

Warren County

Experience-Rated Alternatives (EPO)

Rates Effective 10/01/2009

Company	CDPHP	Blue Shield of Northeastern NY	MVP	Empire Blue Cross
Students	age 25	age 25	age 25	age 25
Dependents	age 19	age 19	age 25	age 19
Co-Pay	\$25	\$25	\$25	\$30
Inpatient Co-pay	\$0	\$0	\$0	\$250
Drug Card	\$10/\$25/\$40	\$10/\$20/\$40	\$10/\$25/\$40	\$10/\$25/\$50
Individual	\$445.60	\$465.76	\$511.72	\$544.18
2-Person	\$891.21	\$954.81	\$1,023.20	\$1,064.32
Family	\$1,188.69	\$1,363.76	\$1,383.38	\$1,577.42
Medicare	\$445.60	\$465.76	\$511.72	\$381.40

*These bids are based on a 100% total replacement. Minimum participation requirement will apply.

*These rates are subject to change due to differences in underwriting criteria and enrollment selection of benefits.

Created by: Capital Financial Group, Inc. 8/25/2009

Warren County

Experience-Rated Alternatives EPO

Estimated Rates Effective 10/1/2009

Company	CDPHP \$25	CDPHP \$30	CDPHP \$25	CDPHP \$25/\$40
Students	age 25	age 25	age 25	age 25
Dependents	age 19	age 19	age 19	age 19
Co-Pay	\$25	\$30	\$25	\$25/\$40
Inpatient Co-pay	\$0	\$500	\$0	\$240
Drug Card	\$10/\$25/\$40	\$10/\$25/\$40	\$10/\$30/\$50	\$10/\$30/\$50
Individual	\$445.60	\$434.93	\$442.24	\$429.84
2-Person	\$891.21	\$869.87	\$884.48	\$859.67
Family	\$1,188.69	\$1,160.23	\$1,179.72	\$1,146.63
Medicare	\$445.60	\$434.93	\$442.24	\$429.84

*These bids are based on a 100% total replacement. Minimum participation requirement will a

*These rates are subject to change due to differences in underwriting criteria and enrollment vs. propos
benefits.

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CDPHP Benefit Comparison	Current Plan		Mirror EPO		EPO 25/40	
	HMO		EPO		EPO	
	In Network	Out of Network *	In Network	Out of Network *	In Network	Out of Network *
	HA14L07, Capital Region, Quarter 1		EA9L07, Capital Region, Quarter 1		EA78L07, Capital Region, Quarter 1	
Deductible	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Coinsurance	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Out of Pocket/Coinsurance Maximum	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Annual Benefit Max	Unlimited	Not Applicable	Unlimited	Not Applicable	Unlimited	Not Applicable
Physician Services						
Office Visits for illness, injury or second opinion (PCP/OB/GYN)	\$25	Not Applicable	\$25	Not Applicable	\$25	Not Applicable
Office Visits for illness, injury or second opinion (Specialists)	\$25	Not Applicable	\$25	Not Applicable	\$40	Not Applicable
Physician Visits during inpatient stay	Covered in Full	Not Applicable	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Well Baby and Child Care including immunizations and inoculations	Covered in Full	Not Applicable	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Annual Adult Physical	Covered in Full	Not Applicable	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Annual Gynecological Exam	Covered in Full	Not Applicable	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Hospitals Services						
Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	Covered in Full	Not Applicable	Covered in Full	Not Applicable	\$240	Not Applicable
Outpatient Surgery	\$75	Not Applicable	\$75	Not Applicable	\$75	Not Applicable
Diagnostic Testing						
Laboratory Services (copay/coinsurance waived if provider is a designated lab)	\$25	Not Applicable	\$25	Not Applicable	\$40	Not Applicable
Radiology and Imaging (copay/coinsurance waived if provider is preferred)	\$25	Not Applicable	\$25	Not Applicable	\$40	Not Applicable
Mammogram	Covered in Full	Not Applicable	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Cytology Screening	Covered in Full	Not Applicable	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Prostate Cancer Screening	Covered in Full	Not Applicable	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Maternity						
Inpatient Physician Services	Covered in Full	Not Applicable	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Inpatient Hospital Services	Covered in Full	Not Applicable	Covered in Full	Not Applicable	\$240	Not Applicable
Newborn Nursery	Covered in Full	Not Applicable	Covered in Full	Not Applicable	Covered in Full	Not Applicable
Emergency Care						
Worldwide Emergency Care	\$100	Paid as In Network	\$50	Paid as In Network	\$100	Paid as In Network
Ambulance	\$100	Paid as In Network	\$50	Paid as In Network	\$100	Paid as In Network
Urgent Care	\$35	Not Applicable	\$35	Not Applicable	\$35	Not Applicable

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CDPHP Benefit Comparison	Current Plan		Mirror EPO		EPO 25/40	
	HMO		EPO		EPO	
	In Network	Out of Network *	In Network	Out of Network *	In Network	Out of Network *
	HA14L07, Capital Region, Quarter 1		EA9L07, Capital Region, Quarter 1		EA78L07, Capital Region, Quarter 1	
Other Services						
Physical Therapy (30 visits per benefit period)	\$25	Not Applicable	\$25	Not Applicable	\$40	Not Applicable
Speech Therapy (20 visits per benefit period)	\$25	Not Applicable	\$25	Not Applicable	\$40	Not Applicable
Occupational Therapy (30 visits per benefit period)	\$25	Not Applicable	\$25	Not Applicable	\$40	Not Applicable
Chiropractic Benefits	\$25	Not Applicable	\$25	Not Applicable	\$40	Not Applicable
Home Health Care (If deductible, maximum is \$50)	Covered In Full	Not Applicable	Covered In Full	Not Applicable	Covered In Full	Not Applicable
Skilled Nursing Facility (up to 45 days per benefit period)	Covered in Full	Not Applicable	Covered in Full	Not Applicable	\$240	Not Applicable
Prosthetic Devices and Durable Medical Equipment	50% Coinsurance	Covered In Network Only	50% Coinsurance	Covered In Network Only	50% Coinsurance	Covered In Network Only
Diabetic Care						
Insulin and Oral Medications (30 day supply)	\$15	Not Applicable	\$15	Not Applicable	\$15	Not Applicable
Diabetic Supplies 30 day supply of needles and syringes	\$15	Not Applicable	\$15	Not Applicable	\$15	Not Applicable
Glucometers	\$15	Not Applicable	\$15	Not Applicable	\$15	Not Applicable
Diabetic DME	\$15	Not Applicable	\$15	Not Applicable	\$15	Not Applicable
Mental Health						
Outpatient Mental Health Services (20 visits per benefit period)	\$25	Not Applicable	\$25	Not Applicable	\$40	Not Applicable
Inpatient Mental Health Services (30 days per benefit period). Biological based mental illness and coverage for children with serious emotional disturbance is available beyond those limits for outpatient and inpatient services.	Covered in Full	Not Applicable	Covered in Full	Not Applicable	\$240	Not Applicable
Chemical Abuse and Dependency						
Outpatient Services (60 visits per calendar year)	\$25	Not Applicable	\$25	Not Applicable	\$25	Not Applicable
Inpatient Detoxification Services (7 days per benefit period)	Covered in Full	Not Applicable	Covered in Full	Not Applicable	\$240	Not Applicable
Inpatient Rehabilitation Services (Up to 30 Days)	Covered in Full	Not Applicable	Covered in Full	Not Applicable	\$240	Not Applicable

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CDPHP Benefit Comparison	Current Plan		Mirror EPO		EPO 25/40	
	HMO		EPO		EPO	
	In Network	Out of Network *	In Network	Out of Network *	In Network	Out of Network *
	HA14L07, Capital Region, Quarter 1		EA9L07, Capital Region, Quarter 1		EA78L07, Capital Region, Quarter 1	
Dependent Coverage						
Dependent to age 19	Extends eligibility to full time student until age 25, including out-of area coverage of prior approved, non routine covered services		Extends eligibility to full time student until age 25, including out-of area coverage of prior approved, non routine covered services		Extends eligibility to full time student until age 25, including out-of area coverage of prior approved, non routine covered services	
Domestic Partner	Not Applicable		Not Applicable		Not Applicable	
Vision Coverage						
Coverage through Rider Only	Vision Hardware and Routine Eye Exam Every 24 Months (Low Option Hardware: \$75 Frames & Lenses/\$75 Contract Lenses)		Vision Hardware and Routine Eye Exam Every 24 Months (Low Option Hardware: \$75 Frames & Lenses/\$75 Contract Lenses)		Vision Hardware and Routine Eye Exam Every 24 Months (Low Option Hardware: \$75 Frames & Lenses/\$75 Contract Lenses)	
Pharmacy						
Coverage through Rider Only	Pharmacy Copay is \$10/\$25/\$40, Mail Order copay is 2.5 times Pharmacy Copay, Contraceptives are covered		Pharmacy Copay is \$10/\$25/\$40, Mail Order copay is 2.5 times Pharmacy Copay, Contraceptives are covered		Pharmacy Copay is \$10/\$30/\$50, Mail Order copay is 2.5 times Pharmacy Copay, Contraceptives are covered	

	Current Plan Rates	Mirror EPO Rates	% Change From Current Plan	EPO 25/40 Rates	% Change From Current Plan
Single	\$404.34	\$445.60	10.2%	\$429.84	6.3%
Employee and Spouse	\$808.68	\$891.21	10.2%	\$859.67	6.3%
Employee and Child(ren)					
Family	\$1,078.62	\$1,188.69	10.2%	\$1,146.63	6.3%

****The EPO is an exclusive provider organization, which provides extensive benefits (like the HMO), but with the freedom to see any physician in the CDPHP Universal Benefits, Inc. (CDPHP UBI) network without a referral. Like the HMO, members must go to participating CDPHP UBI providers. Certain services require prior authorization.**

*Please refer to the Underwriting rate sheet to verify rates, purchased riders, and Underwriting conditions.

This document has been provided to you for informational purposes only. Coverage is always subject to the member's eligibility, specific contract benefits and CDPHP medical policy. For specific benefit questions, please contact your marketing Representative.