

2007 - 2008 NYSBG ASSOCIATION RATES



55 Water Street
New York, NY 10041

*Sole Proprietor Plans
Downstate New York Region
Rates Effective 4/1/07 - 3/31/08*



180 East Main Street
Suite 205
Patchogue, NY 11772

**Call Us at (800)427-5358 or
Visit Us Online at www.nysbg.com**

www.nysbg.com

COVERED SERVICES	#1 HIP PRIME HMO (25/40/500/100) with Rx	#2 HIP SELECT PPO (20/20/D&C/50) with Rx	#3 HIP PRIME POS (20/20/0/35) with Rx	#4 HIP PRIME HMO (10/10/0/35) with Rx
Plan Type	HMO	PPO	POS	HMO
Physician Copay	\$25	\$20	\$20	\$10
Hospital Copay	\$500	Ded. & Coins	\$0	\$0
ER	\$100	\$50	\$35	\$35
Specialist Copay	\$40	\$20	\$20	\$10
Ambulatory Surgery Copay	\$75	Ded. & Coins	\$0	\$0
Prescription Drug (Generic/Brand/Non-Formulary)	\$10 Generic/No Brand \$100 Deductible	\$10/\$20/\$40	\$20/\$30/\$50 \$50 Deductible	\$10/\$20/\$40
In-Network Coins/Ded.	NA	90%/10%/\$1,000	NA	NA
In-Network Coins Max	NA	\$2,500	NA	NA
Non-Network Coins/Ded.	NA	70%/30%/\$2,000	70%/30%/\$1,500	NA
Non-Network Coins Max	NA	\$5,000	\$7,000	NA
Preventive Dental	Included	Included	Included	Included
Dependent Age	23	23	23	23
Monthly Rates				
Employee	\$397.03	\$406.27	\$473.49	\$511.75
Employee/Spouse	\$780.07	\$798.56	\$932.95	\$1,009.47
Employee/Child	\$726.44	\$743.64	\$868.58	\$939.80
Family	\$1,186.05	\$1,214.29	\$1,419.93	\$1,536.99

Rates Include a \$14 Monthly Billing & Administration Fee.

Plans are available through membership in the New York State Business Group:
\$60 annual membership dues, payable to NYSBG are required upon enrollment and will be billed annually thereafter.

Out-Of-Pocket Max does not include the Annual Deductible

Rates are subject to NYS Department of Insurance approval. Illustrations are for comparative purposes only. See plan summary for more details.
Certificate of Insurance governs.

**PLEASE CONTACT YOUR AGENT OR BROKER OR CALL:
NYSBG/ELITE 1-800-427-5358**

(800) 427-5358

HMO/PPO/POS
for groups of 1



New York, NY 10041

HIP Rates Effective
4/1/07

1 HIP PRIME HMO (25/40/500/100) with Rx	2 HIP SELECT PPO (20/20/0/50) with Rx	3 HIP PRIME POS (20/20/0/35) with Rx	4 HIP PRIME HMO (10/10/0/35) with Rx
\$25 Office Visit Copay (except for primary/preventive to age 19)	\$20 Office Visit Copay (except for primary/preventive to age 19)	\$20 Office Visit Copay (except for primary/preventive to age 19)	\$10 Office Visit Copay (except for primary/preventive to age 19)
\$40 Specialist Copay	\$20 Specialist Copay	\$20 Specialist Copay	\$10 Specialist Copay
\$500 Hospital Copay	Hospital: Ded & Coins	\$0 Hospital Copay	\$0 Hospital Copay
\$75 Ambulatory Surgery/OP Copay	Ambulatory Surgery: Ded & Coins	\$0 Ambulatory Surgery/OP Copay	\$0 Ambulatory Surgery/OP Copay
\$100 ER Copay	\$50 ER Copay	\$35 ER Copay	\$35 ER Copay
Rx: \$10 generic/No brand/\$100 Ded.	Rx: \$10/\$20/\$40	Rx: \$20/\$30/\$50 - \$50 Ded.	Rx: \$10/\$20/\$40
DME: Not Covered	In-Network Coins/Ded: 10%/\$1,000	Non-Network Coins/Ded: 30%/\$1,500	DME: Appliances In Full -\$0 Ded.
PDN: Not Covered	In-Network Coins Max: \$2,500	Non-Network Coins Max: \$7,000	PDN: Covered In Full
30 Day Skilled Nursing Fac. Limit	Non-Network Coins/Ded: 30%/\$2,000	DME: Appliances In Full -\$0 Ded.	Unlimited Skilled Nursing Fac.
40 Home Health Care Visits	Non-Network Coins Max: \$5,000	PDN: Covered In Full	200 Home Health Care Visits
I.P. Therapies: Not Covered	30 Day Skilled Nursing Fac. Limit	Unlimited Skilled Nursing Fac.	I.P. Therapies: 90 Days
O.P. Therapies: 30 Visits/\$40 Copay	40 Home Health Care Visits	200 Home Health Care Visits	O.P. Therapies: 90 Visits/\$10 Copay
I.P. Mental Health Care: 30 Days	I.P. Therapies: 30 Days/Ded & Coins	I.P. Therapies: 90 Days	I.P. Mental Health Care: 30 Days
I.P. AL/SA Detox: 7 Days	O.P. Therapies: 30 Visits/\$20 Copay	O.P. Therapies: 90 Visits/\$20 Copay	I.P. AL/SA Detox: 7 Days
I.P. AL/SA Rehab: Not Covered	I.P. Mental Health: 30 Days/Ded & Coins	I.P. Mental Health Care: 30 Days	I.P. AL/SA Rehab: 0 Days
O.P. AL/SA Rehab: 60 Visits/ \$25 Copay	I.P. AL/SA Detox: 7 Days/Ded & Coins	I.P. AL/SA Detox: 7 Days	O.P. AL/SA Rehab: 60 Visits/ \$10 Copay
O.P. Mental Health: \$35 Copay/ 20 Visit Limit	I.P. AL/SA Rehab: 30 Days/Ded & Coins	I.P. AL/SA Rehab: 0 Days	O.P. Mental Health: \$25 Copay/ 20 Visit Limit
Dialysis Treatment: \$25 Copay	O.P. AL/SA Rehab: 60 Visits/\$20 Copay	O.P. AL/SA Rehab: 60 Visits/ \$20 Copay	Dialysis Treatment: \$10 Copay
Refractive Eye Exam: \$15 Copay	O.P. Mental Health: \$25 Copay/ 40 Visit Limit	O.P. Mental Health: \$25 Copay/ 20 Visit Limit	Refractive Eye Exam: Not Covered
Diabetic Supplies: \$25 Copay	Dialysis Treatment: \$20 Copay	Dialysis Treatment: \$20 Copay	Diabetic Supplies: \$10 Copay
Preventive Dental: Included	Refractive Eye Exam: \$0 Copay	Refractive Eye Exam: \$15 Copay	Preventive Dental: Included
Infertility: Base Benefits Only	Diabetic Supplies: \$20 Copay	Diabetic Supplies: \$20 Copay	Infertility: Base Benefits Only
Eyeglasses \$45 Every 24 Months	Preventive Dental: Included	Preventive Dental: Included	Eyeglasses \$45 Every 24 Months
	Eyeglasses \$0/Contacts \$25 Every 12 Months	Eyeglasses \$45 Every 24 Months	
	Alternative Medicine: \$20 copay/12 visit limit/5 Massage visit limit		
Employee: \$ 397.03	Employee: \$ 406.27	Employee: \$ 473.49	Employee: \$ 511.75
Emp/Spouse: \$ 780.07	Emp/Spouse: \$ 798.56	Emp/Spouse: \$ 932.95	Emp/Spouse: \$ 1,009.47
Emp/Child: \$ 726.44	Emp/Child: \$ 743.64	Emp/Child: \$ 868.58	Emp/Child: \$ 939.80
Family: \$ 1,186.05	Family: \$ 1,214.29	Family: \$ 1,419.93	Family: \$ 1,536.99

The above rates include a \$14 administrative fee.

All rates subject to NYS Insurance Department and home office approval.

This Illustration is for comparative purposes only, for further details please see plan summary. Certificate of Insurance Governs.