

We specialize in providing Employers with benefits options to match their specific needs

PAYROLL PROCESSING AND TAX FILING

- *flexible payroll reporting options including phone, fax, PC or Internet
- *automated calculations, depositing, filing and reconciling of payroll taxes
- *check signing, stuffing and delivery by bonded courier or direct deposit
- *50 years experience in payroll processing and business services

DENTAL INSURANCE PLANS FOR SOLE PROPRIETORS AND SMALL GROUPS

- *in and out of network benefits
- *orthodontia benefit options

*exclusive plan offerings from the Guardian, Oxford Benefit Management and United Concordia

*vision, hearing and work/life services also available

COMPETITIVE RATES FOR WORKERS' COMPENSATION AND NYS DISABILITY PLANS

RECEIVE CUSTOMIZED QUOTES ON ANY OF THE FOLLOWING BENEFIT PLANS

- MEDICAL INSURANCE PLANS
- DENTAL INSURANCE PLANS
- SECTION 125 PLANS (CAFETERIA PLANS)
- GROUP LIFE INSURANCE
- INDIVIDUAL LIFE INSURANCE
- NYS DISABILITY INSURANCE
- GROUP SHORT TERM DISABILITY INSURANCE
- GROUP LONG TERM DISABILITY INSURANCE
- RETIREMENT PLANS
- INDIVIDUAL LONG TERM DISABILITY INSURANCE
- HEALTHCARE FLEXIBLE SPENDING ACCOUNT
- DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT
- (SECTION 125 PLAN REQUIRED FOR FLEXIBLE SPENDING ACCOUNTS)

AFLAC/COLONIAL PRODUCTS INCLUDING:

- SHORT TERM DISABILITY
- ACCIDENT INSURANCE
- CANCER INDEMNITY INSURANCE
- DENTAL INSURANCE

MEDICAL PLANS AVAILABLE FOR SOLE PROPS

PLAN DESIGNS OFFERED THROUGH MVP & CDPHP

	MVP	MVP	CDPHP	CDPHP
	HMO	EPO	HMO	PPO
IN NETWORK BENEFITS				
OFFICE VISIT CO-PAY				
PRIMARY	\$25.00	\$30.00	\$25.00	\$20.00
SPECIALIST	\$40.00	\$50.00	\$25.00	\$20.00
DEDUCTIBLE				
SINGLE	N/A	N/A	N/A	\$200.00
FAMILY	N/A	N/A	N/A	\$500.00
COINSURANCE				
SINGLE	N/A	N/A	N/A	N/A
FAMILY	N/A	N/A	N/A	N/A
HOSPITALIZATION	\$500.00	\$500.00	\$500.00	\$240 After Ded.
EMERGENCY CO-PAY	\$100.00	\$100.00	\$100.00	\$75 After Ded.
OUT OF NETWORK BENEFITS				
OFFICE VISIT COPAY				
PRIMARY	N/A	N/A	N/A	70% After Ded.
SPECIALIST	N/A	N/A	N/A	70% After Ded.
DEDUCTIBLE				
SINGLE	N/A	N/A	N/A	\$1,000.00
FAMILY	N/A	N/A	N/A	\$2,500.00
COINSURANCE				
SINGLE	N/A	N/A	N/A	70%
FAMILY	N/A	N/A	N/A	\$3,000.00
FAMILY	N/A	N/A	N/A	\$7,500.00
PRESCRIPTION BENEFIT				
ANNUAL DEDUCTIBLE (WAIVED FOR GENERIC)	\$100.00	N/A	N/A	\$250.00
GENERIC	\$10.00	\$10.00	50%	\$10.00
PREFERRED BRAND NAME	\$30.00	\$30.00	50%	\$30.00
NON-PREFERRED BRAND NAME	\$50.00	\$50.00	50%	\$50.00
Annual Max	Unlimited	Unlimited	Unlimited	Unlimited
Monthly Rates:				
Employee	\$483.49	\$493.35	\$440.20	\$443.30
Employee/Spouse	N/A	N/A	N/A	N/A
Employee/Children	N/A	N/A	N/A	N/A
Family	\$1,252.09	\$1,289.32	\$1,129.12	\$1,137.06

*Payment is due quarterly in advance to TriState Special Marketing Corporation

*A \$5.00 billing fee is applied to all monthly bills

* Rates are guaranteed through January 1, 2009



FOR SOLE PROPRIETORS

- Group Insurance
- Employee Benefits
- Payroll Services
- Benefit Administration

Greater Southern Dutchess Chamber of Commerce
 The Nussbickel Building
 2582 South Avenue
 Wappingers Falls, NY 12590
 Phone: 845-296-0001 Fax: 845-296-0006
 sharonm@gsdcc.org



SOLE PROPRIETOR HEALTH INSURANCE PROGRAMS-2008

	Oxford Plan # 1 Freedom Metro POS www.oxhp.com		Oxford Plan # 2 Freedom Metro POS www.oxhp.com		Oxford Plan # 3 Freedom Direct POS www.oxhp.com		Oxford Plan # 4 Liberty EPO www.oxhp.com		Oxford Plan # 5 Freedom POS www.oxhp.com		Oxford Plan # 6 Freedom HSAs www.oxhp.com		Oxford Plan # 7 Liberty Direct POS www.oxhp.com		Oxford Plan # 8 Freedom EPO www.oxhp.com	
Monthly Rates	Individual:	\$592.43	Individual:	\$550.47	Individual:	\$531.20	Individual:	\$434.76	Individual:	\$486.70	Individual:	\$294.94	Individual:	\$413.21	Individual:	\$457.34
	Emp & Spouse:	\$1,303.35	Emp & Spouse:	\$1,211.03	Emp & Spouse:	\$1,168.63	Emp & Spouse:	\$956.47	Emp & Spouse:	\$1,070.75	Emp & Spouse:	\$648.88	Emp & Spouse:	\$909.05	Emp & Spouse:	\$1,006.17
	Emp/Child(ren):	\$1,096.01	Emp/Child(ren):	\$1,018.38	Emp/Child(ren):	\$982.72	Emp/Child (ren):	\$804.31	Emp/Child (ren):	\$900.42	Emp/Child (ren):	\$545.64	Emp/Child (ren):	\$764.43	Emp/Child (ren):	\$846.10
	Family:	\$1,836.55	Family:	\$1,706.46	Family:	\$1,646.72	Family:	\$1,347.74	Family:	\$1,508.78	Family:	\$914.31	Family:	\$1,280.95	Family:	\$1,417.75
Referral Requirement	Referrals Required		Referrals Required		No Referrals Required		No Referrals Required		No Referrals Required		No Referrals Required		No Referrals Required		No Referrals Required	
Deductible	In-Net: N/A		In-Net: N/A		In-Net: \$500/\$1,000		In-Net: N/A		In-Net: N/A		In-Net: \$2,850/\$5,700		In-Net: \$500/\$1,000		In-Net: N/A	
	Out-Net: \$1,000/\$3,000		Out-Net: \$1,000/\$3,000		Out-Net: \$1,000/\$2,000		Out-Net: N/A		Out-Net: \$3,000/\$9,000		Out-Net: N/A		Out-Net: \$1,000/\$2,000		Out-Net: N/A	
Lifetime Maximum	Unlimited		Unlimited		Out-Net: \$1,000,000		Unlimited		Unlimited		Unlimited		Out-Net: \$1,000,000		Unlimited	
Coinsurance	In-Net: 100%		In-Net: 100%		In-Net: 90% of \$10,000		In-Net: 100%		In-Net: 100%		In-Net: 100%		In-Net: 90% of \$10,000		In-Net: 100%	
	Out-Net: 70% of \$10,000		Out-Net: 70% of \$10,000		Out-Net: 70% of \$10,000		Out-Net: N/A		Out-Net: 70% of \$10,000		Out-Net: N/A		Out-Net: 70% of \$10,000		Out-Net: N/A	
Office Co-payments	In-Net: \$15/\$25 Copay		In-Net: \$25/\$40		In-Net: \$15/\$25 Copay		In-Net: \$25/\$50		In-Net: \$30/\$50		In-Net: 100% After Deductible		In-Net: 90% After Deductible		In-Net: \$25/\$50	
	Out-Net: 70% after Deductible		Out-Net: 70% after Deductible		Out-Net: 70% after Deductible		Out-Net: N/A		Out-Net: 70% after Deductible		Out-Net: N/A		Out-Net: 70% after Deductible		Out-Net: N/A	
Hospitals	In-Net: \$100 Inpatient Copay / \$100 Outpatient Surgery Copay		In-Net: \$250 per day (\$1,250 calendar yr max), \$250 Outpatient Surgery Copay		In-Net: 90% after Deductible		In-Net: \$300 per day (5 day max) Inpatient/\$300 Copay Outpatient Surgery		In-Net: \$500 per admission Inpatient/\$500 Copay Outpatient Surgery		In-Net: 100% After Ded		In-Net: 90% After Deductible		In-Net: \$300 per day (5 day max) Inpatient/\$300 Copay Outpatient Surgery	
	Out-Net: 70% After Deductible		Out-Net: 70% after Deductible		Out-Net: 70% After Deductible		N/A		Out-Net: 70% After Deductible		N/A		Out-Net: 70% After Deductible		Out-Net: N/A	
Prescription Benefits	Generic: \$10		Generic: \$10		Generic: \$10		Generic: \$10		Generic: \$15		Generic: \$10		Generic: \$15		Generic: \$10	
	Preferred: \$25		Preferred: \$25		Preferred: \$25		Preferred: \$25		Preferred: \$30		Preferred: \$25		Preferred: \$30		Preferred: \$25	
	Non-Preferred: \$50		Non-Preferred: \$50		Non-Preferred: \$50		Non-Preferred: \$50		Non-Preferred: \$60		Non-Preferred: \$50		Non-Preferred: \$60		Non-Preferred: \$50	
	\$50 Annual Deductible- Waived for Generic.		\$50 Annual Deductible- Waived for Generic.		\$50 Annual Deductible- Waived for Generic.		\$50 Annual Deductible- Waived for Generic.		\$100 Annual Deductible- Waived for Generic.		Subject to Deductible		\$100 Annual Deductible- Waived for Generic.		\$100 Annual Deductible- Waived for Generic.	
	Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: Unlimited		Annual Maximum: \$3,000		Annual Maximum: Unlimited		Annual Maximum: \$3,000		Annual Maximum: Unlimited	
Emergency Room	\$75 Copay Waived If Admitted		\$75 Copay Waived If Admitted		\$100 Copay		\$75 Copay Waived If Admitted		\$150 Copay Waived If Admitted		In-Net: 100% After Ded		90% After Deductible		\$75 Copay Waived If Admitted	
Dependents	19/23 yrs		19/23 yrs		19/23 yrs		19/23 yrs		19/23 yrs		19/23 yrs		19/23 yrs		19/23 yrs	
Mental Health Inpatient (Biologically based mental health services treated as any other illness)	In-Net: \$100 per admission (30 days max per calendar yr.)		In-Net: \$250 copay per day- 30 days per yr. max (\$1,250 Calendar max)		In-Net: 90% After Deductible-30 days per yr. max		In-Net: \$300 per day (5 day max) 30 Days per calendar yr max.		In-Net: \$500 per admission- 30 Days per calendar yr max.		In-Net: 100% After Deductible- 30 days per yr. max		In-Net: 90% After Deductible-30 days per yr. max		In-Net: \$300 per day (5 day max) 30 Days per calendar yr max.	
	Out-Net: 70% after Deductible (30 days max per calendar yr.)		Out-Net: 70% after Deductible (30 days max per calendar yr.)		Out-Net: 70% after Deductible (30 days max per calendar yr.)		Out-Net: N/A		Out-Net: 50% after Deductible (30 days max per calendar yr.)		Out-Net: N/A		Out-Net: 70% after Deductible (30 days max per calendar yr.)		Out-Net: N/A	
Mental Health Outpatient (Biologically based mental health services treated as any other illness)	In-Net: \$25 Copay per office visit (30 visits max per calendar yr.)		In-Net: \$40 Copay per office visit (30 visits max per calendar yr.)		In-Net: 90% After Deductible-30 visits per yr. max		In-Net: \$50 Copay per office visit (30 visits max per calendar yr.)		In-Net: \$50 Copay per office visit (30 visits max per calendar yr.)		In-Net: 100% After Deductible- 30 visits per yr. max		In-Net: 90% After Deductible-60 days per yr. max		In-Net: \$50 Copay per office visit (30 visits max per calendar yr.)	
	Out-Net: 70% after Deductible (30 days max per calendar yr.)		Out-Net: 70% after Deductible (30 days max per calendar yr.)		Out-Net: 70% after Deductible (30 days max per calendar yr.)		Out-Net: N/A		Out-Net: 50% after Deductible (30 days max per calendar yr.)		Out-Net: N/A		Out-Net: 70% after Deductible (60 days max per calendar yr.)		Out-Net: N/A	
Chiropractic	In-Net: \$25 Copay		In-Net: \$40 Copay		N/A		In-Net: \$50 Copay		In-Net: \$50 Copay		In-Net: 100% After Ded		N/A		In-Net: \$50 Copay	
	Out-Net: 70% After Deductible		Out-Net: 70% After Deductible		N/A		N/A		N/A		N/A		N/A		N/A	

Payments are due quarterly in advance to TriState Special Marketing Corp.

****A \$15.00 billing fee is applied to all quarterly bills****