

Health Insurance Program

January 1 - December 31, 2012

BSNENY + MVP PLANS

| BSNENY AND MVP PLANS | BSNENY 250D Select #10392000 (2+) #00981128 (SP) | BSNENY POS 7100 #10392000 (2+) #00981128 (SP) | MVP EPO HYBRID 30/50 #212370 | MVP EPO HD #212370 (NEHD06S/F) | MVP EPO HD #212370 (NECHD-29S) |
|---|--|--|------------------------------------|--|--------------------------------------|
| Monthly Premium for | \$347.42 Single | \$334.48 Single | \$420.70 Single | \$296.22 Single | \$258.95 Single |
| 2+ Employer Groups | \$712.24 2-Person | \$685.67 2-Person | \$841.40 2-Person | \$592.44 2-Person | \$517.90 2-Person |
| <i>(With Paid Employees)</i> | \$986.76 Family | \$948.94 Family | \$1093.82 Family | \$770.17 Family | \$673.27 Family |
| Monthly Premium for | \$347.42 Single | \$334.48 Single | \$483.80 Single | \$340.65 Single | \$297.79 Single |
| (SP) Sole Proprietors | \$712.24 2-Person | \$685.67 2-Person | \$967.61 2-Person | \$681.31 2-Person | \$595.59 2-Person |
| <i>(Without Paid Employees)</i> | \$986.76 Family | \$948.94 Family | \$1257.90 Family | \$885.70 Family | \$774.27 Family |
| Preventive Care (Physical, Well-Child Visit, Mammogram, Pap Smear, Colonoscopy) | Covered in Full | Covered in Full | Covered in Full | Covered in Full | Covered in Full |
| Physician Visit | \$25.00 | \$25.00 After Deductible | \$30.00 | 20% After Deductible | 20% After Deductible |
| Specialist Visit | \$40.00 | \$25.00 After Deductible | \$50.00 | 20% After Deductible | 20% After Deductible |
| Hospital Stay | 20% After Deductible | \$500.00 After Deductible | 20% After Deductible | 20% After Deductible | 20% After Deductible |
| Outpatient Surgery | 20% | \$75.00 After Deductible | 20% After Deductible | 20% After Deductible | 20% After Deductible |
| Emergency Room | 20% After Deductible | \$50.00 After Deductible | \$200.00 Copay/Visit | 20% After Deductible | 20% After Deductible |
| Ambulance | 20% After Deductible | \$50.00 After Deductible | 20% After Deductible | 20% After Deductible | 20% After Deductible |
| Urgent Care | 20% | \$35.00 After Deductible | \$30.00 | 20% After Deductible | 20% After Deductible |
| Prescriptions | \$15/50/50% w/Ded \$250 per Member Mail Order : Custom Home Delivery 2 fills at Retail/MO- 2.5 Copays per 90 day supply | \$15/50/50% Mail Order : Custom Home Delivery 2 fills at Retail/MO- 2.5 Copays per 90 day supply | \$10 Generic Only | Tier 1 + 2 (Generic/name brand) 20% after deductible 3-Tier Rx 40% after deductible (Generally non-formulary) | \$5/\$35/\$70 After Deductible |
| Dependent Rider | 26/26 | 26/26 | 26/26 | 26/26 | 26/26 |
| Out-of-Network | Covered | Covered | N/A | N/A | N/A |
| Annual Benefit Max | Unlimited | Unlimited | Unlimited | Unlimited | Unlimited |
| Deductible (In-Network/Out-of-Network) | \$1,000/\$2000 INN \$2,000/\$4000 OON | Combined INN/OON \$1,500/\$3,000 | \$1,000/\$2,500 INN | \$2,500/\$5,000 INN | \$3,500/\$7,000 INN |
| Coinsurance (In-Network/Out-of-Network) | 20% INN 50% OON | \$0 INN 30% OON | 20% INN | 20% INN | 20% INN |
| Out-of-Pocket Maximum (In-Network/Out-of-network) | \$5,000/\$10,000 INN \$10,000/\$20,000 OON | \$5,000/\$10,000 INN \$10,000/\$20,000 OON | \$3,000/\$7,500 INN | \$5,000/\$10,000 INN | \$5,950/\$11,900 INN |

TERMS OF THE CONTRACT PREVAIL IN THE EVENT OF INCONSISTENCIES.

Bouchey & Clarke Benefits, Inc. PO Box 1616 Troy NY 12181-1616 (p) 518.272.9866 (f) 518.874.5002

www.bouchey.com

* Rates DO NOT include \$5 monthly admin fee

Revised: November 2011