><br><br>Covered in full | See benefit for description |

| Telemedicine Program | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | See benefit for description |
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| **ADDITIONAL SERVICES, EQUIPMENT and DEVICES** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| ABA Treatment for Autism Spectrum Disorder | Covered in Full | Covered in Full | See benefit for description |
| Assistive Communication Devices for Autism Spectrum Disorder | Covered in Full | Covered in Full | See benefit for description |
| Diabetic Equipment, Supplies and Self-Management Education<br><br>• Diabetic Equipment and Supplies<br><br>• Insulin (30-day; supply)<br><br>• Diabetic Education | <br><br><br>$ 10 Copayment<br><br>$10 Copay or Paid under Prescription benefit<br><br>$ 10 Copayment | <br><br><br>$ 10 Copayment<br><br>$10 Copay or Paid under Prescription benefit<br><br>$ 10 Copayment | See benefit for description<br><br>Your benefit for diabetic insulin, oral hypoglycemics and diabetic Prescriptions will be provided under this section if Cost-Sharing is more favorable to You than under the Prescription Drug Benefit.<br><br>See Prescription Drug benefit |
| Durable Medical Equipment and Braces | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | See benefit for description |
| Cochlear Implants | Covered in full | Covered in full | |
| Hospice Care<br>• Inpatient<br><br>• Outpatient | <br>Covered in full<br><br>Covered in full | <br>Covered in full<br><br>Covered in full | <br>Unlimited<br><br>Five (5) visits for family bereavement counseling |

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| Medical Supplies | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | See benefit for description |
| Prosthetic Devices<br>• External<br>• Internal | <br>20% Coinsurance after Deductible<br>Covered in full | <br>20% Coinsurance after Deductible<br>Covered in full | See benefit for description |
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| **INPATIENT SERVICES and FACILITIES** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) | Covered in full | Covered in Full | See benefit for description |
| Observation Stay | Covered in full | Covered in Full | See benefit for description |
| Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) | Covered in full | Covered in full | Unlimited medically necessary days per Plan Year |
| Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) | Covered in full | Covered in full | Unlimited medically necessary days per Plan Year |
| **MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Inpatient Mental Health Care for a continuous confinement when in a | Covered in full | Covered in full | See benefit for description. |

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| Hospital (including Residential Treatment) | | | |
| Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) | Covered in full | Covered in full | See benefit for description. Unlimited visits |
| Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) | Covered in full | Covered in full | See benefit for description. |
| Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) | Covered in full | Covered in full | Unlimited; Up to 20 visits per Plan Year may be used for family counseling |
| **PRESCRIPTION DRUGS** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Retail Pharmacy | | | |
| Retail (30-day supply)<br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br>$ (RxR T-1) Copayment<br><br>$ (RxR T-2) Copayment<br><br>$ (RxR T-3) Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Mail Order Pharmacy | | | |
| Up to a 90-day supply<br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br>$ (RxM T-1) Copayment<br><br>$ (RxM T-2) Copayment<br><br>$ (RxM T-3) Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Enteral Formulas<br><br>Tier 1, Tier 2, Tier 3 | $ 10 Copayment | 20% Coinsurance after Deductible | See benefit for description |
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