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 • 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	**$50 Individual** **$150 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**

Benefit Type	Proposed Plan for TCCOG Benefit Description		Village of Cayuga Heights Benefit Description	
BASIC COVERAGE	*In Network*	*Out of Network*	*In Network*	*Out of Network*
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	

Benefit Type	Proposed Plan for TCCOG Benefit Description		Village of Cayuga Heights Benefit Description	
MEDICAL/SURGICAL COVERAGE	*In Network*	*Out of Network*	*In Network*	*Out of Network*
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

Benefit Type	Proposed Plan for TCCOG Benefit Description		Village of Cayuga Heights Benefit Description	
MEDICAL/SURGICAL COVERAGE (Continued)	***In Network***	***Out of Network***	***In Network***	***Out of Network***
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 COVEAGE	***In Network***	***Out of Network***	***In Network***	***Out of Network***
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**

Benefit Type	Proposed Plan for TCCOG Benefit Description		Village of Cayuga Heights Benefit Description	
Major Medical Coverage (Continued)	***In Network***	***Out of Network***	***In Network***	***Out of Network***
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	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

Benefit Type	Proposed Plan for TCCOG Benefit Description		Village of Cayuga Heights Benefit Description	
Major Medical Coverage (Continued)	*In Network*	*Out of Network*	*In Network*	*Out of Network*
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

Benefit Type	Proposed Plan for TCCOG Benefit Description		Village of Cayuga Heights Benefit Description	
Major Medical Coverage (Continued)	*In Network*	*Out of Network*	*In Network*	*Out of Network*
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	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.	

Benefit Type	Proposed Plan for TCCOG Benefit Description		Village of Cayuga Heights Benefit Description	
Prescription Drug Coverage	***Retail***	***Mail-Order***	***Retail***	***Mail-Order***
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%**
Exclusions				
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.