

| Benefit Type  | Proposed Plan for TCCOG<br>Benefit Description                                       | County of Tompkins<br>White Collar, Blue Collar, & Management/Confidential<br>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<br/>Student to 25<sup>th</sup> Birthday</b> | <b>Dependent to 19<sup>th</sup> Birthday<br/>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<br>Individual / Family   | <b>\$100 Individual<br/>\$200 Family</b>   | <b>\$100 Individual<br/>\$200 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<br>Maximum (excludes<br>deductible, and co-payments)   | <b>\$400 per Covered Member</b>  | <b>\$400 per Covered Member</b>   |
| Lifetime Benefit Maximum  | <b>\$2,000,000<br/>Major Medical Only</b>  | <b>\$1,000,000<br/>Major Medical Only</b>   |

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|--|--|---|--|---|
|  | <i>In Network</i>  | <i>Out of Network</i>   | <i>In Network</i>  | <i>Out of Network</i>   |
| <b>BASIC COVERAGE</b>  |  |   |  |   |
| Inpatient Hospital Services<br>• 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<br/>365 Days</b>                                | Covered in full – Member responsible for difference between Provider Charge and Allowed Amount            | <b>Covered in Full<br/>365 Days</b>                                | Covered in full – Member responsible for difference between Provider Charge and Allowed Amount                    |
| Acute Mental Health Care<br>Includes Partial Hospital 3:1 days. (Mandate: 30 days per calendar year, coverage equal to Inpatient Hospital Services)                            | <b>Mandatory Rider<br/>Covered in Full – 30<br/>Inpatient Days</b> | Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 30 Days  | <b>Mandatory Rider<br/>Covered in Full –<br/>30 Inpatient Days</b> | Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 30 Days          |
| Acute Mental Health Care<br>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<br>(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<br/>365 days per calendar<br/>year</b>          | Covered in full – Member responsible for difference between Provider Charge and Allowed Amount – 365 Days | <b>Covered in Full<br/>365 days per<br/>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<br>(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 (42<br/>Days – Lifetime)</b>                    | Covered in full – Member responsible for difference between Provider Charge and Allowed Amount (42 Days-Lifetime) |
| Inpatient Maternity Care<br>(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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|  | <i>In Network</i>                              | <i>Out of Network</i>   | <i>In Network</i>                         | <i>Out of Network</i>   |
| <b>MEDICAL/SURGICAL<br/>COVERAGE</b>   |  |   |   |   |
| Surgical Care including<br>Surgicenters/Freestanding   | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |
| Pre-admission/Pre-Operative<br>Testing<br>(Mandated benefit; same as inpatient)                            | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |
| Diagnostic Imaging, Diagnostic<br>Testing, X-ray, CAT, MRI   | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |
| Diagnostic Laboratory and<br>Pathology   | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |
| Radiation Therapy and<br>Chemotherapy  | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |
| Hemodialysis   | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |
| Routine Mammogram  | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |
| Cervical Cytology (Pap Smear,<br>does not include exam)  | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |
| Chemical Dependency (Mandated<br>60 visits, includes 20 family visits; should be<br>on par with inpatient) | <b>Covered in Full<br/>60 Visits</b>           | Covered in full – 60 Visits<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount | <b>Covered in Full<br/>60 Visits</b>      | Covered in full – 60 Visits<br>Member responsible for difference<br>between Provider Charge and<br>Allowed Amount |
| Physical Therapy/Respiratory<br>Therapy  | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |
| Surgery/Assistant Surgeon  | <b>Covered in Full</b>                         | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount           | <b>Covered in Full</b>                    | Covered in full – Member<br>responsible for difference between<br>Provider Charge and Allowed<br>Amount           |

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| <b>MEDICAL/SURGICAL<br/>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<br>(5 bereavement counseling visits)<br>(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>Deductible/<br/>20% Coinsurance</b>         | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount      | <b>Deductible/<br/>20% Coinsurance</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<br/>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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|   | <i>In Network</i>                              | <i>Out of Network</i>  | <i>In Network</i>                                      | <i>Out of Network</i>  |
| <b>Major Medical Coverage<br/>(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<br>(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<br>1 Per Calendar Year   | <b>Covered in Full</b>                         | <b>Not Covered</b>   | <b>Employees over Age 50 - \$50 Per Year Allowance</b> | <b>Employees over Age 50 - \$50 Per Year Allowance</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<br>(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 | <b>Covered in Full</b>                                 | Covered in full – Member responsible for difference between Provider Charge and Allowed Amount |
| Well Child Visits and<br>Immunizations (mandated<br>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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|--|--|---|---|---|
|  | <i>In Network</i>                              | <i>Out of Network</i>   | <i>In Network</i>                         | <i>Out of Network</i>   |
| <i>Major Medical Coverage<br/>(Continued)</i>                |  |   |   |   |
| Adult Immunizations  | <b>Covered in Full</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/<br/>20% Coinsurance</b>         | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>    | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount |
| Chiropractic Visits  | <b>Deductible/<br/>20% Coinsurance</b>         | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>    | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount |
| Eye Exams - Diagnostic                                       | <b>Deductible/<br/>20% Coinsurance</b>         | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount | <b>Deductible/<br/>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/<br/>20% Coinsurance</b>         | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>    | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount |
| Prosthetics  | <b>Deductible/<br/>20% Coinsurance</b>         | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>    | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount |
| Medical Supplies – including Diabetic Equipment and Supplies | <b>Deductible/<br/>20% Coinsurance</b>         | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>    | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount |
| Office Consultations   | <b>Deductible/<br/>20% Coinsurance</b>         | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>    | Deductible/Coinsurance - Member responsible for difference between Provider Charge and Allowed Amount |

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|  | <i>In Network</i>  | <i>Out of Network</i>  | <i>In Network</i>  | <i>Out of Network</i>  |
| <b>Major Medical Coverage<br/>(Continued)</b>  |  |  |  |  |
| Home Care  | <b>Deductible/<br/>20% Coinsurance<br/>(325 Visit Max.)</b>          | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance<br/>(325 Visit Max.)</b>          | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount |
| Prostate Cancer Screenings<br>(Mandated if office visits covered;<br>coverage must be equal to office visits)  | <b>Covered in Full</b>   | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount        | <b>Covered in Full</b>   | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount        |
| Routine GYN Visits<br>including Pap Smear<br>(Mandated; same as other basic physician<br>services; co-payment allowed on PPO)  | <b>Covered In Full,<br/>including Lab</b>                            | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount        | <b>Covered In Full,<br/>including Lab</b>                            | Covered in full – Member<br>responsible for difference<br>between Provider Charge and<br>Allowed Amount        |
| Diagnostic GYN Visits  | <b>Deductible/<br/>20% Coinsurance</b>                               | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>                               | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount |
| Speech Therapy   | <b>Deductible/<br/>20% Coinsurance</b>                               | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>                               | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount |
| Allergy Testing and<br>Treatment<br>(Injections are inclusive)   | <b>Deductible/<br/>20% Coinsurance</b>                               | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>                               | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount |
| Mental Health Care<br>(Federal Mandate – Unique financial<br>limits not imposed on other benefits<br>prohibited.<br>NYS Mandate – 20 visits per calendar<br>year combined with physician, coverage<br>equal to diagnostic office visit.) | <b>Deductible/<br/>20% Coinsurance</b>                               | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount | <b>Deductible/<br/>20% Coinsurance</b>                               | Deductible/Coinsurance -<br>Member responsible for<br>difference between Provider<br>Charge and Allowed Amount |
| Mental Health Care<br>Mandated for Biologically based<br>Mental Illness & Children with<br>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>  | <i>Retail</i>  | <i>Mail-Order</i>  | <i>Retail</i>  | <i>Mail-Order</i>  |
| Prescription Drugs (If Rx<br>covered, enteral nutrition mandated;<br>coverage must be equal to all other<br>drugs; certain formulas capped at<br>\$2,500 annually.)  | <b>Tier I - \$ 5.00<br/>Tier II - \$10.00<br/>Tier III - \$25.00</b> | <b>Tier I - \$ 5.00<br/>Tier II - \$10.00<br/>Tier III - \$25.00</b>   | <b>Tier I - \$ 5.00<br/>Tier II - \$10.00<br/>Tier III - \$25.00</b> | <b>Tier I - \$ 5.00<br/>Tier II - \$10.00<br/>Tier III - \$25.00</b>   |

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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.