2019 CAPITAL DISTRICT PHYSICIANS HEALTH PLAN - Small Business 2 to 100 — RATES COVER REGION 1: ALBANY

METAL TIER	PLAN CODE	Plan Name	Tier	Monthly Rate	Aggregate / Embedded	DEDUCTIBLE (SINGLE/FAMILY)	OOP MAX (SINGLE/FAMILY)	OFFICE VISIT	SPECIALIST VISIT	INPATIENT HOSPITAL	OUTPATIENT SURGERY	ER	URGENT CARE	PRESCRIPTION DRUGS
Platinum	120	EPO Copayment	Individual Empl/Spouse Parent/Child(ren) Family	$796.71 $1,593.43 $1,354.41 $2,270.63	Embedded	INN $0/$0	$7,500/$15,000 (change from 2018)	$15	$20 (change from 2018)	$500	$100	$100	$35	$4/$30/$60
Platinum	121	EPO Copayment	Individual Empl/Spouse Parent/Child(ren) Family	$787.28 $1,574.56 $1,338.38 $2,243.75	Embedded	INN $0/$0	$7,350/$14,700	$20	$20	$750	$50	$100	$30	$4/$30/$60
Platinum	130	EPO Copayment	Individual Empl/Spouse Parent/Child(ren) Family	$776.27 $1,552.54 $1,319.66 $2,212.36	Embedded	INN $0/$0	$4,000/$8,000	$15	$35	$500	$75	$100	$45	$4/$30/$60
Gold	220	EPO Copayment	Individual Empl/Spouse Parent/Child(ren) Family	$704.33 $1,408.66 $1,197.36 $2,007.35	Embedded	INN $500/$1,000	$7,150/$14,300	Deductible, then $25 Copay	Deductible, then $40 Copay	Deductible, then $800 Copay	Deductible, then $50 Copay	Deductible, then $75 Copay	Deductible then $50	$4/$30/$60; not subject to deductible
Gold	221	Embrace Health EPO Copayment *includes $200 bonus debit card*	Individual Empl/Spouse Parent/Child(ren) Family	$685.73 $1,371.46 $1,165.74 $1,954.34	Embedded	INN $250/$500	$7,150/$14,300	Deductible, then $30	Deductible, then $50	Deductible, then $1,000	Deductible, then $100	Deductible, then $100	Deductible then $60	$10/$50/$80; not subject to deductible
Gold	222	EPO Hybrid	Individual Empl/Spouse Parent/Child(ren) Family	$662.07 $1,324.15 $1,125.53 $1,886.91	Embedded	INN $600/$1,200	$6,250/$12,500	$20	$40	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance	$50	$10/$50/$80; not subject to deductible.
Silver	320	HDEPO Qualified	Individual Empl/Spouse Parent/Child(ren) Family	$594.69 $1,189.38 $1,010.97 $1,694.87	Aggregate	INN $1,750/$3,500	$6,550/$13,100	Deductible, then $30 Copay	Deductible, then $40 Copay	Deductible, then $750 Copay	Deductible, then $150 Copay	Deductible, then $150 Copay	Deductible then $50	Deductible, then $10/$50/$80
Silver	322	EPO Hybrid	Retired in 2019. Replaced with 328 Silver Plan.											
Silver	324	HDHMO Qualified	Individual Empl/Spouse Parent/Child(ren) Family	$471.02 $942.04 $800.73 $1,342.41	Aggregate	$2,200/$4,400	$4,800/$9,600	Deductible, then $25	Deductible, then $50	Deductible, then $500	Deductible, then $200	Deductible, then $300	Deductible then $50	Deductible, then $10/$40/$60
Silver	328	HDEPO EPC Non-Qualified New for 2019	Individual Empl/Spouse Parent/Child(ren) Family	$535.15 $1,070.29 $909.75 $1,525.17	Embedded	$2,500/$5,000	$7,200/$14,400	$0 EPC / $40 Non-EPC	Deductible, then $60	Deductible, then 20%	Deductible, then 20%	Deductible, then 20 %	Deductible then $70	Deductible, then $10/$50/50%

AGGREGATE: For any policy with two or more members, the deductible must be met by any one or any combination of members before the plan makes payments.

EMBEDDED: Each member must meet their individual deductible before plan makes payments. The individual deductible also applies to family deductible level. Once family deductible is met, plan begins payment of services for all contract members.

PEDIATRIC DENTAL: A pediatric dental rider is automatically added to subscribers that have children under the age of 19. Rates will be as noted above **plus $16.46 per child** enrolled (Albany Region) (up to a maximum of 3).
If you have a standalone dental plan, you can sign a waiver to have CDPHP remove the pediatric dental rider.

NOTE: In case of a discrepancy in the display of these plan details and rates, The carrier's actual plan details and rates prevail.

2019 CAPITAL DISTRICT PHYSICIANS HEALTH PLAN - Small Business 2 to 100 RATES COVER REGION 1: ALBANY

METAL TIER	PLAN CODE	Plan Name	Tier	Monthly Rate	Aggregate / Embedded	DEDUCTIBLE (SINGLE/FAMILY)	OOP MAX (SINGLE/FAMILY)	OFFICE VISIT	SPECIALIST VISIT	INPATIENT HOSPITAL	OUTPATIENT SURGERY	ER	URGENT CARE	PRESCRIPTION DRUGS
Bronze	420	HDEPO Qualified	Retired for 2019. Replaced by 424 Bronze.											
Bronze	421	HDEPO Qualified	Individual Empl/Spouse Parent/Child(ren) Family	$412.66 $825.31 $701.52 $1,176.07	Aggregate	INN $6,650/$13,300 (chg from 2018)	$6,650/$13,300 (change from 2018)	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance	Deductible then 0% Coins.	Deductible, then 0%/0%/0%
Bronze	423	HDEPO Non-Qualified	Individual Empl/Spouse Parent/Child(ren) Family	$416.57 $833.14 $708.17 $1,187.22	Embedded	INN $5,500/$11,000	$7,150/$14,300	Deductible, then $35	Deductible, then $80	Deductible, then 50%	Deductible, then $300 Coinsurance	Deductible, then 50%	Deductible then $90	Deductible, then $10/50%/50%
Bronze	424	HDEPO Qualified	Individual Empl/Spouse Parent/Child(ren) Family	$427.97 $855.95 $727.56 $1,219.73	Aggregate	$5,250/$10,500 (chg from 2018)	$6,650/$13,300 (chg from 2018)	Deductible, then $40	Deductible, then $60	Deductible, then $1,000	Deductible, then $300 Coinsurance	Deductible, then $350 Coinsurance	Deductible then $70	Deductible, then $10/$50/$80
Bronze	425	COPAY FIRST ($3,000/$6,000)	Individual Empl/Spouse Parent/Child(ren) Family	$446.33 $892.66 $758.76 $1,272.04	Embedded	INN $6,000/$12,000	$6,850/$13,700	$30	$50	$500	$75	$75	$60	Deductible, then $10/$30/$50

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EMBEDDED: Each member must meet their individual deductible before plan makes payments. The individual deductible also applies to family deductible level. Once family deductible is met, plan begins payment of services for all contract members.

PEDIATRIC DENTAL: A pediatric dental rider is automatically added to subscribers that have children under the age of 19. Rates will be as noted above **plus $16.46 per child** enrolled (Albany Region) (up to a maximum of 3). If you have a standalone dental plan, you can sign a waiver to have CDPHP remove the pediatric dental rider.

NOTE: In case of a discrepancy in the display of these plan details and rates, The carrier's actual plan details and rates prevail.

2019 MVP HEALTH CARE - Small Businesses ALL PLANS INCLUDE DEPENDENT CARE TO AGE 26.

METAL TIER	PRODUCT	TIER	MONTHLY RATE	Aggregate / Embedded	DEDUCTIBLE (SINGLE/FAMILY)	OOP MAX (SINGLE/FAMILY)	OFFICE VISIT	SPECIALIST VISIT	INPATIENT HOSPITAL	OUTPATIENT SURGERY	URGENT CARE/ER	myVistNow (Telemedicine)	PRESCRIPTION DRUGS
GOLD	MVP GOLD 1 EPO	Individual Empl/Spouse Parent/Child(ren) Family	$674.74 $1,349.48 $1,147.06 $1,923.01	Embedded	$850 / $1,700	$6,550 / $13,100	3 Visits @$0, then $15 NoDD	$50*	$500*	$200*	$50 NoDD; $300 NoDD	$15 NoDD	$100/$200 (name brand only); Copayment $5/$35*/$70*
	MVP GOLD 2 EPO HDHP AGGREGATE/EMBEDDED	Individual Empl/Spouse Parent/Child(ren) Family	$638.48 $1,276.96 $1,085.42 $1819.67	Agg/Emb	$1,600/$3,200 AGG	$4,500/$9,000 EMB	Preventive $0; office visit $10 *	$20*	$200*	$100*	$20*/$75*	$10*	Ded. Integrated w/Medical; $5*/$15*/$25* (preventive drugs NoDD)
	MVP GOLD 3 EPO	Individual Empl/Spouse Parent/Child(ren) Family	$659.08 $1,318.16 $1,120.44 $1,878.38	Embedded	$800/$1,600	$4,400/$8,800	Preventive $0; office visit $10 *	$40*	$800*	$100*	$40*/$300*	$10*	Deductible $0/$0; Copayment $10/$35/50%
	MVP GOLD 4 EPO	Individual Empl/Spouse Parent/Child(ren) Family	$694.53 $1,389.06 $1,180.70 $1,979.41	Embedded	$0 / $0	$6,750 / $13,500	Preventive $0; office visit $40	$60	$750	$300	$60/$500	$40	Deductible $0/$0; Copayment $10/$40/$60
	MVP GOLD 6 EPO	Individual Empl/Spouse Parent/Child(ren) Family	$701.94 $1,403.88 $1,193.30 $2,000.53	Embedded	$350/$700	$6,550/$13,100	$30 NoDD	$50 NoDD	$1,000*	$300*	$50 NoDD / $100 NoDD	$30 NoDD	Deductible $0/$0; Copayment $10/$40/$60
	MVP GOLD 8 EPO	Individual Empl/Spouse Parent/Child(ren) Family	$637.65 $1,275.30 $1,084.01 $1,817.30	Embedded	$4,000/$8,000	**$7,900/$15,800**	$30 NoDD	$50 NoDD	20% *	20% *	$50 NoDD; **$300 NoDD**	$30 NoDD	Deductible, $0/$0; copayment $10/**$40/$60**
	MVP GOLD 9	DISCONTINUED. REPLACED BY SILVER 7 EPO.											
SILVER	MVP SILVER 1 EPO	Individual Empl/Spouse Parent/Child(ren) Family	$579.86 $1,159.72 $985.76 $1,652.60	Embedded	$2,100/$4,200	$6,550/$13,100	$30 NoDD	$50*	20% *	$300 *	$50*/$350 *	$30 NoDD	Deductible $100/$200 (name brand only); Copayment $8/$35*/$70*
	MVP SILVER 3 EPO HDHP AGGREGATE/EMBEDDED	Individual Empl/Spouse Parent/Child(ren) Family	$556.28 $1,112.56 $945.68 $1,585.40	Aggregate / Embedded	$2,200/$4,400 Aggregate	$4,800/$9,600 Embedded	$25*	$50 *	$500 *	$200*	$50*/$300*	$25*	Ded. Integrated w/Medical; $10*/$40*/$60* (preventive drugs NoDD)
	MVP Silver 7 EPO	Individual Empl/Spouse Parent/Child(ren) Family	$573.57 $1,147.14 $975.07 $1,634.67	Embedded	**$3,100/$6,200**	**$7,700/$15,400**	$30 NoDD	$40 *	$500 *	$150 *	$40*/$200 *	$30 NoDD	Deductible $0/$0; Copayment $10/$40/$60
	MVP Silver 10	DISCONTINUED. REPLACED BY SILVER 7 EPO.											

2019 MVP HEALTH CARE - Small Businesses ALL PLANS INCLUDE DEPENDENT CARE TO AGE 26.

METAL TIER	PRODUCT	TIER	MONTHLY RATE	Aggregate / Embedded	DEDUCTIBLE (SINGLE/FAMILY)	OOP MAX (SINGLE/FAMILY)	OFFICE VISIT	SPECIALIST VISIT	INPATIENT HOSPITAL	OUTPATIENT SURGERY	URGENT CARE/ER	myVistNow (Telemedicine)	PRESCRIPTION DRUGS
BRONZE	**MVP BRONZE 2 EPO EMBEDDED**	**Individual** **Empl/Spouse** **Parent/Child(ren)** **Family**	**$448.51** **$897.02** **$762.47** **$1,278.25**	**Embedded**	$5,000/$10,000	$7,150/$14,300	3 visits at $0, then $35 *	$60*	30% *	$300*	$60*/$350*	$35*	Ded. Integrated with Medical; Copayment $10*/$40*/$60*
	MVP BRONZE 3 EPO HDHP EMBEDDED	**Individual** **Empl/Spouse** **Parent/Child(ren)** **Family**	**$456.14** **$912.28** **$775.44** **$1,300.00**	**Embedded**	$5,900/$11,800	$6,550/$13,100	$30*	$50*	30% *	$100*	$50*/$300*	$30*	Ded. Integrated w/Medical; $10*/$40*/$60 * (preventive drugs NoDD)
	MVP BRONZE 6 EPO HDHP EMBEDDED	**Individual** **Empl/Spouse** **Parent/Child(ren)** **Family**	**$472.93** **$945.86** **$803.98** **$1,347.85**	**Embedded**	$6,550/$13,100	$6,550/$13,100	$0*	$0*	$0*	$0*	$0*/$0*	$0*	Ded. Integrated w/Medical; $0*/$0*/$0* (preventive drugs NoDD)
	MVP BRONZE 8 EPO EMBEDDED	**Individual** **Empl/Spouse** **Parent/Child(ren)** **Family**	**$492.77** **$985.54** **$837.71** **$1,404.39**	**Embedded**	$7,350/$14,700	$7,350/$14,700	$30 NoDD	$0 *	$0*	$0*	$0*/$0*	$30 NoDD	Ded. Integrated w/Medical (Name Brand Only) $25/0%*/ 0%*

*** Member amount after deductible is met.** **NOTE: In case of a discrepancy in the display of these plan details and rates, The carrier's actual plan details and rates prevail.**

BENEFITS SHOWN IN RED ARE A CHANGE FROM THE 2018 PLAN.

AGGREGATE: For any policy with two or more members, the deductible must be met by any one or any combination of members before the plan makes payments.

EMBEDDE Each member must meet their individual deductible before plan makes payments. The individual deductible also applies to family deductible level. Once family deductible is met, plan begins payment of services for all contract members.

MVP'S WELL LIFE REWARDS PROGRAM: All plans inlude up to $200 per sub/per cal yr for completing health related activities; plus $125 reimbursement (per sub/per cal yr) for kids sports/weight management-gym membership/massage therapy/tobacco cessation courses.

PEDIATRIC DENTAL COVERAGE TO AGE 19: For all plans covering children up to the age of 19, MVP will automatically add pediatric dental coverage in compliance with the Affordable Care Act. If you have a standalone dental plan, you can sign a waiver to remove the pediatric dental rider.

TELEMEDICINE BENEFIT - access care anywhere, anytime on your computer, tablet or smartphone with 24/7 online doctor visits. Board-certified doctors and therapists.

2019 BLUESHIELD OF NORTHEASTERN NEW YORK - Small Business 2 to 100 RATES SHOWN COVER REGION 1

METAL TIER	PLAN CODE	PRODUCT	TIER	MONTHLY RATE	Aggregate / Embedded	DEDUCTIBLE (SINGLE/FAMILY)	OOP MAX (SINGLE/FAMILY)	OFFICE VISIT	SPECIALIST VISIT	INPATIENT HOSPITAL	OUTPATIENT SURGERY	ER	URGENT CARE	PRESCRIPTION DRUGS
PLATINUM	POS 2701	Platinum Standard Copay	Individual Empl/Spouse Parent/Child(ren) Family	$732.21 $1,464.41 $1,244.75 $2,086.78	Embedded	INN $0/$0; OON $5,000/$10,000 with 50% co-ins.after ded.	INN $2,000/$4,000; OON $10,000/$20,000	$15	$35	$500	$100	$100	$55	$10/$30/$60
	3101	Platinum Radius Copay*	Individual Empl/Spouse Parent/Child(ren) Family	$733.40 $1,466.80 $1,246.78 $2,090.19	Embedded	INN $0/$0; OON $250/$500 with 20% co-ins.after ded.	INN $5,000/$10,000; OON $6,600/$13,200	$0 pediatric PCP; $0 for first 3 adult PCP visits, then $15	$20	$250	$100	$100	$50	$10/$35/$70
GOLD	POS 1101	Gold Standard Copay	Individual Empl/Spouse Parent/Child(ren) Family	$643.53 $1,287.05 $1,093.99 $1,834.05	Embedded	INN $600/$1,200 no co-ins.; OON $5,000/$10,000 50% co-ins.after ded.	INN $4,000/$8,000; OON $10,000/$20,000	$25 after deductible	$40 after deductible	$1,000 after deductible	$100 after deductible	$150 after deductible	$60	$10/$35/$70
	POS 9801	Gold Radius High*	Individual Empl/Spouse Parent/Child(ren) Family	$678.09 $1,356.19 $1,152.76 $1,932.56	Embedded	INN $0 no co-ins.; OON $250/$500 with 20% co-ins. after ded.	**INN $7,000/$14,000; OON $7,000/$14,000**	$0 pediatric PCP; $0 first 3 adult PCP visits, $25	$40	$750	$200	$200	$75	**$10/$35/$70**
	POS 6301	Gold EX High POS/PPO Wrap	Individual Empl/Spouse Parent/Child(ren) Family	$702.32 $1,404.63 $1,193.94 $2,001.60	Embedded	INN $0 no co-ins.; OON $2,000/$4,000 with 20% co-ins.after ded.	**INN $7,000/$14,000;** OON $10,000/$20,000	$0 pediatric PCP; $0 first 3 adult PCP visits, $25	$40	**$750**	$200	**$200**	$75	**$10/$35/$70**
	HMO 3201	Gold HMO POS *	**Discontinued in 2019. Replaced with Gold Radius High 9801.**											
	POS 3401	Gold Radius *	Individual Empl/Spouse Parent/Child(ren) Family	$636.82 $1,273.63 $1,082.60 $1,814.92	Embedded	**INN $750/$1,500 with 20% co-ins.; OON $750/$1,500 with 20% co-ins. After ded.**	**INN $7,900/$15,800; OON $7,900/$15,800**	$0 pediatric PCP; Adult $25	$50 adult visits	20% after deductible	20% after deductible	$200	$100	**$10/$35/$70**
	6501	Gold EX POS/PPO Wrap	Individual Empl/Spouse Parent/Child(ren) Family	$658.87 $1,317.74 $1,120.08 $1,877.79	Embedded	**INN $750/$1,500 20% co-ins.after ded.;** OON $5,000/$10,000 50% co-ins.after ded.	**INN $7,900/$15,800;** OON $10,000/$20,000	$0 pediatric PCP; Adult $25	$50 adult visits	20% after deductible	20% after deductible	$200	$100	**$10/$35/$70**
	2901	Gold EPO HIGH	Individual Empl/Spouse Parent/Child(ren) Family	$733.49 $1,466.98 $1,246.94 $2,090.44	Embedded	INN $0/$0; OON $0/$0	INN $7,000/$14,000 OON $0/$0	$0 pediatric PCP; $0 first 3 adult PCP visits, $25	$40	$750	$200	$200	$75	$10/$35/$70

2019 BLUESHIELD OF NORTHEASTERN NEW YORK - Small Business 2 to 100 RATES SHOWN COVER REGION 1

METAL TIER	PLAN CODE	PRODUCT	TIER	MONTHLY RATE	Aggregate / Embedded	DEDUCTIBLE (SINGLE/FAMILY)	OOP MAX (SINGLE/FAMILY)	OFFICE VISIT	SPECIALIST VISIT	INPATIENT HOSPITAL	OUTPATIENT SURGERY	ER	URGENT CARE	PRESCRIPTION DRUGS
GOLD	3301	Gold EPO	Individual Empl/Spouse Parent/Child(ren) Family	$688.86 $1,377.72 $1,171.06 $1,963.25	Embedded	INN $750/$1,500 OON $0/$0	INN $7,900/$15,800 OON $0/$0	$0 pediatric PCP visits, $25	$50	20% after deductible	20% after deductible	$200	$100	$10/$35/$70
SILVER	POS 5601	Silver Standard	Individual Empl/Spouse Parent/Child(ren) Family	$574.05 $1,148.10 $975.88 $1,636.03	Embedded	INN $1,700/$3,400 no co-ins. ; OON $5,000/$10,000 50% co-ins after ded.	INN $7,500/$15,000; OON $10,000/$20,000	$30 after deductible	$50 after deductible	$1,500 after deductible	$100 after deductible	$250 after deductible	$70 after deductible	$10/$35/$70
SILVER	6801	Silver EX 8000 POS/PPO Wrap	Individual Empl/Spouse Parent/Child(ren) Family	$563.83 $1,127.67 $958.52 $1,606.92	Embedded	INN $3,450/$6,900 0% Coinsurance; OON $5,000/$10,000 50% coinsurance	INN $6,650/$13,300; OON $10,000/$20,000	0% after deductible	0% after deductible	0% after deductible	0% after deductible	0% after deductible	0% after deductible	$10/$35/$70 after deductible
BRONZE	POS 7001	Bronze Standard	Individual Empl/Spouse Parent/Child(ren) Family	$468.47 $936.93 $796.40 $1,335.13	Embedded	INN $4,000/$8,000 50% co-ins after ded.; OON $5,000/$10,000 50% Co-ins after ded.	INN $7,600/$15,200; OON $10,000/$20,000	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	$10/$35/$70 after deductible

INN In Network **OON** Out of Network *** PLAN INCLUDES AWAY FROM HOME CARE GUEST MEMBERSHIP**

ALL RATES COVER BLUE SHIELD REGION 1.

ALL PLANS INCLUDE ONE $250 WELLNESS DEBIT CARD PER CONTRACT - RENEWS ANNUALLY

FOR REGION 2 RATES PLEASE CALL BENEFIT CHOICES 518.431.1419

ITEMS IN RED INDICATE CHANGES FROM 2018 COVERAGE.

(Agg.) **AGGREGATE:** For any policy with two or more members, the deductible must be met by any one or any combination of members before the plan makes payments.

(Emb.) **EMBEDDED:** Each member must meet their individual deductible before plan pays. Individual deductible also applies to family deductible level. Once family deductible is met, plan begins payment of services for all contract members.

PEDIATRIC DENTAL: A pediatric dental rider is automatically added to subscribers that have children under the age of 19. **The rate per child is $20.67 - DETAILS AVAILABLE ON DENTAL CHART.**

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