

**The Greater Tompkins County Municipal Health Insurance Consortium
PPO Benefit Plan**

Benefit Type	TCCOG Benefit Description		Town of Ulysses – EPO Benefit Description	
WHO IS COVERED				
Type of Premium Tiers • Individual • Family	2-Tier (Individual and Family)		2-Tier (Individual 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 age 25	
Domestic Partner	Covered			
MEDICAL NECESSITY				
Pre-Certification	Pre-Certification Applies to: All Inpatient admissions, excluding maternity, home health care, infusion therapy, Durable Medical Equipment (DME) over \$200, MRI, CAT scans, and PET scans.		Per-certification applies to: All Inpatient admissions, Diagnostic X-rays, Home Health Care and Durable Medical Equipment. A penalty of \$500 or 50%, whichever is less will apply if pre-certification is not obtained.	
COST SHARING EXPENSES	PPO In Network	PPO Out-of-Network	PPO In Network	PPO Out-of-Network
Deductible Individual / Family	None	\$250 / \$750	None	Not Covered
Deductible Carry-Over Y/N	No	No	No	N/A
Co-Payment	\$10, except where noted	None	\$20, except where noted	N/A
Coinsurance	None	20%, except where noted	None	N/A
Annual Out-of-Pocket Maximum (includes deductible, excludes co-payment)	None	\$1,000/\$3,000 Includes deductible and coinsurance, not co-payment. Excludes artificial insemination and prescription drugs.	None	N/A

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Lifetime Benefit Maximum	None	None	None	None
HOSPITAL INPATIENT SERVICES	<i>In Network</i>	<i>Out of Network</i>	<i>In Network</i>	<i>Out of Network</i>
Inpatient Hospital Services <ul style="list-style-type: none"> • Inpt. Adm. for mastectomy must be covered for as long as attending physician deems medically necessary) (Unlimited days per Calendar Year)	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
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	Mandatory Rider Deductible/Coinsurance	Mandatory Rider Covered in Full	Not Covered
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
Detoxification (7 days per Calendar Year)	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Skilled Nursing Facility	Covered in Full 120 days per calendar year	Deductible/Coinsurance 120 days per calendar year	Covered in Full 120 days per calendar year	Not Covered
Physical Rehabilitation (60 days per Calendar Year)	Not Covered	Not Covered	Covered in full – 60 days per calendar year	Not Covered
Chemical Dependence and Abuse Rehabilitation (30 days per Calendar Year) (2 admissions per Life)	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
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	Deductible/Coinsurance	Covered in Full	Not Covered

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Newborn Nursery Care	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Internal Prosthetics	Included in inpatient services		Included in inpatient services	
HOSPITAL OUTPATIENT SERVICES				
Surgical Care including Surgicenters/Freestanding	Co-Payment	Deductible/Coinsurance	Co-Payment (\$50.00)	Not Covered
Pre-admission/Pre- Operative Testing <small>(Mandated benefit; same as inpatient)</small>	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Diagnostic Imaging, X-ray, CAT, MRI	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Diagnostic Laboratory and Pathology	Covered in Full	Deductible/Coinsurance	Co-Payment	Not Covered
Radiation Therapy and Chemotherapy	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Hemodialysis	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Mammogram (Routine)	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Cervical Cytology (Pap Smear, does not include exam)	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Mental Health Care <small>(Federal Mandate – Unique financial limits no imposed on other benefits prohibited. NYS Mandate – 20 visits per calendar year combined with physician, coverage equal to diagnostic office visit, if OV not covered coverage equal to CD)</small>	Co-Payment	Deductible/Coinsurance	Co-Payment – up to 20 visits per calendar year	Not Covered
Mental Health Care <small>Mandated for Biologically based Mental Illness & Children with Serious Emotional Disturbances</small>	Coverage is equivalent to Diagnostic Office visits.		Coverage is equivalent to Diagnostic Office visits	
Chemical Dependency <small>(Mandated 60 visits, includes 20 family visits; should be on par with inpatient)</small>	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered

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Covered Therapies (Includes aggregate of [45] per calendar year of Physical, Speech, Occupational and Respiratory Therapy)	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Cardiac Rehabilitation	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
HOME CARE (Mandated; benefits of not less than 40 4 hr. visits per 12 month period, no more than 25% coinsurance & no more than \$50 deductible) (Unlimited visits per Calendar Year)	Covered in Full	\$50 Ded/20% Coins	Covered in Full – unlimited visits	Not Covered
HOSPICE CARE (Includes 5 bereavement counseling visits) (Unlimited visits per Calendar Year)	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
PHYSICIAN SERVICES				
Inpatient Hospital Surgery	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Outpatient Hospital & Ambulatory Surgery	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Office Surgery	Co-Payment	Deductible/Coinsurance	Covered in Full	Not Covered
Covered Therapies (Includes aggregate of [45] per calendar year of Physical, Speech, Occupational and Respiratory Therapy)	Co-Payment	Deductible/Coinsurance	Co-Payment (up to 45 visits per calendar year of Physical, Speech, Occupational and Respiratory combined.)	Not Covered
Anesthesia	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Additional Surgical Opinion (mandate)	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Second Medical Opinion (mandated for cancer; cover same as office visit)	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Normal Pregnancy	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Prenatal and Postpartum Care	Co-Payment for initial visit, then covered in full	Deductible/Coinsurance	Co-Payment for initial visit, then covered in full	Not Covered

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Complications of Pregnancy and Termination	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Delivery Anesthesia	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
In-Hospital Physician Visits (IHM for mastectomy must be covered for as long as attending physician deems medically necessary)	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Physician’s Office – Preventive Services				
Routine Physical Examinations (1 per Calendar Year)	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Well Child Visits and Immunizations (mandated visits/immunizations full coverage)	Covered in full	Covered in full	Covered in full	Not Covered
Adult Immunizations	Not Covered	Not Covered	Not Covered	Not Covered
Physician’s Office - Other Services				
Diagnostic Laboratory and Pathology	Covered in Full	Deductible/Coinsurance	Co-Payment	Not Covered
Eye Exams Routine	Co-Payment 1 per Calendar Year	Deductible/Coinsurance 1 per Calendar Year	\$15 Co-Payment 1 every 2 years	Not Covered
Eyewear Routine (must purchase eye exam)	\$60 allowance 1 per Calendar year	\$60 allowance 1 per Calendar year	\$60 allowance Every 2 years	Not Covered
Eye Exams - Diagnostic	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Hearing Evaluations Routine	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Evaluations Diagnostic	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Hearing Aids (Children to age 19)	\$600 allowance every 3 years	Not Covered	Not Covered	Not Covered
Diagnostic Office Visits	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered

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Office Consultations	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Diagnostic Imaging Services, X-ray, CAT, MRI, etc.	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Radiation Therapy and Chemotherapy	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Hemodialysis	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Mammogram (Mandated; should be on par with other basic physician services; co-payment allowed on PPO)	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered
Routine GYN Visits including Pap Smear (Mandated; same as other basic physician services; co-payment allowed on PPO)	Covered In Full, including Lab	Deductible/Coinsurance	Covered In Full, including Lab	Not Covered
Diagnostic GYN Visits	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Prostate Cancer Screenings (Mandated if office visits covered; coverage must be equal to office visits)	Co-Payment	Deductible/Coinsurance	Covered in Full	Not Covered
Allergy Testing and Treatment (Injections are inclusive)	Co-Payment – Testing Covered In Full – Treatment	Deductible/Coinsurance	Co-Payment – Testing & Injections	Not Covered
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.)	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
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.	
Chiropractic Care (Mandated if office visits covered; coverage must be equal to office visits)	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Inpatient Consultations	Covered in Full	Deductible/Coinsurance	Covered in Full	Not Covered

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Infertility Care (Mandated if inpatient hospital, medical/surgery covered)	Covered same as similar services under benefit plan – i.e. labs see Diagnostic Laboratory and Pathology benefit, office visit see Diagnostic Office visit benefit.		Covered same as similar services under benefit plan – i.e. labs see Diagnostic Laboratory and Pathology benefit, office visit see Diagnostic Office visit benefit.	
Bone Density Testing (Mandated if x-ray covered; coverage must be equal office visit or x-ray benefit, whichever is better benefit)	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
ADDITIONAL BENEFITS				
Treatment of Diabetes (Insulin & Supplies) Education and DME (Mandated if physician office visits covered; must be covered equal to office visits for a 30 day supply)	Co-Payment	Deductible/Coinsurance	Co-Payment	Not Covered
Durable Medical Equipment (DME)	20% Coinsurance	Deductible/Coinsurance	20% Coinsurance	Not Covered
External Prosthetics Orthotics (foot orthotics excluded) (\$15,000 max per Calendar Year)	Included in DME Benefit		20% Coinsurance up to a maximum of \$15,000 per calendar year	Not Covered
Medical Supplies	20% Coinsurance	Deductible/Coinsurance	20% Coinsurance	Not Covered
Foot Orthotics	Not Covered	Not Covered	Not Covered	Not Covered
Ambulance Service (Includes air)	Co-Payment	Deductible/Coinsurance	\$50 Co-Payment	
Pre-Hospital Emergency Services/Transportation (Mandated for ambulance, coverage must be equal to or better than emergency benefit. Excludes air.)	Co-Payment		\$50 Co-Payment	Not Covered
Acupuncture (10 visits per Calendar Year)	Not Covered	Not Covered	Not Covered	Not Covered
Prescription Drugs (If Rx covered, enteral nutrition mandated; coverage must be equal to all other drugs; certain formulas capped at \$2,500 annually.)	Covered – see RX options	Not covered	Covered – see RX options	Not covered
EMERGENCY SERVICES (Emergency Condition Mandated; coverage on par with inpatient; copayment allowed for POS/PPO; O/N benefit for Emergency Condition must be same covered same as I/N)				

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Facility – Emergency Room	\$35 Co-Payment		\$50 Co-Payment	
Freestanding Urgent Care Ctr	\$25 Co-Payment	Deductible/ Coinsurance	\$25 Co-Payment	
Emergency Room Physician	Covered in Full		Covered in Full	
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 - \$10 Tier II - \$25 Tier III - \$40	Tier I - \$10 Tier II - \$25 Tier III - \$40	Tier I - \$10 Tier II - \$25 Tier III - \$40	Tier I - \$20 Tier II - \$50 Tier III - \$80
	(\$0 generic for children to age 19)		(\$0 generic for children to age 19)	
WAITING PERIODS				
Pre-Existing Condition Waiting Period	No – waived		No – waived	
EXCLUSIONS: The following are common exclusions that will apply. Indicate if coverage should be provided and the applicable deductible/copayment/coinsurance.			EXCLUSIONS: The following are common exclusions that will apply. Indicate if coverage should be provided and the applicable deductible/copayment/coinsurance.	
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 Investigational Svcs	Excluded		Excluded	
Free Care	Excluded		Excluded	
Hypnosis/Biofeedback	Excluded		Excluded	
Military Svc-Connected Conditions	Excluded		Excluded	
No-Fault Automobile Insurance	Excluded		Excluded	
Nutritional Therapy	Excluded		Excluded	
Private Duty Nursing	Excluded		Excluded	
Reproductive Procedures	Excluded		Excluded	
Reversal of elective sterilization	Excluded		Excluded	
Routine Care of the Feet	Excluded		Excluded	

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Self-Help Diagnosis, Training, Treatment	Excluded	Excluded	
Smoking Cessation Prgms	Excluded	Excluded	
Transsexual Surgery - Related Svcs	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.