

Benefit Type	Proposed Plan for TCCOG Benefit Description	City of Ithaca Benefit Description
<b>WHO IS COVERED</b>		
Type of Premium Tiers	<b>2-Tier (Individual and Family)</b>	<b>2-Tier (Individual and Family)</b>
Dependent Coverage <ul style="list-style-type: none"> <li>• Age to which dependents covered</li> <li>• Age to which students covered</li> </ul>	<b>Dependent to 19<sup>th</sup> Birthday Student to 25<sup>th</sup> Birthday</b>	<b>Dependent to 19<sup>th</sup> Birthday Student to 25<sup>th</sup> Birthday</b>
Domestic Partner	<b>Covered</b>	<b>Covered</b>
<b>WAITING PERIODS</b>		
Pre-Existing Condition	<b>No – waived</b>	<b>No – waived</b>
Pre-Certification	<b>Not Required</b>	<b>Not Required</b>
<b>COST SHARING EXPENSES</b>		
Deductible Individual / Family	<b>\$50 Individual \$150 Family</b>	<b>\$50 Individual \$150 Family</b>
Deductible Carry-Over Y/N	<b>Yes</b>	<b>Yes</b>
Coinsurance	<b>20% of Allowed Amount</b>	<b>20% of Allowed Amount</b>
Annual Out-of-Pocket Maximum (excludes deductible, and co-payments)	<b>\$400 per Covered Member</b>	<b>\$400 per Covered Member</b>
Lifetime Benefit Maximum	<b>\$2,000,000 Major Medical Only</b>	<b>\$1,000,000 Major Medical Only</b>

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<b>BASIC COVERAGE</b>				
Inpatient Hospital Services • Inpatient Admission for mastectomy must be covered for as long as attending physician deems medically necessary) (365 days per Calendar Year)	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	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)	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 30 Days	<b>Mandatory Rider Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Acute Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	<b>Coverage is inclusive with Inpatient Hospital Services.</b>		<b>Coverage is inclusive with Inpatient Hospital Services.</b>	
Residential Treatment	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Inpatient Detoxification (7 days per Calendar Year)	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Skilled Nursing Facility	<b>Covered in Full 365 days per calendar year</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 365 Days	<b>Covered in Full 365 days per calendar year</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 365 Days
Inpatient Physical Rehabilitation	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Inpatient Chemical Dependence and Abuse Rehabilitation (49 days per Calendar Year)	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed
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)	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Newborn Nursery Care	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Internal Prosthetics	<b>Included in Inpatient services</b>		<b>Included in Inpatient services</b>	

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

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<b>MEDICAL/SURGICAL COVERAGE (Continued)</b>				
Cardiac Rehabilitation	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Home Health Care	<b>Covered in Full – 40 Visits</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 40 Visits	<b>Covered in Full – 40 Visits</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 40 Visits
Hospice Care (5 bereavement counseling visits) (210 visits per Calendar Year)	<b>Covered in Full</b>	Covered in full - Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Emergency Room	<b>Covered in Full</b>	<b>Covered in Full</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
Ambulance	<b>Covered in Full</b>	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Urgent Care	<b>Covered in Full</b>	<b>Covered in Full</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
<b>MAJOR MEDICAL COVERAGE</b>	<i>In Network</i>	<i>Out of Network</i>	<i>In Network</i>	<i>Out of Network</i>
Inpatient Hospital – Additional Days	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Skilled Nursing – Additional Days	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Elective Sterilization	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Surgery – IP Physician	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Surgery – OP Physician	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount

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<b>Major Medical Coverage (Continued)</b>				
Consultation - Inpatient	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Anesthesia	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Additional Surgical Opinion (mandate)	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
In Hospital Medical Care	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Emergency Care	<b>Covered in Full</b>	<b>Covered in Full</b>	<b>Covered in Full</b>	<b>Covered in Full</b>
Adult Routine Physical 1 Per Calendar Year	<b>Covered in Full</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
X-rays	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Lab Tests	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Maternity	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	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)	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Skilled Nursing Care	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount		
Well Child Visits and Immunizations (mandated visits/immunizations full coverage)	<b>Covered in full</b>	<b>Covered in full</b>	<b>Covered in Full</b>	<b>Covered in Full</b>

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

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<b>Major Medical Coverage (Continued)</b>				
Home Care	<b>Deductible/ 20% Coinsurance (325 Visit Max.)</b>	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount		Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Prostate Cancer Screenings (Mandated if office visits covered; coverage must be equal to office visits)	<b>Covered in Full</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered in Full</b>	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)	<b>Covered In Full, including Lab</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount	<b>Covered In Full, including Lab</b>	Covered in full – Member responsible for difference between Provider Charge and Allowed Amount
Diagnostic GYN Visits	<b>Deductible/ 20% Coinsurance</b>	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	<b>Deductible/ 20% Coinsurance</b>	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Speech Therapy	<b>Deductible/ 20% Coinsurance</b>	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	<b>Deductible/ 20% Coinsurance</b>	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount
Allergy Testing and Treatment (Injections are inclusive)	<b>Deductible/ 20% Coinsurance</b>	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	<b>Deductible/ 20% Coinsurance</b>	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.)	<b>20 Visits Covered in Full with rollover to MM Deductible/ 20% Coinsurance</b>	Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount	<b>1<sup>st</sup> 20 visits covered in full. After 20 visits, benefit limited to \$20.00 Per visit for 50 visits per calendar year</b>	<b>Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount</b>
Mental Health Care Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances	<b>Coverage is equivalent to Diagnostic Office visits.</b>		<b>Coverage is equivalent to Diagnostic Office visits.</b>	
<b>Prescription Drug Coverage</b>	<b>Retail</b>	<b>Mail-Order</b>	<b>Retail</b>	<b>Mail-Order</b>
Prescription Drugs (If Rx covered, enteral nutrition mandated; coverage must be equal to all other drugs; certain formulas capped at \$2,500 annually.)	Plan 1: \$1.00 / \$1.00 Plan 2: \$2.00 / \$5.00 Plan 3: \$2.00 / \$10.00 Plan 4: Included in MM		Plan 1: \$1.00 / \$1.00 Plan 2: \$2.00 / \$5.00 Plan 3: \$2.00 / 10.00 Plan 4: Included in MM	

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<i>Exclusions</i>		
Acupuncture	<b>Excluded</b>	<b>Excluded</b>
Blood products	<b>Excluded</b>	<b>Excluded</b>
Certification Examinations	<b>Excluded</b>	<b>Excluded</b>
Cosmetic Services	<b>Excluded</b>	<b>Excluded</b>
Custodial Care	<b>Excluded</b>	<b>Excluded</b>
Dental (non-accidental services)	<b>Excluded</b>	<b>Excluded</b>
Developmental Delay	<b>Excluded</b>	<b>Excluded</b>
Experimental and Investigational Services	<b>Excluded</b>	<b>Excluded</b>
Free Care	<b>Excluded</b>	<b>Excluded</b>
Hypnosis/Biofeedback	<b>Excluded</b>	<b>Excluded</b>
Military Service-Connected Conditions	<b>Excluded</b>	<b>Excluded</b>
No-Fault Automobile Insurance	<b>Excluded</b>	<b>Excluded</b>
Nutritional Therapy	<b>Excluded</b>	<b>Excluded</b>
Private Duty Nursing	<b>Excluded</b>	<b>Excluded</b>
Reproductive Procedures	<b>Excluded</b>	<b>Excluded</b>
Reversal of elective sterilization	<b>Excluded</b>	<b>Excluded</b>
Routine Care of the Feet	<b>Excluded</b>	<b>Excluded</b>
Self-Help Diagnosis, Training, and Treatment	<b>Excluded</b>	<b>Excluded</b>
Smoking Cessation Programs	<b>Excluded</b>	<b>Excluded</b>
Transsexual Surgery and Related Services	<b>Excluded</b>	<b>Excluded</b>
Weight Loss Services	<b>Excluded</b>	<b>Excluded</b>

**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.