Benefit Type	Proposed Plan for TCCOG Benefit Description	Town of Groton Benefit Description
WHO IS COVERED		
Type of Premium Tiers	**2 – Tier (Individual/Family)**	**3-Tier (Individual, 2 person(Sub/Spouse or 2 person and 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 19th 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**	**$100 Individual** **$300 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		Town of Groton 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		Town of Groton 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		Town of Groton 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		Town of Groton 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**		
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		Town of Groton 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		Town of Groton 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**
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		Town of Groton 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.