

**New York State Health Insurance Program
Dental and Vision Coverage (non-GSEU Enrollees)
Rates Effective January 1, 2020**

Dental Plan (Preferred Plan)

	Monthly Net Rate	Monthly Enrollee Cost	Net Rate/ Biweekly Cost(1)
Full Share Employer Cost			
Individual	24.14	-	11.08
Family	67.96	-	31.19
COBRA (Full Share Enrollee Cost)			
Individual	24.14	24.14	
Family	67.96	67.96	

Vision Plan*

	Monthly Net Rate	Monthly Enrollee Cost	Biweekly Cost(1)
Full Share Employer Cost			
Individual	4.06	-	1.86
Family	9.23	-	4.24
COBRA (Full Share Enrollee Cost)			
Individual	4.06	4.06	
Family	9.23	9.23	

* Excludes NYSCOPBA (A04, A48, C04 & C48), APSU (A37 & C37) & Council-82 (A25, A50, C25 & C50)

Vision Plan with Laser Vision Benefit**

	Monthly Net Rate	Monthly Enrollee Cost	Biweekly Cost(1)
Full Share Employer Cost			
Individual	7.90	-	3.63
Family	13.07	-	6.00
COBRA (Full Share Enrollee Cost)			
Individual	7.90	7.90	
Family	13.07	13.07	

** NYSCOPBA (A04, A48, A64, C04, C48 & C63), APSU (A37 & C37) & Council-82 (A25, A50, C25 & C50)

(1) for LWOP rates.