

**GGCC - COMPARISON SHEET BENEFITS and RATES**  
**MVP, BSNENY, CDPHP 2010**

Benefits	MVP CoPlan HMO 25/40	Blue Shield of NENY Community Blue HMO 206 Plus	CDPHP HMO \$25	CDPHP Attentivare EPO Chamber Only Plan
<b>Dependent / Full Time Student</b>	25/25	19/25	19/25	19/25
<b>Referrals</b>	Required	Not Required	Required	Not Required
<b>Deductible</b>	Not applicable	Not applicable	Not applicable	\$500 for individual/ \$1,250 for family
<b>Coinsurance</b>	Not applicable	Not applicable	Not applicable	20%
<b>Coinsurance Maximum</b>	Not applicable	Not applicable	Not applicable	\$2,000 for individual/ \$5,000 for family Out of Pocket Max: \$2,500 ind / \$6,250 family
<b>Annual Benefit Maximum</b>	No maximum	No maximum	No maximum	\$1,000,000
<b>Office Visit CoPayment</b>	\$25 Primary Care / \$40 Specialist	Choose One: \$10/\$40, \$20/\$30 or \$25/\$25	\$25 Primary Care / \$25 Specialist	Well visits Covered in Full \$25 Co-Pay for Sick Visits
<b>InPatient Hospital</b>	\$500 Co-Pay	<b>\$250</b> Co-Pay (waived for maternity admission)	\$500 Co-Pay	Deductible then coinsurance
<b>OutPatient Surgery</b>	\$75 Co-Pay	<b>\$150</b> Co-Pay	<b>\$100</b> Co-Pay	Deductible then coinsurance
<b>ER</b>	\$100 Co-Pay (In-patient co-pay applies if admitted)	\$100 Co-Pay (In-patient co-pay applies if admitted)	\$100 Co-Pay (In-patient co-pay applies if admitted)	Deductible then coinsurance
<b>Ambulance</b>	\$100 Co-Pay	\$100 Co-Pay	\$100 Co-Pay	Deductible then coinsurance
<b>Out of Network Coverage</b>	None	\$1,000 deductible, 30% coinsurance/ <b>\$1,000,000</b> <b>Annual Max/Unlimited</b> <b>Lifetime Max</b>	None	None
<b>Durable Medical Equipment</b>	50% Co-Pay, not subject to deductible/\$25,000 lifetime maximum	50% w/ \$1,000 Annual Maximum	50% Coinsurance	50% coinsurance, not subject to deductible/\$25,000 lifetime maximum
<b>Diabetic Supplies</b>	PCP Office Visit copay per item/31 day supply per dispensing.	Supplies and Equipment: PCP Copay	<b>\$15</b> Copay per item or 30 day supplies/drugs	Drugs and Supplies: \$15 (up to 30 day supply) Glucometers: \$15 Not Subject to Deductible
<b>Prescription</b>	\$100 deductible per member each calendar year	\$0 Ded	\$0 Ded	\$0 Ded
<i>Generic</i>	\$10 Co-Pay	\$15 Co-Pay	\$4 Generic	\$4 Co-Pay - Generic
<i>Brand Name</i>	\$30 Co-Pay	\$50 Co-Pay	50% coinsurance w/no maximum	50% coinsurance w/no maximum
<i>Non-Formulary</i>	\$50 Co-Pay	50%	<b>50%</b>	<b>50%</b>
<b>Domestic Partner Coverage</b>	Not Covered	Covered	Covered	Covered
<b>Home Health Care</b>	\$25 Co-Pay per visit/ 60 visits max	<b>40 Visits PCP Copay</b>	Covered in Full	Deductible (\$50) then coinsurance
<b>Dental Coverage</b>	Preventive Only/Kids Only - \$25 co-pay	Preventive Only/Each Family Member - Specialist Co-Pay	Not Covered	Not Covered
<b>Vision Coverage</b>	Not Covered	Lenses Covered in full. Frames & Contacts - co-pays. Exam - <b>PCP</b> Co-Pay	Not Covered	Eye Exam every 2 yrs w/ Hardware

Quarterly Rates do not include administrative fees.

MVP quarterly rates subject to increase for all new enrollees.

	2010				hmo		epo	
	MVP		BSNENY		CDPHP		CDPHP	
<b>Sole Proprietors Rates</b>	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly
Single	\$521.95	\$1,565.85	\$554.06	\$1,662.18	\$463.92	\$1,391.76	\$396.95	\$1,190.85
2 - Person	\$1,043.92	\$3,131.76	n/a	n/a	n/a	n/a	\$793.92	\$2,381.76
Family	\$1,403.30	\$4,209.90	\$1,440.58	\$4,321.74	\$1,209.81	\$3,629.43	\$1,055.04	\$3,165.12
<b>Groups - 2 -49 Rates</b>								
Single	\$453.87	\$1,361.61	\$508.07	\$1,524.21	\$406.96	\$1,220.88	\$348.21	\$1,044.63
2 - Person	\$907.76	\$2,723.28	n/a	n/a	n/a	n/a	\$696.42	\$2,089.26
Family	\$1,220.26	\$3,660.78	\$1,320.97	\$3,962.91	\$1,061.24	\$3,183.72	\$925.48	\$2,776.44