Created By:	Trevor Serraro
Phone #:	914-277-8600
Effective Date:	01/01/2010
Group Name:	Company 1X

SERVICES	Quote 1 (EPO Preferred-E0299S) In-Network	Quote 2 (HDHP EPO Preferred-NEHD08S) In-Network	Quote 3 (PPO Preferred-P0237S) In-Network	Quote 3 (PPO Preferred-P0237S) Out-Network
DEDUCTIBLES/MAXIMUMS				
Annual Deductible	N/A	Individual: $2500 Family: $5000	None	$2,000/$5,000
Co-insurance	N/A	0%	None	40%
Benefit Year	N/A	Calendar	Contract Year	Contract Year
Lifetime Maximum Coverage	N/A	Not Applicable (Except for DME; External Prosthetics; Ostomy Supplies Max)	None	$1,000,000
Annual Out-of-Pocket Expense	N/A	Individual: $3500 Family: $7000	None	$6,000/$15,000
PHYSICIAN SERVICES - Office				
PCP OFFICE VISIT (Well Baby and Child Care covered with no copay according to Mandate)	N/A	Covered in full; after deductible. Well Baby and Child Care covered in full.	$40/Visit	Subject to Deductible and Coinsurance
Adult Preventive Care: Periodic Physicals, Gynecological Exams	N/A	Covered in full Safe Harbor Benefit Includes: Annual Physical; Semi-Annual GYN; Immunizations-Vaccines; Mammography; Prostate Cancer Screenings, Bone Density Screenings and Colonoscopies/Sigmoidoscopies	Covered in full Includes: Annual Physical; Semi-Annual GYN; Immunizations-Vaccines; Mammography; Prostate Cancer Screenings, Bone Density Screenings and Colonoscopies/Sigmoidoscopies	Subject to Deductible and Coinsurance Includes: Annual Physical; Semi-Annual GYN; Immunizations-Vaccines; Mammography; Prostate Cancer Screenings, Bone Density Screenings and Colonoscopies/Sigmoidoscopies
Specialist Office Visit	N/A	Subject to Deductible Only	$40/Visit	Subject to Deductible and Coinsurance
Surgery	N/A	Subject to Deductible Only	Subject to Office Copay	Subject to Deductible and Coinsurance
Vision Exams	N/A	Not Covered	Not Covered - Optional Riders Available	Covered In Network Only With Optional Rider
Laboratory Services	N/A	Subject to Deductible Only	Covered in full	Subject to Deductible and Coinsurance
Second Surgical Opinions - Not required/Optional	N/A	Subject to Deductible Only	Subject to Office Copay	Subject to Deductible and Coinsurance
X-Ray Services	N/A	Subject to Deductible Only	Subject to Office Copay	Subject to Deductible and Coinsurance
High Tech Imaging Services (e.g. CT's, MRAs, MRIs, PET Scans, MRCP's and CTA's)	N/A	Subject to Deductible Only	$150 Per Procedure	Subject to Deductible and Coinsurance
PHYSICIAN SERVICES - Hospital				
Surgery	N/A	Subject to Deductible Only PRIOR NOTICE is required for all Elective Admissions. PRE-CERT is required for all Inpatient Surgeries.	Covered in full	Subject to Deductible and Coinsurance
Anesthesiology	N/A	Subject to Deductible Only	Covered in full	Subject to Deductible and Coinsurance
Radiology	N/A	Subject to Deductible Only	Covered in full	Subject to Deductible and Coinsurance
Visits/Consultations	N/A	Subject to Deductible Only	Covered in full	Subject to Deductible and Coinsurance

MVP reserves the right to adjust rates off-cycle for any Federal or State assessments and benefit mandates that are imposed on health plans.

Created By: Trevor Serraro
Phone #: 914-277-8600
Effective Date: 01/01/2010
Group Name: Company 1X

SERVICES	Quote 1 (EPO Preferred-E0299S) In-Network	Quote 2 (HDHP EPO Preferred-NEHD08S) In-Network	Quote 3 (PPO Preferred-P0237S)	
			In-Network	Out-Network
HOSPITAL				
Hospital Inpatient	N/A	Subject to Deductible Only PRIOR NOTICE is required for all Elective Admissions.	$1,000 First Admission Only; Limited to 3 copays maximum per family per contract year.	Subject to Deductible and Coinsurance
Hospital Outpatient - Surgery	N/A	Subject to Deductible Only Requires PRE-CERT.	$150/Visit	Subject to Deductible and Coinsurance
Hospital Outpatient - Lab & X-Ray	N/A	Subject to Deductible Only	Lab - Covered in full Xray - $40/Visit	Subject to Deductible and Coinsurance
Hospital Outpatient - High Tech Imaging Services (e.g. CT's, MRAs, MRIs, PET Scans, MRCP's and CTA's)	N/A	Subject to Deductible Only	$300 Per Procedure	Subject to Deductible and Coinsurance
Hospital Outpatient - Therapeutic Services (Chemotherapy, Dialysis, Radiation Therapy, e.g.)	N/A	Subject to Deductible Only	$40/Visit	Subject to Deductible and Coinsurance
MATERNITY				
Physician Services	N/A	Subject to Deductible Only	Initial diagnostic visit copay only	Subject to Deductible and Coinsurance
Hospital Services	N/A	Subject to Deductible Only CONCURRENT NOTICE is required.	May be subject to Inpatient Hospital Copay	Subject to Deductible and Coinsurance
Nursery Care	N/A	Subject to Deductible Only Initial Newborn exam covered in full.	Covered in full	Well Child Services Covered in full; other charges for well-newborn subject to coinsurance.
EMERGENCY HOSPITAL CARE				
Emergency Room Care (Worldwide)	N/A	Subject to Deductible Only	$100/Visit when not admitted; if admitted, subject to hospital inpatient copay	Subject to Deductible and Coinsurance
MENTAL HEALTH				
Inpatient Hospital Services	N/A	30 Days per member, per calendar year. Subject to Deductible Only	30 day maximum In/Out Combined per contract year; May be subject to Inpatient Hospital Copay	30 day maximum In/Out Combined per contract year; Subject to Deductible and Coinsurance
Outpatient Visits - Facility	N/A	20 Visits per member, per calendar year - combined with Office visits. Subject to Deductible Only	20 visits per contract year combined for In/Out Services and Facility visits; Subject to Office Copay	20 Visits per contract year combined for In/Out Services and Facility visits; Subject to Deductible and Coinsurance
Outpatient Visits - Office	N/A	20 Visits per member, per calendar year - combined with Facility visits. Subject to Deductible Only	20 visits per contract year combined for In/Out Services and Office visits; Subject to Office Copay	20 Visits per contract year combined for In/Out Services and Office visits; Subject to Deductible and Coinsurance

MVP reserves the right to adjust rates off-cycle for any Federal or State assessments and benefit mandates that are imposed on health plans.

Created By:	Trevor Serraro
Phone #:	914-277-8600
Effective Date:	01/01/2010
Group Name:	Company 1X

SERVICES	Quote 1 (EPO Preferred-E0299S) In-Network	Quote 2 (HDHP EPO Preferred-NEHD08S) In-Network	Quote 3 (PPO Preferred-P0237S) In-Network	Quote 3 (PPO Preferred-P0237S) Out-Network
SUBSTANCE ABUSE				
Detoxification Services	N/A	7 Days per member, per calendar year. Subject to Deductible Only	7 day maximum; May be subject to Inpatient Hospital Copay	Covered In Network Only
Inpatient Rehabilitation Services	N/A	Not Covered	Not Covered	Not Covered
Outpatient Rehabilitation Visits - Facility	N/A	60 Visits per member, per calendar year - combined with Office visits. Subject to Deductible Only	60 Visits per Contract Year combined with In/Out Services and Office visits; Subject to Office Copay	60 Visits per Contract Year combined with In/Out Services and Office visits; Subject to Deductible and Coinsurance
Outpatient Rehabilitation Visits - Office	N/A	60 Visits per member, per calendar year - combined with Facility visits. Subject to Deductible Only	60 Visits per Contract Year combined with In/Out Services and Facility visits; Subject to Office Copay	60 Visits per Contract Year combined with In/Out Services and Facility visits; Subject to Deductible and Coinsurance
OTHER SERVICES				
Ambulance	N/A	Subject to Deductible Only	$150 Copay Per Trip	Subject to Deductible and Coinsurance
PREVENTIVE DENTAL CARE (Periodic Exams & X-Rays)	N/A	Not Covered	Not Covered - Optional Riders Available	Same as In Network Benefit
Chiropractic Benefit	N/A	Subject to Deductible Only	Subject to Office Copay	Subject to Deductible and Coinsurance
Durable Medical Equipment/External Prosthetic Devices/Ostomy Supplies	N/A	Subject to Deductible Only; $25,000 Lifetime Maximum. Requires PRE-CERT for In and Out of Network Svcs.	50% of Cost; $25,000 Lifetime Maximum In/Out combined.	50% coinsurance, no deductible; $25,000 Lifetime Maximum In/Out combined.
Therapy Services	N/A	Physical, Occupational and Speech Therapies: Subject to Deductible Only 30 Visits per member, per calendar year.	Physical/Occupational/Speech Therapy 30 Visits Per Contract Year In/Out Combined; Subject to Office Copay	Physical/Occupational/Speech Therapy 30 Visits Per Contract Year In/Out Combined; Subject to Deductible and Coinsurance
Cardiac Rehabilitation	N/A	Subject to Deductible Only 36 Visits per member, per calendar year.	36 visits for short-term acute diagnosis in/out combined; Subject to Office Copay	36 visits for short-term acute diagnosis in/out combined; Subject to Deductible and Coinsurance
Organ Transplants	N/A	Subject to Deductible Only Requires PRE-CERT.	Subject to Copays as Noted for Medical Svcs	Covered In Network Only
Home Health Care	N/A	Subject to Deductible Only 60 Visits per member, per calendar year. Subject to Deductible. Requires PRE-CERT.	60 visits per contract year in/out combined; Subject to Office Copay	60 visits per contract year in/out combined; 20% Coinsurance, no deductible
Skilled Nursing Facility	N/A	Subject to Deductible Only 60 Days per member, per calendar year. Requires PRE-CERT.	60 days per contract year in/out combined; Covered in full	60 days per contract year in/out combined; Subject to Deductible and Coinsurance
STUDENT/DEPENDENT COVERAGE				
Riders	N/A	Full Time Student to 25	Unmarried Dependent to Age 23	Same as In Network Benefit
PRESCRIPTION COVERAGE				
Applicable Riders	See Pharmacy Riders List	After Deductible: $10 Formulary Generic $30 Formulary Brand $50 Non-Formulary	See Pharmacy Riders List	Covered In Network Only

MVP reserves the right to adjust rates off-cycle for any Federal or State assessments and benefit mandates that are imposed on health plans.

Created By: Trevor Serraro
Phone #: 914-277-8600

Effective Date: 01/01/2010
Group Name: Company 1X

SERVICES	Quote 1 (EPO Preferred-E0299S)	Quote 2 (HDHP EPO Preferred-NEHD08S)	Quote 3 (PPO Preferred-P0237S)	
	In-Network	In-Network	In-Network	Out-Network
Pharmacy Rider				
Rider_1	500S - $10 Prescription Drug Generic Only	NEHD-011 - Contraceptive Prescription Drug Add on (Group)	500S - $10 Prescription Drug Generic Only	500S - $10 Prescription Drug Generic Only
Rider_2	520S - Contraceptive Drug Add On	NEHD-011 - Contraceptive Prescription Drug Add on (Group)	520S - Contraceptive Drug Add On	520S - Contraceptive Drug Add On
Rider_3	N/A	N/A	525PS - Open Rx for PPO	525PS - Open Rx for PPO
Medical Rider				
Rider_1	N/A	NEHD-007 - NEHD-007 - NATIONWIDE Network Rider	N/A	N/A
Rider_2	N/A	NEHD-007 - NEHD-007 - NATIONWIDE Network Rider	N/A	N/A
Monthly Rates				
Single (per enrolled employee)	$450.92	$296.66	$518.61	
Double (per enrolled employee)	$901.84	$593.32	$1,037.22	
Parent + Child(ren) (per enrolled employee)	$885.71	$583.27	$1,018.83	
Family (per enrolled employee)	$1,305.28	$859.55	$1,501.43	
Group Monthly Premium	**$3,543.75**	**$2,332.80**	**$4,076.09**	
Yearly Rates				
Single (per enrolled employee)	$5,411.04	$3,559.92	$6,223.32	
Double (per enrolled employee)	$10,822.08	$7,119.84	$12,446.64	
Parent + Child(ren) (per enrolled employee)	$10,628.52	$6,999.24	$12,225.96	
Family (per enrolled employee)	$15,663.36	$10,314.60	$18,017.16	
Group Annual Premium	**$42,525.00**	**$27,993.60**	**$48,913.08**	

MVP reserves the right to adjust rates off-cycle for any Federal or State assessments and benefit mandates that are imposed on health plans.