

Benefit Type	Proposed Plan for TCCOG Benefit Description	Village of Cayuga Heights Benefit Description
WHO IS COVERED		
Type of Premium Tiers	2 – Tier (Individual/Family)	2 – Tier (Individual/Family)
Dependent Coverage <ul style="list-style-type: none"> • Age to which dependents covered • Age to which students covered 	Dependent to 19th Birthday Student to 25th Birthday	Dependent to 19th Birthday Student to 25th Birthday
Domestic Partner	Covered	
WAITING PERIODS		
Pre-Existing Condition	No – waived	
Pre-Certification	Not Required	Pre-certification required for all inpatient admissions, physical therapy, durable medical equipment, and home health care
COST SHARING EXPENSES		
Deductible Individual / Family	\$100 Individual \$300 Family	\$50 Individual \$150 Family
Deductible Carry-Over Y/N	Yes	Yes
Coinsurance	20% of Allowed Amount	20% of Allowed Amount
Annual Out-of-Pocket Maximum (excludes deductible, and co-payments)	\$400 per Covered Member	\$400 per Covered Member
Lifetime Benefit Maximum	\$2,000,000 Major Medical Only	\$2,000,000 Major Medical Only

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	<i>In Network</i>	<i>Out of Network</i>	<i>In Network</i>	<i>Out of Network</i>
BASIC COVERAGE				
Inpatient Hospital Services • Inpatient Admission for mastectomy must be covered for as long as attending physician deems medically necessary) (365 days per Calendar Year)	Covered in Full 365 Days	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full 70 Days	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Acute Mental Health Care Includes Partial Hospital 3:1 days. (Mandate: 30 days per calendar year, coverage equal to Inpatient Hospital Services)	Mandatory Rider Covered in Full – 30 Inpatient Days	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 30 Days	Mandatory Rider Covered in Full – 30 Inpatient Days	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 30 Days
Acute Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Coverage is inclusive with Inpatient Hospital Services.		Coverage is inclusive with Inpatient Hospital Services.	
Residential Treatment	Not Covered	Not Covered	Not Covered	Not Covered
Inpatient Detoxification (7 days per Calendar Year)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Skilled Nursing Facility	Covered in Full 365 days per calendar year	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 365 Days	Covered in Full 365 days per calendar year	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 365 Days (Non par in area not covered)
Inpatient Physical Rehabilitation	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Inpatient Chemical Dependence and Abuse Rehabilitation (49 days per Calendar Year)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Inpatient Maternity Care (Mandated, 48 hrs regular delivery, 96 for c-section; one home care visit covered in full, not subject to any other home care visit limitations)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Newborn Nursery Care	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Internal Prosthetics	Included in Inpatient services		Included in Inpatient services	

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MEDICAL/SURGICAL COVERAGE				
Surgical Care including Surgicenters/Freestanding	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Pre-admission/Pre-Operative Testing (Mandated benefit; same as inpatient)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Diagnostic Imaging, Diagnostic Testing, X-ray, CAT, MRI	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Diagnostic Laboratory and Pathology	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Radiation Therapy and Chemotherapy	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Hemodialysis	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Routine Mammogram	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Cervical Cytology (Pap Smear, does not include exam)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Chemical Dependency (Mandated 60 visits, includes 20 family visits; should be on par with inpatient)	Covered in Full 60 Visits	Covered in full – 60 Visits Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full 60 Visits	Covered in full – 60 Visits Member responsible for difference between Provider Charge and Allowed Amount
Physical Therapy/Respiratory Therapy	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full (Facility only)	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Surgery/Assistant Surgeon	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount

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MEDICAL/SURGICAL COVERAGE (Continued)				
Cardiac Rehabilitation	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Home Health Care	Covered in Full – 40 Visits	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 40 Visits	Covered in Full – 40 Visits	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 40 Visits (Non-par in area not covered)
Hospice Care (5 bereavement counseling visits) (210 visits per Calendar Year)	Covered in Full	Covered in full - Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Emergency Room	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Ambulance	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Urgent Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full
MAJOR MEDICAL COVERAGE	<i>In Network</i>	<i>Out of Network</i>	<i>In Network</i>	<i>Out of Network</i>
Inpatient Hospital – Additional Days	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Skilled Nursing – Additional Days	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Elective Sterilization	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Surgery – IP Physician	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Surgery – OP Physician	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount

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Major Medical Coverage (Continued)				
Consultation - Inpatient	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Anesthesia	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Additional Surgical Opinion (mandate)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
In Hospital Medical Care	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Emergency Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Adult Routine Physical 1 Per Calendar Year	Covered in Full	Not Covered	Not Covered	Not Covered
X-rays	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Lab Tests	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Maternity	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
In-Hospital Physician Visits (IHM for mastectomy must be covered for as long as attending physician deems medically necessary)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Skilled Nursing Care	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount		
Well Child Visits and Immunizations (mandated visits/immunizations full coverage)	Covered in full	Covered in full	Covered in Full	Covered in Full

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Major Medical Coverage (Continued)				
Adult Immunizations	Not Covered	Not Covered	Not Covered	Not Covered
Cervical Cancer Screen	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Chemotherapy	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Office Visits	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Chiropractic Visits	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Eye Exams - Diagnostic	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Hearing Evaluations Routine	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aids	Not Covered	Not Covered	Not Covered	Not Covered
Durable Medical Equipment	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount (Non-par in area not covered)
Prosthetics	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount (Non-par in area not covered)
Medical Supplies – including Diabetic Equipment and Supplies	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount (Non-par in area not covered)
Office Consultations	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount

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Major Medical Coverage (Continued)				
Home Care	Deductible/ 20% Coinsurance (325 Visit Max.)	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance (325 Visit Max.)	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount (Non-par in area not covered)
Prostate Cancer Screenings (Mandated if office visits covered; coverage must be equal to office visits)	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered in Full	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Routine GYN Visits including Pap Smear (Mandated; same as other basic physician services; co-payment allowed on PPO)	Covered In Full, including Lab	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	Covered In Full, including Lab	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Diagnostic GYN Visits	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Speech Therapy	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Physical Therapy (Non- facility)			Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Allergy Testing and Treatment (Injections are inclusive)	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Mental Health Care (Federal Mandate – Unique financial limits not imposed on other benefits prohibited. NYS Mandate – 20 visits per calendar year combined with physician, coverage equal to diagnostic office visit.)	Deductible/ 20% Coinsurance	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	1st 20 visits covered in full. After 20 visits, benefit limited to \$20.00 Per visit for 50 visits per calendar year	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	Coverage is equivalent to Diagnostic Office visits.		Coverage is equivalent to Diagnostic Office visits.	

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	<i>Retail</i>	<i>Mail-Order</i>	<i>Retail</i>	<i>Mail-Order</i>
<i>Prescription Drug Coverage</i>				
Prescription Drugs (If Rx covered, enteral nutrition mandated; coverage must be equal to all other drugs; certain formulas capped at \$2,500 annually.)	Tier I - 20% Tier II - 30% Tier III - 50%	Tier I - 20% Tier II - 30% Tier III - 50%	Tier I - 20% Tier II - 30% Tier III - 50%	Tier I - 20% Tier II - 30% Tier III - 50%
<i>Exclusions</i>				
Acupuncture	Excluded		Excluded	
Blood products	Excluded		Excluded	
Certification Examinations	Excluded		Excluded	
Cosmetic Services	Excluded		Excluded	
Custodial Care	Excluded		Excluded	
Dental (non-accidental services)	Excluded		Excluded	
Developmental Delay	Excluded		Excluded	
Experimental and Investigational Services	Excluded		Excluded	
Free Care	Excluded		Excluded	
Hypnosis/Biofeedback	Excluded		Excluded	
Military Service-Connected Conditions	Excluded		Excluded	
No-Fault Auto Insurance	Excluded		Excluded	
Nutritional Therapy	Excluded		Excluded	
Private Duty Nursing	Excluded		Excluded	
Reproductive Procedures	Excluded		Excluded	
Reverse elective sterilization	Excluded		Excluded	
Routine Care of the Feet	Excluded		Excluded	
Self-Help Diagnosis, Training, and Treatment	Excluded		Excluded	
Smoking Cessation Programs	Excluded		Excluded	
Transsexual Surgery and Related Services	Excluded		Excluded	
Weight Loss Services	Excluded		Excluded	

Note: This benefit grid provides a summary of benefits only and does not, nor is it intended to, replace the legal contract.

*Payments for all out-of-network benefits are based on participating provider allowances. Any difference between the allowance and the out-of-network provider's actual charge is the responsibility of the member, in addition to any applicable deductible, copayment or coinsurance amounts.